

Psycho-social  
REHABILITATION  
in burn care  
for Children AND  
Young People

Why me?  
What will  
I LOOK LIKE?  
When will  
I FEEL better?  
WHO can I TALK to?  
how will I COPE?








## Introduction **Why this training?**

This training aims to make sure all staff working in or with burn services in London and the South-East have appropriate knowledge of the psycho-social aspects of care for their job role. While hospitals provide good physical care, a major review in 2001 suggested that psycho-social support for burn patients could be improved. Burn care standards published in 2008 aimed to do this. This training is designed to promote, encourage and embed the National Burn Care Group standards for psycho-social care into the patient care pathway.

Depending on your job role, we recommend that you follow either the adult tier one, two or three manuals and/or the children and young people's training. You should agree which is best for your role with your line manager. You may benefit from more than one level of training.

Our training can be delivered in many different ways, from self-directed study to group training sessions. Your trainer will suggest the best approach for you and your team. Throughout the course you will take part in reflection, discuss case studies and recap theoretical information. We've provided references throughout for further information.

**Throughout the manual you will see a variety of symbols. These are:**

	<p><b>Key information</b></p>
<p><i>These sections provide a discussion of some of the important theoretical information and knowledge relating to the key aims of the module. These sections can be taught with the aid of the PowerPoint slides.</i></p>	
	<p><b>Case study</b></p>
<p><i>These sections introduce a patient scenario. Each one is usually followed by some questions or a structured discussion on the issues raised. You can replace the case studies with your own if you think it would be more appropriate.</i></p>	
	<p><b>Task</b></p>
<p><i>These are tasks designed to encourage thinking and learning around the main teaching points. Active participation in tasks will lead to optimal learning.</i></p>	
	<p><b>Reflection</b></p>
<p><i>Students are asked to reflect on their own experiences and patients they have worked with to encourage integration of their learning into their work. Although learners can reflect individually, they will gain more from sharing experiences.</i></p>	
	<p><b>Further reading</b></p>
<p><i>Further information such as journal articles, books and web links are given here.</i></p>	



## Module 1 Children, young people and burn injuries

**Aim: To review how burn injuries can have a psycho-social impact on children, young people and their families.**

Unfortunately, burns – accidental and non-accidental – are very common. Around 175,000 people with burns go to UK Accident and Emergency Units each year, with 16,100 being admitted to hospital. Approximately 6,400 of these admissions are people under the age of 16 (National Burn Care Review, 2001 cited in Phillips and Rumsey, 2008). The most common type of burn injury is scalds, which make up an estimated 60% of all burn cases (Alnababtah et al, 2011).

Burn injuries can range from minor to extremely severe. For those who survive, the psychological and social consequences can be far reaching. Burn injuries can be very traumatic for children, young people, and their families and friends.

For children and young people with moderate to severe injuries, hospital stays may be long and repeated, over many years and in some cases, continue for the child's entire life. Surgical, therapeutic and medical regimes can be lengthy and arduous. Other psychological and social effects for children, young people and their families can include pain, trauma and changed appearance.

*We use 'parents' throughout this manual as a general term. However, please note that this also refers to a child's non-parental carers or guardians where applicable.*



### The unique needs of children and their families

Psycho-social care is a general term used to describe psychological and social support given to patients. Every patient admitted to a burn unit has significant physical needs that require attention from a multi-disciplinary team. However, many children, young people – and their families and friends – also need support and reassurance in their personal and social life. Without it, patients may never completely recover from their trauma or adapt to their injuries and new appearance. This can cause long-term psychological and social difficulties. Ultimately, the patient may withdraw from society, struggle in school or work and not feel able to live a full and happy life.

The term 'quality of life' is used to reflect how well a patient adapts to their changed physical, psychological and social circumstances. The more difficulties they have, the more it will affect their quality of life. Some children and young people and/or their families will show a lot of resilience and 'bounce back' from the trauma. However, others will find it more difficult. Comprehensively meeting a patient's needs and helping them to help themselves will increase their well-being and overall quality of life.



### Case study one: Monique

Monique is four years old. She has 7% partial thickness scalds to her face, hands and chest after pulling a recently boiled kettle down from the kitchen worktop. The swelling from Monique's injuries has temporarily affected her eyesight. She has been in hospital for two days and is likely to stay there for at least a few more days.



### Task

Put yourself in Monique's shoes. What might some of her concerns be? What do you think the hospital experience will be like for a four-year-old with significant and painful injuries?

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Put yourself in Monique's parents' shoes. What might some of their concern/fears be?

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### Developmental needs of children

Hospitalisation early in a baby's life can lead to delayed development. Stress, the body focusing on healing and the psychological, social and physical suspension of a normal routine may result in a baby learning to talk or walk later than expected. The baby's behaviour will change, which parents or ward staff may notice. The child may become more 'clingy', distant or fearful. If an infant had already begun walking, they may return to crawling or sitting on your lap. Similarly, a baby who is eating solids may now want a bottle again.

Older children in your care may also show signs of regression after serious and life threatening injury. This can become clear in behaviour like thumb sucking, lack of concentration, becoming tired easily, baby talk, and wanting to sleep in their parent's bed. This is usually the child's way of dealing with stress, fear, loneliness and/or pain. Regression should be explained to parents so they can understand the change in their child's behaviour. With love, comfort, presence and normal daily routine, these feelings of vulnerability

should begin to pass and the child's confidence should return. However, in some cases professional intervention may be needed.

**Top tips**

- Advise parents that reversing regression takes time – months in some cases. They should encourage their child rather than trying to force change and becoming angry or upset.
- Advise parents not to overcompensate and keep routines the same.



**Case study one: Monique (continued)**

Monique has been in hospital for a week now. The swelling to her eyes is returning to normal. However, she is still experiencing pain and distress, especially during dressing changes. Monique has communicated well with the nursing and other staff. But recently she's stopped answering questions and seems to prefer to use 'baby talk' far below the vocabulary level you know she has, and for what is expected for an average four-year-old.



**Task**

Using your own knowledge and then referring to the developmental chart in Appendix one, what behaviour/skills would you expect Monique to demonstrate at four years old? How might she feel and act and what might her needs be?

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**Communication of distress and anxiety**

Burn injuries are unique because of the length of hospitalisation, the pain experienced and the number of surgical and medical interventions a child may have to endure. This can traumatise the child and they may remain emotionally vulnerable for a long time. Painful treatments can be seen by children as some kind of punishment and the child may have been told to 'be brave'. This can be unhelpful as it may encourage the child to suppress their fear, anger and frustration and not talk about what they are going through.



### Task

In your experience, what types of communication and behaviours do children and young people show to communicate distress and anxiety?

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### Challenging behaviours: Children

Crying, refusing to eat, withdrawing or throwing tantrums can be construed as misbehaviour. However, these are actually natural responses to being scared and in hospital. The chart below shows some ways in which a child may show their feelings:





It is important to let the child show their feelings through crying or screaming if they need to. Tell them you understand that they are scared, angry or upset. Let them know that their feelings are normal and that you are there if they need to talk about them.

**Top tip**

- Encourage talking rather than crying. For example, you could say: ‘I can see you’re upset, but try and tell me what’s happening.’



**Children, young people and pain**

Medical, surgical and therapeutic interventions for children and young people with burn injuries can be difficult, tiring, ongoing and painful. This not only causes the child a great deal of distress, but is also stressful for parents. It can impact on staff too.

Research has shown that if a child is very anxious and distressed before a medical or surgical procedure, the pain they experience can be worse.

Research has also shown that children and their families commonly identify painful procedures as the aspect of medical care they fear most (Royal College of Nursing, 2009). It is crucial that children are well prepared for painful procedures and that medical staff listen to them and respond if they show signs of pain. This is especially important because a negative hospital experience can lead to ‘fear and avoidance of medical care’ in the future (Noel et al, 2010).

It can be difficult to determine if a child is in pain, distressed or anxious, especially as procedural pain is hard to assess and so is often under-treated (Gandhi et al, 2010). It can be useful to look for changes in the child’s behaviour, appearance, activity level and observations. You should also remember that language, ethnicity and cultural factors influence how a child expresses pain (Royal College of Nursing, 2009). Some cultures express pain very openly, while others do not. Children and young people may also express anger towards parents for ‘putting them through it’. Module two has advice on how parents can deal with this.



**Preparation for procedures**

Trying to address the child or young person’s worries before medical or surgical procedures can be helpful. Some worries you can talk through are:



For children and adolescents, being involved in preparation for procedures can be a positive experience. Providing an honest, accurate, verbal and visual (if possible) account of the procedure can help prepare them and can be an opportunity to correct and deal with any misunderstandings, worries or fears the child or family have.

### **Top tips**

- Tailor your approach for each individual. The way you explain a procedure should vary greatly depending on the age of the child/adolescent, their developmental level, individual preferences and cultural needs.
- Language should always be simple, clear and honest. It is also important to remember to use child-sensitive language, for example 'make an opening' instead of 'cut' (LeRoy et al, 2003).
- Good practice guidelines suggest that you should cover what the procedure might feel like (for example, a cold or warm sensation), what colours, smells or sounds the child/young person might encounter (for example, the sound the equipment will make) and also how they are likely to feel after.
- Get the child/young person involved in the discussion as much as possible and encourage them to ask questions. This will help the child/young person feel more in control of the situation. You could also find out about their previous experiences in hospital.
- Research indicates that for younger children (age three to five years), anxiety levels are managed most effectively if the child is prepared for surgery the night before. On the other hand, older children (age five to 12 years) respond more positively when the information is presented to them a week before surgery (LeRoy et al, 2003).
- There is strong evidence to suggest using relaxation strategies is an effective technique to control chronic pain (Eccleston et al, 2002).



### **Medical language and terminology**

Medical jargon and terminology can easily slip into conversations with children and their families. Poor communication and the use of specialist medical words can cause the child and their family to feel anxious and intimidated. Young people and their families may already think that they won't be able to understand the treatment, interventions or what is said to them. Using medical jargon can exacerbate this anxiety. The knock on effect could be the child or young person misunderstanding what they have to do as part of their treatment or during a procedure.

### **Top tips**

- It is often easier to describe a procedure, rather than refer to it by its technical name.
- Check what language the child uses to describe their injuries/treatment and body parts. They may have words they prefer to use and are appropriate for their age.
- Ask directly what the child and family's understanding of the treatment/procedure is.
- If you talk about treatments or procedures to colleagues in front of the child and/or family always explain what you have said to them afterwards using lay language.
- Ask what the child and family are most frightened of – this is a good opportunity to alleviate their fears and correct any misunderstandings.



## Involvement of parents in procedures

Evidence suggests that children prefer their parents to be present and are likely to experience less distress this way. This may also benefit the parents (Piira et al, 2005), perhaps helping to lessen their own anxiety as it allows them to feel that they are able to help in some way, thus relieving feelings of helplessness and loss of control that are

so common in parents of hospitalised children.

It is useful to spend time with the parent before they become involved in the procedure. Parents benefit from an explanation of exactly what the intervention involves so they understand their role in the procedure better and can be guided by staff (Bauchner et al, 1994). Leaflets and written guidance given in advance can also help prepare the family for taking an active and constructive role in the process. Parents can also help by holding and comforting their child, using distraction, encouraging them with coping techniques, and praising them for cooperation.



## Further reading

- **Good practice in postoperative and procedural pain.** Published by the Association of Paediatric Anaesthetists (2008).
- **Good practice guidelines for the management of invasive and/or distressing procedures with children.** Published by the British Psychological Society (2010).
- **Management of pain in children with burns** by Gandhi et al. Published in the International journal of pediatrics (2010).



## Distraction techniques

It is possible to use pharmacological interventions such as sedation, pain relief and topical anaesthesia to reduce pain and distress. However, this is not always practical and often not suitable throughout the whole rehabilitation process.

Staff may become less sensitive to a child's discomfort, pain (as well as fear of pain) and want to 'just get the dressing change over and done with as soon as possible' without making sure that appropriate sedation and/or distraction is in place. This can lead to more distress next time and anxious parents.

Non-pharmacological interventions for reducing pain and distress, including distraction techniques, have proven effective in a range of clinical settings. They have many advantages over medical options and are low-cost. Getting parents involved in distracting their child also gives them a vital role and may help lower their anxiety.

When choosing an appropriate distraction technique you will need to consider the child's age and stage of development. We have included a table outlining age-appropriate distraction techniques in the Appendix. Books, nursery rhymes, cartoons, television, bubbles, jokes and games can all be useful. Talking with the child will also work in some cases.

Some children may prefer to be involved in their treatment, which can help distract them from any pain. You can use stickers as a reward after the child has been through a long and painful procedure, or has been particularly good during a dressing change.

### Top tips

- Making a child laugh is a good distraction technique – it is difficult to laugh and cry at the same time.
- Try using items that are familiar to the child, such as their favourite teddy.





BC Hospital, 2009

As mentioned in the diagram above, access to the internet is very important to many adolescents. Social networking sites can be beneficial for adolescents, allowing them to connect with the 'outside world', stay in contact with friends, and providing a forum for them to express their feelings and thoughts. However, the social norm of regularly 'updating' online contacts about your experiences and feelings can also have drawbacks for adolescents, families and friends.



### Case study two: Declan

Declan is 15 years old and suffering from 15% deep dermal burn injuries caused in a house fire. To pass the time in hospital, he uses his laptop. You have noticed that he spends a lot of time on social networking sites. Recently you have observed that he gets particularly agitated and upset after using his laptop, and seems to have withdrawn into himself.

What do you think might be worrying Declan? How might you best support him?

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### Useful online resources for teenagers

- iFace, Changing Faces (a network for young people with disfigurements)  
[www.iface.org.uk](http://www.iface.org.uk)
- Teens First for Health, Great Ormond Street Hospital  
[www.childrenfirst.nhs.uk/teens](http://www.childrenfirst.nhs.uk/teens)
- ChildLine website  
[www.childline.org.uk](http://www.childline.org.uk)

## Module 2 Parents and families

**Aim: To review how to recognise and understand parents' and families' physical, psychological and social needs.'**

When a child or young person has burn injuries, it affects parents, siblings and other close family members too. They face many challenges. Parents will usually be a significant source of support and will be key to helping their child recover both physically and psychologically. It is important to remember that if parents and families cope well themselves, they will be able to provide better long-term support for the child. But they may have lost confidence in their ability to care for their child and keep them safe.



### Case study three: Peter and Annie

Peter and Annie have been through a worrying 24 hours. Their son Jonny, who is two years old, climbed out of his bed and fell, trapping himself next to a boiling hot radiator. They heard Jonny cry, but delayed responding as they hoped he would settle back down. Jonny was brought by ambulance to the local burn centre. He is acutely unwell and sedated. Peter and Annie have not left him in the last 24 hours and you notice they haven't eaten, taken a break or slept.



### Task

What are the main worries and feelings Peter and Annie could have at this time?

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### Parents' ability to cope

Parents often feel guilty, blaming themselves for their child's injury. The temptation for them to become overprotective is understandable. Yet, the best support they can give their child is to help them manage independently. Many parents will imagine the whole world is being critical of and judging them, wondering how they could let such an accident happen. It is important to remind the parent that these feelings are entirely normal and other parents on the ward know how they are feeling. Some parents may not want to face their own feelings, instead choosing to ignore the extent of their child's injuries or seeking further surgical options to help 'fix' their child.

For most parents, being with their child in hospital, as an in- or outpatient, is a daunting and sometimes extremely overwhelming experience. It is vital to equip parents to cope with this sterile and alien environment, so they can support their child. Research has shown a strong relationship between parental emotional states, family environment and how paediatric burn survivors recover and adjust (LeDoux et al, 1998).

Financial worries relating to hospitalisation/attending appointments can also be a cause for concern and add additional pressure to the family, especially if a parent has had to take time off work to care for their child/teenager. If a parent has to give up/take time off work they should be encouraged to speak to their employer to find out what support/assistance is available to them.

### Top tips

- If parents look after themselves well, they will be able to look after their children well.
- Remind parents that, however good a parent they are, accidents still happen.
- Suggest that parents look into whether they are eligible for financial assistance such as tax credits, interest free loans or benefits.
- It can be unhelpful for staff to talk about their own parenting experience with parents on their unit.

Great Ormond Street Hospital (GOSH) gives the following advice to parents about 'How to cope in hospital':

- Nominate one person who will pass on news to everyone else. This means you only have one phone call to make to let friends and family know how your child is doing, and you do not have to repeat the same thing over and over again.
- Write down questions in advance for the medical team if you think you may forget when they come to speak to you.
- Don't be intimidated by doctors – they shouldn't mind explaining or repeating anything that you didn't understand the first time.
- Talk about your experience to your partner, family, friends and professionals.

(Adapted from original information produced by the GOSH Trust)



### Further reading

- **Relationship between parental emotional states, family environment and the behavioural adjustment of pediatric burn survivors** by LeDoux et al. Published in Burns (1998).
- **Considerations for the provision of psycho-social services for families following paediatric burn injury – a quantitative study** by Philips and Rumsey. Published in Burns (2008).
- **Coping in hospital, looking after yourself** by the GOSH Trust. Available at: [www.gosh.nhs.uk](http://www.gosh.nhs.uk) (2010).





## Parental anxiety

Making sure parents get adequate support is one of the most important aspects of good holistic care of paediatric burn survivors. Children of all ages depend on their parents. They look to them for reassurance and for an example of how to behave and relate to a situation. If a parent feels supported, confident and comfortable, their child will reflect this in their behaviour and outlook.

Making decisions about medical treatment that will help improve function and/or change their child's appearance can be difficult and emotional for parents. For many, the big question is 'should we put our child through this?'

Factors that can influence decision-making include the risk involved, the nature of the treatment and the length of time their child will have to spend in hospital or recovering. Parents usually have conflicting thoughts and emotions about painful procedures. They may feel ashamed, guilty, angry, upset, confused and/or frightened. You should explain that this is normal and part of the process of making such a hard decision.

### Top tips

- Some procedures will be difficult to watch. If the parent is worried, this anxiety may rub off on their child. In these cases, you should encourage the parent to ask someone the child trusts to be with them instead.
- It can help parents to think of past times when they have managed during difficult situations to give them a sense of emotional strength.
- Sometimes parents will be anxious because they themselves are unsure of what is happening. Always check the parent's and the child's understanding of what will happen before starting anything that may be distressing or painful.
- Parents can help their child cope by making them laugh or by talking. For older children, parents could get them to speak for 10 minutes about their favourite pop star, for example.
- If parents become overwhelmed, it can help if they try and focus on one thing at a time, such as doing what is needed today, rather than looking towards the future. This can help their situation seem more manageable.



## Clinical communication

Ineffective communication with speakers of languages other than English can lead to misdiagnosis, lack of understanding about the purpose of care and children/adolescents not doing what you ask. It can have moral, legal and professional implications too (Ledger, 2002).

There is often room for improvement when it comes to communication and building relationships with children and their families. If you are treating a non-English speaking child or family, the Language Line service or interpreters can be useful. However, it is not practical to use these every time. Inevitably, health care professionals often ask a friend or relative of the child to translate information. Children may have a better command of English than their parents so are asked to interpret or explain. This can put the child in a difficult position and should be avoided wherever possible.

When it is not possible to provide written communication in the particular language, it can be useful to

give a written summary of what has been said in English. This can be translated at a later stage, rather than the family trying to remember all the information staff tell them. Useful tips for communicating with children and families whose first language isn't English:

- Explain why you are there.
- Avoid using medical terminology and complex words.
- Speak clearly and take care to pronounce your words correctly.

Ideas to use if the patient or their family doesn't understand or you are asked to repeat yourself:

- It may be that they are having difficulty understanding particular words you are using, so perhaps change some of the more complex words in your explanation.
- Try to avoid the short form of words (isn't, hasn't, won't) or common sayings as these can be particularly difficult to understand.



### **Reflection**

Reflect on some of your recent conversations with parents who were either (1) very worried or anxious or (2) speakers of other languages. What went well and what didn't go so well? How can you make sure communication between the parent, child and multi-disciplinary team is the best it can be?



### **Engaging children and parents in the communication process**

You should encourage parents to talk to their child about their burn injuries. Parents supporting their child and helping them to build skills and confidence for handling future challenges is crucial. Parents should help their child develop a narrative that explains what happened to them which they are comfortable telling people.

It is important that parents explain what is happening to their child in simple language they know the child will understand. If the child is very young and will not understand words, the familiarity and intimacy of parent-child communication will still provide reassurance and comfort. Sometimes it can feel difficult for parents and health professionals to 'tell the child the truth'. However, not doing this will lead to a loss of trust and a far more difficult relationship in the future.

The following suggestions may work for parents who don't know what to say or how to comfort their child:

- Explain how the nurse/doctor is going to help your child (for example, by giving them medicine, making them sleepy or putting on a new bandage).
- If they ask if it 'will hurt', and it potentially will, say so, in language the child will understand.
- Reassure your child that you will stay with them (or that you will be there when they wake up).
- Talk about the hospital, who works there and encourage your child to talk to other children.

**Top tips**

- Children don't need to know everything at once. Parents can help decide how much is appropriate to tell them and at what age.
- Remind parents that they are unlikely to cause problems by talking to their child, but they may miss problems by not talking to them.
- It can be helpful for parents to engage their child in the procedure by giving them choices to make them feel like they have some control. For example, they could give their child the choice of washing themselves or being washed.
- It is very important that there is open communication within the family; parents also need to talk with siblings about what is happening and address any concerns they may have.



**Case study three: Peter and Annie (continued)**

Peter and Annie have another child called Max who is eight. Max woke up when the ambulance arrived and was scared by what had happened to his brother Jonny. Peter and Annie feel lucky to have close neighbours who offered to look after Max that night while they went to the hospital. In the morning, Max spoke to his parents on the phone and then his granny picked him up. Max has now been with his granny for three days and has seen his parents briefly a couple of times. They told him she will look after him for the rest of the week and 'to be good'.



**Task**

What might be some of Max's worries for himself and his brother? What advice could you give his parents on supporting Max?

Max's worries for himself:

Max's worries for his brother:

Advice to support Max:

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Have a look at the scenarios below. What issues may arise in these situations? Discuss and write these down.

Max has to return to school tomorrow but Jonny is still in hospital.

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Max is looking forward to visiting Jonny in hospital for the first time at the weekend.

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Max has started to misbehave and his granny says he is acting 'out of character'.

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### Siblings

As a health care professional, your concerns will centre on the child you are caring for. But it may be appropriate to consider how siblings are managing too. They may have been witness to, or even hurt in the incident. Research has shown that siblings of burn injury survivors not only struggle emotionally, but also socially and academically. Siblings can feel traumatised and also guilty that it didn't happen to them instead. They may have seen their parents in more distress than they've ever witnessed before.

Children with major burns are often cared for at a hospital many miles from home. Siblings may have little or no contact with the health care team or with family members who are with the child. It is common for siblings to be left for long periods with friends or family, told simply to 'be good', and have their daily routine change significantly. Siblings may be jealous of the attention the sick child gets too.

Siblings will also be in the position (especially if they attend the same school) of having to answer lots of questions from other children and teachers. They may feel able to do this, but they should be armed with phrases to deflect unwanted attention or questions. These could be:

- 'I think I've answered enough questions for now thank you.'
- 'My brother/sister hasn't been well, but I would rather not talk about it.'

Siblings may feel responsible for the well-being and happiness of their sibling with burn injuries at school, or they may feel a responsibility is being placed on them which they don't want or can't manage (Lehna, 2010). It is important that, as appropriate, siblings are kept informed and allowed to express their feelings and opinions.



### Further reading

- **Sibling experiences after a major childhood burn injury** by Lehna. Published in *pediatric nursing* (2010).

## Module 3 Returning to home and school

**Aim: To review some of the challenges associated with the child leaving hospital and returning to their 'normal' daily routine.**



### Case study four: Jake

Jake is 11 years old. He was injured at a party during the summer holidays when his friend put lighter fluid on the barbeque. Jake has been in hospital for some time and is starting to prepare to return home. Jake's burns were mainly to his face, torso, arms and hands. He is still having intensive physiotherapy for his hand injuries as he is finding writing and other tasks, such as eating, difficult. He is starting secondary school in September and has expressed worries about explaining the scars and his poor hand movement to his new classmates. He can't wait to go back to playing football on a Sunday and is wondering how he can be involved as he's not yet fit enough to play.



### Task

What may be some of the issues that arise when a young person like Jake prepares to return home and go to a new school?

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### Preparation for discharge

After initial hospitalisation and treatment, the child or young person and their family will start rehabilitation. Eventually, they will have to prepare to go home. This unfortunately does not mean the end of treatment as they may still have to attend dressing clinics and other hospital services. Children and their parents will need to be more responsible for their own care. This could include taking medicines, massage and wearing pressure garments. They will also have to prepare to return to school and social environments and to meet yet more professionals involved in their care. Children and their families may worry about having less information available to them after leaving

hospital. They may also be concerned about being unable to easily access the burn service, which could be many miles from their home. In addition, children and young people may be required to visit the hospital for regular appointments as there may be much more therapy and reconstructive surgery in the years to come. Recovering from burn injuries is a life-long process.

There are many worries children and their families could have about going home. Some are:

- Settling back into a 'normal routine'. For example, will parents be able to go back to work?
- Missing staff members from the ward.
- Getting used to medication, treatments and pressure garments.
- Coping with being stared at or answering questions about the way they look and what happened.
- Teasing or bullying at school.
- Catching up with schoolwork.

People may notice scarring and difference in appearance when the child or young person goes out in public. It is normal for people to notice things that look different. Young children are naturally curious and can ask very straightforward and sometimes blunt questions. Adults might stare or do a 'double-take'. They may forget to say, 'hello' and instead blurt out, 'what happened?' or ask someone with them, 'did you see that child?'. Some people are genuinely concerned. Others may be familiar with the young person's situation and offer support or a friendly word. Children and their families often report feeling completely unprepared to deal with this sort of curiosity, saying it leaves them feeling angry, upset or wary about going out.

It is normal to discuss medication, scar management, future appointments and who to call in an emergency before discharge. But it can be helpful to discuss the difficulties that children, young people and their families may come up against and how to manage them too.

The **EXPLAIN-REASSURE-DISTRACT** model helps parents and the child or young person to effectively handle other people's curiosity and/or questions:

For example, a parent can use the model to help their child interact with others at a football club by saying:

'Molly's face looks different. That's all. She likes football just like you.'

**EXPLAIN:** 'Molly's face looks different'

**REASSURE:** 'That's all'

**DISTRACT:** 'She likes football just like you'

The model is successful because it allows the parents or child/young person to:

- Make the first move in social situations.
- Act in a way that makes them feel empowered, and helps boost self-esteem.
- Resolve any curiosity.
- Model how to respond to curiosity so the young child can increase their own social skills and responses when meeting new people and dealing with difficult situations.



### Task

Look back at Jake's case study. What are some phrases Jake could use to explain what happened to the following groups?

His school friends:

Handwriting practice area for 'His school friends:' consisting of a large rectangular box with horizontal dashed lines.

His teacher:

Handwriting practice area for 'His teacher:' consisting of a large rectangular box with horizontal dashed lines.

His football coach:

Handwriting practice area for 'His football coach:' consisting of a large rectangular box with horizontal dashed lines.



### Development of own coping strategies

As professionals, we don't often have long periods to spend with patients.

However, you can give the following advice to the child or their parent at dressing changes, during a physiotherapy session or even during discharge planning. For older children or teenagers, it could be useful to put it in an information leaflet that they can think through or work on as a task.



### Helping the child find their own narrative:

- Discuss the words they want to use and encourage them to describe their scars factually or in a fun way. For example, they may prefer 'bendy' scar to 'horrible' scar.
- Write down, or get them to write down, a few things they might like to say to people (being mindful that they need a variety of responses, including an 'explanation' statement and a 'moving the conversation on' statement).
- Let them choose their favourite responses. If they want, they can write these on a card and keep it in their pocket or somewhere special.
- When they are comfortable with their responses, suggest they try them out. Try an easy situation first (for example, with a friend when you are nearby).
- Ask how this first experience felt and make any changes to help the child feel more confident.
- Remind the child or young person who they can turn to when things don't go well.



### School reintegration/transition

Returning to school is a big part of successful rehabilitation. School forms an important part of a child or young person's world. Their daily routine of lessons and play, learning and spending time with friends, will have been interrupted by hospitalisation and rehabilitation. Absence from school will affect them both socially and academically.

Children who have injuries from burns and scalds are also likely to miss more days from school in the future when they return for reconstructive surgery. However, it is important to remember that most children will adapt well, return to school and catch up academically if they are given the appropriate support.

Research has shown that parents play a vital role in the returning to school process (Horridge et al, 2010). Sometimes there is a period of intermediate rehabilitation at home where children or young people may be home-schooled. Parents' confidence in themselves, their children and their children's school is very important.

As much as possible, school reintegration needs to be carefully managed. Below are some useful tips for doing so.

#### Top tips

- The child and family can role play going back to school. This may highlight any concerns the child has.
- Suggest the parents contact their child's teacher or head teacher and request a meeting to share information before the child returns to school.
- The child or young person may be entitled to special dispensation for exams and missed coursework. The medical team can provide a supporting letter.
- The child or young person may benefit from extra tutoring to help them catch up. Their school may be able to provide this.
- Suggest that the parent organises regular meetings with their child's teacher(s) to find out how they are managing socially, what coping strategies they are using and whether they are effective.



- Let the parent know about any school rehabilitation programmes or school specialists you have in the hospital. If there is no access to this service in your organisation, give them information about Changing Faces' school specialists. They provide training, information and advice for teachers in schools.
- Many families worry about how massage will continue when the child or young person returns to school. Encourage them to think about their worries and discuss them with the school nurse.



### Further reading

- **BurnEd: parental, psychological and social factors influencing a burn-injured child's return to education** by Horridge et al. Published in Burns (2010).



### Bullying and appearance-related concerns

Although not every child who returns to school with burn injuries will be bullied, they may be more susceptible to it. Children become more sensitive and judgemental about appearance as they grow older. Teasing and bullying can involve name calling, making fun, taunting, pushing, hitting and threatening. Cyber bullying is when a person, or a group of people, uses the internet, mobile phones or other digital technologies to threaten, tease or abuse someone (ChildLine, 2011).

Children who look noticeably different are particularly vulnerable to taunting and teasing. But it is important to stress to the family that just because the child looks different, it does not mean that they will automatically be bullied.

### Dealing with it:

The advice to 'just ignore it' is not an effective strategy. It is important to reinforce a child's sense that adults can help and to increase their feelings of control and confidence. All reports of teasing, name calling and bullying should be taken seriously and an adult (for example, a parent, carer or teacher) should challenge all unkind behaviour.

#### Advice for parents:

- If you are there when bullying happens, be firm and understanding. Let the other child know that it is not OK to name call, threaten or bully and tell them what behaviour you would like to see. You may want to speak to their parent or teacher.
- Teach them how to walk away from a situation: Look confident, walk as calmly as possible, use positive self-talk ('I can spend time with people I like' or 'I will go and find my friends') and discuss a safe place, or person they could go to.
- Encourage them not to react aggressively to name calling – bullies thrive on a reaction.
- Encourage your child to stick up for themselves by using the 'fogging' technique to respond to verbal taunts: Look confident, use a calm, friendly and puzzled tone of voice, use rehearsed phrases – 'so!' or 'excuse me?' or 'and the point is?' – then walk away feeling in control.
- Encourage your child to talk about their feelings.
- Encourage your child to spend time with supportive friends.
- Organisations such as ChildLine, Changing Faces or the Anti-Bullying Alliance have more useful advice and support.



### Making the decision between functional and cosmetic interventions

Burn scars, especially moderate to severe ones, take months and maybe even years to mature. They often result in ongoing hospitalisation and treatment, and may need further surgery to reconstruct areas, relieve pain and discomfort and improve functionality.

However, as surgical techniques advance, much more can be done to 'improve' the appearance of scars too. Addressing 'aesthetic imperfections' is a financial and psychological challenge for the service provider, children, young people and their family.

Often patients and their families will want surgical interventions sooner rather than later. They can sometimes appear impatient and may have unrealistic expectations about what the surgery can achieve. They may find it useful to speak to other children and parents who are 'further down the line' to help them make informed decisions. It is important for the child and their family to know they can be part of the decision-making process.

Before the child or young person and their parents make their decision, it is important to make sure they have:

- Talked through the procedure and its risks and benefits with the surgeon and medical team.
- Thought about the questions they want to ask beforehand.
- Asked for a second opinion if they still feel unsure.
- Spoken to families who have already had treatment if they wish to.
- Had time to talk through the options as a family.

In some cases, children and parents may turn down procedures that are deemed to be for cosmetic or aesthetic purposes only. They may be happy with the way they look and may have adjusted well to their injury and subsequent scarring. They may also just want to take a break from arduous treatment and surgical interventions, before considering the procedure again in the future. This option to defer treatment should be explained clearly to the child or young person and their family.

### **Top tip**

- Get the patient and their family to write down all their questions about the surgery or treatment. Ensure their questions are answered before they agree to it.



### **Further reading**

- **Managing the future after burns: My child has burns, a guide for parents** by Clarke and Kish. Published by Changing Faces (1999).

## Module 4 Working with young people, children and families

**Aim: To review the challenging aspects of providing care in a burns environment.**



### Case study five: Denzel

Denzel is eight months old and has been admitted to the unit with scald injuries to his lower legs. There is a clear upper limit to the scalded skin area, which is of uniform depth.

The mother explains that ‘the little ‘un switched on the bath tap and climbed in, and stood in the scalding water. It was horrible’. She becomes tearful when she describes how she found him screaming in pain and saw layers of skin falling away like paper.



### Task

How does this make you feel?

Handwriting practice area with five horizontal dashed lines.

What are your concerns?

Handwriting practice area with five horizontal dashed lines.

What do you need to consider?

Handwriting practice area with five horizontal dashed lines.

Who do you seek support from?

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### Non-accidental injuries

Most children and young people you come into contact with will have accidental burn and scald injuries. However, an estimated 6-10% of cases on a paediatric unit will be non-accidental (intentional) or caused by neglect.

Child abuse and neglect have long-term consequences, both physically from injuries but also psychologically. The child may go on to experience low educational attainment, difficulty with relationships, have other mental health problems such as depression, anxiety and eating disorders as well as have low self-esteem. Health professionals are in an ideal position to recognise any potential neglect or abuse and act upon it. However, this can be emotionally stressful for all involved.

In some cases, there may be a previous history of child abuse or domestic violence. The child may have had burns or come to hospital repeatedly for 'accidental' injuries. There may have been a trigger event such as minor misbehaviour or a toileting accident, or a sibling may be blamed for causing the burn.

Intentional contact burns are frequently multiple. They have a sharp, demarcated edge and involve unusual areas of the body such as the back, shoulders or buttocks. Intentional immersion scalds from hot water usually affect the lower limbs. This sometimes includes the buttocks or perineum. They may cover both arms and/or both legs like a glove or stocking. There is often a clear upper limit to the scalded skin area, which is of uniform depth. Intentional immersion scalds may not affect the skin behind the knee, in the crook of the elbow or the central part of the buttocks: the limbs may be bent at the time of immersion or the buttocks may press against the surface of the bath, which is cooler. Intentional scalds and burns may be accompanied by other intentional injuries or signs of neglect.



### Factors to consider when doing an assessment

- Does the description of how the burn was caused fit with this child's stage of development?
- Does the pattern of the burn fit with the cause given?
- Is the description of how the burn happened consistent with the environment where it took place?
- Do the clinical features of the burn fit with the mechanism described?
- Was there a delay in seeking treatment?
- Is the parent concerned about their child's injury or are they more worried about themselves and what people are thinking?

### When to suspect maltreatment if a child has burns or scalds:

- If the parent gives no explanation of the injury or one that is implausible, inadequate or inconsistent with the child or young person's:
  - ◆ presentation
  - ◆ normal activities
  - ◆ existing medical condition, age or developmental stage
  - ◆ account, when compared to the parent's.
- If the child is not independently mobile.
- If the injury is on a soft tissue area that you would not expect to come into contact with a hot object in an accident (for example, the backs of hands, soles of feet, buttocks or back).
- If the injury is in the shape of an implement (for example, a cigarette or iron).
- If there is any indication of forced immersion, for example:
  - ◆ scalds to buttocks, perineum and lower limbs
  - ◆ scalds to limbs in a glove or stocking shape
  - ◆ scalds with sharply delineated borders.
- If the child discloses or acts out what happened using play.



#### How it can affect staff

Investigating abuse, particularly when a child has sustained multiple injuries, can make everyone involved feel anxious. Health care professionals are uniquely placed to identify early indicators of concern. However, they may face difficulties and worries when it comes to acting on them. These include:

- Concern about missing a treatable disorder.
- Fear of losing the positive relationship with a family under their care.
- Discomfort about disbelieving, thinking ill of, suspecting or wrongly blaming a parent.
- Divided loyalties to parents and children and breaching confidentiality.
- Understanding why the maltreatment might have happened, and that there was no intention to harm the child.
- Losing control over the child protection process and doubts about the benefits.
- Stress.
- Concerns over their personal safety.
- Fear of complaints.
- Not being able to 'think clearly'.

It is essential that all health care professionals have access to advice and support from designated professionals for safeguarding children. Professionals should also be aware that there are Local Safeguarding Children Board procedures for safeguarding children. See the section on 'Looking after yourself' on page 35 for more information.



### Task

Who is the child protection officer/designated contact at your hospital? Write their contact information here:




### Further reading

- **CORE-INFO: Thermal injuries on children.** Published by NSPCC and Cardiff University (2008).
- **Guidance on when to suspect child maltreatment.** Published by NICE (2009).



### Additional points to think about

#### Mental health

For young burn survivors, access to psychology and therapy services specifically designed to meet their needs is very important. Adolescence is often a time when young people of both genders place a much stronger emphasis on their appearance. A burn injury that affects how their body functions and/or is disfiguring can cause great distress and anxiety. This can lead them to avoid going out socially and cause unsettling feelings of anxiety and shame.

Health professionals working with teenagers need to be particularly aware of emotional and psychological issues typically associated with this developmental stage, such as self-harm and eating disorders (Scottish Government, 2009). If the young person has had mental health concerns before, for example depression, the accident may reactivate this and it is important to initiate a referral to the appropriate services in your centre.



### Task

What are the psychology and counselling services available to children, adolescents and their families at your burn centre?




What are the referral procedures if you are worried about a patient or their family?



### Needs of children and adolescents with learning disabilities

Children and young people with learning difficulties can be especially prone to accidents and incidents causing burn and scald injuries. They may also find the incident, treatment and hospitalisation more difficult to understand than others of the same age. Some staff working in hospital environments are trained to act as advocates for this group and are able to offer support with any treatment decisions and in understanding complex information. The parents of these young people can also help advise on the child's daily routine. Adhering as much as possible to this may help them feel more secure in an unfamiliar environment.

Hormonal changes during adolescence combined with the stresses of recovering from a burn incident 'can exacerbate learning difficulties'. Without careful assessment, some adolescents with learning disabilities may be incorrectly labelled as having behavioural problems (Gentry and Campbell, 2002). This is a challenge for health professionals.

#### Top tips

- Pay close attention to any signs of distress – research has shown that adolescents with learning difficulties are two to three times more likely to experience severe emotional anxiety than other teenagers (Gentry and Campbell, 2002).
- For some children or young people, you may have to find alternative ways of fostering independence and autonomy such as using an advocate.
- Some patients may have difficulty processing verbal information, so it might be helpful to allow more time for, and find more innovative ways of, explaining procedures. The charity Mencap have produced guidelines for writing accessible information.
- Speak to the child or young person's carer and family, who are likely to have a more in depth knowledge of their individual way of communicating pain and distress.



### Looking after others

It is common for health professionals to get used to the environment and emotions involved with recovery from burn injuries. It can be easy to forget that many people who enter this environment haven't set foot in a place like it before. It can be easier for some people if they are prepared for what they may experience beforehand. Overleaf is an account of a child's teacher who can still recall how distressing her first time on a burn ward was:

'I was due to attend a case conference at a hospital, ahead of the return to school of a child who had been treated for burns. To my surprise, the meeting was actually on the ward, in a small glass-walled room beyond which you could see some beds. A toddler of about three zig-zagged by on a trike, her arms straight and rigid inside huge dressings, which covered her hands too, if she had any hands left. In the nearest side-room a distraught parent paced endlessly next to a bed whose occupant was so small he or she was almost invisible, with several electric fans blowing above them. I struggled to do my job in the case conference. I was so shocked and upset. I thought I was being ridiculous but couldn't quieten my inner turmoil. I'm not a squeamish person – just a teacher who had never been on a burn ward before. This probably sounds so ordinary to any health professional, especially if you work with children or with burns. But even as I jot down these notes I can feel my emotions beginning to roll again.'



### Task

What potential issues does this account address and how could you better support/prepare this visitor?

A large rectangular area with a dashed border, containing ten horizontal dashed lines for writing.



### Traumatic stress

Following a traumatic event, most people experience a wide range of physical and emotional reactions. This is completely normal.

Those involved in the incident, as well as their family/friends, may experience:

- Rapid heartbeat.
- Difficulty concentrating.
- Aches and pains and/or muscle tension.
- Loss of appetite.

- Being startled easily.
- Fear and anxiety.
- Anger, irritability and mood swings.
- Desire to withdraw from others and/or feeling numb.
- Distressing nightmares or flashbacks.
- Disturbed sleep.
- Questioning of faith.
- Regression (in children).

With the right support, these upsetting emotions/feelings will eventually ease and encouragingly, many people will be able to recover well from a traumatic experience. However, this is likely to take some time and will also very much depend upon the individual in question.

### **Top tips**

- Having a good support network will be of great benefit to children, young people and their families and it is important they keep communicating with friends, family and co-workers.
- Inform the individual that they can ask for help if they want it and that seeking help does not reflect badly on them.
- Let them know that the better they look after themselves, i.e. eating and sleeping well, the better they will be able to deal with the physical and emotional reactions they are experiencing.
- Remember that the severity of the incident does not necessarily determine whether an event is traumatic. It is rather the subjective experience of the incident that is most influential.

### **What is post-traumatic stress disorder?**

- Post-traumatic stress disorder (PTSD) develops following a stressful event or situation of an exceptionally threatening or catastrophic nature.
- Around 25-30% of people experiencing a traumatic event may develop PTSD.
- PTSD is a disorder that can affect people of all ages, including children.
- The most characteristic symptoms of PTSD are re-experiencing symptoms.

People with PTSD involuntarily re-experience aspects of the traumatic event in a very vivid and distressing way. This includes flashbacks where the person acts or feels as if the event was recurring; nightmares; and repetitive and distressing intrusive images or other sensory impressions from the event. Reminders of the traumatic event arouse intense distress and/or physiological reactions. In children, re-experiencing symptoms may take the form of re-enacting the experience, repetitive play or frightening dreams without recognisable content.

Adapted from NICE Clinical Guideline 26 (March 2005)

## When should you refer a patient?

### Traumatic stress

Traumatic stress can have a negative impact on functioning at home, school or work. It can also make it very difficult to form close, supportive relationships. If symptoms persist for more than a month after the event or are getting progressively worse, it is important that you contact the psycho-social lead for your team as soon as possible so that the individual can receive support from a counsellor or therapist trained in helping patients with traumatic stress.

### Post-traumatic stress disorder

If you are worried about a patient or family member speak to your psycho-social lead as soon as possible. They will be able to screen the patient for this disorder against set criteria and offer appropriate therapy. General Practitioners are also able to screen for PTSD and make appropriate referrals for therapy. This is valuable for a parent to know after discharge.



### Further reading

- **What is Traumatic Stress?** by the International Society for Traumatic Stress Studies. Available at: <http://www.istss.org/WhatisTrauma/3243.htm> (2011).
- **Post-Traumatic Stress Disorder (PTSD). The management of PTSD in adults and children in primary and secondary care.** Published by NICE (2005).



### Task

Who is the psycho-social lead/team at your hospital? Write their contact information here:


What are the referral mechanisms for patients you are worried about?




## Looking after yourself

Working for a burn service can be hard. It can be difficult seeing children who have been severely injured or are in pain or distressed every day. It is emotionally demanding work.

It is very important that you look after yourself. If you don't, your ability to care for your patients may suffer and you may experience symptoms of stress and trauma yourself. This in turn may start to affect your own life, relationships and health.

Keep an eye on your own feelings. Notice if your normal behaviour or responses to your patients or colleagues seem to change – especially if you are irritated by small things that wouldn't normally worry you. Similarly, note if you seem to 'take work home', can't stop thinking about work issues or patients, or your behaviour or relationships seem to change for no obvious reason. You may find yourself worrying about a particular child who reminds you of your own. Certain scenarios could also trigger personal memories that you find difficult to deal with.

Sometimes you and your colleagues may feel the need to let off steam about your job or the families you are caring for. This is OK and there should be a confidential space in your service to do this. It can help if you reflect on your reaction to the children and families you are caring for and share your thoughts with your colleagues. Try not to bottle things up.

There may be times when you are affected more than usual by a child, their circumstances or the severity of their injuries. If you feel this is affecting you, recognise it is not a sign of weakness or that you are not doing your job properly. Instead, it is a sign that you probably need to have a chat with someone and take some space for yourself. Sometimes when you're faced with especially distressing situations, psychological specialists may offer a time to 'debrief'. Take up this opportunity if it is available to you. You will discover that many other staff probably feel the same and it can be comforting to know that you are not alone.

'Burnout' is when staff in caring professions are persistently emotionally exhausted and have a reduced sense of accomplishment. This will begin to affect patient care. If you believe this is happening to you, or to one of your colleagues, seek support from your manager.

There should be an opportunity to talk through some of these issues with your colleagues in a safe and confidential way. This should be separate from your manager and your appraisal. It is important you allow time to express some of these feelings as a team. Otherwise it can affect patient care and everyone's performance.

### Top tips

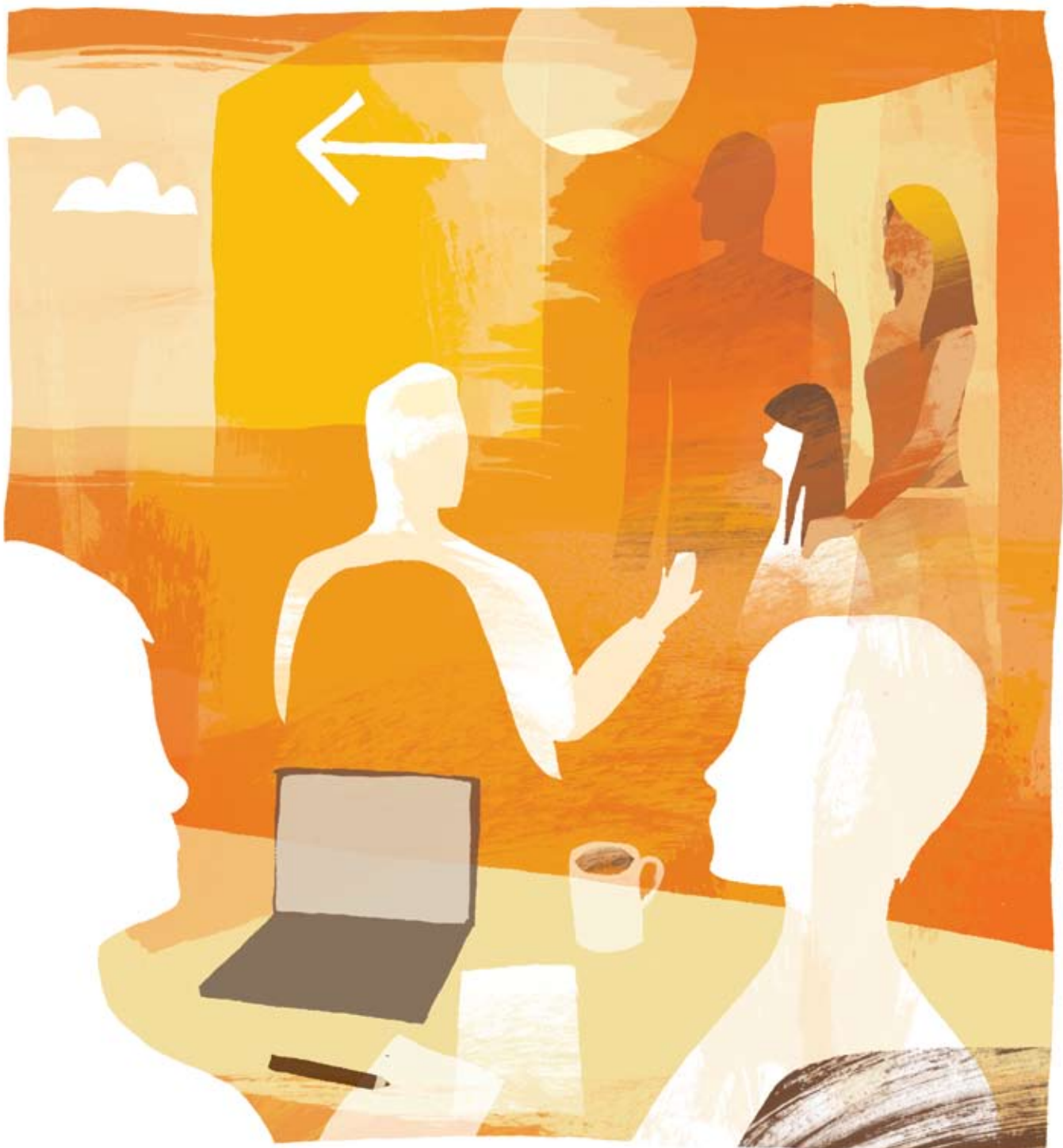
- Try to switch off from work when you are off duty. Do something you really enjoy that will help you unwind.
- Take the leave that is available to you.
- Notice how you feel with your patients. Have a chat with a colleague or a supervisor if you feel you are getting short tempered or irritated.
- Notice and acknowledge a change in your behaviour, for example, increased anxiety, tension, alcohol use, irritability or a different pattern to sleeping or eating.
- It is OK to feel sad. Sometimes staff can also get tearful. It is not a sign of weakness. We are all human and can't always switch off our feelings.
- Use clinical supervision if it is available to you. It will make you more able to care empathically for your patients as well as improving your own sense of well-being.



## Reflection

What have you learned from participating in this training? How will you apply it to your clinical practice?

We would like to thank Evender Harran, Senior Consultant, NSPCC Child Protection Consultancy for his contribution to the Child Protection section in this module.





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## Appendix one Child development summary, three to nine months

	Physical	Intellectual	Communication	Social
THREE MONTHS	<ul style="list-style-type: none"> <li>Lifts head when on stomach</li> <li>Kicks legs and arms</li> <li>Interested in and plays with own hands</li> <li>Can't hold own weight to stand</li> </ul>	<ul style="list-style-type: none"> <li>Recognises main caregivers</li> <li>Reacts to sudden sounds</li> <li>Shows eagerness when offered milk</li> </ul>	<ul style="list-style-type: none"> <li>Responds well to familiar voices</li> <li>Squeals, coos and babbles</li> <li>Cries when hungry or uncomfortable</li> </ul>	<ul style="list-style-type: none"> <li>Can be soothed by voice or touch</li> <li>Enjoys being played with</li> <li>Smiles when happy</li> <li>Likes routine activities</li> </ul>
SIX MONTHS	<ul style="list-style-type: none"> <li>Sits with support</li> <li>Rolls over</li> <li>Can pass toy from hand to hand</li> <li>May be able to stand, if supported</li> <li>Ready for solids</li> </ul>	<ul style="list-style-type: none"> <li>Is interested in objects</li> <li>Becoming more curious</li> <li>Makes requests for attention</li> <li>Once a toy is out of sight, believes it is gone for good, which sometimes causes distress</li> </ul>	<ul style="list-style-type: none"> <li>Turns towards sounds</li> <li>Starts to experiment with sound</li> <li>Enjoys watching other people</li> <li>Laughs</li> </ul>	<ul style="list-style-type: none"> <li>May show fear with strangers</li> <li>Recognises several familiar people</li> <li>Likely to have a favourite toy or blanket</li> <li>Likes to play with a rattle</li> <li>Socially interactive</li> </ul>
NINE MONTHS	<ul style="list-style-type: none"> <li>May crawl</li> <li>Attempts to walk when supported</li> <li>Sits unsupported</li> <li>Pulls to standing, but is likely to fall back down</li> </ul>	<ul style="list-style-type: none"> <li>Enjoys splashing in bath</li> <li>Recognises names</li> <li>Points at pictures in books</li> <li>Very curious</li> </ul>	<ul style="list-style-type: none"> <li>Copies simple sounds</li> <li>Understands the meaning of 'no'</li> <li>Shouts to get attention</li> </ul>	<ul style="list-style-type: none"> <li>Clingy with familiar adults</li> <li>Watches what is going on</li> <li>Copies facial expressions</li> </ul>

## Appendix one Child development summary, one to four years

	Physical	Intellectual	Communication	Social
TWELVE MONTHS	<p>Crawls</p> <p>Sits easily</p> <p>Pulls to standing position, may be able to stand independently</p> <p>Walks when supported</p>	<p>Begins to understand cause and effect</p> <p>Learns that an object exists even when it can't be seen</p> <p>Attempts to solve simple problems</p> <p>Can self feed, albeit messily</p>	<p>Joins sounds together</p> <p>Begins to name objects/people</p> <p>Understands simple words or signs</p> <p>Responds to own name</p>	<p>Uses gestures</p> <p>Cries when caregiver leaves</p> <p>Enjoys games like peek-a-boo</p> <p>Can give and take objects</p> <p>Begins to show signs of jealousy</p> <p>Can give hugs</p>
TWO YEARS	<p>Squats</p> <p>Walks</p> <p>Stacks large objects</p> <p>Can run</p> <p>Capable of bowel and bladder control</p>	<p>Uses and understands that objects can relate to each other, i.e. drum and drumstick</p> <p>Has a longer attention span</p> <p>More skilled at self feeding</p> <p>Likes to explore</p>	<p>Uses two and three word sentences</p> <p>Imitates single words or signs</p> <p>Can use simple words</p> <p>May have tantrums when upset</p>	<p>Imitates caregiver</p> <p>Plays beside other children</p> <p>Starts to learn the art of sharing and turn-taking</p> <p>Can ask for help when needed</p>
THREE TO FOUR YEARS	<p>Can go to the toilet</p> <p>May be able to sleep through the night without wetting</p> <p>Likes to move about</p> <p>Jumps</p> <p>Can walk on tiptoes</p> <p>Can sit cross-legged comfortably</p>	<p>Can name colours</p> <p>Holds pencil well</p> <p>Can draw faces and people</p> <p>Can pay attention for much longer</p> <p>Can generally dress/undress, may need help with fastenings</p> <p>Understands 'who', 'what', 'where' questions</p> <p>At four, can combine four+ words</p> <p>At four, should be able to use a fork, brush teeth and wash hands</p>	<p>Understands simple explanations and can have simple conversations</p> <p>More inquisitive</p> <p>Behaviour should be getting better, i.e. fewer tantrums</p> <p>Enjoys asking questions</p> <p>By four, speech should be clear and easily understood by strangers</p>	<p>Shares and takes turns</p> <p>Shows empathy</p> <p>May be cheeky with adults</p> <p>May have a 'best friend'</p> <p>Becoming more self-sufficient</p> <p>Likes pretend play</p>

## Appendix one Child development summary, five to 12 years

	Physical	Intellectual	Communication	Social
FIVE YEARS	<p>Dances</p> <p>Plays ball games</p> <p>Has good balance</p> <p>Active</p>	<p>Can remember past events</p> <p>Creates more detailed drawings</p> <p>Can dress/undress</p> <p>Completes puzzles</p> <p>Can count to 10</p> <p>Aware of different emotions</p>	<p>Becoming more articulate</p> <p>Capable of learning lots of songs and rhymes</p> <p>Can relay name, address and age when asked</p> <p>Is capable of controlling temper</p> <p>Uses humour</p>	<p>Undertakes more complex play</p> <p>Uses and enjoys imagination</p> <p>Shares well</p> <p>Protective of babies and toddlers</p>
SIX TO SEVEN YEARS	<p>Very active and has lots of energy</p> <p>Can ride a bike</p> <p>Can play with a skipping rope</p>	<p>Can tell time</p> <p>Can read age-appropriate books and materials</p> <p>Knows left and right hands/day time and night time</p>	<p>Can understand more complex instructions</p> <p>Can read out loud to others</p> <p>Talks with correct grammar</p> <p>Likes to listen to stories</p>	<p>Knows how to cheat</p> <p>Can be jealous of others</p> <p>Likes to copy adults</p> <p>Cooperates and shares with peers</p> <p>Plays with friends, usually of same gender</p>
10 TO 12 YEARS	<p>There is likely to be a considerable growth spurt</p> <p>May develop secondary sex characteristics</p> <p>Plays sport with increasing skill</p>	<p>Can write stories</p> <p>Reads well</p> <p>Can write letters</p>	<p>Enjoys and can participate in discussion</p> <p>Has interests and hobbies</p>	<p>Friends are becoming more important</p> <p>Begins to desire a level of independence</p> <p>Likes some privacy</p>

## Appendix 1 Child development summary, 12 to 14 years

	Physical	Intellectual	Communication	Social
12 TO 14 YEARS	<p>Puberty is more than likely to have begun</p> <p>Very likely to be sensitive to their changing body</p> <p>Noticeable height and weight gain</p> <p>Increased need/desire to sleep</p>	<p>Concerned with body image</p> <p>Anxious about being seen as 'normal'</p> <p>Starts to explore their individual identity – for example with different clothes and hairstyles</p> <p>Can recognise own shortcomings</p> <p>Begins to think more abstractly</p>	<p>May seem rude at times, or have difficulty communicating clearly</p> <p>Tests the limits imposed on them</p> <p>Can sometimes revert to childish behaviour, especially at times of anxiety or stress</p> <p>Impulsive</p> <p>Mood swings</p>	<p>Needs privacy</p> <p>May be influenced by peer pressure</p> <p>Begins to develop 'crushes' – interest in sexuality increases</p> <p>Need for social approval</p> <p>Change in relationship to parents, stronger importance placed on friends</p>



### Further reading

**Child development chart** by the Parent Guru. Available at: <http://www.ask-nanny.com/child-development.html> (2008).

**Child development** by Kiwi Families for Passionate Parents. Available at: <http://www.kiwifamilies.co.nz/Topics/Parenting/Child-Development.html> (2007).

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## Appendix two Distraction techniques

Group	Age	Distraction technique
Infants	0 to 12 months	<ul style="list-style-type: none"> <li>Gentle heat, for example, using a warm blanket</li> <li>Controlled multi-sensory stimulation</li> <li>Dummy/pacifier</li> <li>Rocking motion</li> <li>Touch/massage</li> <li>Swaddling</li> <li>Blowing bubbles</li> <li>Music/singing/lullabies</li> <li>Playing with rattles</li> </ul>
Toddlers	13 to 24 months	<ul style="list-style-type: none"> <li>As above</li> <li>Cold sensations, for example, ice cubes applied to appropriate area</li> <li>Sitting on caregiver's lap</li> <li>Cuddling</li> <li>Massage</li> <li>Interactive books</li> <li>Playing with caregiver's keys or jewellery</li> <li>Verbal praise</li> <li>Puppet play</li> <li>Playing with medical equipment, such as a stethoscope</li> </ul>
Pre-school	2 to 4 years	<ul style="list-style-type: none"> <li>As above</li> <li>Deep breathing</li> <li>Interactive toys</li> <li>Drawing/colouring</li> <li>Story telling</li> <li>Watching cartoons</li> <li>Non-medical conversation</li> <li>Reading with caregiver</li> </ul>



Group	Age	Distraction technique
Young children	5 to 7 years	As above Playing handheld electronic games Thumb squeezing Guided imagery Engaging in fantasy stories Playing interactive games such as 'I spy' Counting Conversations about popular TV/cartoon characters
Older children	8 to 11+ years	As above Video games Listening to music of their choice Card games Watching favourite movie/TV programme Squeezing a ball or stress toy Slow, controlled breathing Talking about favourite place, hobby or topic



### Further reading

**Reducing distress during venepuncture** by Duff and Bliss. Published in Recent advances in paediatrics 22 (2010).

**Child life, education and creative arts therapy** by the Children's Hospital of Philadelphia. Available at: <http://www.chop.edu/service/child-life-education-and-creative-arts-therapy/childrens-needs-by-age/> (2011).



## Appendix three **Contact details** cut out and keep



### **Psycho-social services**

Team leader:

Contact details:

Other contacts:

The referral procedure is:

### **Psychological and counselling services available to children and young people at my burn centre/unit**

Team leader:

Contact details:

Other contacts:

The referral procedure is:

### **Child protection officer/designated contact**

Name:

Contact details:

The referral procedure is:



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Authors: Gemma Borwick and Salma Khanche for Changing Faces, registered charity number 1011222;  
charity registered in Scotland SC039725

Commissioned by the London and South East Burns Network

We wish to acknowledge the following for their help and advice in developing and evaluating these resources:

Our advisory group:

Dr Julia Cadogan, Consultant Clinical Psychologist; Dr Beth Dodson, Child Psychotherapist; Dr Mandy Giles, Lead Clinical Psychologist; Dr Caroline Helm, Consultant Child Psychotherapist; Alison Martin, parent; Jo Myers, Lead Nurse (Burns); Dr Liz Pounds-Cornish, Clinical Psychologist; Shirley Rose, Changing Faces Practitioner; Dr Theresa Rose, Consultant Psychotherapist; Rahila Zaman-Jalil, Schools Specialist

The pilot participants from:

Broomfield Hospital, Chelmsford; Chelsea and Westminster NHS Foundation Trust, London; Frenchay Hospital, Bristol; Queen Victoria Hospital NHS Foundation Trust, East Grinstead; Stoke Mandeville Hospital, Aylesbury

Additional thanks to:

The team at Changing Faces, London; Emma Shall, Volunteer; Lauren Hamilton, Volunteer; Evender Harran, NSPCC Senior Consultant; Dr Mohammed Ziaur Rahman, Paediatric Consultant; Pete Saggars, London and South East Burns Network Manager; Jane Frances, Policy Adviser in Education; Clare Cooper, Clinical Psychologist

ISBN 978-1-900928-33-5

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Editor | Jennifer Campbell

Illustrations and cover typography | Danny Jenkins

Design | Binding Associates

Print | Doveton Press on ECF paper from sustainable sources, FSC accredited

