Clinical Practice Guidelines Social Work; Paediatric Burn Patient Management

NSW Statewide Burn Injury Service

Date: Aug 2011

Version: 2.0

Release Status: Final

Release Date: Aug 2011

Author: Sandra Spalding, Judy Goodson

Owner: Agency for Clinical Innovation

Acknowledgements

Aug 2011

Background

The Social Workers at the Children's Hospital at Westmead have collaborated to develop the following *Guidelines* for Paediatric Social Work services in the acute burns setting. The social worker's role in the multidisciplinary burn team has integral to the treatment of burn injured children.

TABLE OF CONTENTS

1. Introduction

Social Work psychosocial assessment and intervention forms part of the total treatment plan. Relevant information about psychosocial functioning is shared with the team members as appropriate to ensure consideration of such information in the treatment plans of other team members.

Social work intervention following traumatic burn injury includes the psychological, emotional and social impact on patients and their families/caregivers.

Referral to social work as soon as possible after admission (or at least within the first 24-hrs of admission) is important to ensure that appropriate crisis care and support is provided to the patient, caregivers and significant others. Immediate needs are identified and assessed utilising counselling skills in family relationships, trauma intervention and loss and grief. A preliminary psychosocial assessment is undertaken to begin identifying patient and family strengths, existing coping mechanisms and available support networks.

Decisions regarding social work intervention for individual patients are determined by psychosocial assessment with constant reappraisal, which continues throughout contact with the patient/caregivers. The objective is to develop as comprehensive a profile of the patient and his/her world as possible in order to more accurately determine targets of intervention that will:
- contribute to resolution of the trauma associated with the burn accident and injury
- assist with treatment compliance and
- assist in the adjustment to altered body image.

2. Principles of Social Work Intervention

2.1 To assist patient/primary caregivers/significant others in dealing with the crisis and trauma associated with criteria

- the burn injury
- burns treatment and hospitalisation

2.1.1 Trauma Responses to Burn Injury

The individual patient/primary caregivers/significant others response to traumatic burn injury will be different. While these may be very unpleasant they are for the most part normal.

- Trauma symptoms that present within the first month post trauma are generally referred to as reactive or acute stress disorder. Symptoms include dissociation, intensive re-experiencing of the event, avoidance of trauma related stimuli, emotional numbness and physiologic hyperarousal.

- Symptoms common to the paediatric patient include **re-experiencing of the trauma** (nightmares, flashbacks); **hyperarousal** (sudden awakening from sleep, agitated/irritable, trouble falling asleep); **mood related symptoms** (crying, sadness, fearfulness); **related cognitive symptoms**; thought problems (illusion/psychosis), **development** (regression to "babyish" behaviour including bed wetting, tantrums and attention-seeking behaviour, clinging and dependent).

- Primary caregivers and patient (if appropriate) need to be educated regarding normal trauma reactions in both adults and children bearing in mind developmental stage of the child.

- Prompt relief of these symptoms through the use of psychopharmacologic intervention may be indicated as the very young patient is unable to process emotions verbally. Older children are also often too distraught or agitated to verbalise emotions.

    (After discussion with the medical consultant a referral may be made to Psychiatry.)

- Careful assessment will determine when the paediatric patient is ready and able to process the traumatic experience through counselling/psychotherapy. A checklist such as the symptom checklist 'Acute Stress Disorder Symptom Checklist' may be useful (devised for children in a burn intensive care unit - developed by R. Robert et al).

- PTSD (Post-traumatic Stress Disorder - where ASD symptoms persist beyond 1 month) may occur in patients or primary caregivers following a burn injury. PTSD can be relieved through counselling/psychotherapy but may also require pharmacotherapy.

- A referral to Psychiatry may be indicated following discussion with the medical consultant.

2.1.2 Burns Treatment and Hospitalisation

- When working with burns patients it is important to acknowledge the impact of burns treatment and hospitalisation. These may contribute to "layered" trauma eg the burn incident, burn dressing changes, debridement, grafting, physiotherapy. Weeks or months of recovery are filled with experiences of sometimes overwhelming distress.

- Children often experience an overwhelming powerlessness which increases fear and anticipation of pain.

- Children also lack any understanding of the purpose and necessity for painful therapeutic procedures.

- Having to confront uncovered burn wounds and overhearing comments of staff can be extremely upsetting.

Distraction from aversive procedures with the Play Therapist present can be extremely useful.

- The burn incident, associated traumas (as above) and hospitalisation can contribute to the experience of anticipatory fear and anxiety, regression, withdrawal, learned helplessness.

- Primary caregivers need information relating to possible "institutionalisation" of the patient due to lengthy hospitalisation periods.

Providing appropriate information and involving the patient may reduce the experience of repeated trauma.

2.1.3 Pain Management

- The management of pain plays a central role during the hospitalisation period. Poorly managed pain can increase anxiety and vice versa. (Rhonda Robert et al 2000).

- Clinical and experimental research studies on pain have shown that psychological factors modify pain perception and expression (Holroyd & Lazarus (1982), Marie-Christine Frenay et al 2001).

- A number of coping strategies (in addition to pharmacological methods) have been found to assist patients with painful experiences. Choice of strategy must be based on careful assessment with the patient and/or primary caregivers.

- Attempts must be made to understand the elements of pre-morbid, post-trauma and generalised hospital anxiety.

- Developmental considerations must influence the choice of any pain management strategy.

Physical
- Breathing techniques,
- Progressive muscle relaxation-focus on physical sensations (Bernstein & Borkovec 1973; Relaxation for Children - Jenny Rickard 1996)

NB: may require medical clearance.

Cognitive
- Emotive Imagery and Covert Modelling (M J Mahoney, 1974).
- Cognitive Restructuring and Stress Inoculation (Meichenbaum, 1977).
- Meditation (a cognitive-relaxation procedure) (Bernstein & Borkovec (1973) - Meditations for Children - Starbright & Moonbeam - (Maureen Garth, 1992).
- Pain Control Featuring Eye Movement Desensitisation and Reprocessing (EMDR) (Mark Grant - 1997 - audiotape). (The features of EMDR include Bilateral Stimulation and Focus of Attention (Francine Shapiro). NB: formal training required).
- Distraction methods.

Useful Assessment Tools
Self-anchored scales (where the poles of a likert-type scale are 'anchored' by concrete experiences/emotions/events which can be described by the patient).
Rating scales (are also likert type but are used to attempt to measure a dimension of the patients feelings, behaviours or experiences - used when patient unwilling or unable to measure them - can also be used to supplement patient self-rating).

2.2 To obtain information regarding the circumstances of the burn injury

- Details surrounding the circumstances of the burn injury are important in assessing for possible non-accidental injury (NAI) or neglect.

- It is important to remember that the full history of the circumstances emerges over a number of days due to the trauma and shock experienced by primary caregivers/significant others.

- Information from attending ambulance officers, referring medical practitioners/facility needs to be considered.

- Inconsistencies in reports from various sources need careful investigation.

- Information regarding circumstances is collected by a number of hospital staff eg the admitting Medical Officer, the Burns Unit RMO, the Registrar, Medical Consultant and the Social Worker. Nursing staff and other multidisciplinary team members may also become aware of pertinent information when communicating with patient/primary caregivers/significant others.

- Available information is discussed at the weekly Multidisciplinary Burns Unit clinical meeting and decisions are made regarding consultation/referral to the Child Protection Unit or referral to the Dept of Community Services (DOCS).

NB: **That the Children & Young Persons (Care & Protection) Act (1998) requires all multi-disciplinary staff to be responsible for protecting children. Any concerned team member therefore has a right and responsibility to notify DOCS regardless of the collective team decision.**

2.3 To identify psychosocial factors that will impact on treatment and compliance and successful treatment outcomes and to determine intervention goals with patient/primary caregivers

When working directly with paediatric patient's developmental consideration will determine both what can be expected to be achieved through the therapeutic process and what assessment methods/tools are most appropriate.

In paediatrics a clear understanding of social contextual factors (including developmental considerations) are critical, as they may constitute either resources or obstacles to coping and adjustment. These include:

- Family Structure/Relationships/Support Networks

- Previous History of Trauma Experience (including major losses)

- Mental Health History of Both Primary Caregivers and Child

- Drug and Alcohol history of both primary caregivers and patient.

- General Coping Style of Primary Caregivers

- Parenting Style Disciplining of Child
  - Parenting Style
  - Disciplining

- Developmental Achievements

- School Performance/Learning

- Behavioural Problems

- Temperament and Coping of Patients

- Body Image and Self-Esteem

- Peer Relationships

- Siblings

- Cultural/Environmental Influences

NB: **A sound knowledge of the therapeutic use of child's play in assessment and intervention with paediatric patients is important.**

2.3.1 Family Structure/Relationships/Support Networks

- The development of a geno-gram together with the family is useful as it provides a "map" of the family structure. Information about family relationship patterns and extended family and other support networks can then be added.

- A positive and supportive family and social environment has been shown to serve as a "life stress buffer" for children {Dubow & Tisak (1989) & Gottlieb (1981)}.

  (NB that perception of available support rather than actual numbers are associated with life stress protection (Cohen, 1988).

- A religious orientation has also been shown to reduce the impact of life stress (Park, Cohen & Herb 1990).

- Social class and education may influence the type and quality of support available.

- Cultural mores may also strongly influence relationships and available support.

Useful assessment tools may include:
- Index of Marital Satisfaction (Walter W Hudson, 1974).
- Index of Family Relationships (Walter W Hudson, 1974).
- Index of Parental Attitudes (Walter W Hudson, 1976).
- Child's Attitude towards Father (Walter W Hudson, 1976).
- Child's Attitude towards Mother (Walter W Hudson, 1976).

2.3.2 Previous history of trauma experience (including major losses)

- Trauma causes psychological wounds and healing from trauma requires time and depends heavily on the understanding support and protection provided by primary caregivers and other caretakers (Monahon 1993). Patients from families who have recent histories of multiple trauma events and who have poor coping skills are at risk. Further, the burns trauma experience may reactivate old unresolved traumas thus compounding the current burns trauma.

- The existence of a previous history of trauma or an environment characterised by chronic stress may simply represent an unfortunate chain of events (ie conceptually distinct sources of life stress) or it may indicate a personality variable related to the chronic occurrence of negative experiences. (ie small and major events may be intrinsically inter-related).

- A thorough assessment of context is critical, as negative life experiences do not always predict negative outcomes. For some children and adolescents negative life challenges may have a generalised strength enhancing effect which serves to develop confidence in coping resources (La Greco et al 1992).

- Patients/primary caregivers can be helped through the assessment process to identify strengths and weaknesses in coping skills used in previous trauma experiences.

NB   That patients/primary caregivers may also be retraumatised following the initial incident, when the trauma is a public event involving either the legal system, the media, or both.   (Monahon, 1993).

2.3.3 Mental health history of both primary caregivers and child

A thorough assessment of the family's mental health history is important as family members with a history of anxiety disorders or depression may be at risk.

Studies have shown that chronically depressed individuals are generally more likely to use maladaptive coping strategies such as avoidance (Altshuler & Rubie (1989) & Peterson (1989) or blunting (Miller 1980).

These maladaptive strategies are modelled for the children who in turn may have limited or inappropriate coping skills.

There is a relationship between the incidence of physical and/or mental illness of parents and the presence of emotional and or behavioural problems in children. (Some studies suggest that the incidence is 3 x greater than "normal" population.)

- It is extremely important to distinguish between previous depressive episodes and reactions to the current burn incident.

- Primary caregivers who are currently receiving treatment for clinical depression or any other mental illness should have their ongoing management discussed with them. Parents from country areas or those unwilling to leave the hospital may be referred to a hospital Psychiatrist who is able to liaise with the primary caregivers regular psychiatrist.

- Country caregivers already being treated by their country Mental Health Team may also be referred to a Mental Health Team local to the hospital who can liaise with the parent's own mental health facility.

- Patients currently being treated for ADD, ADHD, depression or any other mental illness for example should also have their medication reviewed and discussed with the local paediatrician/psychiatrist. This is usually done by the Burns medical resident or registrar involved or by a hospital psychiatrist.

- Primary caregivers with a mental illness may not have the resources to meet the demands of the patients' physical or emotional needs. The availability of extended family and/or community resources to assist the primary caregivers needs early assessment.

    In some instances it may be necessary to involve the Department of Community Services if a patient's care is deemed to be compromised.

2.3.4 Drug and Alcohol History of both Primary Caregivers and Patients

Primary caregivers who are drug users or on methadone programs need careful assessment and monitoring.

- Drug usage may have led to compromised care of the child and been the primary causal factor in the burn injury.

- Primary caregivers on drugs may emotionally and/or physically be unavailable to the patient.

- Long-term patient car and compliance with care regimes may be less than optimal.

- Liaison and consultation with the hospital's Child Protection Unit is important as is referral to the Department of Community Services when necessary.

NB: The importance of assessment for non-accidental injury (NAI).

- Monitoring and management of primary caregiver behaviour on the ward is extremely important.

- Ward expectations of primary caregivers must be communicated to them clearly.

- Inappropriate/disruptive/obstructive behaviours must be carefully managed with the collaboration of all multidisciplinary team members.

- Where appropriate arrangements may be made for primary caregivers to have their methadone dispensed at a clinic/pharmacy close to the hospital.

- Primary caregivers resident at the hospital who may receive "take away" doses of methadone over a weekend/public holiday need to have safe storage practice/options discussed with them.

- Alternate significant caregivers may need to be negotiated as well as the possibility of ward grandparent support.

- Patients who are drug users (including engaging in the practice of "chroming") or abuse alcohol require special care and attention.

- Consultation with juvenile Drug and Alcohol specialists may be necessary.

2.3.5 General coping styles of primary caregivers

The concept of coping is a complex one that needs to be understood by social workers, as accurate assessment will determine targets of intervention and the strategies that can be usefully implemented. Family coping may be defined as "the collective behaviours and/or thought processes of family members for the purpose of dealing with an identified threat or challenge to the family or a member" (Thomas, Barnard & Sumner, 1991).

Understanding primary caregivers coping style is important as coping/non-coping is learned vicariously by children observing their primary caregivers coping efforts and the consequences of those efforts.

- There are a number of theoretical conceptual frameworks for understanding coping. Despite apparent differences all emphasise "a basic distinction between two (2) fundamental types of coping.
  - Problem - focussed coping
  - Emotion - focussed coping" (Compas et al 1992)

- The major difference between these 2 coping styles has to do with the "intervention or function of coping efforts." (Compas et al 1992)

- Problem - focussed coping - efforts to change or master some aspect of the person, the environment or the relationship between these that is perceived as stressful

  - Strategies include:
  - Problem solving/planning
  - Confronting the issues associated with burns trauma.

- Emotion focussed coping - efforts to manage or regulate the negative emotions associated with the stressful episode.

  - Strategies include:
  - Denial/avoidance
  - Distraction/imagination
  - Wishful thinking
  - Self control of feelings
  - Seeking meaning
  - Self blame
  - Expressing and sharing feelings.

NB: **Coping efforts vary not only according to individual characteristics but also according to the stressful situation being confronted. Any one coping strategy (as above) is neither "good" not "bad" - but may be useful or unhelpful depending on the situation. Care in assessment cannot be overstated.**

Useful tools for measuring coping styles:
- Multidimensional Coping Inventory (MCI), (Endler & Parker, 1990.), (Contains 44 items that covers task oriented, emotion oriented and avoidance oriented coping behaviours.)

NB: **As with all measurement tools professional knowledge and wisdom must determine if and when they might be useful adjuncts to psychosocial assessment.**

2.3.6 Parenting style/disciplining of child

Parenting styles and the disciplinary strategies employed clearly interact in a complex fashion. It is important to review parenting practices with the primary caregivers so that they can be helped to identify strengths which will enable them to support their child and also to learn new parenting skills or adjust old ones if necessary with the objective of providing as nurturing an environment as possible. This process may continue post discharge.

Parenting Style
- Parents/primary caregivers are extremely important as they generally have the greatest single influence on the child's life. For this reason parental psychosocial well-being and parenting skills must be a primary concern in working with the paediatric burns patient.

- It is well documented that children's lives (including adjustment to life events) do vary according to the family's treatment of them.

- Variations in parenting input or style may be temporary (ie, a function of a family crisis or even improvement of a family's condition) or they may be enduring.

- What is important is the attitude and feelings of parents towards their children and how they view their role as parents. These qualities together with parental expectations of their children form a background to the application of the family's specific methods of child rearing.

- Child rearing ideology reflects not only cultural or national norms but also attitudes shaped by membership of a particular social class.

- Careful assessment will establish whether parenting styles will negatively influence the patients' ability to cope with the trauma of the burn injury, compliance with sometimes rigorous treatment regimes and long term adjustment.

Disciplining
- "Discipline" refers to a process of training and guidance that fosters growth and development.

- Disciplining children is one way of socialising them. (This includes the development of self-discipline, eg, the ability to adjust own needs to the needs of others.)

- The disciplinary strategies used reflect parental attitudes which may be affectionate and approving or rejecting and hostile, for example.

- An understanding of the ways in which parents/primary caregivers administer reinforcements and punishments is useful as is the way in which the patient experiences and interprets parental efforts.

2.3.7 Developmental achievements

- Assessment of developmental accomplishments permits realistic review of the patient's behaviour in terms of past developmental patterns, present behavioural manifestations and the future impact on adjustment in the long-term.

- It is important to establish the influence of the patients physical and social environment on patterns of development.

- Any effort to bring about changes in a patient's observable behaviour and personality must be aimed at the developmental processes themselves rather than the individual behaviour per se.

- Developmental functioning of the patient in terms of emotional, cognitive and behavioural achievements will influence targets of intervention and the therapeutic approach most likely to bring about change.

- While social work interest in development has to do with processes and functioning rather than chronological age development it may be necessary for the patient to undergo a developmental assessment in some instances.

Referral to Occupational Therapy for developmental assessment may be made after consultation with the burns team.

2.3.8 School performance/learning difficulties

- Poor school performance due to learning difficulties may or may not be a problem from the burn injury perspective if the school environment and home environment are nurturing and supportive.

- Poor school performance with no learning difficulties but coupled with behavioural problems indicates that problems with compliance and adjustment post-burn is highly likely.

- Assessment of previous severe trauma is important as unresolved trauma experience can contribute to damaged egos, low self-esteem and even anxiety disorders, which in turn may impact on school performance.

- The social work assessment must also not overlook the devastating effects on self-esteem of the daily onslaught of negative criticism (pre-burn) that some children endure (Thompson & Rudolph 2000).

- Self-esteem is a by-product of achievements and relationships so the key to mental health in burn survivors must take into account their schoolwork and their relationship with family, peers and significant others (Simon 1988).

- Assessment may therefore include liaison with schools.

2.3.9 Behavioural problems

- Burn survivors present with a diversity of behavioural problems, which have the potential to complicate not only the hospitalisation period but also compliance with treatment regimes and long-term adjustment.

- Pre-burn injury behavioural difficulties may be compounded by the burn injury experience and the resulting physical consequences (scarring).

- Many patients present with a history of aggression, anxiety, low self-esteem, depression and ADHD for example which may all contribute to behavioural problems.

- One tool to identify the relationship between problem behaviours and environmental influence is the ABC model (Antecedents - Behaviour - Consequences) (Mahoney & Thoresen 1974).

- With older patients assessment and intervention will include direct work with the patient. It is important to include covert influences when assessing behaviours of the older child. Covert influences include the cognitive and affective processes which can influence both Antecedents and Consequences (Ellis 1998).

- The social worker may work together with primary caregivers and multidisciplinary team workers to develop behaviour management programs for implementation on the ward.

- Primary caregivers may also need assistance in managing behaviours post discharge.

Useful assessment tools include:
- Patient - data logs
- Self (or primary caregivers) monitored data sheets
- Self-anchored scales
- Dimensions of Anger Reactions (R W Novaco 1975).

2.3.10 Temperament and coping of patients

Coping efforts are influenced by both characteristics of the person and characteristics of the situation in which he or she is coping (Compas et al in Greca et al, p.10).

- Patients differ in their vulnerability to the effects of life stress.

- Environmental variables such as family stability and support enable the child's coping.

- Temperament of the child may also aid resistance to stress.

- In order to assess the role that stress will play in a patient's adjustment post burn it is useful to review the patient's usual cognitive appraisals of other stressful occurrences and how the patient copes.

- While it is useful to review past coping strategies of patients it is also extremely important to continue to assess and reassess the patients responses to the different challenges of burns treatment at different points in the course of treatment.

2.3.11 Body image and self-esteem

Body image and self-esteem are clearly interrelated. A major task for the social worker in a burns unit is to assist parents/primary caregivers to rebuild sometimes shattered body images and self-esteem.

Body image is a construct of ones self-concept which refers to the individual attributes considered most important. Self-concept does not imply positive or negative feelings about the self. Self-esteem on the other hand is based on evaluations and judgements about one's perceived characteristics.
- Burn patients constitute a group whose emotional development may be altered as a result of living each day with a scarred or sometimes deformed body.

- Patients often have to cope with experiences that their non-burned peers do not face or rarely confront.

- Patients with facial disfigurements may be at greatest risk.

- R. Kanigova, who developed the concept of a "Disfigured face syndrome" (D F syndrome), wrote that because these patients suffer "loss of face" literally, they also lose their personality (1985).

  - The development of the D F syndrome is influenced by –
  - The location of the disfigurements (the periorbital region is the most critical).
  - The age – (adolescence being the most difficult).
  - The family and social background.
  - The ability to preserve ones self-concept (Knigova 1985).

- Self-esteem is essential for psychological survival "When you reject parts of yourself, you greatly damage the psychological structures that literally keep you alive" (McKay & Finney 1992).

- Patients with low self-esteem may avoid situations that aggravate the discomfort of self-rejection by taking fewer social, academic and carer risks.

- Low self-esteem links ability to engage with this, express sexuality, be the centre of attention, hear criticism, ask for help and solve problems.

- Patients with low self-esteem may blame or get angry, or become unrealistically perfectionist.

Many studies show clearly that parenting style strongly influences self-esteem. Studies of young children show clearly that primary caregivers style of childrearing during the first 3-4 years determines the amount of self-esteem that a child starts with (Durrell, 1984; Briggs, 1970).

- The essence of self-esteem are ones core beliefs which determine oneself as worthy safe, competent, loved, powerful, autonomous (McKay and Fanning 1992); (Ziller et al 1969).

- Assessment must also include review of how the patient experiences treatment from others especially parents/primary caregivers/significant others. (Cobb, 1976).

    - Some children may be especially vulnerable to developing low self-esteem. These include:
        i. largely absent primary care giver (feelings of disabandonment)
        ii. experience of deprivation neglect or abuse (feelings of rage towards parents and consequent guilt)
    - following divorce (feeling responsible for driving parent away)
    - victims of extreme or capricious criticism.

Useful References
- Building Self-esteem in Children (Bernie, Savoy, 1985).
- Teen Esteem: A Self-Direction Manual for Young Adults (Impact Publishers); (Palmer & Froehner, 1989).
- Happiness its up to you (Beecher, 1995).
- Liking Myself (Palmer, 1995).

Useful Assessment Tools
- Index of Self-esteem (Hudson, 1974).

2.3.12 Peer relationships

Peer relationships form part of the larger social context of interactions.

Peer relationships contribute in unique and major ways to shaping the child's personality, social behaviours, values and attitudes.

The child's status in their peer group and the friendships they establish strongly affect their self-concept.

Poor relationships with peers during childhood may predict later emotional maladjustment and delinquency (Achenbach & Edelbrock, 1981). Burns survivors with poor peer networks may be especially at risk.

One characteristic which may be highly valued by the culture of the peer group and associated with popularity is physical attractiveness. Loss or perceived loss of physical attractiveness from burn injuries can seriously impact on self-image and personality.

2.3.13 Siblings

- Sibling relationships form part of the patient's intimate social context so need careful assessment in order to ensure that the needs of siblings are also considered.

- Siblings are also potentially profoundly affected by a burn injury in the family. They may be severely traumatised by the injury itself (which they may have witnessed or been a part of) and the crisis situation that follows.

- Siblings may also be affected by the physical separation from the patient and/or the primary caregiver. Siblings from the country may spend extended periods in the care of others. Feelings of anxiety, loss and abandonment conflict with sibling's concern for the patient.

- The psychosocial care of siblings is important for two reasons:-
  - their own health and well being in the face of a burns trauma,
  - to ensure that siblings can play a positive role in the patient's recovery and adjustment long-term, eg,
  - sibling interactions can provide opportunities to develop and practice social interaction skills,
  - siblings can serve as confidants and sources of support in times of emotional stress (Lamb, 1982, p.6).

NB: The extent to which siblings help shape the patients personality and social development varies according to the patients sex; the sex of the siblings; ordinal position; spacing between siblings; number of children in the family and parental treatment.

2.3.14 Cultural and environmental influences

"Cultural sensitivity in social work practice means the ability to intervene cultural awareness and an appreciation of the socio-cultural factors that influence people's experiences into all phases of the helping process". (Jackson, 1993 & Hayes).

- Children who have migrated to Australia may have experienced death, injury imprisonment, assault or torture to loved ones and family as well as many other changes and losses. They may therefore be more vulnerable. (Tuncliffe, 1996).
-
- Psychosocial assessment must include the potential multidimensional influences of the cultural/environmental background of patients/primary caregivers/significant others.

- Adherence to traditional cultural norms, values and expectations is variable but may significantly influence not only treatment and compliance issues but also attitudes to scarring/disfigurement. (Blakeney et al 1990).

- For example: Where physical beauty is highly valued marriage prospects may be deemed to be negatively impacted on. Patients may experience social rejection.

- Children who have strong culturally determined physical features or colouring and who may have experienced criticism with racial overtones pre burn may find the additional burden of visible scarring in particular overwhelming.

- Cultural expectations may also conflict with medical and nursing practices. The social worker may take on a strong mediating/advocacy role to ensure that best practice burns care guidelines can proceed with minimum conflict.

2.4 To review patient/primary caregiver/significant others responses to altered body image, lifestyle changes and future functioning ability

Body image and associated life style choices and functioning will need appropriate assessment and intervention at different developmental stages of the patient. Body image takes on new and different characteristics and significance as the patient matures. Intermittent counselling may be indicated throughout the developing years.

- Body image is an integral feature of being human. For some individuals any threat to body image can severely impact on all areas of human functioning.

- Patient fears regarding future losses need to be sensitively explored as many patients find it difficult to articulate for fear of having their "worst fears" confirmed. Common fears include inability to walk, play sport.

- Assessment of pre-burn injury body image and lifestyle of the patient will provide a baseline for evaluating the impact of losses incurred. Assessment will include the interpretations/opinions of primary caregivers and significant others where appropriate.

- Primary caregivers/significant others therefore need to be co-opted as part of the 'treatment' team for the paediatric patient.

- Medical/physiotherapy opinion is important regarding any anticipated loss of physical potential.

- It is important to assess whether consequent lifestyle changes are inevitable or whether there are psychological or social impediments to achieving previous goals or potential.

- Patient attributions to physical losses will determine rehabilitation efforts.

- Careful assessment of patient problem solving strategies are important as strategies may involve a degree of self-deception and distortion of reality, which may prevent the realistic and sometimes painstaking solution of physical and emotional problems.

- Coping style and inappropriate choice of problem resolution strategies may lead to a chaotic alienated existence for the patient which lacks long-term purpose and meaning.

- It is important to stress the important role played by primary caregivers in terms of their expectations of the patient and the strategies used to ensure compliance and thus outcome and/or physical function.

NB: Be aware of:
- **primary caregivers who attribute all things negative to the patients' burn injury.**
- **Learned helplessness in patient and/or primary caregivers.**
- **The possible negative influence of depressed primary caregivers.**

- Anxiety can cause a great deal of suffering and may tend to bring indirect defences into play.

- Patients may adopt a "don't care" attitude which may mask their grief as well as a craving for nurturing and a need for dependency.

- Patients may use compensatory tactics to defend against feelings of inadequacy and inferiority linked to real or imagined personal "defects" or weaknesses.

- Patients may retreat into "ill" role in order to manipulate others.

- Physical and/or psychic withdrawal may occur with patients withdrawing into a shell of numbness and passivity.

NB: Apathy and defeated resignation may be extreme reactions to stress and frustration that can continue over a long period.

- Conversely some patients (particularly males) may resort to violence as a way to address their problems. They may feel rejected and "ugly" and may discharge their resentment and pain through maladaptive behaviours eg vandalism, stealing, fire setting and sometimes vicious assault.

2.5 To provide education and information as appropriate to patient/primary caregiver/significant others regarding psychosocial responses to burns treatment, recovery and adjustment

A primary motivation for educating and providing information to patient/primary caregivers is to alleviate stress and anxiety about post-burn psychological and emotional responses. Education also aims to attempt to prevent misunderstanding about physical treatment and healing following a burn injury and also the motives behind observed behaviours.

- Frequently concerns regarding the child's physical welfare or survival are initially so intense that primary caregivers can pay little attention to the child's emotional reactions or needs.

- Severely burned children may themselves put initial energy into their physical recovery and may exhibit more delayed emotional reactions to their injuries and the associated traumatic event.

- Primary caregivers/significant others need help in working together with their children towards recovery from trauma associated with the different stages of burns treatment and long-term adjustment.

- It is important not to minimise the impact of a burns trauma on the lives of patients and their families.

- It is also important for patients/primary caregivers to understand that physical and emotional healing from burns trauma can and does occur.

- Informed primary caregivers who recognise and understand the effects of trauma on their child are better able to make the commitment to the often hard work of parenting that contributes so much to restoring their child's sense of safety and balance.

- A great deal of the patients healing is dependent on the understanding and acceptance that primary caregivers convey to their children. Primary caregivers need information about how to manage particular behaviours.

- Primary caregivers need to understand the various ways in which a burn injury trauma can affect the lives of all family members (including siblings) as well as the factors that can influence reactions.

- A burn injury can be an emotional event that the patient struggles to come to terms with over a long period of time.

- Primary caregivers need information about concrete and practical ways in which their child can be helped to heal and cope.

- Information provided to primary caregivers should include guidelines on when to be concerned about children's reactions to traumatic burn injury.

- Preventive education for primary caregivers may also be useful either individually through group education programs on the ward or by directing primary caregivers to the Kidsafe facility at The Children's Hospital at Westmead.

2.6 To enhance existing coping strengths and strategies of patient/primary caregivers/significant others and to prevent the development of maladaptive coping mechanisms

Accidental injuries that require repeated or painful medical procedures, long periods of hospitalisation or disfiguring physical consequences have the potential to create post traumatic stress for children (C J Frederick, 1985).

The earlier assessment of patient/primary caregiver coping capacity occurs and appropriate intervention implemented the less opportunity there will be for maladaptive and disruptive cognitive and behavioural patterns to become established.

- Each patient's experience of the traumatic burn injury is unique. The particular aspects of traumatic burn injury interact with all that is special and characteristic about the individual patient and influences their efforts at coping.

- Some patients show no immediate signs of trauma and appear symptom-free.

- Regardless of first reactions there is a strong possibility for traumatic memory to resurface unpredictably over time causing distress and disruption for the patient.

- A range of observable patient reactions and behaviours are possible post burns trauma. These may well need to be addressed in order to enable adjustment and coping.

- Signs of unresolved post-burn psychological trauma in patient/primary caregivers need to be carefully monitored and assessed.

- Unresolved pre-burn trauma may need to be processed in order to enable resolution of the burns trauma. These may manifest both in hospital and post discharge.

- It is important to assess for primary caregivers coping style and teach more effective coping skills where appropriate.

NB: That mothers and fathers often adopt different roles in family coping.

Referral to Psychiatry be Appropriate

Reactions include among others:
- Fears and anxieties which can significantly affect the patients sense of safety long after discharge.

  a. Primary caregivers can have difficulty understanding the patient's fear of repeat trauma. Young and regressed patients are unable to appreciate the "probability" of repeat occurrences.

- Startle responses triggers may be specific (eg an ambulance siren) or difficult to isolate.

- Older patients may deny their fear. They work hard at trying to convince themselves that they have nothing to fear when with their peers for example but then become extremely fearful at home. These patients are desperate to gain control and power over their fears.

- Behavioural regression is common including:
  - Loss of control over aggressive behaviour and their capacity to comfort themselves.
  - The patient previously able to tolerate small disappointments and frustration may no longer be able to do so.

  - Toileting accidents are quite common in the young patient as well as a return to night time wetting or thumb sucking for primary school aged patients.

  - Patients may temporarily lose a sense of pleasure in activities and become unusually serious.

  - Sleep related difficulties are common. Nightmares and disrupted sleep patterns are most common with night terrors being less so.

  - Patients may be unable to tolerate minor perceived rejections.

  - Patients may seem excessively "selfish" or "uncaring" in interactions with siblings, peers and others.

  - Some patients may become reckless and disregard their own safety. Needs careful assessment and appropriate precautions put in place.

  - The patient's interpretations regarding the causes of the burn injury are important. Self-blaming interpretations impact on coping efforts and can also affect relationships with family and peers.

  - Patients may develop excessive and unrealistic concerns about the body (which may indicate an attempt to communicate about their psychological pain).

- Personality changes can occur following a burn injury which may be temporary or long lasting. The patient's attitude about themselves their lives and the people around them can change.

- Psychosocial responses following traumatic burn injury are an expression of the patient's inner pain, confusion or distress. Understanding the exact nature of the patient's distress can be difficult.

- While sorting out the meaning of and identifying the origins of the patient's symptoms can be difficult it is an extremely important task for the social worker.

- Patients may be coping well with the burns trauma and treatment for example but are reacting instead to the heightened level of worry and fear in their primary caregivers.

- It is critically important that primary caregivers coping strategies are carefully assessed so that coping strengths can be appropriately enhanced and effectively utilised to assist the patient's coping efforts.

NB: It is important that the social worker consult with the Department of Psychiatry whenever necessary or appropriate to ensure optimal care during the hospitalisation period and short and long term follow up.

Teaching Parents
- Cognitive behavioural coping strategies has been shown to reduce physiological arousal and increase patient's cooperation (Klingman et al 1984) Peterson & Shigetomi (1981 & also 1984).

- Active rehearsal of coping skills may be necessary for maximum effectiveness (Klingman et al 1984).

Useful therapeutic strategies:
- **Systematic desensitisation**
- **Behaviour management**
- **Cognitive Behavioural Therapies**
- **Relaxation/meditation.**

The Speech Pathologist is familiar with the application of augmentative communication techniques for non-verbal patients. To identify patient/primary caregivers and significant others practical support needs and facilitate management thereof.

2.7 To identify patient/primary caregivers and significant others practical support needs and facilitate management thereof

Burn injuries are generally unanticipated and may require urgent medical attention. Primary caregivers/responsible adult's initial response is usually to transfer the burn patient to a medical facility as quickly as possible. Transfer from local hospital to specialist burns facility may follow.

- Primary caregivers therefore often arrive at hospital unprepared with few or no financial resources or clothing/personal items.

- An initial task for social workers may be to assist the primary caregivers with their immediate practical concerns/needs in order to enable them to focus on the burns trauma and related treatment information.

- Practical assistance to primary caregivers may include:
  - organising hospital accommodation for primary caregivers
  - crisis food voucher assistance (NB: resources are limited for financial/material support)
  - referral to community welfare organisations (eg, The Smith Family, St Vincent de Paul Society, Salvation Army).

- Where necessary social workers liaise with relevant government organisations and write letters of support as appropriate (eg. Dept of Community Services, Police, Dept of Housing, Dept of Immigration, Centrelink [primary carers on Newstart Benefits may require exemption from seeking employment for a period of time], IPTAAS).

- Write letters on behalf of primary caregivers to their employers as requested or arrange for support letters to be written by medical staff.

- Families who have experienced a house fire may need assistance with alternative accommodation arrangements.

- Alternative accommodation may also need to be arranged where living arrangements are not conducive to the ongoing care and rehabilitation of the patient.

- When one or both primary caregivers are also burned - social work tasks may include:-
    - to negotiate with extended family regarding support for patient or establish the person to whom relevant medical information should be given.
    - to liaise with staff from the adult treatment unit.
    - to arrange for visits from the less severely burned family member where appropriate.

Ward Grandparents Scheme support may be arranged so as to free up primary caregivers to negotiate necessary practical tasks.
To participate in the development of discharge plans together with multidisciplinary team members and prepare patient/primary caregivers/significant others for discharge. (McKeehan, 1980).
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2.8 To participate in the development of discharge plans together with multidisciplinary team members and prepare patient/primary caregivers/significant others for discharge (McKeehan 1980)

Social workers play an important role in preparing patients/primary caregivers/significant others for the transition from hospital to home and their local community, including pre-school and school.

- Through participation in discharge planning meetings with primary caregivers and multidisciplinary staff members the social worker is able to identify the psychosocial needs and/or obstacles faced by families after discharge.

- The required involvement of primary caregivers in the patient's care post discharge may be substantial as home care regimes may include daily dressings, regular splinting and strict exercise programs.

- The demands of care regimes are often demanding and stressful but primary caregivers need to fully understand and appreciate that non-compliance may lead to compromised mobility.

- Compromised mobility can potentially seriously impact on self-esteem, body image and general psychosocial adjustment in the long-term.

- On-going non-compliance with care regimes needs careful assessment and monitoring with the possibility of referral to the Department of Community Services on the basis of "neglecting" medical care requirements and/or the patient being considered "at risk" regarding future compromised adjustment.

- Research shows that the patients psychosocial adjustment following a burn injury is strongly influenced by the adjustment achieved by primary caregivers. Compas et al (1992), Cahners & Bernstein (1979).

- Primary caregivers who find it difficult to accept the patient's altered body image will negatively influence the patient's adjustment efforts.

- Helping primary caregivers to deal with their emotional reactions during the hospitalisation period (eg. grief, guilt, blame and anger) can help them to :-
  - come to terms with their sadness/discomfort about their child's appearance and
  - have the energy and commitment to comply with the demands of rehabilitation.

- Preparing parents/primary caregivers who are concerned about physical disfigurement/changes to body image for reintegration into their normal environment is an important social work role. Alexander & Quay, (1983) & Quay v Alexander, (1985).

- Burned patients/primary caregivers may be constantly alert to the reactions of others in their environment. (NB: that body image and self-esteem are strongly influenced by the individuals perceptions of how others perceive them.)

- The social worker may use modelling and/or role-playing techniques to prepare patients/primary caregivers for the reintegration process.

- Helping parents/primary caregivers to develop a "script" for providing information to the curious can be useful.

- The social worker may accompany the parents/primary caregivers on excursions to the local shopping centre as a pre-discharge exposure to the "real" world.

- These excursions provide in vivo practice opportunities for learned new coping skills.

- The social worker may participate in pre-school and school visits in order to educate staff about the psychosocial impact of burn injuries and to discuss emotional and behavioural management strategies.

- Discharge following a significant burn injury may result in changes to family routine and family roles. Patients/primary caregivers need to be prepared for potential changes.

- Siblings should also be prepared for the patient's return home and be provided with an opportunity to discuss reactions to the change to pre-burn family life.

- Referral to appropriate community resources may be negotiated with the primary caregivers, eg. Family Support Services, respite care services, multicultural support services.

2.9 To make arrangements for psychosocial follow-up post discharge

The acute phase of inpatient treatment is generally followed by planned periods of intervention in line with the process of trauma recovery and the ongoing development of the child.

Post-discharge psychosocial follow up may be required by patients/primary caregivers/siblings.

In addition to the support provided by primary caregivers and extended family, patients often need ongoing professional counselling as they reintegrate into their normal world.

Primary caregivers/significant others need to be educated regarding behavioural changes that may indicate that the patient is experiencing psychosocial adjustment difficulties (eg. regression, social isolation, using burn injuries as an excuse to avoid unpleasant/challenging tasks).

- It is extremely important that a thorough psychosocial assessment of the patient is undertaken to determine causes of behavioural changes.

- Body image and self-esteem issues take on new qualities which present the patient with different challenges at the different developmental stages.

- The patients who require long-term follow up will invariably have had to wear pressure garments which "hide" the actual burn scars. Once pressure garments are no longer required to be worn many patients experience a re-activation of many of the issues related to exposure of their scars and acceptance by their peers.

Useful Therapies

- Social workers utilise therapies that they are familiar with or formally trained in an eclectic fashion.

- Cognitive - Behavioural Therapies can be extremely effective in helping both patients and primary caregivers to process and resolve the multiple long-term issues which may be associated with burn injuries.

Resources

- Counselling Children (5th ed), (Thompson & Rudolph, 2000)
- Handbook of Cognitive - Behavioural Therapies (2nd ed), (Dobson (ed), 2001).
- Handbook of Play Therapy, (Schaefer & O'Connor (eds), 1983).
- Cognitive Behavioural Play Therapy, (Knell, 1993).
- 101 Favourite Play Therapy Techniques, (Kaduson & Schaefer (eds), 1997).
- Children & Trauma, (Monahon, 1993).
- Coping Strategies for Burn Survivors and Their Families, (Bernstein et al 1988).
- Liking Myself, (Palmier, 1977).
- The Mouse, The Monster & Me, (Palmier, 1977).
- When Something Terrible Happens, (Haegaard, 1991).
- Children Can Learn to Cope with Loss and Change, (Haegaard, 1991).

NB: **Cognitive functioning as well as affective and emotional development must be considered in therapeutic work with children.**

To develop therapeutic and educational group work programs for patient groups and primary caregivers groups to facilitate in order psychosocial adjustment.

2.10 To develop therapeutic and educational group work programs for patient groups and primary caregivers groups to facilitate in order psychosocial adjustment

- Support groups for burn survivors and their families have been shown to be therapeutic in promoting emotional recovery.

- Group programs provide a way to address the complexity and multitude of problems that burn patients and their families may experience.

- Careful consideration must be given to the appropriate criteria for group composition or group formation.

- Groups may therefore target inpatients, primary caregivers/siblings/significant others, outpatients or peer group depending on need.

2.10.1 Inpatient groups

- Decisions regarding which patients participate in inpatient groups are made by the social worker.

- Participation decisions are based on patient needs or the social workers awareness of patient problems.

- Patient personality manifestations and the meaning of their behaviour also need consideration.

2.10.2 Primary caregivers groups

- Groups for primary caregivers primarily focus on education and information.

- Input from the various members of the multidisciplinary burns team is important.

- Primary caregiver groups are usually (but not always) open to all those attending in patients.

- Groups may focus on the impact of hospitalisation and treatment and what primary caregivers can expect and what is expected of them.

- Educating primary caregivers about the needs of burn patients at different developmental stages is also appropriately covered in groups.

NB: It is extremely important to reinforce for primary caregivers that each burn is different therefore treatment, patient's cosmetic outcome and adjustment issues will be different.

2.10.3 Outpatient groups

- Outpatient groups may provide recreational or educational resources.

- Post-discharge groups are excellent mutual aid forums where the social worker is primarily a facilitator (eg, groups run at the Annual Burns Camp).

- It is often helpful to initiate procedures in outpatient groups whereby members are able to support each other between sessions.

- Outpatient groups may also target particular developmental age groups eg transitions groups which prepare those patients who are required to move from paediatric care to adult care facilities.

- Groups may also target patients with burns with particular physical/cosmetic consequences eg young women who have burns to the breast area.

- Social workers attend the annual CHW Children's Camp for burn survivors. Social work responsibilities include:

- the provision of emotional support to individual children as required
- the education of support staff regarding psychosocial issues and general behavioural management
- facilitating formal group sessions for different age groups.

NB: Social workers should be well versed in group dynamics and processes.

2.10.4 The Speech Pathologist has an awareness of the effect of thermal, chemical and inhalation burns on speech articulation (Fraulin et al 1996).

To contribute to education programs for the various multidisciplinary team professional groups or others as required or requested.

2.11 To contribute to education programs for the various multidisciplinary team professional groups or others as required or recquested

- Social workers are available to educate others about the social work role or about issues associated with a burn injury eg normal post traumatic stress reactors; the grief process associated with loss of the perfect child or loss through death; the influences of developmental stages on hospitalisation, coping and adjustment.

- Through formal documentation in medical records social workers provide information regarding:

  - Psychosocial assessment and
  - Alert the multidisciplinary team to the influences that may impact on the patients recovery process
  - Recommendations for management of particular issues or concerns
  - Details of planned ongoing social work management.

- Through in-service training sessions social workers educate staff about the process of conducting a psychosocial assessment and therapeutic intervention with patients/primary caregivers.

- Social workers participate in pre-school and school visits in order to educate teachers about the psychosocial impact of burn injuries and to discuss emotional/behavioural management strategies.

- On request social workers provide in-service training sessions for staff at community organisations eg Department of Community Services.

- Specialist burns social workers may be consulted by peers from local hospitals.

- Social workers may contribute to inter hospital burns symposiums by presenting case studies or profiling an aspect of social work therapeutic intervention.

- Social workers participate on discussion panels regarding the psychosocial care of burns patients as requested.

- Social workers as part of the multidisciplinary team contribute to the tertiary programs for medical students, social work students and nursing students.

NB: The involvement of social work students with burns patients is not considered appropriate due to the long-term nature of treatment and rehabilitation.

2.12 To provide supportive group counselling opportunities for staff following the dearth of a patient or when managing extremely challenging parent/primary caregivers/significant others

- Burned patients and their physical care demands as well as managing primary caregivers from sometimes quite dysfunctional family backgrounds can pose a major challenge for staff.

- Social workers play an important role in mediating and/or managing the stress of patients/primary caregivers in order to avoid conflict situations.

- Patients with large percentage (TBS) burn injuries can be extremely complex to care for.

- The behaviour of anxious primary caregivers may begin to reflect the strain of parental concern and their guilt feelings by becoming increasingly intolerant and demanding towards staff.

- Primary caregivers may become argumentative and express open dissatisfaction towards staff members.

- Nursing staff are also frequently confronted with an angry, crying patient who is experiencing a great deal of pain and discomfort.

- The social worker provides support group opportunities for staff to :-
  - talk about experiences or concerns,
  - to ventilate about difficult episodes or conflict they might have with patients/primary caregivers.

- Social workers are available to discuss strategies for managing difficult relationships with parents/primary caregivers.

- Social workers can help multidisciplinary team members to understand individual family dynamics and the cultural values/beliefs that influence family functioning.

2.13 To develop and/or participate in research programs which include the psychosocial aetiology factors and sequelae of burn injuries or the evaluation of intervention outcomes

Social work practice and research should not be mutually exclusive. As noted by Briar & Miller (1971) - "Every (social work) clinician …………….. is a researcher and any dichotomy is thus artificial." (p.82)

- A primary social work role is to mediate in the psychosocial world of experiences of patients/primary caregivers/significant others in order to enable positive adjustment following a burn injury.

- Social Workers are accountable to demonstrate not only what they do but how effectively they perform.

- Social Workers in the Burns Unit also have a responsibility to add to the knowledge base that defines service development and provision.

- The search for incremental interdisciplinary knowledge about the psychosocial impact of burn injuries is therefore extremely important for practice to be relevant and effective.

- Incremental practice knowledge needs to combine clinical methods in direct practice with skills in scientific evaluation.

- It is by investigating clinical phenomena that we can determine if social work is effective.

- Social work effectiveness needs to be quantified in terms of explicit and measurable problem formulation and measurable focussed problem solving techniques.

- The goals and intervention methods utilised can then be re-examined and modified.

- Research can assist with the identification of patient/primary caregivers psychosocial needs and therefore contribute to appropriate services.

- Social workers need time to collect data, analyse them and communicate them in writing or in oral presentations.

- The establishment of a research support group across Burns Units may be a useful goal.

NB: Issues of confidentiality need to be addressed and resolved. There also needs to be an emphasis on peer involvement with an ongoing commitment to measurable progress over time.

- Social workers require tangible support through:

    - The allocation of time for agreed to research activities
    - Access to statistical and methodological consultation when necessary
    - Clerical assistance when necessary
    - Funding where necessary.

2.14 To attend regular meetings for social workers in Burn Units and to participate in national social work professional activities as appropriate

Social workers in Burns Units can benefit from working together to optimise skills and resources. In turn service delivery and outcomes for patients/primary caregivers may be enhanced.

- Work in a Burns Unit can be extremely demanding but it can also be extremely satisfying.

- One way to increase work satisfaction is to attend regular social work peer group meetings which operate on the principles of confidentiality and trust.

- These meetings are can serve to:

  - facilitate good inter-unit communication
  - facilitate peer support
  - encourage clinical practice review
  - address professional social work issues
  - provide opportunities for ongoing clinical practice updates and or education
  - focus attention on specific tasks
  - assist in meeting individual professional needs
  - opportunities to discuss the efforts of the group.

- Meetings should be facilitated and coordinated by a team leader appointed on a rotational roster.

2.15 To attend the Australian & New Zealand Burn Association annual scientific meetings and other relevant national and international conferences

- Attending national and international conferences provides a unique opportunity to network and meet peers.

- Conferences provide information about current trends in medical and other multidisciplinary team treatments which may impact on the psychosocial care of patients/primary caregivers.

- Conferences provide a forum for educating others about the dynamics of the social work role as part of the multidisciplinary team.

- Conferences provide an opportunity to showcase the clinical social work role through case examples.

- Conferences provide a venue for disseminating data from current research efforts.

- Conferences may stimulate a review of aspects of current practice and encourage continued investigation and learning.

- Conference attendance can assist in maintaining enthusiasm and commitment to working in a Burns Unit.

- As ANZBA conferences rotate venue annually attendance can provide opportunities to visit other units to see how they function and to learn from colleagues.

- Social work participation at conferences through presentation of papers or posters needs to be encouraged and supported by the Heads of Burns Unit.

- Social work attendance at conferences also needs to be supported financially.

2.16 To ensure continuing supervision and professional development of social work staff

In order to retain social work staff on Burns Units and to ensure optimal, "best practice" social work service delivery it is imperative that staff receive regular clinical supervision and that they be encouraged to continue learning and growing through professional development opportunities.

- Supervision may be a component of management and serve to assist in the planning, organising, motivating and managing of professional activities.

- Supervision may also be independent of management with a focus on clinical skill development.

- The increasing demand for accountability and evaluating competence in all areas of social service intervention however requires a dual focus on management and clinical skills.

NB: For this reason independent supervision will need to be negotiated with management

- The supervisory role is important in ensuring that data on patient/primary caregiver outcomes and the effectiveness of overall social work services are interpreted correctly for planning purposes.

- Good social work service delivery also depends on effective and appropriate training so that individual skills can be enhanced.

- Ongoing professional training should therefore be encouraged.

- Professional training can assist in maintaining social work staff enthusiasm and commitment to their work. Training may incorporate in-services, in-house professional development programs, workshops, seminars as well as post-graduate tertiary qualification courses.

- Supervision therefore needs to nurture individual social worker abilities and encourage skill acquisition within the context of management goals and service development.

- Supervision also provides an opportunity to express personal feelings/sentiments related to individual cases.

- Due to the stressful nature of the work supervisor's have a responsibility to monitor stress levels, be alert to burn-out symptoms and to address these timorously.

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