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London and South East
Burns Clinical Network

Psycho-social care and support of adults with burn injuries


How will
I cope?
Who can
I talk to?

Contents

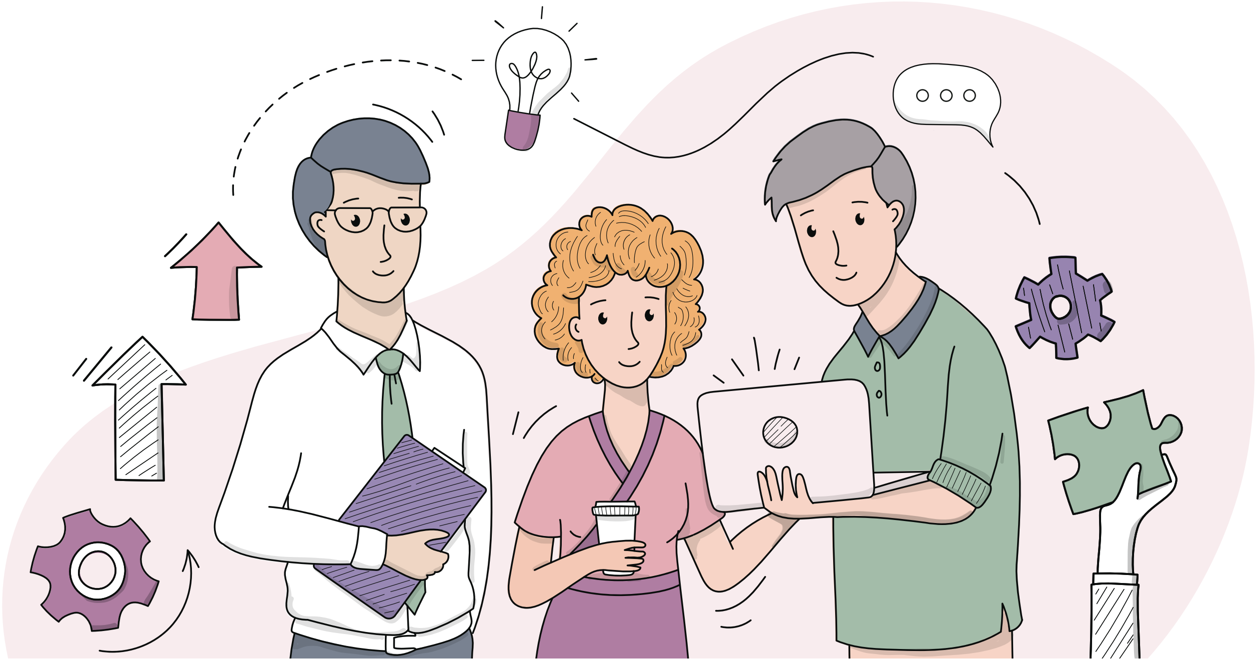
Module 1 | What is psycho-social care?

Module 2 | Recognising patient needs

Module 3 | The wider impact of burn injuries

Module 4 | Coping with change

Why this training?



The purpose of this training is to ensure that staff working in or with burns services gain appropriate knowledge of the psycho-social aspects of care for their job role. While hospitals provide a good level of physical care, a major review in 2001 suggested the psycho-social support provided for burns patients could be improved. Standards produced in 2008 aimed to secure this improvement in care. The original training package was designed in 2010 to promote, encourage and embed the National Burn Care Group standards for psycho-social care into the patient care pathway. It has been updated in 2023 based on more than ten years of teaching sessions and feedback from hundreds of students.

This training package is designed to meet a variety of learning styles and throughout the course you will participate in reflection, a discussion of case studies and recap theoretical information. References are provided throughout the modules to provide further information on the topics covered. This course can be completed in a variety of ways from self-directed study to group training sessions. Your trainer will suggest the best way to complete this package for you and your team.

Key Symbols

Throughout this manual you will see the following symbols:

Key information: These sections provide a discussion of some of the key theoretical information and knowledge relating to the key aims of the module.

Case study: These sections introduce a patient scenario. Each one is usually followed by some questions or a structured discussion on the issue raised. You can replace the case studies with your own if this is thought to be more appropriate.

Task: These are tasks designed to encourage thinking and learning around the main teaching points. Optimal learning is achieved through active participation in these tasks.

Reflection: Learners are also asked to reflect on their own experience and patients they have worked with to encourage integration of their learning into their work. Although all reflection can be undertaken individually, learners will gain more from sharing experiences.

Further reading: Further information such as journal articles, books and web links are given here.

Module 1 | What is psycho-social care?

Aim: to understand the importance of psycho-social care and to review your role in the provision of this support for burns patients.

Case study 1: To understand the importance of psycho-social care in addition to physical care for burns patients, it is important to first look at what we mean by psycho-social care. This module aims to explore this concept. Let us consider a case study of a current, recent, or historical patient who was admitted to the burns service. Think about your role in this patient's care provision.

Task: Consider your role in their care and the role of other members of the MDT.

Key information: Psycho-social care can include supporting patients with their emotions, feelings, and behaviours and in addition, helping them to communicate with others. Some patients will require support and reassurance to manage areas of their personal and social life; this may also include meeting the needs of their family and friends.

It is important to note that in general human beings are remarkably resilient. Most of our patients will be fine and have the resources and resilience to handle the experience of a burn injury. Difficulties tend to emerge when our resources, or indeed our belief in our resources to cope, cannot meet the perceived demands of the situation.

Burns injuries, especially if they are severe, can be a life changing experience and may involve a long stay in hospital and further treatment after discharge. Patients may need help and specialist support to develop new strategies to cope with the effects of their injuries. This can include helping them adapt to physical limitations and functional changes, and a changed appearance or scarring. Without such support people may develop long term psychological and social difficulties, such as becoming withdrawn from society, struggling in school and work, and not feeling able to live a full and happy life. The term ‘quality of life’ is used to reflect how much a person’s physical, psychological, and social needs contribute to their ability to enjoy their life.

Meeting a patient’s needs and helping them to help themselves will improve their quality of life. We will use the acronym SPECS to describe how to see the potential areas of a patient’s life where they may need psycho-social support.

Social

Interacting and successfully communicating with family, friends, colleagues and other members of society. Participating in daily life activities and social occasions.

Physical

Includes needs such as eating, sleeping, drinking, exercising, washing, dressing etc. May be a rapid change from being totally independent to needing help with simple tasks.

Emotional

These needs may be easier to recognise. Expression of sadness, anger, loneliness, anxiety, depression, confusion and others. Some may report positive feelings such as being ‘happy to be alive’.

Cognitive

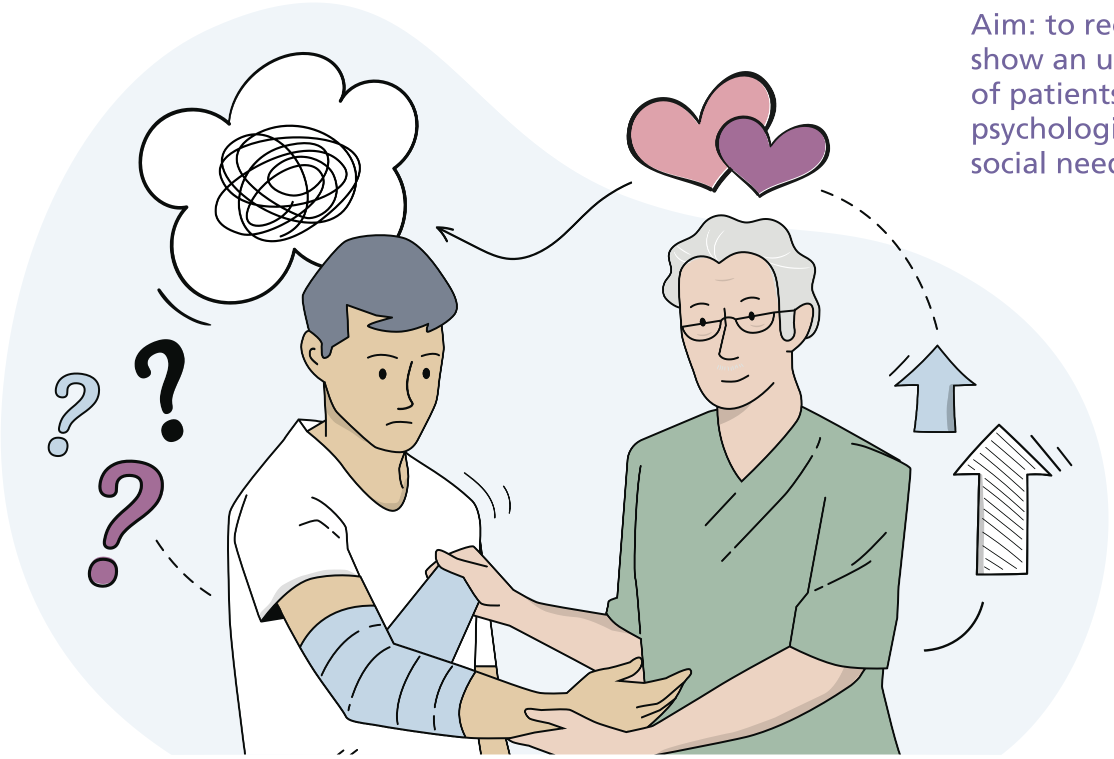
May seem slowed down or less sharp if they cannot attend school or work for a long time. May worry more, e.g. about money if they are unable to work, or if they needed to support others. Hobbies and routines may be difficult to stick to when hospitalised for any length of time. Keeping your mind active is important for quality of life.

Spiritual

May question the religion or beliefs or seek comfort from them. They may not be religious, but may still have questions such as ‘Why me?’ or in the case of a parent ‘Why not me?’. They feel they are being ‘punished’ in some way.

Physical and psycho-social care should both be included and incorporated into the patient’s care. Effective, holistic care will consider all these needs for all patients. From admission, throughout their hospital stay, on discharge and through community follow-up, these needs should be assessed, acknowledged, and met as effectively as possible.

Module 2 | Recognising patient needs



Aim: to recognise and show an understanding of patients' physical, psychological, and social needs.

Task: Using the same patient for case study 1, or a different person, apply what you have just learned in Module 1 to identify and write down a SPECS perspective of their needs.

Community

All patients will have feelings about themselves and what has happened to them. They may need time to process the event, the dynamic nature of their injuries, their time in hospital, how they will cope, returning home and so on. However, their family, friends, colleagues, and other people they don't even know yet will also have thoughts, feelings and beliefs about them. This section will explore some of these issues.

Task: Sometimes feelings can lead us to behave in particular ways. Think of another three potential feelings or behaviours the patient might have, and three feelings or behaviours people around them might feel and add them to the box below.

Patient's own feelings/ behaviours	Society's feelings/behaviour
• Withdrawal – not wanting to go out	• Strangers ask difficult questions
• Depressed	• They may stare and look
• Relieved to be home	

Task: Here are some potential situations that may arise after discharge from hospital. Discuss what issues might arise, how a patient might feel or act in these situations and how others might feel or act.

- Leaving the hospital and going home for the first time
- Going to a coffee shop to meet up with his friends
- Returning to work or college
- Collecting their children from school
- Trying to do regular chores around the house

Communicating with patients

There are two main types of communication: verbal (speech) and non-verbal (body language). These two forms of communication go hand in hand. When we communicate, most of the messages we send to others come through our body language. This might be our posture, the way we are holding our hands and arms, eye contact and our facial expression. The other important part of communication is the 'way' we say our words, for example if we said, "do you want a cup of tea?" angrily, then it wouldn't sound welcoming or caring. The words that are spoken are thought to be the least important when sending a message. If a carer had their arms crossed, and wouldn't look the patient in the eye, there is little chance of having a successful relaxed conversation. The most approachable carer would have a relaxed body posture, maintain good, natural eye contact, smile and have their hands in a relaxed position by their side.

Top tip

- Think before you speak; also think about what your body is saying as well as your words.

Communication in a health care setting

For many patients and their families, the hospital environment can be a distressing and daunting place. As we have seen from module 1, patients will meet many professionals in clinical and non-clinical roles during their stay at a burns service. At times, patients may experience a lack of control, independence, lack of dignity and understanding. We know that loss of control, unfamiliarity and high levels of unpredictability all contribute to high levels of stress. This may be accompanied by feelings of distress, pain and other complications due to their injuries. Patients can therefore feel vulnerable during a long stay in hospital. For this reason, it is very important to communicate empathically with the patient. This gives the opportunity to reassure them and allow them to express their feelings and worries if they wish to.

Top tip

- Hospitals can be daunting and distressing places for patients and their families. If you are meeting them for the first time, always remember to introduce yourself (preferably with a smile) and say what you are there to do.

Normalising feelings

As we have seen earlier in the teaching material, patients, their friends, and families may experience a variety of feelings and emotions throughout their time in hospital. Any patient who has experienced hospitalisation for burn injuries is likely to experience a range of unfamiliar or even overwhelming emotions. This is usually perfectly normal and understandable. It is important that the patient and staff understand and acknowledge this. A patient may also try to hide their feelings or suppress their emotions, and some will try to 'be brave' or 'hold it together' for the sake of their family. As a member of the multi-disciplinary team, it is very important that you help the patient to recognise that expressing their feelings is OK.

Top tip

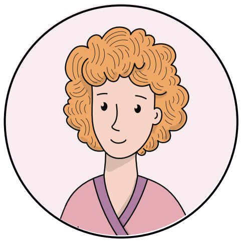
- It can really help a patient if you tell them how they are feeling is normal. Hospitals can be daunting.

Task: Even if you are in a role at the hospital where you don't contribute to patient care directly, or if you are busy and don't have a lot of time, you may still be able to help to normalise a patient's feelings. Here are some examples, try the next two yourself.

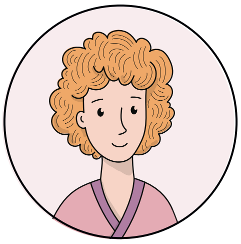
Scenario 1.

Patient: "I just feel so sad and depressed; life will never be the same again."

You: "I'm sorry to hear that. It can be hard to imagine a positive future at this point in time. Would you find it helpful to talk to someone about how you are feeling?"

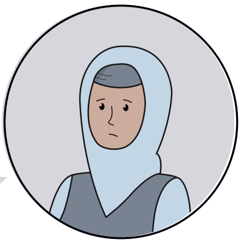


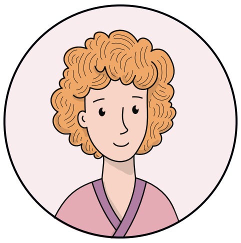
Scenario 2.



You: "How are you feeling today?"

Patient: "I don't want to bother you with how I'm feeling, you don't want to know."



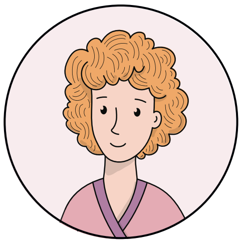


You: "Well, I may not be the best person to talk to right now but lots of people struggle to be in hospital. What would you usually do if you are having a difficult time or have worries about the future?"

Scenario 3. What might you say if…

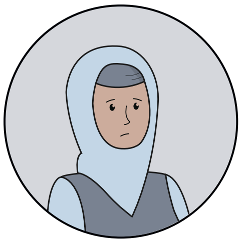
Patient: "I want a cup of tea now." (Said angrily)

You:

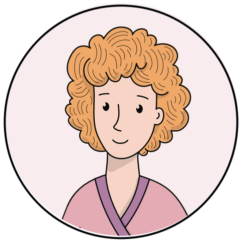


Scenario 4. What might you say if…

Patient: "Don't draw back my curtains today; I want to sit in the dark."



You:



Working with difference

In your service you are likely to meet staff and patients who are different from you in some or many ways and who may respond differently to illness. Some cultures express their emotions very openly and some will be much more reluctant. Some patients will have large extended families and expect lots of visitors, and some will want to be more private. Of course, the same will apply to staff members that you work with. They too may have different ways of talking about things, doing things, and reacting to situations.

Some people form opinions about others based on what they look like or what they wear. Often these conclusions can be incorrect, and we must be careful not to stereotype people before we know anything about them. Many of your patients may have very different ways of doing things at home compared to the hospital. They may also not like the ways and routines of the hospital as they are strange and different, e.g., the food.

If you are uncertain about what would be best for a patient, then ask. Generally, people don't mind being asked. You may not be able to change something, but it does show that you care and are interested.

Top tips

- Try not to make assumptions about the way people are used to doing things, or about how they are. The reality may be very different to what you see.
- Try to treat everybody as an individual and with respect.

Task: Think of a time when you have personally experienced a difficulty in managing difference between you and a patient or their family, or the rest of the burns team. What did you do that helped when working with this difference? Would you do anything differently looking back on the situation now? What do you think the patient, their family and/or the team needed at the time? How did their needs fit with your own? How did you deal with this? What was un/helpful?

Practicalities and logistics

When patients are admitted to the hospital they will be in a strange and unfamiliar environment. They will probably not have much control over their life as many things, such as waking up, mealtimes and visiting hours will be dominated by the hospital routine. Patients may have many questions about their new environment, and it is important to know the answers to give them or to find out from someone else and to make sure you go back to the patient to pass on this information.

Task: What practical things are there in your hospital that patients should know about? For example, they may want to know about mealtimes, visiting hours, who is who, travel (for family wishing to visit), where the hospital shop is, parking regulations and so on. If you do not know the answers to these questions, please try to make time to find out, so you can help a patient and their family if they need this information.

Reflection: Think of a patient on the ward now, or who has been there in the past. How well were we able to meet their needs? Could we have done anything else?

Further reading:

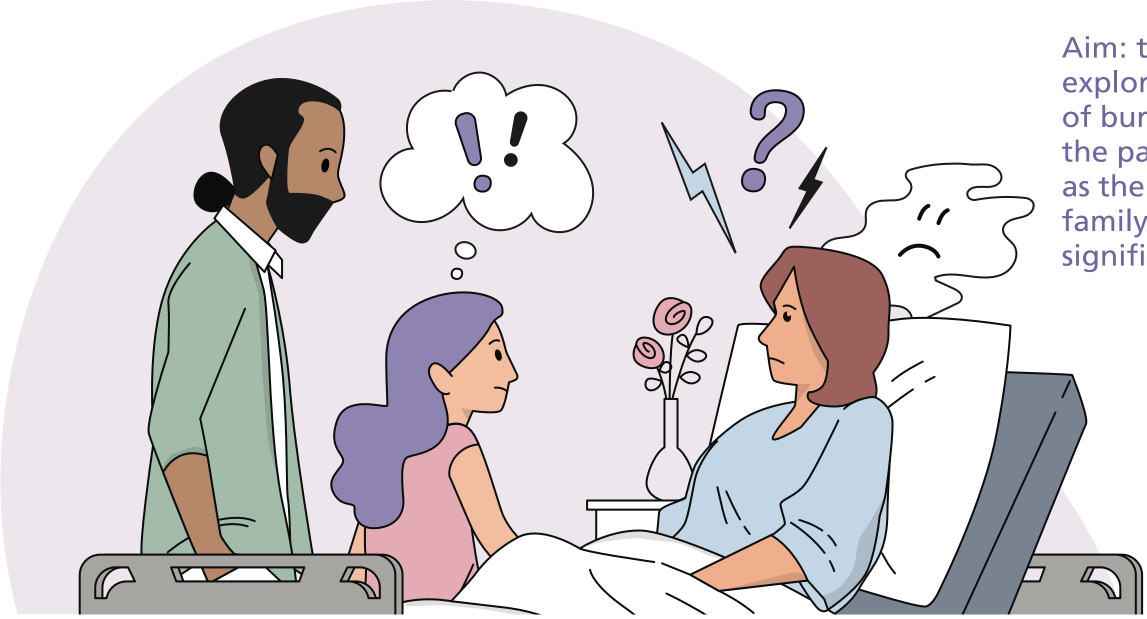
Clarke A (1999) **Managing the future after burns, Addressing Psycho-social Needs, a guide for health professionals.** Changing Faces.

Partridge J, and Robinson E (1995) **Psychological and Social Aspects of Burns**. Burns, 21(6), 453-457.

Rumsey N, Clarke A, and Musa M (2002) **Altered body image: the psychosocial needs of patients**. British Journal of Community Nursing, 7(11), 563-566.

Rumsey N, Clarke A, and White P (2003) **Exploring the psychosocial concerns of outpatients with disfiguring conditions.** Journal of Wound Care, 12(7), 247-252.

Module 3 | The wider impact of burn injuries



Aim: to continue to explore the impact of burn injuries on the patient, as well as the patient's family, friends, and significant others.

Task: How patients feel - In an intense environment like a burns service when patients and their families may be struggling to get used to a new situation, people may behave out of character. The frustration of being in hospital, in pain and being away from family can be very difficult. Imagine the following scenarios. How would you feel? How might these feelings make you behave?

Both your hands are bandaged. Think of the things you can't do. How would that make you feel?

You are missing your brother's big birthday party that has been planned for months because you are not fit enough to leave hospital.

You are not able to take or collect your five-year old daughter to and from school in her first term. She is very upset and does not want to go with her father/mother/friend.

These are some of the things that a patient who faces a long time (or even a short time) in hospital might not be able to do. The suddenness, the frustration and the sadness can be hard to take in and as a result people can behave differently. They can be overwhelmingly angry or sad and behave in ways that can be a surprise to them and their family. People can get cross and edgy about small things that would normally just go over their heads e.g., whether the curtains are drawn a certain way or what they are eating. This can be a frightening experience as the patient will be dealing with the unfamiliar feelings as well as a strange hospital environment.

Managing our own feelings

Key information: It is not surprising then that working on a burns unit can generate lots of different feelings about ourselves, our colleagues and our patients. We all need to find a way to manage these feelings and still be able to do our jobs to a high standard of professionalism. We may experience feelings, such as upset, irritated, angry, or sad towards some patients or families. There are also some patients who we will feel more affected by because they remind us of ourselves or someone else we already know and have feelings about. Sometimes this connection is not always conscious but can be a powerful influence on how we want to treat them. However, as a healthcare professional we need to try to treat everyone the same. This can be difficult sometimes especially when you feel a patient is directing their feelings at you.

Next time you experience strong feelings about a patient or their family, take a moment to be curious and think about what is happening. Try to recognise your own emotions but also to step back from them and maintain an open mind. Consider the situation they are finding themselves in. If you have a really strong emotional reaction to someone, it can be a sign that the patient is feeling overwhelmed or out of control and you are taking some of that emotional load. In an intense environment where a patient or a family is struggling to get used to a new situation this can be quite common.

Monitor your reaction to your patients and make sure you have somewhere to offload those feelings. Make sure they do not spill over into the care of that patient or other patients.

Top tips

- Put yourself in patients’ shoes occasionally. Think about how you might feel in their situation.
- Remember that the person is probably angry with their situation, not you. This can be helpful to keep in mind when trying not to take something personally. It can also help to offload by finding a safe space with someone to talk about strong feelings of upset, anger etc.
- Try not to judge. It can be unhelpful to label patients as ‘difficult’. Remember it is the situation that you are finding difficult, not the person, and they are probably finding things difficult too. Look at the section on ‘Looking after yourself’.

Further information: There are lots of strong emotions that patients might feel and experience especially after a burn injury.

Stages of grief

Elisabeth Kübler-Ross's Stages of Grief (1997) is a well-recognised framework for understanding loss. Although originally designed to help individuals to understand the grief process of death and dying, the same ideas can also be useful in cases where people are experiencing loss or are grieving for what they 'used' to have. The idea is that individuals can go through various stages of grief. The stages in the model aren't designed to run one after another, meaning that people can go back and forth between emotions, or skip stages. The five stages are: denial, anger, bargaining, depression and learning to cope with the new situation.

Denial is a response we may frequently see in burns patients. Individuals may avoid issues. Sometimes it's as though they choose to ignore the extent of what has happened. They may not want to look in the mirror, participate in dressing changes or accept that their life has changed in any way. "If I ignore it, then it will go away", or "It's not as bad as it seems".

Denial can be very helpful in the early stages of recovery. It allows us to take in more slowly the psychological impact of what has happened and often our body needs the energy for the physical healing. Sometimes what has happened is so 'big' and 'awful' we need the time to get used to it. Denial becomes a problem if people are getting close to discharge, and they have an unrealistic view of how they're going to manage when they get home; or if people don't want to take part in rehabilitation because they think that things are going to 'just get better'.

Top tips

- It may well be normal for patients to experience some 'denial' in the early stages of recovery.
- Work with patients slowly to help them get used to the new situation they are in.
- You may find you have to repeat things – "there may be some things that will change when you get home".

Anger - This can be expressed in a variety of ways. They may be angry with themselves or another individual, possibly for causing their injuries, or for not preventing them. "I shouldn't have been so stupid", or "I can't believe he didn't check the smoke alarm." Patients can also get angry at other people (staff, friends, and families). They might be snappy, short tempered or insist that even small things are always done very precisely and get really angry if they are not.

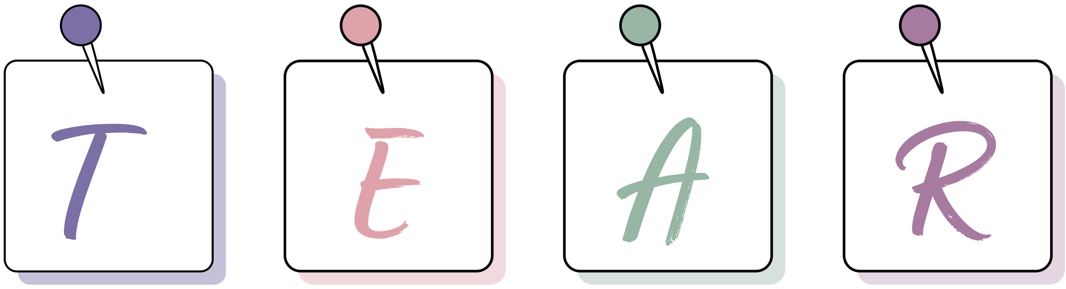
Obviously as a staff member you do not have to accept abuse or swearing from patients or families, but try acknowledging their anger, "I know you are angry, that is OK". Or agree with them how you are going to do something before you start. Do not raise your voice or get into an argument with patients – that is likely to make the situation worse. Even if you think they are being unreasonable, think about it from their point of view. Anger is a very common phase in recovering from a traumatic injury – try to see the anger as a normal part of recovery and try not to label the person as 'just an angry patient'. Most people do not want to be angry all the time – it is just that their feelings are overwhelming in that moment.

Top tips

- If a patient shouts at you, stay calm. Don't shout back. It is likely to make things worse; try not to get defensive either.
- Negotiate if you can. It will help your patient to feel in control.

Other potentially useful models are **William Worden's (2018) Four Tasks of Grief**. Although Worden's tasks refer to the deceased, as in a person, we could also apply the concept of any loss to the tasks – as in functional loss, amputation or change of appearance resulting from the burn injury.

He also used the acronym **TEAR**:



1. **T**o accept the reality of the loss - some denial can serve a purpose in that it allows you to slowly absorb the full weight of the loss.
2. **E**xperience the pain of grief.
3. **A**djust to an environment with the "deceased" missing.
4. **R**einvest in a new reality and find an enduring connection with the "deceased" while embarking on a new life.

One further concept to help us make sense of loss is **Stroebe and Schut's (1995) Dual Process Model of Grief and in particular the concept of Oscillation.** Healthy grieving means engaging in a dynamic process of going back and forth between confronting and avoiding the loss. It is not all or nothing, nor switched on until everything is done, but a process that a person may dip in and out of.

Summary

These models may be useful in helping staff make sense of the patterns and variety of emotions that patients go through when experiencing loss or change due to burn injuries. However, it is also important to note that not everyone will go through all these emotions or tasks or in a particular order. Other major life events such as a divorce and previous experiences of loss can also influence the experience of present loss.

Further reading and links:

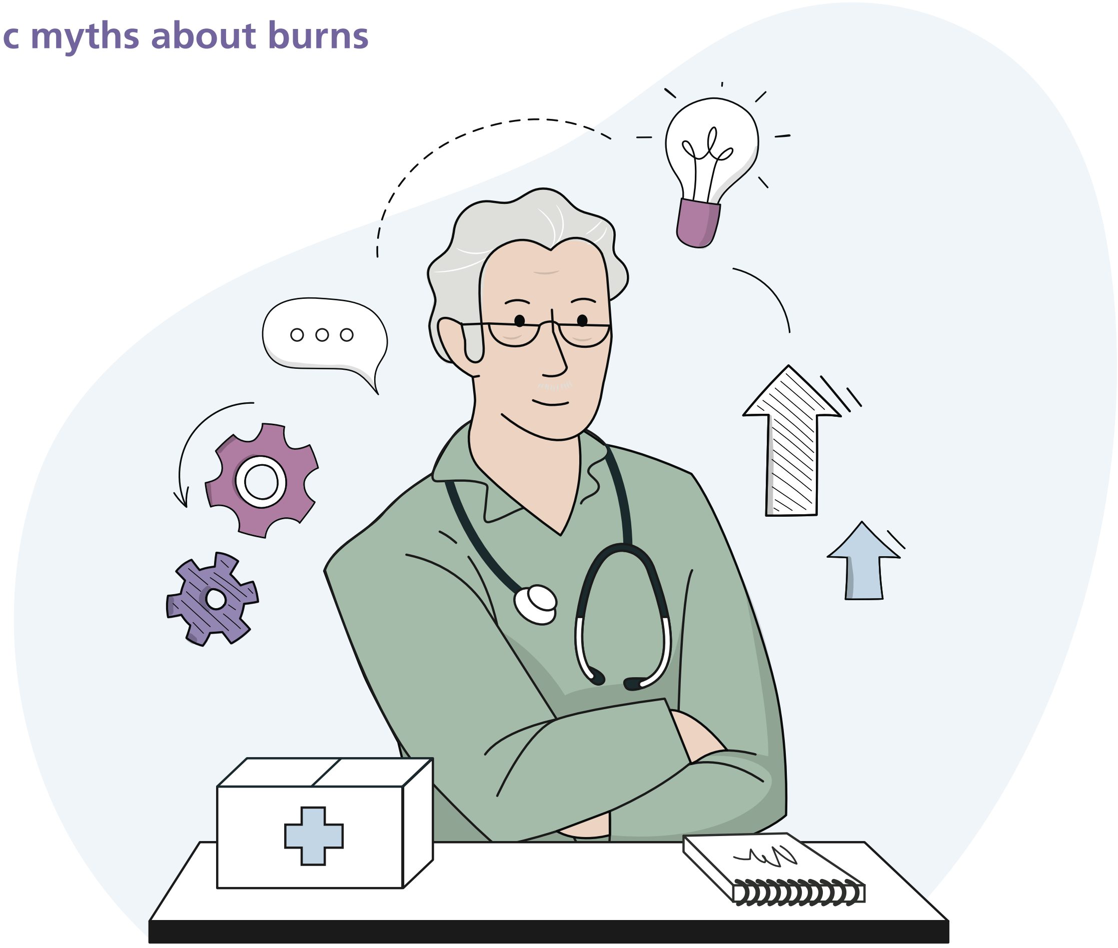
Kübler-Ross E (1997) **On Death and Dying.** New York: Simon & Schuster.

Worden, William (2018) **Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner (5th ed).** New York: Springer Publishing Company.

Stroebe, M., & Schut, H. (1999). **The Dual Process Model of Coping with Bereavement: Rationale and Description.** Death Studies, 23, 197-224

Task: Looking at these models, can you identify any past or present patients who might be or have been experiencing this. Which ones have you observed?

Classic myths about burns



Usually, the first thing we know about a patient with burns, even before we meet them, is what their burn injury is, such as size (TBSA), location and depth. We may also know about the cause of the injury and some personal information about them – their age, gender, what language they speak.

However, as you will learn in this section, certain factors are more or less helpful in predicting distress and there are some 'common sense' assumptions about the impact of burns injuries that can actually be unhelpful myths that we will challenge.

Myth 1:

The size of the burn matters - the bigger, the more distressing it feels.

There is no direct relationship between the size of the burn and distress. Some of the most upset people we see have very small burns and yet, other people with large burns do not seem that bothered. Perceived severity relates to the individual's own opinion of their injury. Objective severity describes how one may 'quantify' their injuries, for example, '30% deep dermal burns'. Psychologically, there is often a difference between perceived and objective severity. It is important to remember it is how severe the patient believes their injuries to be that is key not what anyone else thinks or what the numbers say. To know, we have to ask.

This explains why some people who have widespread injuries may be less concerned than someone who has a relatively small burn. This might seem illogical but try not to compare one patient with another. Each patient's feelings are equally valid.

Myth 2:

Site matters, especially on the face is the worst, or if it is visible (e.g. hands).

Similarly, there is no direct relationship between where the burn is and distress. Some of the most upset people we see have burns that are hidden and nobody else is likely to see and yet, other people with visible burns do not seem that bothered. Once again, to know, we have to ask.

Myth 3:

As the injury heals the person looks better and therefore should feel better.

It does not always follow that people feel better as their injuries heal. In fact, some people become more distressed when they do not feel an expected psychological boost from physical healing. Psychological recovery does not run concurrently with physical recovery. Even when a patient's injuries are showing signs of improvement, or the scars are fading, they might not be feeling any better psychologically. This can be hard for patients to understand, and they will often say things like, "the injuries are looking so much better; I don't understand why I don't feel better." In fact, it may be that the psychological recovery can only really start after the body has stopped using all its energy on the physical recovery. When the physical recovery has taken place that may leave more time for patients to think about their injuries and the impact on their lives. Only then can patients begin to make sense of what has happened to them and how it might affect their lives and the lives of those close to them. Some people may seem to cope at this stage and others may start to struggle. Sometimes the people who seemed to cope in hospital can struggle once they are discharged.

Myth 4:

People want you to tell them if they are looking better.

When there is a mismatch between how a person feels and how they look to others, this can cause distress and unhelpful expectations from others, such as 'but you should feel better'.

The good news is that most adults and children who experience a burn injury will recover psychologically without the need for professional support. Indeed, not everyone will want or need professional support for managing burns, and we invite you to visit our burns support page for information, support groups, events, useful websites, and other resources.

Further reading:

Kleve L and Robinson E (1999) **A survey of psychological need amongst adult burn-injured patients.** Burns, 25, 575-579.

Moss TP (2005) **The relationships between objective and subjective ratings of disfigurement severity, and psychological adjustment.** Body Image, 2, 151-159.

Positive impacts

Not everyone will experience a negative reaction to their injuries, or they may not have a catastrophic impact on their daily life. Some will cope with minimal help or perhaps after reading a self-help guide or someone else's story of overcoming adversity. Some may report 'feeling happy to be alive' or 'it could have been much worse'. Patients may go on to be positive role models for others. Sometimes people find it very valuable to meet other people who have shared experience of burns and people can share useful coping strategies with each other. At its most powerful there is a rare outcome called Post-Traumatic Growth where a person experiences positive psychological change as a result of adversity and other challenges to rise to a higher level of functioning than previously.

A lot of research has been done to try and work out why some people seem to learn to cope, and others don't and there is no clear answer. Sometimes it can be long after the injury (even years) that someone who seems to have coped begins to break down. This can be shocking for a patient and their family because it seems so unexpected. There is more about this in module 4.

Further reading:

Lansdown R, Rumsey N, Bradbury E, Carr A & Partridge J (eds) (1997) **Visibly Different: coping with disfigurement.** Butterworth Heinemann. London.

Normalising

Normalising behaviours is very important to allow the patient to feel free to express their emotions. It may be difficult for you to spend time with the patient whilst carrying out your daily job role. However, a conversation about how they feel can happen any time, during a dressing change or when giving them their medication. Ensure the patient knows that how they are feeling is understandable to others, and that it is OK to cry or show sadness. Try to avoid saying things like, "don't worry" or "you'll feel better soon" because just at that moment that might seem impossible for a distressed and anxious patient; it may be better to say, "many people feel that way after going through what you have, it is very normal and understandable".

Behaviours that can be difficult to respond to

Whilst it is important to normalise the behaviour of patients when they are dealing with sadness, loss, and grief, it is also important to recognise when some behaviours are not helpful or acceptable.

We suggest behaviour that is abusive to themselves, or others (including family, friends, staff, and other patients) is recorded and dealt with in a way appropriate to your service or trust policy. Patients need to be made aware if their behaviour is inappropriate. Also, if a patient displays any suicidal thoughts or actions, this should be reported immediately. Patients may say things like, "I can't believe this has happened to me, I wish I was dead". While this comment may be upsetting for people to hear, it reflects the depth of a person's feelings and how overwhelmed they feel. There may not be any real threat of carrying out a suicidal wish. However, it can be difficult to be sure, and you must ensure you are up to date on any trust/hospital policies in dealing with suicidal (and abusive) behaviour and get a suicide risk assessment completed as soon as possible.

If you are worried about a person's behaviour or some of the things they are saying, be sure you know how to seek help from the psychological specialists that work in your service.

Top tip

- Do you know what your local policy is for what to do if someone expresses suicidal ideas; or people who are showing physical or verbal abuse?

Self injury and suicide

Some staff may find it especially difficult to work with people who have harmed themselves or tried to kill themselves. Although these are two very different types of situations with different intentions, they are sometimes grouped together, which can be unhelpful. To be clear, suicide involves a deliberate attempt to end one's life, while self-harm is more likely to be an attempt to cope with life. The idea that someone could or would burn themselves intentionally may be difficult for some of us to imagine, making it harder to understand or emphathise with the person and remain non-judgmental. What is important is that everyone should be treated with dignity, kindness, respect and given access to the same treatment options, regardless of how their burn injury was sustained.

Sadly data suggests that this is not always the case. Shame, stigma, and fear of negative judgment by healthcare professionals may reduce the likelihood of patients coming forward for timely and appropriate treatment of self-harm burn injuries. One study found that whilst the majority of healthcare professionals working in burns and plastic surgery departments were found to hold positive attitudes towards those who have self-harmed, a significant minority held negative or ambivalent attitudes[1] and are less likely to offer surgical options.

One commonly held belief is that self-harm is attention seeking. This is an unhelpful generalisation and should be challenged. Self-harm is more often a deeply private behaviour, kept as a guilty secret. When a patient comes forward for treatment it may have taken them a considerable amount of courage to do so, and they are putting a great deal of trust in our services to help them. This may still be the case even if they appear angry, ambivalent, withdrawn or tearful. Whilst some people may disclose self-harm as a means of seeking support, this is an opportunity for us to signpost or refer them on to other services that have the specialist skills to provide the right support. Therefore, it is more helpful to see this not so much as 'attention-seeking' behaviour, but as a communication of a need for help. We are not in a position to stop people from self-harming, but it may be that we are in a unique position to provide the right attention, in the right way, at the right time, which in turn may decrease subsequent motivation to self-harm and increase engagement with the right support services. Therefore our response is so important in setting the tone for the future[2].

It is essential that burns services have specific plans and policies in place for the care of patients who present with injuries that are the result of recent and or historic self-harm. In the UK we have national (NICE) guidelines that are regularly updated[3] and apply to all healthcare professionals. NICE guidelines clearly state that treatment should be guided by the injury, not the mechanism.

Top tip

- If you want to learn more about self-harm, some of the reasons why people might self-harm and some advice on how to respond, the Royal College of Psychiatrists has produced[4] a leaflet that is accessible online and can be printed.
- Familiarise yourself with local and national policies which will guide you in your responsibilities, how to conduct a risk assessment, what to say, do and document.
- When you are treating any wound remember to ask about pain relief – just because someone has injured themselves does not mean they should or would want to suffer in pain. Indeed the initial reason for self-harm may have passed and accessing healthcare and wound management should be encouraged.

Further reading and links:

1 https://journals.sagepub.com/doi/10.1177/2059513118764100

2 https://sshp.wales/en/knowledge-base/myths-about-self-harm/

3 Recommendations | Self-harm: assessment, management and preventing recurrence | Guidance | NICE

4 https://www.rcpsych.ac.uk/mental-health/mental-illnesses-and-mental-health-problems/self-harm

Traumatic stress

Some patients may be experiencing symptoms or signs of trauma, the most common of which are nightmares or flashbacks - feeling that they are 'reliving' parts of the incident all over again. These experiences can be very vivid and frightening, and it can take patients some moments to 'come back to reality'. Patients may also be very hypersensitive to sudden noises, unexpected activity, and sounds and feelings around them. It is as though their mind and body are noticing every single little thing and this can be very exhausting. This can also be associated with high levels of anxiety.

Others might feel very 'numb' or still feel shocked or may describe the incident as 'all being in slow motion'. Some people may have no conscious memories of the incident at all. This may feel unnerving as people will often want to piece together what happened to help make sense of it.

The good news is that most people who experience a burn injury will recover psychologically without the need for professional support. Indeed, not everyone will want or need professional support as with time these problems should diminish in intensity and frequency. However, if they don't get better within a few weeks of returning home and leaving the artificial environment of hospital they should speak with or be referred to a psychological professional and offered a trauma assessment.

What is post-traumatic stress disorder (PTSD)?

If a person is unable to naturally process what has happened, they can develop Post-Traumatic Stress Disorder. There is a specific checklist of symptoms, distress levels and functional impairment. For example, in ICD-11 it is characterised by all the following:

1. Re-experiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares. Re-experiencing may occur via one or multiple sensory modalities and is typically accompanied by strong or overwhelming emotions, particularly fear or horror, and strong physical sensations.
2. Avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event(s); and
3. Persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises.The symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational, or other important areas of functioning.

Of course, it might be hard to distinguish which symptoms are due to the effect of the injuries and which are part of a trauma response. In a way this doesn't matter. The important thing is that you and your patient understand that this kind of reaction might be normal for a while. If the problems are continuing and your patient is very distressed, then seek help from one of the psycho-social specialists in your service.

Top tips

- Reassure the patient who is suffering from a nightmare or other form of re-experiencing. Calmly keep reminding them where they are, that they are safe and stay with them untill they are aware again. Sometimes it can help to encourage the patient to concentrate hard on something in the room like a personal item or to touch something like the bed or bandage.
- If a patient has a nightmare do not wake them up or tell them about it the next day. This is unhelpful and can impair healthy natural processing that might be happening during their sleep. Instead speak calmly and softly to them reassuring them that everything is ok, that they are safe, and they can carry on sleeping.
- Try to avoid sudden actions or noises when you are around your patient. Tell them or warn them about what you are doing especially if you must make a sudden noise. Try to work slowly and predictably if you can.

Families

So far, we've just talked about the patient and what they might be feeling. We must remember that families may be feeling similar or different things too and this can vary from individual to individual. They are likely to be going through their own experience even if they were not there when the injury happened. They may be experiencing grief and may have some of the same questions. They may feel they have 'lost' the person as they knew them, especially if they are likely to have a long-term disability or scarring as a result of the incident or require many treatments over several years. Families will have their own ways of grieving and will not experience the same emotions at the same time as the patient. They may have feelings of guilt and be preoccupied with thoughts about how things could have been different. Remember too that families may have been involved in the incident and we know that witnessing, or hearing about an incident, may also trigger symptoms of traumatic stress.

All this can sometimes make for misunderstandings and tensions between family members. You can do a lot to help patients and families understand this and encourage them to keep communicating.

Top tips

- Consider that families may also be experiencing strong feelings about what has happened. They may be experiencing their own grief reactions.
- Try to encourage them to keep communicating with each other.
- Families may need help as much as your patient – in some situations it might be just as appropriate to talk to a family member or suggest they talk to one of the psychological specialists in your service.

Task: Below are a series of scenarios that you might come across. Thinking about some of the concepts we have just explored, consider what you think might be going on and about what you might do in each situation.

You've noticed someone is displaying unusually aggressive behaviour when having their dressings changed. They are being rude and dismissive to staff. They are also avoiding looking at their injuries.

A patient’s adult children came to visit the hospital a while ago and haven’t been back since. What might you say to the patient, and would it be important to encourage their family to come back? If so, how might you do this?

The team has started discharge planning, but the person does not want to engage with the team and keeps putting off the conversation. What would you do?

Important points to remember

- It is important that patients are allowed to express their feelings
- As patients’ injuries get better, the way they feel may not
- Families may express more negative views than the patients themselves
- Some people may require a bit of time and space to get used to their new appearance; this is OK

Notes

Module 4 | Coping with change

Aim: to investigate factors that predict good psycho-social outcome and the role of the health care professional in facilitating this.

Predicting patient outcome

Some patients will seem to cope well with what they have experienced and their injuries. However, others may seem to struggle to cope. Some of your patients may just need encouragement and support from their pre-existing social support network, or to rely on their pre-existing coping strategies. Other patients may need to talk through their feelings in greater depth with staff or members of the specialist psycho-social team.

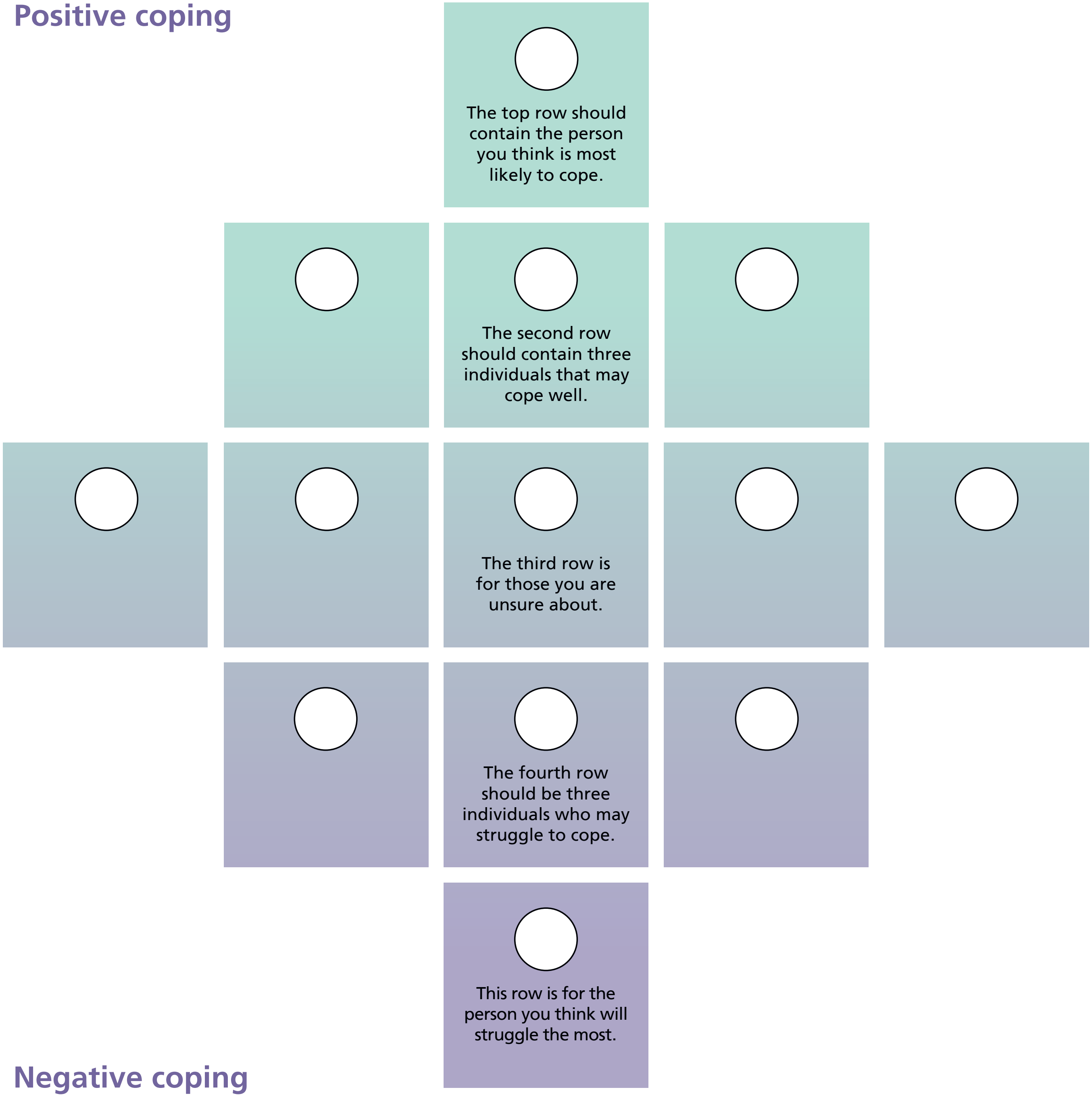
How can we predict which individuals will need what level of help? Unfortunately, this is not an exact science, and we are all very individual in the way we respond to injury. However, researchers have looked at some factors that may play a part in how patients cope. This can help us as health professionals to identify individuals who may be at risk of significant psychological distress.

Task: Think about patients you have cared for on your ward. Consider those who you think have coped well with the changes they have experienced as a result of a burn injury and those who struggled. Use the space on the next page to discuss why you think those that coped well did so, and some of the reasons for those who found it harder.

Task: Factors influencing positive coping - This task can be done as a group or solo activity. On the opposite page you will find a brief description of several characters from different backgrounds. The information you are given about them may or may not affect how they cope psychologically with their injuries. You decide.

On the grid below, place each character on the grid according to whether you think they may cope well or whether they may struggle. You may have very little to go on. Usually you would have more information, but it should get you thinking and putting what you have already learned into practise! If you are in a group setting share the characters out and explain your reasoning to each other. Once all the characters are placed on the grid you can discuss any differences in opinion and rearrange the grid by consensus.

Positive coping



The top row should contain the person you think is most likely to cope.

The second row should contain three individuals that may cope well.

The third row is for those you are unsure about.

The fourth row should be three individuals who may struggle to cope.

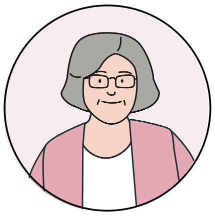
This row is for the person you think will struggle the most.

Negative coping

Characters

D

D has a great easy manner with people that means they make friends easily and is a good listener.



B

B has been happy to learn how to change their own dressings and remains hopeful about the future.

J

J has always worried about what other people think of them and is fearful of what others might ask.

P

P is well respected by their peer group, some of whom have been to visit, and they are regularly speaking on the phone with others.

A

A would be able to cover up their burns with clothes.

T

T has a close family who have listened and understood T's concerns during their time in hospital.

V

V's appearance is very important to them. They always spend up to an hour preparing their hair, clothes, and make-up to feel ready to leave the house. V has invested large sums of money in beauty treatments, including plastic surgery, in the past.

R

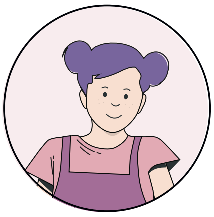
R is a 17-year-old male.

M

M does not seem to have anyone who cares for them. They have not had any visitors and has not been observed talking to others on the phone.

Dr F

Dr F is a successful academic who has published many books on 20th century politics.



N

N is unlikely to have any permanent scarring.

S

S left school at 14 and did not do well academically.

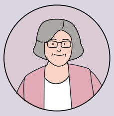
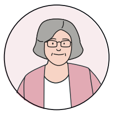
G

G is often described as a 'workaholic' and their identity is tied to what they do. This injury occurred at work and is likely to cause some permanent functional changes which will make returning to work in their usual role challenging.

Factors predicting positive coping

How did you get on? This is a challenging task because there is so little information for you to use. The aim is to identify assumptions you are holding and to demonstrate that some factors may help to influence positive coping in individuals. Research shows that there are a variety of factors (rather than just one as used in this task) that may help to predict whether someone may cope well or may struggle (Hobbs 2015). These factors are discussed in more detail below:

Factor	Description
Social support (M, T)  	This is a very important factor. Numerous studies show that having a strong social support network can help the individual meet their psycho-social needs. Having a good social support network also helps the patient steer clear of the issues surrounding social avoidance and associated problems of withdrawal. In our examples, M might be at risk if there seems to be no one who is around for them. T can communicate well with family, and this may well help when they are discharged to get through some difficult times. International statistics (OECD, 2022) also show that individuals who say they have family and friends they can count on to help them in times of trouble are consistently more likely to be satisfied with their personal health, and research has linked social isolation and loneliness to higher risks for a variety of physical and mental conditions including high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, cognitive decline and Alzheimer's disease.
Communication/ social skills (D) 	Several studies have suggested that social skills are central to managing the impact of appearance related change and most importantly, that these skills can be learned (Robinson et al 1996). If the patient has good social skills, then this will facilitate the ability of others to look beyond appearance and maximise social support. These kinds of skills are likely to be useful in helping to manage the impact of these injuries.
Visibility/ disguiseability (A) 	Although you might think it would be, visibility is not a strong predictor of adjustment – remember the earlier section on Burn Myths. The visibility of scars can exacerbate distress, but some people will be equally distressed by scars that they can cover or hide. The ability to cover up scars can be a very powerful coping mechanism but might be superficial and hide a greater vulnerability underneath. Those coping less well may wear heavy clothing even during the summer, or excessive make-up for example. Overall, disguiseability may have an impact, but is not a strong predictor of positive coping.
Perceived severity (N) 	Perhaps the most common myth about outcome following burns is the perception that the seriousness or extent will be proportional to psychological distress. Kleve and Robinson (1999) highlight the importance of 'perceived severity' or 'noticeability' rather than objective severity as a critical indicator of good or poor outcome. In other words, it is how the individual interprets the injury that is critical to their long-term recovery. Scarring is multifactorial and highly subjective. Possible changes in pigmentation, vascularity, nerve sensitivity or even how it feels to touch may play a part in how someone feels about their injuries. Because we do not think N's scars are likely to be permanent that does not mean they will automatically cope better.
Education (S, Dr F)  	Your level of education does not serve to predict good or poor adjustment. This just does not tell us anything useful about someone's likelihood of coping.

Age (R) 	There is some evidence to suggest that appearance concerns do decline with age, however this is open to much interpretation and some young people may not be bothered, while some elderly people may be very bothered. Crucially we would need to ask each person to know. Throughout our lifespan we go through many major life events. A number of these occur during teenage and young adult years. It can be especially difficult to cope during times of transition and change in our lives (e.g., marriage, bereavement or moving home). It can also be difficult to cope when there are strong influences to be 'like our peers'. This is especially so in teenage years. However, studies suggest that large numbers of older people have appearance related concerns too.
Optimism (B) 	Research has suggested that the more optimistic a person is, the more likely they are to adjust.
Social acceptance (P) 	This relates to how one is accepted in their social group. There may be specific social ideals and the closer someone is to these social ideals the more likely they are to cope. P's acceptance by their peer group may help them to cope.
Fear of negative evaluation (J) 	Some individuals may place a larger weight on the opinions of others over their own, and this may be more noticeable in certain social situations. This may in turn increase their anxiety. J may worry more than others about how others will 'accept me' with these injuries and this may make them vulnerable.
Involvement in treatment (B) 	The more involved you are in your treatment and given informed choices about your treatment plan, the more likely you are to cope better in the long term.
Perceived importance of appearance (V) 	Some people place much greater value on their external appearance and might have strict criteria for what it requires for them to look acceptable. We know for example that people with anorexia overestimate their weight and figure because they have a very 'narrow' idea of what a 'normal' weight is like. If you perceive your appearance to be fundamentally important to you and your place in society you may be less likely to cope with a change to that appearance, especially if you perceive that to be negative. People who have always been uneasy about their body image may be more vulnerable to problems in coping. V might be at risk if they were already unhappy with their appearance and may seek to get rid of any scarring or appearance change because of the burn, which is often not possible.
Loss (G) 	Injuries that occur at work can bring extra layers of complexity around blame and responsibility. Companies can easily get it wrong by contacting employees too frequently, so they feel harassed, or not enough so they feel abandoned and neglected. There should be an HSE (Health and Safety Executive) investigation into injuries over a certain percentage that occur at work. There may be an impact on people's income in the short if not long term. Functional changes which change someone's ability to work and earn money can be particularly worrisome and there may be a drive for certainty about the future that the burns team will struggle to give. For G, who is so heavily invested in their working life, there is likely to be loss and grief, as we discussed earlier, to negotiate.

Strategies for support

Sometimes you will hear people talking about ‘adjustment’. You may even say it to yourself that certain patients may be adjusting well or adjusting less well. However, we have tried to avoid the concept of ‘adjustment’. It can suggest that people will eventually feel completely OK about their injuries, that they can get back to their old selves and put the psychological distress behind them. This may happen for a few people. However, what is far more likely is that, even in the best of circumstances, people learn to cope with the new situation as best they can. Even years after the event, a situation can come up which will take someone back or catch them by surprise and they will have to learn new coping strategies to deal with that new situation. It is therefore best to think of the coping process as a long term one and that people may get used to their new circumstances.

The psycho-social care and understanding that you can offer while someone is in your service is the beginning of that and will really help people to develop coping strategies that they will be able to take out of the hospital and into their lives.

It is often very simple things that will help and, as we have seen in the previous modules, acknowledging someone’s distress and sense of helplessness is often the most important thing.

This section will cover some strategies for supporting patients. It will then go on to look at the psychological support available in your service and what support they provide.

Explain - Reassure - Distract

This is a model originally designed to help parents and children effectively manage other people’s curiosity and/or questions about an injury or visible difference, and it can be easily adapted for use by adults. It is completely natural and normal for people to notice when someone looks different from how we expect them to. Our instincts use visual cues to help us identify who may be trusted and who may be a potential threat to us. This is true for strangers but also for people we know who have seen us before. When our patients look very different because of their injuries or their dressings they are going to attract attention from people and we may need to acknowledge this with them and help prepare them for what it will feel like to become the object of attention, curiosity and possibly questions.

It is better to be prepared with responses rather than try to come up with something on the spot, often when it feels more difficult to respond in the way that we would want to. The aim of Explain - Reassure - Distract is to manage an awkward but predictable situation of curiosity and questions by first offering a brief explanation of what has happened to satisfy the curiosity enough to reduce the likelihood of further questions. Secondly, by offering enough reassurance, this should place the burn-injured person in the safety and not threat category and further reduce the need for more questions. Thirdly, moving the subject on to something neutral and potentially of mutual interest will signal that things are ok and serve to distract the person further away from the topic of the injury.

One of the benefits of Explain - Reassure - Distract is that different ‘scripts’ can be prepared and rehearsed for different types of people depending on the nature of the relationship to a person and what age they are. Different levels of information can be offered to different people depending on what the person feels they might be comfortable to share about the situation. The explanation a person might give, for example to close friends, will differ from one they might give to a random inquisitive stranger.

What sort of things might we say to someone in this situation?

‘Often people ask questions because they’re worried about you. They might have noticed you’ve been off work or away from home and be curious, or they might see that you have dressings and not know why. Explaining and reassuring can satisfy this. They do not need to know all the details about what happened and why, nor do you have to answer questions if you do not want to. Let’s think of what you will feel comfortable to say if someone asks what has happened to you?’

Talking about something else or asking an unrelated question can either distract or subtly signal to the other person that you want to talk about something else.

Example 1.

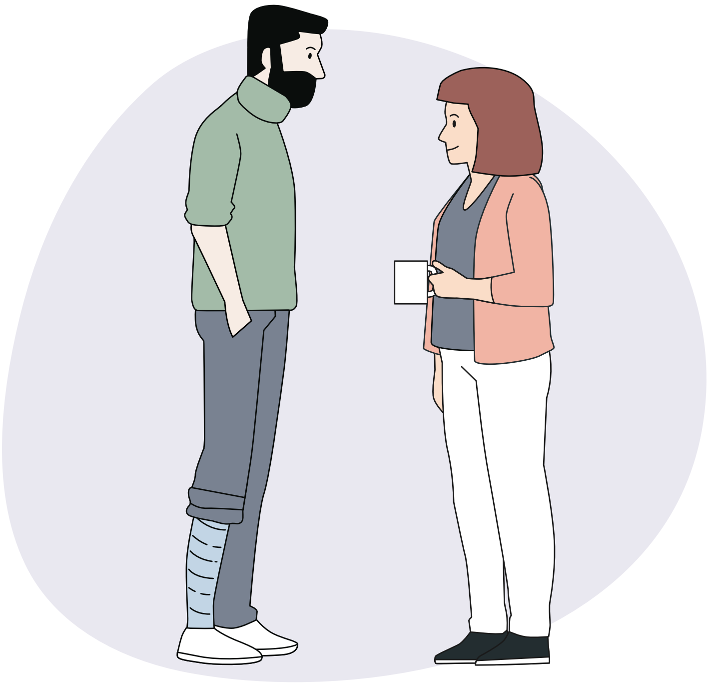
On the bus a child asks, **'what is that?'** or stares at burn marks or scars.

'I hurt my hand when I was cooking, but I went to the hospital and it's getting better. I like your toy dog, does it have a name?'

1. **Explain**
'I hurt my hand.'

2. **Reassure**
'I had hospital treatment, I'm better now.'

3. **Distract**
'What is your toy's name?'



Example 2.

Going back to work for the first time in a month following a burn injury to the leg. A colleague asks **'Where were you, what is that?'**

'I just had a burn from a hot water bottle that leaked on my leg. The wound got infected, so I needed to stay in hospital for longer for an operation and to recover. Hey, did you see X?' (Mutual colleague/shared interest sporting event/shared interest TV show).

1. **Explain**
Hot water bottle scald, infection, hospital treatment.

2. **Reassure**
All good now looked after me well. Plus, some health advice to avoid own potential injury.

3. **Distract**
Connection to mutual interest or current event.

Task: Explain - Reassure - Distract - Think of a patient you worked with recently who is likely to generate curiosity from others and might need to use Explain - Reassure - Distract. If they asked for your help to create a response to a question about what happened to them what suggestions would you give them?

What else can you say? It can also be helpful to remember certain little tips when you are providing support to your patients.

One of the most important things we can offer when someone shares their worries or concerns with us is to offer validation. Validation means that you indicate you have the capacity to understand where the other person is coming from, even if you disagree with what they say or do (Rather & Miller, 2015). Recognizing that someone's feelings and thoughts make sense given their context, can show that we are listening non-judgmentally and can help build stronger relationships. You might feel like you want to cheer someone up or help them feel better at that moment, but this isn't always possible in the short-term or helpful in the long term. It is OK for you and the patient to stay with the feelings as they are and to suggest it might be helpful to talk to someone about it when they feel ready to.

Remember

We don’t ‘get used’ to a changed appearance. Sometimes it’s as if you see the scars afresh again every time you look in the mirror. No amount of other people telling us we look OK makes much difference to how we really feel inside. In fact, this can trigger strong negative emotions when what others say is so different to what the patient feels.

Task: Saying the right thing - Even though we mean well there are some things that we will commonly say that do not necessarily help people to cope.

Look at the following comments. You may hear health professionals or friends and family saying the following things. What is the problem with saying something like this? Can you think of something else that you might say instead?

“I’m sure you’ll get used to it”.
“It doesn’t look that bad”.
“It is all going to be fine, don’t worry”.
“I’m sure people won’t notice”.
“It’s amazing what plastic surgery can do these days!”
“Your scars will fade”.

Top tips

You may find some of these comments helpful:

- “It sounds like you are worried about how you are going to look in future. We hear this often and it is very understandable right now.”
- “It sounds like you are concerned about what other people may think or feel or ask about your injuries. Would it be helpful to talk to us about that?”
- “Your skin is going to need time and care to heal as well as it can. Right now, you can focus on things that you can influence like trying not to pick or scratch, eat well, drink well, doing your physiotherapy exercises. The rest is up to your body.”
- “We have a team who can help you prepare for going back home when you are ready, especially if you are worried about others seeing you.”

Notes

Providing helpful information

Providing timely, realistic, and informative advice for patients is also important. Patients often struggle psychologically with the following:

Lack of predictability: the experience your patients will go through because of their burns injury and receiving treatment is almost certainly unpredictable, unintentional, and completely sudden. They may have complex needs as a result of the trauma associated with their injuries and these needs may vary and change on a day-to-day basis. Their daily routine is also likely to be changeable for a while. This unpredictability might extend after leaving hospital when people will find it hard to predict people's reactions to their burns or scarring.

Lack of familiarity: a patient is unlikely to be familiar with the hospital environment and the routine of a burns service. This may also extend to the various job roles of staff members and changing shift patterns.

High rate of change: this can certainly be the case early in treatment when there can be fast changes to a person's medical condition requiring different treatments and care plans. Post discharge there may also be many other changes to routine for a patient and their family to contend with.

The three factors above all increase a patient's psychological vulnerability.

You can do a lot to help ease this. You can ensure patients receive information about their care and treatment. This can help to decrease their psychological vulnerability. The information can be given to them through a variety of methods and on several occasions, on admission, ward rounds, via patient information leaflets, and via volunteers or named nurses.

You may want to ensure some of the following points of information are given to your patients at various stages throughout their recovery and if not in person, then in a patient leaflet for them to refer to.

* Treatment options * Ward and service staff – who does what and why * Introduction to inpatient psychological services * Ward housekeeping, for example: mealtimes, changeover times etc * Support groups * Patient stories (positive role models) * Un/Expected feelings (to normalise) * Access to chaplaincy (spiritual) services and staff.

Task: Information needs - Can you think of any other information your service gives to patients? Do you have any ideas about any new initiatives your service could try to help patients in this way?

Looking in the mirror - There may be guidelines in your service for supporting patients to see themselves for the first time. If so, use them and work with your team closely.

This can be a difficult moment for patients and their families. The appearance of burn injuries during treatment and healing can look really bad to patients and families, and it can be hard to visualise how things will improve as healing and recovery takes place. There are several things you can do to help your patients especially when they are looking in the mirror for the first time.

- Make sure you feel comfortable doing this. Don't worry if you would rather a more specialist member of staff worked with the patient and say so.
- Work with your multi-disciplinary team and the patient to think about when to start.
- Prepare them for what they might see; it is important to take time over this.
- Ask them if they would like you to describe what you can see first.
- Make sure you have enough time set aside and take as long as is needed to support your patient.
- Make sure you have a private space and you will not be disturbed.
- Consider whether they may want someone from their support network there with them.
- If you feel uneasy about answering any questions then suggest someone else who can answer it, or say that you will find the answer for them, or ask a specialist member of the psycho-social team.
- Review the section 'Saying the right thing'. This might give you some ideas on what to say.

Looking after yourself

Working for a burns service can be hard. It can be difficult seeing people every day who are injured, in pain or distressed. It can be emotionally demanding work.

It is therefore very important that we all take active steps to look after ourselves. Our ability to care for our patients may suffer and we may experience our own symptoms of stress. This in turn may start to affect our own lives, relationships, and health.

Keep an eye on your own feelings. Notice if your normal behaviour or your response to your patients or your colleagues seem to change (see the section 'Managing our own feelings') especially if you seem to be irritated by small things that wouldn't normally worry you. Similarly notice if you seem to 'take work home', can't stop thinking about work issues or patients, or your behaviour or your relationships seem to change for no obvious reason.

Sometimes you and your colleagues may feel a need to let off steam about your patients or your job. This is OK and there should be a space in your service to do this that is confidential and away from patient areas. It can help if you reflect on your reaction to your patients and share your thoughts with your colleagues. Try not to bottle things up but have a chat about things.

There may be times when you are more than usually affected by patients, their circumstances, or the severity of their injuries. It is tough seeing people in distress every day. If you feel this is affecting you, it is not a sign of weakness or that you are not doing your job properly, rather it is a sign of your compassion and care. To sustain this compassion for the patients we meet, it is important to have a chat with someone to offload and to take time for yourself. Sometimes when there are especially distressing situations the psychological specialists may offer a time to 'debrief'. Take up this opportunity if it is available to you. You will discover that other staff probably feel the same and it can be very supportive 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 by doing their work. This will then begin to affect patient care. If you believe this to be happening to you, or to one of your colleagues, seek support from your manager.

Supervision: Ideally 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, individually and as a staff team.

Self-Care Since Covid-19

Many of the ways that burns teams used to get together and socialise in person outside of work seem to have changed and may not have gone back to how they were before the pandemic. We tend to use modern technology to communicate with each other, which is instant and convenient, but can leave us feeling less connected than we might do in person. It may require more thought for burns teams to find new ways to re/create that sense of connection as a team and to maintain or strengthen our relationships as colleagues outside of the clinical environment. This can be very important for some people.

Another result of the pandemic has been the increase in research and evidence about the high levels of stress experienced by NHS staff. Many NHS Trusts now have specific services and programmes for staff well-being. Look out for information about what staff well-being support is available in your service.

Top tips

- Switch off from work when you are off duty. Try to do something you really enjoy that will help you unwind.
- Take the leave that is available to you and try to plan out longer breaks and holiday throughout the working year.
- Notice how you feel when you are with patients. Have a chat with a colleague, team leader or mentor if you feel you are getting short tempered or irritated.
- Notice and acknowledge a change in your behaviour or routines e.g. increased anxiety, tension, alcohol use, irritability, or a different pattern to sleeping or eating.
- It is OK to feel sad about what you experience at work, or for certain patients to stay longer in your thoughts; sometimes as staff we will have strong feelings too. This is not a sign of weakness. We are all human and cannot always switch off our feelings.
- Use the spaces to reflect that may be available to you such as supervision, reflective practice, or team check-ins. It will help your ability to care empathically for your patients as well as improve your own sense of well-being.
- Ask others who seem to manage things well what sorts of things they do to process what happens at work.

Notes

Referral to psychological and or psychiatric services

It is helpful to know who and where you can refer patients to when they need additional support during and after admission to the burns service. This will vary from service to service and according to patient need. Some services have a full psychosocial team who will screen every patient and take responsibility for finding the right services or providing that support directly and the back up of liaison psychiatry for those with chronic and acute mental health issues. It is important that you know what services your patients have access to and how to refer to those services. Each service should have some level of psychosocial screening, psychosocial specialist support and clear policies on supporting those with psychological and psychiatric problems.

Reflection: Think of a current patient and what strategies you (or someone else) might use to support them.

Think of something that you have covered in modules 3 and 4 that you can use in your work with your patients.

Notes

Further reading and links:

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Kübler-Ross E (1997) On Death and Dying. New York: Simon & Schuster .

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Author: Dr Lisa Williams, Psychosocial Lead for London and South East England Burns Network

Original Material by Gemma Borwick and Clare Cooper for Changing Faces.
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Revised and updated material by Dr Lisa Williams, Dr Aayesha Mulla, Dr Madeleine Jago and Louis Cursan

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