Psychosocial Interventions for Improving Adherence, Self-Management and Adjustment to Physical Health Conditions

Children and Young People

Education Resource for Multidisciplinary Staff working within Specialist Children’s Services
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<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>7</td>
</tr>
<tr>
<td>Developmental Considerations</td>
<td>15</td>
</tr>
<tr>
<td>Planning and Implementing Core Level Psychosocial Assessment and Intervention</td>
<td>21</td>
</tr>
<tr>
<td>Psychosocial Interventions - Behaviour Change</td>
<td>29</td>
</tr>
<tr>
<td>Psychosocial Interventions - Reducing Distress</td>
<td>61</td>
</tr>
<tr>
<td>Adherence to Treatment</td>
<td>71</td>
</tr>
<tr>
<td>Self-Management</td>
<td>83</td>
</tr>
<tr>
<td>Adjustment</td>
<td>91</td>
</tr>
<tr>
<td>Books / References / Links</td>
<td>101</td>
</tr>
</tbody>
</table>
Introduction

The Scottish Government Health Directorates (SGHD) in the policy document ‘Better Health, Better Care: National Delivery Plan for Children and Young People’s Specialist Services in Scotland’ (SGHD, 2009) charged NHS Education for Scotland (NES) with building psychological capacity and capability in Scottish Paediatric Healthcare. As such, the development, delivery and evaluation of an educational programme on Psychosocial Interventions to improve Adherence, Self-Management and Adjustment to Physical Health Conditions for Children and Young People was commissioned.

This educational resource supports NHS staff working in Specialist Children’s Services from all disciplines and practice areas. It acknowledges that all staff contribute to psychosocial care and aims to enhance competency and confidence within individual levels of expertise. The resource is designed as an adjunct to knowledge and to build on skills which already exist within work practice on the psychosocial dimension of care. It is anticipated that staff will adhere to relevant best practice guidelines, governance structures, clinical supervision and/or reflective practice when undertaking this work to enable the stimulation of personal and professional growth and care of their own well-being.

The benefits of early intervention at the appropriate level for children, young people and their families are well documented. Helping children and young people learn about their condition and have a better understanding of how it impacts on their experience of life, empowers them to make changes and identify strengths and resources which help. In situations where the presenting difficulties or challenges require specialist psychosocial or therapeutic interventions, staff should be aware of the need to refer to specialist services.

Psychosocial Interventions are based on effective communication, supportive interaction, an awareness of the developmental tasks for children and the social context in which they live their lives. The child, young person and/or family member work in partnership with healthcare staff and are fully involved in decision making and the development of a particular intervention. Each intervention will be tailored to the needs of the individual child or young person. Although there are similarities in living with a physical health condition, the experience will be unique to each child. Their thoughts, experiences, feelings and expectations will only be known through effective assessment whether formal or informal. Attending to the child’s thoughts, feelings and behaviour are part of any psychosocial intervention and will guide progress.

Psychosocial Interventions outlined in this resource aim to improve adherence, self-management and adjustment to physical health conditions. These aspects of psychosocial functioning were targeted as they pose challenges for children, young people and their families and are known to impact on health outcomes. They are common to all physical health conditions and therefore will be routinely identified by healthcare staff. Appropriate early interventions are known to be clinically effective.
Using the Resource

This resource aims to develop core level skills in psychosocial intervention relating to adherence, self-management and adjustment to paediatric physical health conditions. It is meant to be a flexible learning tool which can be used to meet individual learning needs. Participants can for example, use the resource to learn about a particular psychosocial intervention/area of care, or with more time, can read through the chapter more systematically. Throughout the resource, the use of the word ‘child’ refers to all children and young people (0 – 18 yrs) and ‘parent’ refers to parent or carer.

This NES initiative has a major contribution to make towards meeting objectives detailed in Scotland’s Social Policies. At the beginning of each unit, outcomes pertaining to children and young people will be outlined under the following colour code:

- Getting it Right for Every Child (GIRFEC)
- The Healthcare Quality Strategy for NHSScotland
- European Association for Children in Hospital (EACH Charter)

This will enable staff to be mindful of the policy context of the application of clinical practice and the outcomes which will be achieved through their work with children and young people. There are also links to related resources and toolkits which help staff to support children’s well-being and behavioural/emotional health.

Overall Learning Outcomes

This resource aims to develop core skills in psychosocial interventions with children and young people relating to the topics “Adherence to Treatment”, “Self-Management” and “Adjustment to Paediatric Physical Health Conditions”. On completion of all three components, participants will:

- Understand the role of effective communication in working with children, young people and their families.
- Understand the developmental and social context of children’s and young people’s experiences.
- Plan and implement appropriate core level psychosocial assessment and intervention to support “Adherence”, “Self-Management” and “Adjustment to physical health conditions” for children and young people.
- Move up a level to understand the types of interventions required for changing behaviour and reducing distress and determine the most appropriate to use in collaboration with the child and in line with individual need.
- Be aware of the psychosocial impact of living with physical health conditions for children and young people in relation to ‘Adherence,’ ‘Self-management ‘and ‘Adjustment to physical health conditions’ and how to offer appropriate support when required.
- Understand when current knowledge requires to be modified due to newly acquired knowledge.

References

European Association for Children in Hospital (2001). EACH Charter
Scottish Government (2009b). Getting It Right For Every Child
Communication
Policy Context & Outcomes

Getting it Right for Every Child (GIRFEC)
- Feels listened to and taken seriously
- Feels involved in the important day-to-day decisions that affect them

The Healthcare Quality Strategy for NHSScotland
- Clear communication and explanation about conditions and treatment
- Effective collaboration between clinicians, patients and others

European Association for Children in Hospital (EACH Charter)
- Article 5 – Children and Parents have the right to informed participation in all decisions involving their healthcare

Learning Outcomes

Understand the role of effective communication in working with children, young people and their families
- Identify the conditions, communication skills and styles which are necessary for effective communication.
- Be aware of the context and required outcomes when considering which communication skill and style to use.
- Understand the social and interactive nature of communication and its impact on developing supportive relationships.

Communicating with children and young people about their health, symptoms, treatments, self-care and other related issues is something all healthcare staff undertake routinely. Good communication lies at the heart of psychosocial assessment and intervention as it forms the basis of a supportive relationship. The need to communicate effectively is something all healthcare staff need to think about. There is an increasing number of children and young people living with chronic and life limiting conditions and their core involvement in decisions about their health and future is essential.

Working in partnership with parents is essential, in particular, when talking about new or difficult information, for example, at times of diagnosis or transitions. Children are guided in their reaction and responses to events by noting how their parents are coping. They develop their confidence and security to deal with novel events from observing and interacting with significant
attachment figures. In this way, parents’ coping directly impacts their child’s coping. As children develop, they acquire the ability to monitor their own needs and responses and the cognitive capacity for self-care. Even when young people become independent, however, the support of family members is beneficial and enhances health outcomes at all stages of the child’s development.

Although all healthcare interactions require communication, the quality of the communication is a key variable in developing supportive relationships and enabling children and their families to maximise adjustment to their physical health condition. This in turn promotes concordance and self-management. In order to communicate effectively, there are certain conditions which require to be met.

Communication Conditions

- **Being empathetic** – Understanding the issues raised from the child’s perspective and demonstrating this understanding to them.
- **Adopting a non-judgmental stance** – Accepting the child’s opinions and values without evaluating.
- **Being genuine** – Being yourself with the child and not playing out a ‘role’.
- **Being concrete and pragmatic** – Clarifying meanings, keeping it simple and being specific.
- **Showing warmth** – Being interested in and positive about the child. Showing care towards them.

These communication conditions were described by Carl Rogers (1951) in developing a client-centered approach and have been documented by others since then.

Meeting these communication conditions is the first step to achieving effective communication. Additional communication skills can be utilised to build on these basic principles of communication. These additional skills can enhance interactions between healthcare providers, children and families and form the basis of any psychosocial approach.

Communication Skills

The three basic communication skills used in working with children, young people and their families are **asking, listening and informing**. These skills are the means by which communication styles are put into practice.

**Asking**

This communication skill is used to gain information and insight from the child and other family members. Asking questions places a demand on the child or family member to answer, so consideration must be given to the right choice of question to ask and whether it can be used in conjunction with other means of communication which can soften the experience for the child and family. There are different types of questions which can be used.

**Closed questions** – This is a good way of gaining specific information. Closed questions elicit short answers such as ‘Yes’ or ‘No’ or factual brief information. They are asked when the clinician requires a specific answer or to find a solution.

For example:

- *Have you been short of breath?*
- *Where do you feel the pain?*
- *Have you been sleeping well?*
**Open Questions** – This style of asking a question invites the child or family member to tell the clinician what is important to them and allows greater flexibility in the direction the answer takes. This implies interest in their perspective on the health condition which helps build a good relationship.

It is also a good way of gaining information on issues which are important to the child and family. This helps to elaborate thoughts and feelings which may otherwise have gone undetected. It allows the child and family more active involvement and can help them feel valued.

Asking only a few open questions with careful listening and responding can balance the conversation and help the child and/or family feel at ease. An open question is an invitation to be fully involved in the health conversation and should reflect the non-judgmental and respectful quality of a child-centred interaction. Open questions usually start with:

- **What?**
- **When?**
- **Where?**
- **Why?**
- **How?**

<table>
<thead>
<tr>
<th>Question</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>What do you think helps you manage your diabetes?</em></td>
<td><em>What do you think helps you manage your diabetes?</em></td>
</tr>
<tr>
<td><em>How can I help you?</em></td>
<td><em>How can I help you?</em></td>
</tr>
<tr>
<td><em>Can you tell me when the symptoms started?</em></td>
<td><em>Can you tell me when the symptoms started?</em></td>
</tr>
<tr>
<td><em>May I ask you what concerns you most about your condition?</em></td>
<td><em>May I ask you what concerns you most about your condition?</em></td>
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<tr>
<td><em>Tell me more about your worries for the future?</em></td>
<td><em>Tell me more about your worries for the future?</em></td>
</tr>
<tr>
<td><em>Why do you think you feel tired often?</em></td>
<td><em>Why do you think you feel tired often?</em></td>
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</table>

Skilful asking generally makes use of both open and closed questions. Initially a few key open questions allow exploration of the child’s view of their health with the use of closed questions to gain specific information or detail.

**Communication without Questions**

Asking questions is such a core part of communicating about health that it is sometimes the easiest option but may not be the most effective way to interact with children or family members. They may feel insecure about answering or feel threatened if there are too many questions for them to answer. It is useful to consider alternatives and friendlier ways of gaining information.

**Observing non-verbal clues**

This information can then be communicated with the child.

For example:

- If a child appears upset during a conversation, rather than asking ‘*What’s upsetting you?*’ simply say ‘*You appear to be upset*.’ This invites rather than demands that the child tell what they are feeling upset about.

**Using ‘seem to be statements’**. These statements are based on empathic understanding of what lies behind the child’s tone or use of words.

For example:

- Rather than asking ‘*Why are you worried?*’ make an empathic comment ‘*You seem to be worried*.’ This invites the child to expand should they wish to.

**The use of ‘I’ statements**. These statements draw the child into explaining more about a situation.

For example:

- Instead of asking ‘*Were you confused about when to take your medication?*’ describe your own reaction ‘*I found that I was confused about when you were to take your medication when you told me that*.’ This communicates a personal interest and strengthens trust by alignment with
the child or family member.

**Invite a child to answer a question.** An invitation to answer a question is always less threatening than asking even the most necessary questions.

For example:

‘Only answer this if you feel you want to, but how did your friends react when you told them that you have diabetes?’

**Use minimal responses.** This invites the child or family member to continue talking without interruption. Therefore, instead of asking a supplementary question, a gentle ‘Yes…’ or ‘Go on…’ encourages them to continue if they so wish.

**Use of non-verbal techniques.** Another way to invite a child or family member to communicate is to use a gesture or facial expression, a slight movement of the hand, or raising the eyebrows a little in a questioning expression.

### Listening

There are many reasons why listening well can be a very effective and useful communication skill. It can be used to hear information which is central to the child or family’s experience of living with a chronic health condition and which otherwise would be missed. All children like to be listened to and respond in an open and optimistic manner when they feel valued.

Listening enhances communication and can leave the impression that the clinician has spent more time with the child and/or family than they actually have. Listening is very useful at the start of a conversation as it allows the clinician to know what the issues are for the child and family. It may take a lot of courage for the child to attend the appointment and meet with the clinician and tell them their story. An early interruption when the child or family member is speaking can leave them with the impression of not being valued.

At frequent episodes throughout the meeting listening is required. This may be in response to asking an open question or in response to the child or family member appearing upset, confused, annoyed or anxious. There are times when just listening is the most healing and important role the clinician can adopt. This is particularly true when breaking bad news at diagnosis or supporting the child and/or family when distressed or upset. Listening can be communicated in the following ways:

**Invitation:** This is usually facilitated by a lack of distraction, eye contact and an open question.

**Silence:** This can be used with effect but only if the clinician is fully attending to what the child or family member is saying. Often the clinician is aware of inner responses to what is being said, e.g. agreeing, disagreeing or analysing which even if not voiced can interrupt active listening. Try to avoid using silence as an opportunity to think of what needs to be asked or done next as this prevents full attention being given to the child’s story. Silence in this context is used for actively listening to what is being said.

**Reflections:** In order to demonstrate that the clinician is listening they can reflect back a short summary of what they have just heard. This is a restatement of all or part of what the child has just said. This can be broken down to:

**Simple reflections** - in which part of the child or family member’s statement is repeated as heard.

**Paraphrase** – what is heard is changed before being fed back.
For example:

‘So from what you are saying you are angry about your diagnosis.’

In doing this, the clinician must reflect on what the child or family member means in order to be able to say it differently. This will enable the child or family member to agree or disagree and elaborate. Either way, they give more information. Paraphrasing requires skill and practice but is a useful clinical tool. It demonstrates that the child and/or family has been listened to, improves rapport, allows clarification and encourages the child and/or family to talk.

Summary: This is a restatement of the main points of a consultation or part of a consultation.

For example:

‘So today we have been discussing how you have been coping with giving your own injections. On the one hand you are happy that you can now do this yourself and don’t have to let your Mum or Dad do it. It makes you feel proud that you have achieved this. On the other hand, however, you are still worried that it might hurt or that you will not do it properly so it takes longer to actually do it.’

This summary can be followed by asking ‘Is there anything else?’ to ensure that nothing important has been missed.

Summarising helps to improve recall, demonstrates listening, provides a formulation of the problem and possible action. It allows the clinician to re-emphasize particular aspects of what the child has said and highlighting them. It is a gentle way of bringing part of a consultation to a close before moving on. It is usually used at the end of a consultation.

Informing

This is a very commonly used communication skill and is a routine part of healthcare. It can be used in a wide range of situations. Giving information is important in helping children, young people and their parents to make sense of what is happening and to prepare them for what will happen next. It allows them to be actively involved in their care and to check that their understanding is correct. Giving appropriate, honest and clear information helps develop trust and a supportive relationship with healthcare staff.

Prior to informing, it can be useful to have an understanding of what the child and young person already knows. This allows the information to be individually tailored. Giving information should be planned and structured with clarity about what information is given and who is giving it. Different and varied methods of giving information can be used including verbal, written, visual and play materials depending on the developmental stage.

To improve this skill some straightforward observations can be made. These include:

- Taking care not to overload the child or family.
- Trying to avoid using jargon and medical terminology.
- Checking that the information has been understood at regular intervals.
- Tuning into how receptive the child or family is.
- Taking care not to rush.
- Being guided by the child and family.
- Using informing in combination with asking and listening.

Learning Activity

- What are the conditions required for good communication?
- Name the three basic communication skills?
- Identify some methods of communicating without questions
Styles of Communication in Healthcare

The style of communication refers to the approach and attitude that characterises interaction with children and families. It is a way of talking with them about health. There are different styles of communication which can be used in working with children and families which serve different purposes. The three most common styles of communication used in healthcare are directing, following and guiding.

All of these styles of communication are in use in everyday life and are often intermixed. The skill in communicating with children and families about health is to be aware of the context and what is to be achieved. This will require shifting between the three styles in any conversation depending on the circumstances.

Prior to conversing with the child or family, some consideration should be given about the most appropriate style of communication to use. This must be flexible enough to adjust depending on the context of the conversation.

For example, if the goal of the meeting is to educate the child and/or family in some aspect of care, then it will be appropriate to think of adopting a directing style to impart the knowledge and a following style to gain the child and family’s perspective on what they have just learnt. If they become upset or anxious then communication may continue in a following style. If the child or family requires clarity about different options then a guiding style may be the most useful.

Directing

This style of communication is one in which the child or family is informed or told directly what to do. Informing is the predominant feature of this style of communication. Directing assumes that the clinician has the knowledge and expertise to offer help and the role of the child and/or family is to take it on board. The clinician using this style of communication usually has the responsibility for ensuring that the child and/or family has the knowledge and skills to deal with the condition, monitor their performance and adjust goals depending on consequences.

This style is used mainly when education is required either initially following diagnosis or to update education at transition stages. It is also used when the child requires decisions, actions and advice on health. The child and family may expect this style of communication and is one with which they are familiar in the context of educational environments.

Following

Attentive listening is the predominant feature of this style of communication with the child and family. Good listening has at its core a desire to understand the child’s world in relation to the topic in question. The clinician allows the child or family member to lead and listens to their story and experiences.

This style of communication is often used at diagnosis after the initial information has been given. It allows the child and/or family to communicate their thoughts and feelings if they wish to do so. It may take some time after diagnosis for the child to communicate openly which allows the clinician to follow. It is important for the clinician not to miss the opportunity to follow the child’s lead which may occur at any time during a conversation. Following is also useful at the beginning of a meeting with a child to catch up with how they have been and gain a clear understanding of the child’s view.
Guiding

With this style of communication, the clinician helps the child and/or family to find their own means of adjusting to the condition. The role here is to guide the child and/or family towards the options and elicit those which may be the most suitable but allowing them to decide. A good guiding style presents the child and family with alternatives from which they choose.

Parental Role

In addition to using these styles of communication to maximum effect in clinical practice, it is also worth informing parents and carers of their usefulness.

For example, consider the role of a parent in supporting an eight year old to monitor blood glucose.

<table>
<thead>
<tr>
<th>Communication Style</th>
<th>Process</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Directing</td>
<td>Parent tells the child what to do at every opportunity</td>
<td>Frustration</td>
</tr>
<tr>
<td></td>
<td>May comment on every hesitation</td>
<td>Reduced confidence</td>
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<tr>
<td></td>
<td>Usually corrects the slightest mistake</td>
<td></td>
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<tr>
<td></td>
<td>May take over</td>
<td></td>
</tr>
<tr>
<td>Following</td>
<td>Watches, but offers no assistance</td>
<td>Lack of interest implied</td>
</tr>
<tr>
<td>Guiding</td>
<td>Does a little of both of the above</td>
<td>Child works at their own pace</td>
</tr>
<tr>
<td></td>
<td>Watches calmly</td>
<td>Develops the ability to self</td>
</tr>
<tr>
<td></td>
<td>May make suggestions</td>
<td>regulate</td>
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Reflective Exercise

Reflect on recent communication with children or young people in a healthcare context

Do you have a preferred communication style?

Are you guided in your use of communication styles and skills by the context and requirements of the communication?

Reflect on what you have read on communication

Are there changes that you will make in future communications with children and young people?

What are the key learning points for you?

References
Developmental Considerations
Policy Context & Outcomes

Getting it Right for Every Child (GIRFEC)
- Developing a level of independence or autonomy appropriate to age and stage

The Healthcare Quality Strategy for NHSScotland
- Clear Communication and explanation about conditions and treatment
- Effective collaboration between clinicians, patients and others

European Association for Children in Hospital (EACH Charter)
- Article 4.1 – Children and parents shall have the right to be informed in a manner appropriate to age and understanding
- Article 7 – Children shall have full opportunity for play, recreation and education suited to their age and condition and shall be in an environment designed, furnished, staffed and equipped to meet their needs

Learning Outcomes

Understand the developmental context of children’s and young people’s experiences
- Demonstrate awareness of the developmental achievements for children and young people when planning and implementing psychosocial interventions
- Understand the developmental implications for children and young people in relation to adjustment, adherence and self-management
- Apply this understanding to develop individually tailored child-centred psychosocial interventions

When engaging in any form of psychosocial assessment or intervention with children, young people and their families, it is important to consider their developmental stage. Children's understanding and view of the world will differ according to their developmental stage. Each developmental stage is characterised by a series of achievements which children progress through and which determine their response to events. Therefore language and style of interaction must be adjusted to reflect this. The developmental achievements and implications for practice are now outlined.
Developmental Achievements - Pre 5 years

- In the main, knowledge is acquired through direct experience.
- The child’s experience is bound by the here and now.
- The child’s understanding of the body and how it functions is basic.
- Comprehension may be in advance of verbal skills.
- Security and reassurance are very important even if it is unclear whether the child understands.
- Children like routine and control of their environment.
- Children fear separation due to limited understanding of time and future.
- Children are forming primary attachments and relationships.
- Children differ in their developmental abilities and temperament.

Implications for Adjustment, Adherence and Self-Management

- Use cuddles to console and reassure.
- Maintain continuity in staff when possible.
- Maximise opportunity to play and explore.
- Have clear and predictable guidelines about separation from primary caregiver(s) and family members.
- Use different methods to elicit understanding. Do not depend on verbal communication solely.
- Shape behaviour by small steps.
- Understand how predictable routines and schedules help children feel safe and secure.

Developmental Achievements – 5 to 7 years

- Children at this age develop a vivid imagination and may believe in magical thinking.
- Children may be vulnerable to thoughts and feelings of guilt and responsibility for their condition.
- Children may relate their condition to punishment.
- Children may have fears about their condition being contagious.
- Children are attending school and developing peer relationships.
- Children imitate adult behaviour.
- Children believe that death is a reversible process.
Implications for Adjustment, Adherence and Self-Management

- Use drawing as a means of exploring the child’s understanding of the body and how it functions e.g. outline drawings.
- Talk with children about the meaning of their condition to them to identify misconceptions. For example, a child with diabetes may believe they are responsible for their condition by eating too many sweets in the past and are now being punished by dietary limitations.
- Awareness that most children perceive the cause of illness as external to themselves.
- Understand the importance of parental attention, praise and encouragement.
- Awareness of the role of modelling in facilitating adaptive coping.

Developmental Achievements – 6 to 10 years

- Children are aware of the reality of long term and life threatening conditions.
- Children have an understanding of the body and its functions including an awareness that the cause of illness is internal to the body.
- Children may experience new emotions as their cognitive skills develop. These new emotions may be confusing for children.
- Children may express adjustment difficulties through behaviour.
- Gender differences become more pronounced.
- Children become more aware of ways in which they differ from their peers.
- Children begin to lay aside magical thinking and undertake real tasks.
- Children are developing academic and social competencies.

Implications for Adjustment, Adherence and Self-Management

- Explore children’s understanding of their condition.
- Provide age appropriate information, give choices and include the child in decision making.
- Understand the functions of the child’s behaviour including what they may be communicating through their actions.
- Identify children’s strengths and build them into adjustment, adherence and self-management programmes.
- Allow children when possible to experience mastery in tasks they undertake. This will build confidence and a sense of control of their condition.
Developmental Achievements – Young People

- Increasing autonomy.
- Developing a sense of identity.
- Coping with pubertal change.
- Development of intimate relationships.
- Growing awareness of body image.
- Relationship with peers of primary importance.
- Increasing capacity for abstract thought.

Implications for Adjustment, Adherence and Self-Management

- Support to achieve self-sufficiency in self-care. Clarity of roles in terms of responsibility.
- Continuing support and encouragement from family.
- Peer support. This may include virtual support groups.
- Awareness that adherence difficulties reach a peak in adolescence. Address barriers.
- The young person works collaboratively with the healthcare team. In the main, communication is directed to them.

- Young people may want to be seen independently or may want more confidentiality in healthcare.
- Even though developing advanced cognitive capacities, many young people remain primarily oriented to the present and are less influenced by longer-term risks.
- May try to find meaning out of having a chronic condition. Issues around acceptance may arise.
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<thead>
<tr>
<th>Reflective Exercise</th>
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<tbody>
<tr>
<td>Think about the children and young people you work with.</td>
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<tr>
<td>What adjustments can you identify making in practice in line with the child’s developmental stage?</td>
</tr>
<tr>
<td>How often do you take time to consider what the child or young person is thinking, feeling or experiencing?</td>
</tr>
<tr>
<td>How will you use your knowledge of development to inform psychosocial work with children and their families?</td>
</tr>
</tbody>
</table>
Planning and Implementing Core Level Psychosocial Assessment and Intervention
Planning and Implementation of Psychosocial Assessment and Intervention

- **Presentation**
- **Further Assessment**
  - **Yes**
    - For example: Talk with relevant others, Observation, Functional Analysis, Behavioural Recordings, Self Report Measures
  - **No**
    - Psychosocial Intervention Not Required
    - Education and Advice
    - Psychosocial Intervention
    - Referral to Specialist Services, e.g. Paediatric Psychology, CAMHS

- **Monitor Progress**
- **Discharge**
Policy Context & Outcomes

Getting it Right for Every Child (GIRFEC)
- Feels listened to and taken seriously
- Feels involved in the important day-to-day decisions that affect them

The Healthcare Quality Strategy for NHSScotland
- Clinical excellence
- Effective collaboration between clinicians, patients and others

European Association for Children in Hospital (EACH Charter)
- Article 8 – Children shall be cared for by staff whose training and skills enable them to respond to the physical, emotional and developmental needs of children and families

Learning Outcomes

Plan and implement appropriate core level psychosocial assessment and intervention to support “Adherence”, “Self-Management” and “Adjustment to physical health conditions” for children and young people

- Recognise the role of and reasons for assessment in planning and implementing psychosocial interventions.
- Be aware of the different types of assessment and the context in which they are used to gain a comprehensive understanding prior to intervention.

Demonstrate awareness of the principles pertaining to planning and implementing core level psychosocial interventions.

Understand the general theoretical evidence on which psychosocial interventions relating to adherence, self-management and adjustment are based.
The Role of Psychosocial Assessment

Psychosocial assessment is undertaken to gather together pertinent information which forms the basis of a shared understanding of the presenting difficulty between the child, family and assessor. The initial step is usually talking with and observing the child, young person and their family to gain an insight into their thoughts, beliefs, experiences, hopes and strengths. This may be all that is necessary but often further assessment is required to gain a comprehensive shared picture. It may be helpful to talk with others who are familiar with the child in settings in which the child spends time for example, teaching or nursery staff, other family members or healthcare staff. Further assessment of the child in their day-to-day settings in terms of behaviour or mood may also be required.

Types of Psychosocial Assessment

Interviews/Talking with the child and family

This activity can be unstructured, semi-structured or structured.
- **Unstructured** – this gives the child or the family the opportunity to tell their story.
- **Semi-structured** – this gives some structure to the interview. It provides flexible guidelines and a starting point from which to progress.
- **Structured** – most often used to make a diagnosis or for research purposes. It follows a clearly defined set of questions and allows for little flexibility.

Initial Interview

During the initial meeting with the child and family and depending on individual circumstances, further information on some or all of the following can be gained.
- The presenting problem/difficulty.
- Demographic information.
- Developmental history.
- Family circumstances and history.
- Previous attempts to resolve the problem.
- Views on the cause and solutions.
- Other people and agencies involved.
- Strengths, motivational factors and risks.

Further helpful information and perspectives can be obtained by talking with other people involved with the child in the context of the presenting difficulty. This decision will be made in collaboration with the child and/or their family.

Reasons for Psychosocial Assessment

- Assessment forms the basis of a shared understanding of the presenting difficulty.
- Based on assessment, interventions can be tailored to individual children and families taking account of personal contextual factors.
- Assessment can be utilised to monitor progress and evaluate outcome.
- Assessment can also inform research. For example, there is currently little data on how racial and ethnic differences in attitudes, beliefs and behaviours affect adherence to treatment, self-management and adjustment.
Observational Assessment

Observation of the child requires to be appraised with reference to age and developmental stage. All healthcare staff are trained to be observant in their daily practice so this method of assessment will be familiar. During assessment, observation of the following may be undertaken in line with individual circumstances.

- Orientation (e.g. person, time).
- General appearance and behaviour (e.g. gait, posture, dress, personal hygiene, activity level).
- Speech and Thought (e.g. coherence, speed, open, guarded, general response style).
- Mood and Affect (e.g. sad, anxious, angry, labile, blunted, flat).
- Social skills and interactions with significant others.
- Response to encouragement.
- Attitude towards self.

Assessing Behaviour - Functional Analysis (A.B.C)

Setting Conditions

Antecedents

Behaviours

Consequences

To help gain an understanding of behaviour, it is useful to think of the triggers and maintaining factors which are influential. What happens before or sets the stage for the behaviour?

What happens after the behaviour or what are the consequences which result? This is known as the ABC analysis or functional analysis and gaining information on the antecedents, behaviour and consequences will help inform the type of intervention required should behaviour change be required.

Step 1

(B ehaviour)
Define the behaviour of concern

- Description of the behaviour.
- Frequency.
- Duration.
- Intensity.
- Sequences if present (which behaviours go together).

Step 2

(A)ntecedent
Identify antecedent events

- Antecedent refers to the event occurring immediately prior to the target behaviour.
- Relationship between the antecedent and the behaviour may not be obvious.
- The event immediately preceding the behaviour is relevant.

Step 3

(C)onsequences
Identify consequent events

- Consequent refers to the consequences for the child following the behaviour.
- What stimuli are presented as a result of the behaviour?
- What stimuli are withdrawn as a result of the behaviour?
Behavioural Recordings

This type of psychosocial assessment can take many forms but is essentially a means of seeking clarity in any of a number of settings or parameters. Healthcare staff will already be accustomed to using behavioural recordings in daily practice for example, pain diaries, fluid charts, blood pressure and temperature recordings. The behavioural recording used in psychosocial assessment will be determined by the individual requirement but may include daily diaries, typical day or charts recording particular parameters such as the following:

- **Settings** - persons, places, times, situations.
- **Parameters** - frequency, intensity, number and duration (F.I.N.D.).

Self-Report Measures

There are many self-report measures that may be used in practice to gain a standardised outcome of different aspects of functioning. The following are examples of some areas of functioning that may require to be assessed:

- Quality of Life (e.g. The Paediatric Quality of Life Inventory 4.0 (PedsQL)).
- Behaviour (e.g. The Strengths and Difficulties Questionnaire).

Any behaviour that occurs repeatedly is likely to serve some function for the child. Outcomes are usually to obtain something or to avoid something. Behaviour may serve multiple functions.

As a result of the information gained from this assessment, a support plan can be drawn up collaboratively with the child and family based on a range of possible interventions which:

- Aim to change or manage the triggers.
- Aim to change the response to or outcome of the behaviour.
- Aim to teach a more adaptive response that is as effective in getting needs met.

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Example of an ABC Diary

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**Time Setting**

Antecedents: What happens beforehand?

Client Behaviour

Consequenses: What happens next?

**Example of an ABC Diary**

- **Quality of Life** (e.g. The Paediatric Quality of Life Inventory 4.0 (PedsQL)).
- **Behaviour** (e.g. The Strengths and Difficulties Questionnaire).

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- Aim to change or manage the triggers.
- Aim to change the response to or outcome of the behaviour.
- Aim to teach a more adaptive response that is as effective in getting needs met.
Principles of effective Intervention

- Always keep minimal intervention in mind. Is it required? Before commencing a formal intervention are there informal or practical approaches which may be helpful.

- Consider who is involved in the intervention. Is it child or family focused? Can family members play a supportive role? Keep in mind the daily context in which the child lives.

- If intervention requires behavioural change, start with strengthening or developing positive behaviours. It is usually easier than reducing or eliminating unwanted/undesirable behaviours.

- If intervention requires behavioural change, start with strengthening or developing positive behaviours. It is usually easier than reducing or eliminating unwanted/undesirable behaviours.

- Start with focusing on areas in which success is more likely in order to encourage participation and develop a sense of mastery and control. Once achieved the child will feel more confident in coping with more challenging issues.

- Consider interventions which are the best fit for the child and family members. Be mindful of the individual child, family and condition factors which are relevant.

- From the onset, be aware of the merits of effective communication and age appropriate care. Interventions must be developmentally determined.

Theoretical Background

Interventions which are utilised to influence behaviour and adaptive coping in relation to Psychosocial Adherence, Self-Management and Adjustment to physical health conditions are based on a number of psychosocial theories. See below a brief review of the most influential theories.


- **Social Cognitive Theory (Bandura, 1986).** This theory assumes that behaviour is influenced by expectations about outcomes and confidence in personal ability (self-efficacy) to perform a given behaviour or make the desired behaviour change. On the basis of this theory a child who feels confident in their ability to take on a task (e.g. exercise or self-venepuncture) and believes that it will be beneficial, is more likely to achieve their goal. Self-management interventions focus on increasing self-efficacy through problem-solving and goal setting.

- **The Stress Coping Model (Lazarus, 1992).** Interventions focus on managing the stress of the condition and self-management interventions attempt to improve coping.
Transtheoretical Model (Prochaska & DiClemente, 1984) Interventions focus on readiness to change and how prepared an individual is to change behaviour. Stages of change include pre-contemplation, contemplation, preparation, action and maintenance. This model proposes that targeting an intervention to the individual’s stage of readiness to change will increase the chances of success. An individual’s motivation and their unique differences in their stage of change will need to be considered when implementing self-management interventions.

Cognitive Behavioural Theories (Beck et al, 1979) Psychosocial interventions based on cognitive behavioural approaches were an extension of behavioural work. The mediating role of cognitive processes and the influence which thoughts or internal speech has on behaviour is highlighted. Psychosocial interventions based on cognitive behavioural approaches include problem-solving, learning new cognitive skills and self-reinforcement.

Motivational Interviewing (Miller & Rollnick, 2002) This patient-centred approach is often used to assist in promoting positive health behaviour after overcoming barriers. It allows the young person to work through their ambivalence about behaviour change by activating their own motivations for change and adherence to treatment.

Learning Activity
- Think about a psychosocial intervention you could plan and implement. What are the steps you need to take in doing this?
- What is the underlying theoretical background?

Reflective Exercise
Assessment and observation are a fundamental part of working with Children and Young People in Specialist Children’s Services

What are the similarities and differences between psychosocial assessment and other assessment techniques?

Try to complete an A.B.C. diary in thinking about a child who presented with behaviour problems?

References


Psychosocial Interventions
Behaviour Change
Policy Context & Outcomes

Getting it Right for Every Child (GIRFEC)
- Receiving appropriate healthcare and guidance from services
- Applies strategies for addressing and managing avoidable risks to health
- Developing skills for coping with and managing disabilities and long term conditions

The Healthcare Quality Strategy for NHSScotland
- Caring and compassionate staff and services
- Effective collaboration between clinicians, patients and others
- Continuity of care
- Clinical excellence

European Association for Children in Hospital (EACH Charter)
- Article 4.2 – Steps should be taken to mitigate physical and emotional stress and pain
- Article 5 – Children and parents have the right to informed participation in all decisions involving their healthcare

Learning Outcomes

Move up a level to understand the types of interventions required for changing behaviour and determine the most appropriate to use in collaboration with the child and in line with individual need.

- Be aware of how children learn to behave and the functions which that behaviour serves.
- Demonstrate awareness of a range of psychosocial interventions which modify behaviour.
- Understand when current practice requires to be modified due to newly acquired knowledge.
- Demonstrate understanding of the partnership model of working with children and families in undertaking psychosocial interventions.
Understanding Behaviour

Observing and understanding a child’s behaviour is a fundamental basis of any psychosocial intervention. Behaviour of any type serves a function for the child and is often used as a form of communication. Working with children and families to improve adherence, self-management and adjustment to a chronic physical condition including those that result in disfigurement requires knowledge of:

- How children learn behaviour.
- The function which it serves.

How children learn behaviour

Children learn in a number of ways. Behavioural management interventions are based on the principles of different styles of learning which can be manipulated to achieve desirable outcomes for the child and family.

Operant Conditioning

The focus of understanding behaviour from this perspective is to observe the consequences.

Behaviour **increases** in frequency or intensity under the following conditions:

**Positive Reinforcement** – A behaviour occurs more frequently (e.g. taking medication) because it is followed by positive consequences (e.g. a smile).

**Negative Reinforcement** – behaviour occurs more frequently (e.g. avoids friends) because it is followed by the omission of an anticipated negative event (e.g. they won’t see the effects of steroid treatment).

Behaviour **decreases** in frequency or intensity under the following conditions:

**Punishment** – A behaviour decreases in frequency or intensity (e.g. tantrums or illness behaviour) because it is followed by a negative event (e.g. ignoring).

**Frustrative Non-Reward** – A behaviour decreases in frequency (e.g. exercise) because it is followed by the omission of an expected reward (e.g. acknowledgement, praise).

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Be careful to target the correct behaviour.
Classical Conditioning

This approach to understanding learning focuses on stimulus and response. Classical conditioning was discovered by Russian physiologist Ivan Pavlov. This learning process occurs through associations between an environmental (unconditional) stimulus and a naturally occurring (conditional) stimulus. An unconditioned stimulus is one that occurs naturally and automatically triggers an unconditioned response.

For example, when children smell a favourite food, they may immediately feel hungry. Here, the smell of the food is the unconditioned stimulus and the feeling of hunger the unconditioned response. The conditioned stimulus is a previously neutral stimulus that after becoming associated with the unconditioned stimulus eventually triggers a conditioned response.

In this example, if the smell of food is repeatedly paired with a whistle eventually the whistle alone will trigger the conditioned response. The conditioned response is a learnt response to a previously neutral stimulus. In this way a child can learn to fear a neutral stimulus if it is paired over time with fearful stimuli or feel calm in a previously feared situation.

Classical conditioning has been usefully applied to help children learn more adaptive responses. For example, hospital wards or clinics, environments unfamiliar to many children and often threatening to them can become less feared by creating a positive environment. Pairing this feared environment with pleasant and positive experiences helps the child learn new associations. Instead of feeling anxious or tense they learn to stay relaxed and calm.

Observational Learning – Modelling

Children learn behaviour through modelling the behaviour of others. In order for modelling to occur the child must pay attention and remember the behaviour. They must also be motivated to reproduce the behaviour and have the ability to undertake it. These factors will vary from child to child and therefore each individual child will learn and respond individually. To help a child learn new patterns of behaviour allow them to observe a person performing the desired actions. For some children the opportunity to observe peers modelling the behaviour has the most effective outcomes. This can be reinforced by observing their peer being rewarded for this behaviour for example by praise.

The Function of Behaviour

Behaviour serves many purposes. Some of these are as follows:

- To obtain favourable outcomes.
- To avoid unfavourable outcomes.
- To express emotion.
- To obtain social contact.
- To stimulate.
Psychosocial Interventions to increase Desirable Behaviour

Positive Reinforcement - Reward Systems

Rewarding children following any desirable behaviour will increase the likelihood that a particular behaviour will be repeated. Rewards should not only be given for outstanding performance, perfection or completion but also for any steps in the right direction. This will help to shape the behaviours and gives the child encouragement to continue. Reward systems should be continued even if initially they do not appear to be working or are rejected by the child. Praise is one of the most common forms of reward.

Benefits of Praise

- It is rewarding.
- It encourages desirable behaviour.
- It educates the child about appropriate behaviour.
- It can motivate the child.
- It encourages positive interaction between children and others.
- It enhances relationships.
- It promotes self-esteem.

How to use Praise

- Be specific.
- Praise immediately.
- Praise appropriate behaviour.
- Praise effort as well as outcome.
- Be enthusiastic (smile, maintain eye contact, warm tone).
- Do not link with a criticism.
- Target specific behaviours.
- Praise in front of others.
- Be consistent with praise.
- Increase praise for challenging situations.
- Model and encourage self praise.

Social rewards such as praise or attention are one form of reward. It may be useful to use tangible rewards when encouraging a child to engage in or accomplish a difficult task. Tangible rewards can be spontaneous in situations where the child already exhibits the desired behaviour but there is a need to increase the frequency of occurrence, for example, trying to encourage a child to cooperate with the increased frequency of physiotherapy during an exacerbation of their condition.

Tangible rewards can also be planned if there is a need to increase a rare or non established behaviour. For example, establishing new dietary patterns. One method of implementing a planned reward programme is the use of star charts.

Specific Guidelines for using Rewards

- Define the target behaviour clearly.
- Keep it simple and phrase it in a positive manner.
Target one behaviour at a time.

Start with small steps and work towards bigger goals.

Decide when and where the process will occur.

Make up a smiling-face chart, sticker chart or points chart.

Explain to the child that they can win points, stickers or smiling faces by carrying out the target behaviour.

Give the child a sticker, smiley face or points every time they reach their target.

Give the reward immediately.

Once they have earned the reward, it cannot be taken from them.

The behaviour should be backed up by praise every time it occurs.

Ask the child to list a set of rewards that they would like to be able to obtain with their points, stickers or smiling faces.

Agree on how many points or faces are necessary to obtain each reward.

Follow through on the plan and review it for effectiveness.

General Guidelines

Present the reward system to the child as a way of helping him or her to learn helpful behaviour.

All involved in the process should understand and agree to using the system.

Use a chart that is age appropriate. Smiling faces, stars or stickers are good for children and points may be used for young people.

The sooner points are given after completing the target behaviour, the quicker the child will learn.

The rewards should be small and inexpensive, not extravagant and in keeping with the achievement.

Rewards should be motivating for the child. Highly valued rewards lead to faster learning.

Try to fine-tune the system so that success is easy to achieve initially. Motivation increases with initial success.

If rewards are not being achieved, make the target behaviour smaller and clearer and ensure that everyone involved understand and are committed to using the system.

If the system is not working, do not criticise the child.

Continue to use the system until the desired behaviour is achieved.

Once the behaviour has become established revise the programme.
Examples of Reward Charts

Colour in a happy face every time you:

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Modelling

Another effective psychosocial intervention which can be used to increase desirable behaviour is to model this behaviour and reward the child when it is learnt.

Guidelines for Modelling

- Inform the learner (young person or parent) about the important aspects of the modelled behaviour to attend to.
- Ask the learner to repeat this information.
- Model the behaviour.
- Ask the learner to give feedback on the modelled behaviour.
- Reinforce the learner for their feedback.
- Ask the learner to imitate the modelled behaviour.
- Reinforce the learner for their efforts, correcting if necessary.
- Repeat the modelling, feedback and reinforcing if necessary.
- Repeat imitation and reinforcement until the behaviour is learnt.

Psychosocial Interventions to Decrease Undesirable Behaviour

Omission of Positive Reinforcement

Receiving no rewards following an undesirable behaviour will lead to the extinction of unwanted behaviour. If the child has previously been rewarded with increased attention (including negative attention) following an undesirable behaviour, any change will initially be met with resistance. The child may work hard to restore the lost attention and the behaviour may become worse before it gets better.

Ignoring

This technique can be used by clinicians working directly with children or the clinician can guide the parents in their use to manage behaviour change at home.

Guidelines for Ignoring

- Ignore (pretend not to notice) minor undesirable behaviours such as moaning or whining.
- As soon as the behaviour starts, turn away or walk away from the child.
- Say nothing and maintain a neutral expression.
- Do not get drawn into any debate, argument or discussion while the child is misbehaving.
- Do not justify your actions to the child at this time.
- If you think the child needs an explanation then say simply ‘when you are calmer we will talk about it’.
- Once the unwanted behaviour has stopped and the child is interacting well reinforce this behaviour with resumed attention.

Time-out from Positive Reinforcement

This technique is intended to reduce the frequency of an undesirable behaviour by ensuring that it is followed by a reduction in the opportunity to gain rewards. The child may receive time-out from an activity where they are simply removed from an enjoyable activity following misbehaviour and placed in an uninteresting place.
This technique can be used by clinicians working directly with children or the clinician can guide the parents in its use to manage behaviour change at home.

**Guidelines for Using Time-out**

- Ensure that the child has been made aware previously of the use of time-out.
- When the behaviour occurs, give two warnings.
- Sit the child in a boring place calmly with clear and straightforward instruction.
- After a set time (one minute for each year of the child’s age), engage the child in a positive activity and praise them for control.
- If the unwanted behaviour recommences, return the child to time-out until thirty seconds of quietness occurs.
- Engage in positive activity with child and praise for control.
- Do not hold grudges after episodes of unwanted behaviour.

**Psychosocial Interventions to Promote Positive Behaviour**

**Problem-Solving**

**Teaching Children and Young People how to Problem Solve**

Healthcare staff and parents can help promote adherence, self-management and adjustment to health conditions by working with children to find solutions to their problems. Once familiar, problem-solving skills can be used more widely in all aspects of their life including interpersonal contact, decision-making and perspective-taking.

**Step 1**

**Define the problem and the feelings involved.**

What is the problem? How does this problem make you feel?

- If the child finds it difficult to define a problem then focus on how they feel. If they are feeling sad, worried or angry then this will be a clue that there is a problem to be solved. Then help them to accurately define the problem. For example, ‘So you feel worried that your friends will tease you about having to take medicine at school’.

- For younger children it may be helpful to practise hypothetical problem scenarios initially through the use of stories or puppets to encourage them to engage in a relaxed and fun way.

**Step 2**

**Brainstorm Solutions**

Help the child to come up with as many different solutions, choices or options as possible to solve the problem. For example, ‘So what are the options?’ ‘What are the solutions to help solve the problem?’ ‘Well done, can you think of any more?’

- If at first the child finds this difficult, suggest a few ideas. Keep it light and fun and be as creative as possible. The use of stories, cartoons and colourful drawings or charts can be helpful.

- Encourage imaginative thinking and try to generate a varied set of solutions. Praise them for generating solutions but in particular for different ideas. Try to model creative solutions if required but allow the child to take the lead. Avoid criticism of ideas.

**Step 3**

**Explore the pros and cons**

Think through the consequences. What would happen if you carried out a particular solution?

- Having generated a number of possible solutions, explore what would happen next if each solution was carried out. Then help the child to assess which option may be the best one.
Try to predict as many outcomes as possible that may arise from their choices. Continue to let the process be fun, focused and engaging. There is no need for the child to discuss every possible solution.

Step 4
Agree an Action Plan.
What is the best solution or choice?

Help the child select one or two best choices from the possible solutions which they would be willing to agree to try out as part of a joint action plan. Give them the choice which fosters responsibility for the problem.

Let them consider if the solution is safe and would help them feel good before deciding. They can try it out on you to practise.

Step 5
Implementation
Is the Plan being carried out?

Prior to trying out solutions in real life, it is helpful to engage in hypothetical problem-solving games where the child can think of situations where they might use the agreed-upon solutions. Then identify an adult familiar with the process who can support the child in implementing their action plan in the context in which it is used. This may be a parent if used in the home, a staff member if in hospital or a teacher for use at school.

Step 6
Evaluating Outcome & Reinforcing Efforts
How did you get on?

Help the child to evaluate how successful they were at carrying out an agreed solution. Was it successful, what did they learn and would they use it again in the future? If it worked for the child, discuss how it could be useful for other situations. If not then help them to think about other choices that may have a better outcome.

Reinforce the child for their efforts at problem-solving by praise and reward.

Specific guidelines for Problem-Solving

- Define the problem.
- Brainstorm options.
- Explore pros and cons.
- Agree on a joint action plan.
- Implement the plan.
- Review progress.
- Revise the original plan.

Guidelines for Informal Problem-Solving

- Make a time and place for clear communication.
- Understand the problem from the child’s point of view. Can you tell me about it? This helps the child to clarify the problem and ensures that there is a shared understanding.
- Summarise your understanding of the problem and share with the child or young person. For example, ‘Now I understand what the problem is. Your friends offer you sweets and you take them because you do not want to be different’.
to them. ‘You know this increases your blood sugar which leads to arguments with your Mum and you feel guilty and ashamed.’ A child will be more motivated to work in collaboration with you if they believe that you have an understanding of how they feel.

Guide the child to think for themself. Ask questions which encourage them to define the problem, think about what caused it, create their own solutions and express their feelings.

The use of open-ended questions will help the child to think it through for themselves. Asking ‘what’ or ‘how’ questions will help engage the child or young person in the process. For example, ‘What happened?’ ‘How did you feel?’ ‘What do you think your friend knows about your condition?’.

Paraphrasing helps to make the child feel valued and listened to.

Discuss one problem at a time.

Divide one big problem into a few small problems.

Define problems briefly.

Explore both positive and negative consequences.

Work with the child to anticipate what to do next when something doesn’t work.

Be positive, creative and humorous. Use books, games, cartoons and puppets to present hypothetical problems to practise the problem-solving steps.

Model effective problem-solving.

Problem-solving is a process of learning how to think about and cope with problems and not about getting it right.

Celebrate success.
Problem-Solving

Step 1. Define the problem and feelings involved

<table>
<thead>
<tr>
<th>What is my problem?</th>
<th>How do I feel?</th>
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Step 2. Brainstorm solutions

List all possible solutions

Well Done!
Step 3. Explore the pros & cons

<table>
<thead>
<tr>
<th>Solutions</th>
<th>Pros</th>
<th>Cons</th>
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Step 4. Agree an Action Plan

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<tr>
<th>Action Steps</th>
<th>Where</th>
<th>Who</th>
<th>When</th>
<th>How</th>
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Step 5. Implementation

*Implement plan*

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Step 6. Evaluate the Outcome & Reinforce Efforts

- Was the plan successful?
- What did you learn?
- Does the plan need to be modified or a new plan made?
- If the plan is not working, return to STEP 2 to make new plan or STEP 3 to modify the existing plan.
- Praise yourself for your efforts and success
Goal Selection

The clinician can use Goal Selection as a collaborative way of helping children, young people and their families identify, initiate and maintain goals which promote good health. Goal Selection works best when there is more than one option available. The process of Goal Selection is determined by a number of steps which are now described.

- **Discuss treatment options** - The clinician outlines the options available with attention to the individual context.

- **Select treatment option** – Following a collaborative discussion with the child, young person and family, a preferred option for management of the condition is selected.

- **Agree an Action Plan** - It is helpful to agree the schedule of management around the child’s daily routine to ensure a minimum of lifestyle changes. This will minimise the impact of the condition and foster confidence in management. There may be little option for negotiation on treatment options depending on the condition and this should be discussed openly and an agreed understanding reached with the child and family.

- **Negotiate contracts** – It is helpful to agree on a contract with older children and young people on the exact details of the management of the condition. This should be based on details elicited from the child or young person and may be driven by and written up by them. It should be signed by both parties and reviewed on a regular basis.

- **Self-Monitoring** – Using diaries and daily calendars can be a useful means of monitoring management goals and allowing adjustments to be made when necessary.

- **Review** – Arrange to review progress and reward any success. It may be necessary to agree new goals or work through challenges identified in maintaining goals which have been initiated.

---

**Goal Selection (Flowchart)**

1. **Discuss Treatment Options**
   - SMART goals
   - Confidence rating
2. **Select Treatment Option**
   - If / Then
   - Support details
3. **Action Plan & Contract**
   - Diary
4. **Self Monitoring**
5. **Review**
Guidelines for using Goal Selection

- After goals have been discussed, negotiated and agreed on, they should be written up in an action plan.
- Plans are written in an age appropriate manner.
- The plan should be precise about how to manage the condition including exacerbations and the roles of all people involved.
- Clear lines of communication should be outlined including up-to-date contact details.

Outcomes of Goal Selection

- Establishes preferences about desirable outcomes.
- Enhances commitment to achieve goals of self-management.
- Establishes proactive patterns of health behaviour.

Examples of materials which can be useful in Goal Selection are detailed now. All of these materials can be modified and personalised for the individual child or young person.
SMART Goals

Once the child/young person has decided upon a health behaviour they want to change, they need to set a goal. Your role is to help the child set a goal that is detailed and likely to be achieved. Goals should be SMART, that is:

**Specific**
Some goals can be vague and difficult to measure. It is important to set goals that are clear and precise. For example, a vague goal would be “I will take my medication” whereas a clear, specific goal would be “I will take my medication every day at 8am and 7.30pm”. To help the child/young person make their goal more specific, ask them questions such as:

What are you going to do?
How are you going to do it?
Where are you going to do it?
When are you going to do it?
With whom are you going to do it?

**Measurable**
Making the goal specific means that it should be easy to measure whether or not the child/young person has achieved their goal. The example above “I will take my medication every day at 8am and 7.30pm” is measurable. The child/young person can record the number of times they took their medication in one week. It would be harder to measure a vague goal.

**Achievable**
Set goals that are within the child/young person’s reach. Failing to achieve a goal can have a negative effect on their motivation to work towards their goal. For example an unrealistic goal could be ‘eat no chocolate or sweets for the next seven days’. A more realistic goal could be ‘eat no more than three portions of sweets or chocolate in the next seven days’. It is important to make the first goal quite easy to achieve to boost the child/young person’s self-confidence and encourage them to carry on. The best way of changing behaviour and maintaining change is to build on small success.

**Relevant**
Does the child/young person think that the goal is relevant to them? [You need to check that the child/young person sees a clear link between their goal and their health or how they feel and that is the behaviour they want to change].

**Timely**
Is the goal the right thing for them to try to achieve right now? If so, set a time frame in which the goal can be achieved. If you don’t set a target date for the completion of the goal, it could go on and on without the child/young person ever achieving it. For example, if your next session with the client is a week away, aim for the goal to be completed by that time. If the goal requires a longer time frame, decide together whether there are any mini-goals that they could achieve in time for the next session.

Adapted from Department of Health (2008), Improving Health: Changing Behaviour- NHS Health Trainer Handbook
Example of a CONFIDENCE RATING CHART

How do I feel?

very confident

Not confident

0 1 2 3 4 5 6 7 8 9 10
Example of an ACTION PLAN/ CONTRACT

My general goal is ......................................................................................................................

My specific goal is .....................................................................................................................

Where? ........................................................................................................................................

When? ..........................................................................................................................................

With whom? .................................................................................................................................

How? .............................................................................................................................................

How will I know how I am doing?

Tick as appropriate

1. I will keep a diary
   
2. I will keep a goal selection chart
   
3. I will use a confidence ruler
   
Child / Young Person Contract

I will keep to my goals and I will let you know how I am doing.

Signature: .................................................................................................................................

Date: ..........................................................................................................................

Healthcare Worker Contract

I will see you and discuss your progress at the next meeting.

Signature: .................................................................................................................................

Date: ..........................................................................................................................
Example of an ‘IF - THEN’ PLAN

Are there any situations that you can think of that could make it especially difficult for you to perform your goal? (a time, place or a feeling that might make it more difficult)

For example, “When I stay overnight at my friend’s house I sometimes forget to take my medication the next morning”

List your difficult situations

•
•
•
•
•

• Now make some plans for how to make them more manageable or less likely that they will happen.

• Fill in the table below with your difficult situations and make an IF/THEN plan

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<th>IF...</th>
<th>THEN...</th>
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Example of a GOAL DIARY

My goal is . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

<table>
<thead>
<tr>
<th>Date</th>
<th>What?</th>
<th>Did you do it?</th>
<th>What made it easy?</th>
<th>What made it hard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
<td>YES (✓) NO (X)</td>
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<td>Tuesday</td>
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Reviewing Behaviour Change

When reviewing behaviour change with a child/young person, helpful questions to ask may be:

• What was tried (and what was the goal)?
• With what effects (and did the child/young person achieve any success)?
• What benefits were there?
• What difficulties were there?
• How did the child/young person manage any difficulties?
• Were there any problems filling in the diary? How could these be solved?
• How confident is the child/young person that they can achieve their goal?
• Is the child/young person getting enough support?
• What have you both learnt that could be useful when filling in future diaries?
• Does the SMART goal need changing?

Remember to **praise any success**. Make sure you praise something the child/young person has done, however small, to boost their motivation and level of self-confidence. This could include any progress towards their goal, attending the meeting, filling in their diary or learning more about what they find difficult. Praising the child/young person may also improve your relationship with them and make communicating easier. Remind the child/young person that successful behaviour change is a long process and we need to build on each small success, learning from any setbacks.

*Adapted from Department of Health (2008), Improving Health: Changing Behaviour- NHS Health Trainer Handbook*
Eliciting Behaviour Change – Introduction to Motivational Interviewing

Motivational Interviewing (MI) is ‘a skilful clinical style for eliciting from patients their own good motivations for making behaviour changes in the interest of their health’ (Miller & Rollnick, 1991). There is an emerging evidence base for the effectiveness of MI in working with young people into early adulthood in relation to health behaviour change. When working with young people, it is the role of the healthcare worker to guide the young person towards helpful solutions or goals which will enable them to manage their condition more effectively. Health patterns where current behaviours or coping styles are not helpful will require change and MI is an effective method of encouraging it. As described by Miller & Rollnick, MI is based on the following assumptions. It is:

- **Evocative.** Every young person has beliefs, values, goals and experiences. Rather than assuming that they lack information or motivation, this approach evokes from the young person the resources they already possess. It hopes to connect health behaviour change with what the young person cares about through gaining insight into their thoughts and evoking their own reasons and goals for change.

- **Collaborative.** The partnership between the young person and the healthcare worker is cooperative and collaborative. The power relationship between the expert clinician and the passive young person is replaced by a collaborative discussion and a joint decision making process in which the young person has an active role. Although person-centred this approach addresses the specific situation in which behaviour change is needed.

- **Honouring of Patient Autonomy.** In the management of long term health conditions, it is the young person and family who ultimately decide what they can and will do in the context of their lives. The healthcare worker can inform and encourage but needs to be mindful that it is human nature to resist change imposed by others and being told what to do.

There are four guiding principles to Motivational Interviewing as described by Rollnick & Miller:

- **Resist the Righting Reflex.** The motivation by healthcare workers to help young people get it right and prevent harm can guide the conversation on health change to the ‘correct argument’.

  For example, if the healthcare worker says to the young person ‘I don’t think you are getting enough exercise, you need to fit it into your daily routine’, it is a natural response for them to argue against this viewpoint or defend this behaviour. As we tend to believe what we hear ourselves say, it may be that in defending the status quo the young person is arguing against behaviour change. It is the child who should be voicing the arguments for change.

- **Understanding the Young Person’s Motivations.** It is the healthcare worker’s role to elicit the young person’s own motivations for change. It is their individual reasons for change that will form the basis of behaviour change.

- **Listen to the Young Person.** This involves an empathic interest in hearing the young person’s view of their health and the need for behaviour change. The answers usually reside within the individual young person and require good listening skills to elicit and understand them.

- **Empowerment.** An important role for the healthcare worker is to support a young person’s hope that change is possible and can make a meaningful difference to their health.
Using Motivational Interviewing approaches to Change Behaviour

Motivational Interviewing approaches aim to resolve ambivalence and help the young person become ‘unstuck’ and move towards change. In achieving this, the young person’s own motivations to change are elicited through recognising change talk and creating the opportunity for change talk to be expressed (Step1). This is followed by providing management/treatment options and change strategies which are created collaboratively (Steps 2 & 3).

Ambivalence

One of the key concepts to consider in motivational interviewing is ambivalence. This is common and easily recognised in talking to young people by listening for simultaneous conflicting statements about their actions regarding their health. Listen for the ‘but’.

**“But...”**

- I want to take my medication
- I know I shouldn’t eat sweets
- I feel better after exercise
- I need to lose weight
- I keep forgetting
- All my friends do
- It is hard to get started
- I don’t know where to start

Change talk

In talking with young people about making behaviour change, listen out for and recognise change talk when you hear it. Change talk can predict behaviour and is an indication of a level of intent. There are different types of change talk described by Rollnick & Miller which include the following:
Step 1

**Involve the young person in decision-making**

From the start, a good guiding style will allow the young person to make decisions about the direction the conversation takes. Asking the young person what they want to talk about and getting to know them signals that their views are important and sets the emphasis in eliciting change talk. If the healthcare worker decides what topics are to be discussed and opens the conversation with these, the opportunity to learn about what behaviour change the young person would like to discuss is lost. So how does the clinician encourage the young person to talk?

- **Agenda Setting** – The healthcare worker offers the young person a number of topics from which they can choose which ones they would like to discuss. Using a ‘bubble chart’ is a straightforward way of engaging the young person. It can also guide the young person to consider some of the topics causing concern by filling in some of the bubbles prior to meeting but leaving some free to elicit the topics which are important to them. The healthcare worker might guide this process by saying:

  ‘If you would like to, we can talk about some changes that you can make to improve your health. Here are some ways that other young people have found useful and like to talk about in managing their condition. Are there any that are more important to you and that you would like to add?’

It is good practice to choose one topic to talk about at a time and to start with one which is important to the young person. It may take a little time for the young person to want to talk about a topic that the healthcare worker considers more of a threat to health but the key to behaviour change is motivation to self-manage. Remember, the experience of mastering small changes in any area will increase motivation and confidence. This often leads to progress in another.
Example of a Bubble Chart
Evocative Questions – Use open questions which evoke desire, ability, reasons and need. These questions lead to answers containing change talk.

For example:

<table>
<thead>
<tr>
<th>Desire</th>
<th>Reasons</th>
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<tbody>
<tr>
<td>What do you wish, want, and hope?</td>
<td>What would be the benefits of? Why would it be helpful to make this change? What problems would you like to get rid of?</td>
</tr>
<tr>
<td>Ability</td>
<td>Need</td>
</tr>
<tr>
<td>What do you do? What can you do? What are you able to do?</td>
<td>How important is it to you for this change to be made? How much do you need to make this change?</td>
</tr>
</tbody>
</table>

Discuss Pros and Cons – Ask the young person about the pros and cons of a behaviour. This will allow you to view both sides of the young person’s ambivalence. The first question will elicit reasons for not changing but lead to the second question which elicits change talk.

For example, if the young person likes to have a lie-in which leaves little time for treatment in the morning, start by asking what is good about the way things are now. It may be ‘What do you like about having a lie-in?’ This question must be asked in an open and interested manner.

Once the young person has given an insight into the ‘good’ aspects of the behaviour, the conversation can be guided by asking about the ‘not so good’ aspects. For example, ‘Are there any downsides to having a lie-in?’ Or ‘Do you think there are any not so good things about having a lie-in?’ It is useful to summarise this conversation for the young person as you see it, using their phrases and words when possible.

Using a Ruler – Using a ruler or rating scale from 1 to 10 is a child-friendly way of assessing motivation and stimulating change talk. It is used in conjunction with open questions.

For example, ‘You have been talking about wanting to get up earlier on a school morning. On this scale from 1 to 10 where ‘1’ is ‘not at all’ and ‘10’ is ‘very much’, where would you place yourself now?’
On the basis of this visual interaction further information can be sought. For example, ‘Why so high?’, ‘Why a two and not a one?’ ‘How can you go higher?’ Or ‘How ready are you to make this change? On this scale from 1 to 10 where ‘1’ is ‘not at all ready’ and 10 is ‘completely ready’, where would you place yourself now?’

At key points throughout the conversation during which change talk is being elicited or to draw it to a close, it can be useful to enhance this by using the following skills. In MI these skills are known as O.A.R.S.

- **Open Questions** – Inviting the young person to talk about what is important to them.
- **Affirming** – Reinforcing change talk by making positive comments.
- **Reflecting back** – Demonstrating understanding and guiding direction.
- **Summarising** – Pulling the main points of the discussion together in a helpful way. Aiding recall and emphasising important points.

A good follow-up once change talk has been elicited is to ask key questions which open up the ‘What next?’ question. For example, ‘So what do you think would be a first step?’ or ‘What do you plan to do now?’

**Step 2**
**Inform the young person about options and check their understanding**

The following approaches to informing the young person and checking their understanding are described by Rollnick, Miller and Butler (2008).

- **Asking Permission** – Continuing with a guiding style, always seek permission before informing the young person about the choices open to them or giving them advice. This enhances collaborative working and ensures that the young person is ready to receive this information. There are a few ways in which permission can be sought.

  The young person may ask for information or advice. In this situation the young person is clearly giving permission to the healthcare worker to offer the relevant information. In order to match the level of information to the individual young person, the healthcare worker may gently ask what they already know and be aware of their developmental stage.

  If the healthcare worker takes the first steps in offering information, it is respectful to ask permission to inform.

  For example:

  *Would it be helpful if I tell you what other young people have found useful?*  ‘Can I make a suggestion?’ ‘There are a few options we can talk about to help with the pain. Would you like to hear them now or are there other things you would like to talk about first?’

  By asking for permission in this way, the young person is actively involved in decisions about
their care and it is more relevant to them in the context of their experiences and lifestyle. It prepares the young person for what they are about to hear and helps the healthcare worker to identify if there are other issues which are of greater priority to the young person at that time.

When asking permission to give advice, the young person may say ‘no’. The healthcare worker should keep this in mind and, in circumstances where it is important for the information to be imparted, other approaches can be considered.

**First Choice** – By asking the young person if they would like to hear the information now or if there are other things they would like to talk about first implies that the information will be given but gives the young person some space to prepare. It is also respectful of the young person’s order of priority. When they have addressed the issues that are important to them, they will be more receptive to receiving this information.

**Prefacing** – It can be useful to preface the information or advice with a comment that confirms the young person’s autonomy. Acknowledging that they can choose to disregard what the healthcare worker is about to say makes them more interested and willing to listen.

For example:

‘I don’t know if you are interested or not but…’

‘You can tell me what you think of this idea…’

**Announcing** – This is the most direct approach.

For example:

‘There is something I need to tell you about just now’. 

These approaches do not have to be used singularly and, at times, may be used in combination.

**Offer choices** – When offering information or advice, where possible, give choices and allow the young person to decide which suits their needs best. There may be times when choices are limited but other times when there may be many possibilities. To increase the likelihood of the young person choosing their preferred option rather than dismiss them all, offer all choices simultaneously. If offered individually, the young person may decide that none fit and the opportunity for change is reduced.

For example:

‘Some of the young people I have spoken to have good strategies for helping them remember their medication. Some find it helpful to set an alarm on their phone, some asked a friend to remind them, some got a parent to text them, some leave their medication on the hall table to remind them. I wonder which of these would work best for you?’

**What Other Young People Do** – When giving information to young people it can be useful to discuss how it has affected others in similar circumstances or what they have found helpful. This gives the young person the opportunity to decide what might work for them and allows the healthcare worker to remain neutral.

For example:

‘Some young people find that doing their relaxation exercises in the evening helps them to keep to a routine but others like to do them at different times during the day. I wonder what you think would work for you?’

**Chunk-Check-Chunk** – This approach to giving information is very valuable when working with young people as it allows the healthcare worker
to modify the pace of work to the young person’s level of development. The healthcare worker gives some information, checks that the young person has understood, and provides further information. In this approach the healthcare worker stops at regular intervals to check that the young person has understood before proceeding.

For example:

‘What do you think about what I have just said?’
‘Is there anything about what I have just said that you want to talk about?’

This style of asking between giving chunks of advice ensures that the young person is fully engaged in the process and feels included in decisions about care. This increases the chances that they will adhere to the options or goals collaboratively agreed to. It also allows the healthcare worker to ensure that information is age appropriate and that misunderstandings can be identified and corrected as the conversation unfolds. It is useful to use this approach when the healthcare worker is required to provide the young person with information or advice.

**Elicit-Provide-Elicit** – This style of imparting information is most useful when changes to health behaviour are required. The focus is not so much on giving information but to help the young person make sense of it and be the leader in making decisions about behaviour changes that they can initiate and maintain.

In order to do this, the healthcare worker needs to elicit the young person’s beliefs, current knowledge and interests in knowing more before giving information. This style of exchange is a cyclical process and, although it has informing at its core, it also requires asking and listening. For the first part of this dialogue, the healthcare worker elicits what is important for the young person to discuss and their current knowledge.

For example:

‘What is important for you to know about…?’

This is an invitation to the young person to inform the healthcare worker what the priorities are for them from their perspective. To determine what the young person already knows, the healthcare worker can ask ‘What do you already know about….?’ Receiving this information then forms the starting point to which the healthcare worker can provide additional knowledge and address potential misunderstandings. It also is the start of change talk.

The second part of this dialogue involves providing information that the young person has requested they would find useful.

The third part is to ask questions which elicit the young person’s responses to the information that they have just received.

For example:

‘Does this cover everything or is there anything else you would like to know?’ ‘What do you think about that?’ ‘Is there anything you would like to ask me?’

**Step 3**

**Listen to the Young Person and hear what they say**

Good listening skills are at the heart of all conversations with young people. These skills honour autonomy and are respectful. They contribute to a rewarding, collaborative and relaxed dialogue which encourages the young person to share their beliefs. To use listening in a guiding way, it is useful to reflect back to the young person at regular intervals to gently guide towards the goal of behaviour change. This will inform what is reflected back and why. Skilful listening leaves the healthcare worker with a wealth of information from which to guide the direction and pace of the conversation. What then does the healthcare worker chose to reflect back?
Reflect Resistance – During conversations with young people who are ambivalent about behaviour change, it is common to hear some arguments to support the status quo. It is difficult for the healthcare worker to not intervene and point out the problems with this course of action or offer advice on what they think would be a more effective approach. By doing this, however, the young person will defend their choice and argue against change. This is counter productive. The young person will already have both sides of the argument in their own mind, so, by reflecting this back in a non-judgemental way, the young person will be less resistant and may initiate change talk. Even if they do not, the healthcare worker will have a clearer picture of the barriers for that young person.

Reflect Change Talk – Adopting the guiding style allows the young person to present the case for change. Asking the questions which elicit change talk will allow the healthcare worker to hear it and reflect it back to the young person. This is a powerful but affirming way for the young person to hear change talk firstly from themselves and then reinforced by the healthcare worker. It gives them the opportunity to introduce a concept, have it recognised and gives space to consider the possibilities.

Hearing the idea spoken aloud perhaps for the first time and having interest shown increases the possibility that it will be considered and result in change to healthcare. When the healthcare worker shows genuine interest in the young person’s own motivations for change, it encourages them to explore and focus on what may previously have remained a fleeting and unstructured internal argument.

Reflective Exercise

We all learn how to behave in similar ways. Think about a childhood example of each of the three ways of learning behaviour outlined in this chapter.

What interventions could you use to increase desirable behaviour?

What are the steps in problem-solving?

Reflect on the techniques which have been outlined in an introduction to Motivational Interviewing.

Which of these techniques do you think you could use in practice?

Can you think of specific examples where these techniques might be helpful?

References


Psychosocial Interventions
Reducing Distress
Learning Outcomes

Move up a level to understand the types of interventions required for reducing distress and determine the most appropriate to use in collaboration with the child and in line with individual need.

- Be aware of some reasons why children and young people may present as distressed or anxious.

- Demonstrate awareness of a range of psychosocial interventions which reduce distress and determine the most appropriate to use in collaboration with the child and in line with individual need.

- Understand when current practice requires to be modified due to newly acquired knowledge.

- Demonstrate understanding of the partnership model of working with children and families in undertaking psychosocial interventions.
Supporting a Distressed Child

Children and young people with physical health conditions can at times become distressed or anxious. This can occur as a result of a change in the condition, treatment, symptoms, anticipating a medical procedure or at transitions. They may also be coping with new or difficult situations in their daily life which is upsetting for them. In supporting distressed or anxious children, it is important to establish a good working relationship with them to explore their distress and coping techniques which they would find helpful.

When a child is distressed or anxious, this should be acknowledged by saying, for example, that many children in the same situation become worried or upset. They can then be introduced to new ways of coping that other children have found helpful. Some of these techniques are as follows:

Relaxation

Children can be taught relaxation as a method of reducing the physical symptoms of anxiety and tension which sometimes present. It can also help distract from unhelpful thinking and increase confidence in their ability to manage anxiety symptoms. It is a skill that may take time to become familiar with but is worth persevering as the child can use it as required once learnt.

There are different types of relaxation but the most common method is progressive muscular relaxation. In this method, each group of muscles is deliberately put under tension and then released. This exercise trains the mind to focus on the difference between tension and relaxation in each muscle group. Time spent working collaboratively with the child will improve the therapeutic relationship. Prior to starting, check that there are no reasons why the child cannot participate in relaxation exercises.

Progressive Muscular Relaxation

General Guidelines

- Set aside 20 minutes each day to go through these relaxation exercises. Do not rush.
- Reduce the possibility of distraction. Turn off bright lights, or phone.
- Get into a comfortable position, either sitting on a comfortable chair or lying down and lightly close your eyes.
- Remove any tight clothing and shoes, uncross legs and place arms by your side.

For example:

- Are there any existing injuries or medical conditions which would be contraindicated.
- Are there any difficulties with sustained attention or following instruction.
- Are there any difficulties with home practice.

This method of relaxation can be presented in age appropriate ways to children and young people as follows.
Progressive Muscular Relaxation (Young People)

‘Learning relaxation is like learning any other skill such as cycling, swimming or golf so the more you practice the better you will become at it. You may find it difficult at first but it is worth sticking with it until it becomes second nature. You will then be able to use relaxation whenever you feel yourself tensing up. Most of us tense particular muscles out of habit when we are stressed and by using these exercises you will be able to let yourself relax these muscles again. This will give you more control over your reactions to stress and tension. During progressive muscular relaxation you will be required to tense and relax various groups of muscles in your body. You will need to practice for 15-20 minutes each day for around two weeks to learn how to relax well. We will start with your upper body and work down’.

Make yourself comfortable. Rest your head back and let your arms and legs go limp. Close your eyes lightly and keep your breathing light and regular. Each time you breathe out, think of the word ‘relax’ and imagine all your worries flowing away with your breath. Let’s take some moments to practice breathing and repeating ‘relax’ with each breath.

Arms and hands
Now I would like you to clench your hands into fists as tightly as possible. Feel the tension building up. Hold for a slow count of 5 and then unclench completely. Feel the tension easing away. Now raise your arms and try to touch your shoulders with the inside of your wrists. Again feel the tension and hold for a slow count of 5. Let your arms drop and rest beside you and feel all the tension flowing down your arms and out of your fingertips.

Shoulders and neck
Press back against the support you are resting against. Increase the tension, feeling it building up in your muscles and hold for a slow count of 5. Now relax and let your head rest lightly. Feel the difference between tension and relaxation. Keep your breathing slow and steady. Now I would like you to hunch your shoulders as hard as you can. Raise them up as far as you can. Higher and higher. Now hold for a slow count of 5. Relax and drop your shoulders. Notice the tension flowing away from your neck and shoulders.

Face
Jaw and tongue - Clench your teeth while pressing the tip of your tongue against the roof of your mouth. Clench tightly and hold for a slow count of 5. Now let go and relax. Allow your tongue to lie loose and part your jaw slightly. Keep your breathing regular and think ‘relax’ every time you breathe out. Notice the tension flowing away from your jaw and tongue. Eyes – Close your eyes tightly and frown as hard as you can. Hold for a slow count of 5. Now ease away the tension, let your eyelids rest lightly together and let your brow go smooth.

Torso
Now tense your chest and stomach muscles by taking a very deep breath. Draw the air far into the lungs and while doing this flatten the stomach muscles by drawing the tummy into your spine. Hold for a slow count of 5. Now breathe out fully and allow your tummy muscles to relax. Feel the tension flowing away from your body leaving you feel calm and relaxed.

Ankles, legs and buttocks
Now tense all these muscles by stretching your legs, pointing your toes and squeezing your
buttocks tightly together. Hold for a slow count of 5. Let your legs relax completely. Again feel the tension leaving your body through your toes making you feel deeply relaxed. Keep breathing quietly and think of the word ‘relax’ each time you breath out.

Now focus on all your muscles being relaxed and floppy like a rag doll. Keep breathing slow and steady. Think of a place or situation in which you feel relaxed. Imagine what you would see, what you would hear, what you would smell, and how you would feel. Just focus on being as relaxed as possible. Stay like this for a few minutes. I will then count to three and I would like you to open your eyes but remain relaxed.

Progressive Muscular Relaxation (Children 6-10 years)

I am going to take you through some relaxation and breathing exercises. These exercises will help you to learn how to relax when you are feeling uptight. During the relaxation exercises I’d like you to make different parts of your body tight and then make them feel all nice and relaxed. I would like you to do exactly what I say, even if you feel silly, because it will help you to feel really relaxed. You should sit in a comfortable chair or lie down in a quiet place. It would be helpful if you were to take off your shoes and loosen any tight clothes. Now gently close your eyes and we’ll begin.

First of all, we will do some breathing exercises. I would like you to slowly breathe in through your nose and breathe out slowly through your mouth. Breathe in slowly and breathe out slowly. Well done. I’d like you to keep breathing slowly, and as you do, you will feel more and more relaxed.

Okay. You should be starting to feel more relaxed. Now we are going to work through your body, making the different parts tight and then relaxed. Let’s start with your hands. Pretend you have a whole lemon in your right hand. Now squeeze that lemon as hard as you can. Try to squeeze all the juice out. Feel the tightness in your hand and your arm as you squeeze. Now drop the lemon. Can you feel all that tightness drain away from your hand? Your hand might feel warm and heavy and that’s good, because it is going from being very tight to being very relaxed.

Now your hand feels nice and relaxed. Now take another lemon and squeeze this one even harder that the first one. Keep squeezing as hard as you can. Now drop the lemon and feel your hand relax. Feel all the tightness drain away. Feel how much better that is now your hand is nice and relaxed. Now pretend you have a lemon in your left hand. Squeeze that lemon as hard as you can. Try to squeeze all the juice out of the lemon. Now drop the lemon and feel all that tightness drain away. Can you see how different your hand feels now it’s nice and relaxed? Now pretend you have a lemon in your left hand and squeeze it as hard as you can. Squeeze it so hard that every drop of juice comes out. Now drop the lemon again and let all that tightness drain away. Feel your hand becoming more and more relaxed and how much better it feels now. Now your hand should be nice and relaxed. Well done.

Now I’d like you to pretend that you are a furry, lazy cat and you want to have a big stretch. Stretch your arms out in front of you. Now lift
them up high over your head and push them back. Feel the pull in your shoulders as you stretch as high as you can. Now let your arms drop back to your slides. Do you notice how your arms and shoulders feel more relaxed now that all that tightness has gone away? Okay. Now let’s stretch like a cat again. Stretch your arms out in front of you then raise them up over your head and push them back. Stretch them up as high as you can. Try to touch the ceiling. Now let your arms drop quickly. Feel all that tightness drain away as your arms and shoulders start to feel nice and relaxed. See how much better it feels now your arms are relaxed and warm and lazy. Well done. Now you should be feeling more relaxed and all the time, keep breathing nice and slowly. Good.

Now pretend that you are a turtle. Pretend that you are sitting out on a rock by a nice, peaceful pond, relaxing in the warm sun. But now you sense danger, so you must pull your head into your shell. Try to pull your shoulders up to your ears and push your head down into your shoulders as much as you can. Hold in tight, and make sure that nothing is sticking out of your shell. Now the danger has passed and you can come out of your shell into the warm sun. Now you can feel all nice and relaxed and all that tightness has drained away. But now there’s more danger, so you’ll have to pull your head in again, pull your shoulders up to your ears and push your head down as much as you can. You have to pull in as tight as you can to protect yourself. Okay. Well done.

You can come out now. It’s safe again, so you can relax your shoulders and your neck. See how much better it feels to be relaxed than to be all tight? Now you can just sit and relax in the warm sun beside the peaceful pool again. Well done.

Now pretend that a tickly fly has just landed on your nose. Try to get him off without using your hands. You’ll have to wrinkle up your nose. Make as many wrinkles in your nose as you can, scrunch your nose up really hard. Well done. You’ve chased him away. Now you can relax your nose until it is as smooth as possible. See how much better it feels now that your nose is nice and smooth and relaxed. But now that tickly fly has come back. Wrinkle up your nose again. Notice how your cheeks and mouth, and your forehead and eyes, all help you to wrinkle up your nose. So wrinkle up your whole face as much as you can. Well done. He’s flown away again.

Now you can relax your nose and your face. Make all the wrinkles disappear and make your nose and your face as smooth and relaxed as possible. Now all that tightness has disappeared and your nose and face feel nice and relaxed. You should be feeling more relaxed now and all the time keep breathing nice and slowly. Well done.

Now I’d like you to pretend that you’re trying to get through a narrow space in a fence. You’ll have to pull your tummy in as much as you can to get through. Keep breathing normally but make yourself as skinny as you can so you can squeeze through the fence. Well done. You can relax now. Let your tummy go nice and soft so it is as relaxed as can be. See how much better it feels now it is all relaxed than when it was all tight. Now try to squeeze through that narrow space again. Pull your tummy in and make yourself as skinny as you can. Keep breathing normally, but hold your tummy in as tight as you can. Well done. You can relax your tummy again. Let your tummy go nice and loose and relaxed so that all that tightness drains away. Good.

Now pretend that you are standing in a big fat mud puddle and you don’t have any shoes or socks on. Squish your toes deep down into the mud. Use your legs to help you push your feet right down to the bottom of the puddle. Keep pushing with your legs and spread your toes apart. Feel the mud squishing up between your
toes. Now step back out of the mud puddle, relax your feet and your legs, let your legs and feet feel nice and relaxed. Now step back into the puddle, squash your toes down into the mud, use your legs to help you push your feet right down to the bottom of the puddle. Keep pushing your feet down as hard as you can. Now step back out of the mud puddle, let all that tightness drain away as your legs and feet relax. Notice how much nicer your legs and feet feel now that they are relaxed and all that tightness is gone. Well done.

Now you should be feeling nice and relaxed all over your body. Think of your hands, and let them relax more now. Think of your arms and let them relax a little more. Now think of your shoulders and your neck and let them relax more. Think of your nose and face and let them relax a little bit more now. Think of your tummy, and let it relax more now. Finally, think of your legs and feet relaxing even more. Now your whole body should feel good and warm and relaxed.

Before we finish I’d like you to do three more breaths, and each time you breathe out, think of how relaxed your whole body is, and just let it relax even more with each breath. Okay. So breathe in. And breathe out. Breathe in. And breathe out. Breathe in. And breathe out. Well done. Now you should be feeling really relaxed and comfortable.

In a moment I will ask you to open your eyes. As you go through each day, remember how good it feels to be relaxed. If you practice each day, you will get better and better at relaxing and you will feel more and more relaxed each time. Now, when you are ready, you can open your eyes, and you will feel nice and calm and relaxed, and you can carry on with whatever you were doing, feeling really good.

Relaxation Exercises for Younger Children (3 – 5 yrs)

These exercises are suitable for children in the 3-5 year age range. They can be done with parents and introduced as a game to make them more accessible.

Simon says – Jump up and down like a kangaroo bouncing off the floor

Simon says – Stretch up your neck. Make it feel long, think you are a giraffe reaching up high for a leaf from the tree. Stretch a bit more for a leaf just out of reach. Got it. Now let go and relax

Simon says – Now you are a big tree, growing tall. Stretch your arms as the branches grow towards the sky. As you breathe in, move your branches in a big circle, up and around. Breathe out as you bring them down to your side.

Simon asks – ‘Do you like animals?’ Pretend to be your favourite animal. Make the animal lick its lips, swallow, hum. Yawn a big yawn. Stretch its mouth wide open. Make a happy face. Make a big smile. Make a surprised face. Raise your eyebrows as high as you can. Make your animal’s mouth move – say ‘ee,oo,ee,oo,eeee’. Stretch your lips for ‘ee’. Make them round for ‘oo’. Then just let your animal relax.

Simon says – Put your hands to your face. Tickle very gently with your finger tips. Your fingers are tiny fairies dancing lightly over your eyelids, over your cheeks and on your ears.

Kneel down. Sit on your heels. Put your head on the ground and rest your arms at your sides. It’s all very quiet and nice and relaxing.
Relaxing Activities

There are other less formal types of relaxation which may be helpful in reducing tension and worry for children. Talk with the child about what things they enjoy doing and what makes them feel good. For example:

- Listening to music
- Playing with their friends
- Watching TV
- Computer activities
- Reading a book
- Cycling
- Walking

Once the child has identified an activity that makes them feel good suggest that they can try doing it when they start to get unpleasant feelings. They may be only able to do this at certain times but, for example, instead of:

- Sitting in their room feeling sad, try going for a walk.
- Worrying about the next day, try reading a book or concentrating on a computer activity.
- Feeling alone and wound up, go out and play with friends.

Visualisation

This technique can be used at the end of formal relaxation exercises to help the child enjoy the feeling of relaxation for a longer period of time. It can also be used in conjunction with other relaxation activities (e.g. listening to music) or on its own. It helps the child replace unpleasant or unwanted thoughts or feelings with more pleasant and restful ones.

Guidelines for Visualisation Exercises

- Check if the child finds it easy to visualise by asking them to focus on a static object and describe it in as much detail as they can.
- If they can do this, help the child identify a personally relevant dream place where they feel relaxed and safe.
- It can be somewhere they have been or an imaginary place.
- Ask them to think about their dream place in as much detail as they can.
- Prompt them to think about the sounds, colours, smells, sensory details e.g. the warm sun on their face or the wind blowing gently in their hair to make the picture as real as they can.
- Encourage them to enjoy their dream place for as long as they can.
- Plan to practice using this technique when they start to get unpleasant thoughts or feelings.

Controlled Breathing

Breathing exercises can be a useful intervention when children become very anxious or panic about an impending event such as a medical procedure. They can also be used if the child begins to hyperventilate. On these occasions, there may not be time to undergo formal relaxation training but the child can regain control over the physical symptoms of anxiety through focusing on controlling their breathing. This is a method that the child can use anywhere and immediately.
Guidelines for Controlled Breathing

- Find a quiet place for the child to sit down.
- Ask the child to close their eyes and focus on the word ‘calm’.
- Ask the child to breathe slowly through their nose from the bottom of their lungs, not the upper chest. This may need to be demonstrated to the child prior to starting. Do this on a count of 3.
- Ask the child to hold their breath for a count of 3.
- Then ask the child to breathe out slowly on the count of 3.
- It sometimes helps to ask the child to place their hands on their stomach, just below the ribcage, with the fingertips from both hands touching lightly. They should feel their fingers coming apart slightly with each inhalation.
- Continue to do this until the child feels calmer.

Guidelines for the Clinician

- Stay calm. The child will be aware of your response and fear can be infectious.
- Be familiar with the above guidelines. The child may be distressed and will need to be talked through the technique.
- Speak slowly with a quiet but firm tone. Do not raise your voice.
- If hyperventilating, the child may become emotional. Repeat calming and soothing statements such as ‘just keep breathing slowly’ ‘think calm’ ‘you are going to be alright’ ‘you are doing really well’.
- Afterwards, allow the child to have a short rest and a drink.

Distraction

A useful technique which can help children disrupt the flow of unpleasant thoughts or worry is to use distraction. This is a here and now method to give short term relief from troubling thoughts and to help children take control of their thoughts. Children can learn to keep their mind busy and focused on more rewarding mental activities. Some distraction methods include:

- Describing something the child can see in detail. For example, an item, a person or drawings on a wall.
- Absorbing mental activities. These can include counting backwards from 100 in 7’s, naming all the animals the child can think of under various letters of the alphabet, think of the names of songs by favourite groups, or trying to spell words backwards.
- Puzzles, computer games or crosswords.
Reflective Exercise

Think about some children you have worked with who have been distressed or anxious.

What were some of the contributing factors?

What skills did you use to help the child cope with their distress?

Reflect on what you have read on psychosocial interventions to reduce distress.

Identify some ways in which you could use these interventions in future practice?

What are your key learning points?
Reflective Exercise
We all learn how to behave in similar ways. Think about a childhood example of each of the three ways of learning behaviour outlined in this chapter. Reflect on the techniques which have been outlined in Motivational Interviewing. What interventions could you use to increase desirable behaviour? What are the steps in problem solving? Which of these techniques do you think you could use in practice? Can you think of specific examples where these techniques might be helpful?

Adherence to Treatment
Policy Context & Outcomes

Getting it Right for Every Child (GIRFEC)
- Receiving appropriate healthcare and guidance from services
- Applies strategies for addressing and managing avoidable risks to health
- Developing skills for coping with and managing disabilities and long term conditions
- Attending health services and medical settings and taking prescribed medication when necessary

The Healthcare Quality Strategy for NHSScotland
- Caring and compassionate staff and services
- Clear communication and explanation about condition and treatment
- Effective collaboration between clinicians, patients and others
- Continuity of care
- Clinical excellence

European Association for Children in Hospital (EACH Charter)
- Article 1 – Children shall be admitted to hospital only if the care they require cannot be equally well provided at home or on a day basis
- Article 8 – Children shall be cared for by staff whose training and skills enable them to respond to the physical, emotional and developmental needs of children and families

Learning Outcomes

Be aware of the psychosocial impact of living with physical health conditions for children and young people in relation to adherence, and how to offer appropriate support when required.

- Define adherence and be aware of the risk factors for poor adherence as well as the predictors of good adherence.
- Be aware of the methods used in assessing adherence to treatment and management tasks.
- Identify strategies for improving adherence.
- Plan and implement appropriate psychosocial interventions, when necessary, based on comprehensive assessment.
- Know the scope of own practice and be aware of situations where referral to a psychologist is required.
Background

The term adherence in healthcare has replaced ‘compliance’ and can be used interchangeably with the term ‘concordance’ or self-care’. It reflects a more active role for children and families in consenting to and following prescribed treatments and management tasks in relation to physical health conditions. The World Health Organisation (2003) defines adherence as ‘the extent to which a person’s behaviour – taking medication, following a diet, and/or executing lifestyle changes, corresponds with agreed recommendations from a healthcare provider’.

The definition of adherence acknowledges:

- that regimens for chronic physical health conditions include multiple behavioural components.
- varying levels of adherence to each component.
- agreement to follow regimens has been secured from the patient.

In the adherence literature, a useful distinction has been noted between

**Inadvertent (non-volitional) non-adherence** which arises as a result of forgetting or a change in routine.

and

**Intentional (volitional) non-adherence** which refers to a reasoned and purposeful decision to omit a treatment because the child is asymptomatic or treatment interferes with their lifestyle.

For this reason it is very helpful to negotiate with the child and/or their family to obtain agreement on what they would be willing to do to treat or manage their condition without compromising their quality of life. Families, children and young people must balance healthcare needs with efforts to achieve normal social and emotional functioning.

The long term maintenance of adherence in paediatric chronic health conditions is a priority as it is life-long and can pervade every aspect of daily functioning. There is evidence that adhering to treatment may have an even greater effect on the health outcomes of children than on those of adults (DiMatteo et al, 2002). Adherence to treatment requires a developmental approach which takes the context of relatively rapid physical, cognitive and emotional changes into account.

The relationship between adherence and health outcomes is complex. Individual variability and responsiveness to treatment need to be considered.

Rates of Adherence

Not all children with chronic health conditions have problems with adherence. Rates of adherence for children with chronic health conditions vary depending on the disease, complexity of the regimen and measures that are used. The following observations have been made in studies to date:

- Adherence is often better for simple behaviours, such as taking medication but is substantially lower for more complex behaviours such as dietary modifications, glucose monitoring and nebulised medications (Quittner et al, 2008).

- There is a consensus across studies that rates of adherence are generally below 50% (La Greca & Bearman, 2003) (Dunbar-Jacob & Mortimer-Stephens, 2001).

- Non-adherence has been estimated to compromise the health outcomes of paediatric treatments by an average of 33% and by as much as 71% (DiMatteo et al, 2002).

- Poor adherence has been cited as the single greatest cause of treatment failure.
Rates of non-adherence to medication treatment range from 25% to 60% for children and young people. (Cox et al, 2002) (Carter et al, 2003)

Correlated to non-adherence

Condition characteristics

Chronicity. Physical health conditions vary in the demands placed on children and families to manage them. For example, diabetes is a chronic condition that requires a continuous lifelong daily effort to control its course and symptoms whereas asthma may be marked by long periods of quiescence and young people may be asymptomatic by adolescence. Illness chronicity has been linked to poorer treatment adherence.

Complexity. The complexity of treatment increases the likelihood of adherence problems. Multidrug regimens including many medications with varied side effects or medications on different administration schedules have a greater impact on adherence. Regimens which involve changes to lifestyle also present problems with adherence.

Pain. The impact of pain on children’s emotional and social functioning increases the likelihood of non-adherence. For treatments that may be painful, anticipatory fear can result in avoidant coping.

Course. The course of the condition is also correlated to adherence. For example, asymptomatic periods, younger age of onset, illness severity as perceived by the family and longer condition duration increase the likelihood of poorer adherence.

Family Characteristics

Poor problem-solving and lack of social support are associated with poorer adherence.

Family conflict, negative feelings in the family and poor psychological adjustment can serve as powerful factors in child non-adherence. These interrupt the practical aspects of behavioural management and the emotional support needed to adhere as well as being upsetting and stressful (DiMatteo, 2004).

Predictors of Good Adherence

Psychosocial factors have a greater influence on adherence than metabolic and demographic factors. These include values, attitudes, positive personal meanings of illness and treatment, therapeutic motivation and emotional wellbeing.

Support from family, peers and healthcare providers is essential for the promotion of adherence. (Kyngas, 2007) In healthcare, parents or carers typically establish behavioural norms and model health behaviours and coping skills for their children. It is important therefore for adaptive coping and health behaviours to be established from the onset.

Continued involvement and reinforcement of behavioural norms are essential. Supportive others can provide information and help and can serve as facilitators and esteem builders. Practical support from parents and emotional support from friends assist children and young people with chronic conditions (DiMatteo et al, 2002). Family closeness, parental warmth and the positivity and cohesiveness of family interaction affect adherence.

Good relationships between the child, family and healthcare staff is associated with good adherence. Trust, emotional support and communication clarity are essential to the patient’s observance of necessary health practices. (DiMatteo, 2004).
Assessment Methods

A wide variety of methods are used to assess adherence to treatment and management tasks in paediatric healthcare. These methods include monitoring physical and psychosocial outcomes. For example:

- Biochemical Assays – Which usually involve obtaining blood, urine or saliva samples to detect the concentration of a particular drug. One of the most direct, objective and reliable methods for assessing adherence to medication but cannot be used to assess other forms of condition management such as exercise, physiotherapy or dietary regimens.

- Behavioural Observation – This form of assessment usually takes the form of self-monitoring of all adherence tasks through the use of daily diaries. This has been shown to be more effective than verbal reports. These records kept by children can be supported by family members, electronic monitoring or metering devices. Some children and young people, however, either misrepresent adherence behaviours or do not complete records daily which may lead to inaccuracies. Self-monitoring also requires a level of effort and time which may not fit in with daily routines.

- Monitors can reveal a spectrum of adherence problems including, underdosing, overdosing, delayed dosing or drug holidays.

- Self-Reports – Assessment of the range of adherence tasks can be undertaken by the child or family members providing self-reports. These reports can include frequency, timing, duration and outcome of adherence tasks. The use of structured interviews or written logs may be used to contribute to the assessment of adherence. Quittner et al., (2008) commented that there were surprisingly few self-report and interview measures in the published literature and those that they detailed were all condition specific. This may be related to the consistent over-reporting of adherence behaviours. (Quittner et al., 2000) (Rapoff, 1999).

Adherence Improvement Strategies

Adherence improvement strategies can be classified as educational, organisational and behavioural.

Educational

- Provide verbal and written information. Educate early and often about the condition, treatment options and benefits of consistent adherence. Be aware of transitions e.g. developmental stages, starting school, change in family circumstances, adolescence, and transfer to adult services which will require updated information. Avoid using fear-based approaches such as continuous reference to complications.

- Develop a collaborative and age appropriate treatment plan with the child, young person and their family. Provide clearly written information on all aspects of the condition and treatment which were discussed. For a medication treatment plan, list generic and brand names, dosage, schedule, duration, common side effects and practical ways of dealing with them. This provides a basis to assess whether dosages, duration of treatment or changes to the daily regimen were understood by the child and family.

- Discuss the benefits of consistent adherence.
Organisational

• Tailoring and simplifying drug regimens (e.g., once daily dose). Use pleasant tasting liquids.
• Increasing accessibility to healthcare services. Regular phone or electronic contact between healthcare staff and child/young person/family.
  • Improving times of clinics
  • Consistency in staff
  • Short waiting times
• Provider supervision and feedback. Use reminders.

Behavioural

• Modify behavioural and emotional difficulties – (operant conditioning, classical conditioning & social learning theory).
• Use praise & reward systems.
• Role playing, modelling.
• Problem-Solving Skills.
• Develop decision making skills.
• Reinforcement.

Evidence

Costello et al (2004) – In a literature review identifying interventions to improve the use of medicines in children, the following methods were found to be successful in improving adherence in children. They are multifactorial:

Educational programmes.
Psychological interventions to reduce stress associated with the healthcare environment and treatment process.
Behavioural programmes that reward good adherence.
Emphasising support from family and peers.
Good communication including providing the amount and type of information desired by children, young people and parents.

Communication Guidelines

• Although only one child within a family may have a physical health condition, the illness experience is felt by everyone.
• Children cope better when adults talk openly with them than when they are kept uninformed.
• Communication must be given at the child’s level of understanding.
• Include the child from the start to establish and maintain trust.
• When children are included appropriately, they can form accurate and hopeful beliefs about their condition and related events. This forms a basis for adaptive coping strategies.
• Children are aware when adults are worried. What children don’t know, they will attempt to interpret themselves.
• Children are resilient, in particular in a supportive environment. Their adjustment is shaped by the quality of communication and how prepared they feel.
• It is helpful to have clarity from the outset about who is responsible for communicating with the child and what information is given.
Communicate at a pace that suits the child. It may take time for the information to be assimilated.

The means of communication may vary e.g. verbally, written materials, drawing or play.

Allow communication to be guided by the questions children ask.

Use language and words with which the child is familiar.

Drotar (2000) made a number of recommendations to improve adherence management in clinical care. These included reward systems for successful adherence behaviours, promoting positive adherence behaviours, understanding setbacks, normalising challenges through problem-solving, positive reinforcement, using technology, individualised treatment regimens and enhanced monitoring.

Psychosocial Assessment – Adherence

Prior to considering which intervention, if any, is required to improve adherence to treatment, an assessment of the presenting difficulties and the context in which they present is required. These assessment techniques are outlined in Chapter 3 and may include any of the following:

- Interview/Talk with child/family
- Talk with relevant others
- Observational Assessment
- Assessing Behaviour (Functional Analysis)
- Behavioural Recordings
- Self-Report Measures

Psychosocial Interventions – Adherence

Based on assessment, a psychosocial intervention tailored to the individual child may be required. This intervention may include any of the following:

**Behaviour Change**
- Positive Reinforcement
- Reward Systems
- Modelling
- Omission of Positive Reinforcement
- Time-out from Positive Reinforcement
- Problem-Solving
- Goal Selection
- Motivational Interviewing Approaches

**Reducing Distress**
- Relaxation
- Progressive Muscular Relaxation - Young People
- Progressive Muscular Relaxation - Children
- Relaxation Exercises for Younger Children
- Relaxing Activities
- Visualisation
- Controlled Breathing
- Distraction
**Scenario One**

**(Louise, aged 12 years)**

Louise was admitted to the ward for observation and education following a three month history of high blood glucose levels. Since admission, she has been concordant with all diabetes self-care tasks and has an excellent knowledge of this condition and its management. Her blood glucose levels have improved almost immediately. She has, however, been noted to take a lot of time preparing to administer insulin and sometimes seems to panic before using her pen. She has told staff that she has been worried about doing it wrong. Louise has kept to herself on the ward and appears nervous. She appears tense and has difficulty getting to sleep but does not meet the criteria for clinical anxiety. Louise lives with her father and older brother following her mother’s death five years previously. Her father works long hours but has been a regular visitor. He admitted that he lets Louise ‘get on with it’ as she is a responsible girl.

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**Which Type of assessment has been used – Tick as appropriate**

- Interview/Talk with child/family
- Talk with relevant others
- Observation
- Functional Analysis
- Behavioural Recordings
- Self-Report Measures

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If Psychosocial Intervention is required – Tick which to consider

<table>
<thead>
<tr>
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If Psychosocial Intervention is not required – Tick which to consider

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<tr>
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<tr>
<td>Refer to Specialist Service</td>
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Please record reasons for your choice(s)

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**Scenario Two**

*(Adam, aged 4 years)*

Adam has recently been diagnosed with childhood absence epilepsy. Since diagnosis, his parents report that Adam will not take his medication. Different preparations of the same medication have been tried including liquid, tablets and granules but Adam has refused to take them all. It has been noted that Adam does not attend to his parents’ requests in a number of situations, in particular, when wishing to avoid something or when tired. He reacts to these situations by hitting out, shouting and refusing to cooperate. His parents have been noted to respond to his behaviour by giving up on their request and trying to make amends for upsetting him. Behavioural problems were also reported in the nursery environment although staff report that he responds to praise, reward and time-out from enjoyable activities for misbehaviour.

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### Which Type of assessment has been used – Tick as appropriate

- Interview/Talk with child/family
- Talk with relevant others
- Observation
- Functional Analysis
- Behavioural Recordings
- Self-Report Measures

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### If Psychosocial Intervention is required – Tick which to consider

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### If Psychosocial Intervention is not required – Tick which to consider

- Education and Reassurance
- No further input Required
- Refer to Specialist Service

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Please record reasons for your choice(s)

[Insert reasoning here]
Scenario One – Answers to Activity

Type of assessment undertaken:

- Interview/Talk with child/family
- Observation
- Behavioural Recordings
- Self-Report Measures

Psychosocial Intervention

Motivational interviewing approaches. This will help to address ambivalence with treatment and elicit Louise’s own motivations for change. Explore some of the reasons why Louise has been adherent on the ward when there are barriers to adherence in her home environment. Address her anxiety about insulin administration.

Positive Reinforcement. Louise would benefit from sharing the responsibility of diabetes management with her father. Encouraging more involvement, interest and positive feedback from him will help reduce anxiety whilst allowing developmentally appropriate independence.

Progressive Muscular Relaxation – Young People. This will help reduce tension and improve sleep onset. It will also help Louise to have more control of anxiety symptoms.

Distraction Techniques or Controlled Breathing. Either of these interventions could be considered to reduce anxiety prior to insulin administration.

Scenario Two – Answers to Activity

Type of assessment undertaken:

- Interview/Talk with child/family
- Talk with relevant others
- Observation
- Functional Analysis
- Behavioural Recordings

Psychosocial Intervention

Adam has learnt to behave in this way as it serves the function of (a) diverting requests which he does not wish to follow and (b) gaining attention from his parents. As his refusal to take medication is currently rewarded, trying different types of medication is unlikely to have any impact. In order to effect behavioural change the following psychosocial interventions could be considered:

Omission of Positive Reinforcement. Ignore Adam’s current undesired behaviour.

Reward Systems. Use rewards for appropriate behaviour. Adam responds well to rewards. All efforts towards taking medication should be rewarded. This goal may need to be broken down into a number of small steps initially.

Modelling. Assess the opportunity for Adam to observe one of his peers taking medication and being rewarded for this behaviour.

Time-out from Positive Reinforcement. This intervention could be considered in order to manage general misbehaviour.

Remember to change one behaviour at a time and to take into account any situational information which has been gained. For example, as tiredness triggers undesired behaviour, allow him to rest when necessary and keep new requests to a minimum when he is tired.
References


Reflective Exercise

We all learn how to behave in similar ways. Think about a childhood example of each of the three ways of learning behaviour outlined in this chapter. Reflect on the techniques which have been outlined in Motivational Interviewing. What interventions could you use to increase desirable behaviour? What are the steps in problem solving? Which of these techniques do you think you could use in practice? Can you think of specific examples where these techniques might be helpful?

Self-Management
Learning Outcomes

Be aware of the psychosocial impact of living with physical health conditions for children and young people in relation to ‘Self-management’ and how to offer appropriate support when required.

- Define self-management and demonstrate awareness of the variables which impact on success.

- Be aware of the issues to be considered in self-management.

- Plan and implement appropriate psychosocial interventions when necessary based on comprehensive assessment.

- Understand the social and developmental context of the child and young person’s experience.

- Know the scope of own practice and be aware of situations where referral to a psychologist is required.
Background

**Self-management** is defined as ‘The individual’s ability to manage the symptoms, treatment, physical and psychosocial consequences and lifestyle changes inherent in living with a chronic condition.’ (Barlow et al, 2002).

He also states that for self-management to be effective, it needs to encompass the ‘ability to monitor one’s condition and to effect the cognitive, behavioural and emotional responses necessary to maintain a satisfactory quality of life’.

**Self-management** ‘involves the performance of a set of procedures by children and/or their caregivers to help control a chronic disorder. Specific self-management skills performed are a function of task demands presented by different illnesses, the rhythm of the disorder, treatment expectations, beliefs of others, the problem of uncertainty, the age or abilities of a child, and the contexts within which action is taken.’(Creer, 2000)

Elements of self-management include:

- goal selection
- information collection
- information processing and evaluation
- decision making
- action
- self-monitoring

According to Creer, successful mastery and performance of self-management skills over time and across settings should result in the following outcomes:

- Changes in mortality and morbidity indices of the illness.
- Improvement in the quality of life experienced by children, their carers and members of their families.

The development of self-efficacy beliefs on the part of children and their carers that they can perform whatever skills are needed to contribute to the control of their disorder, in part through their becoming partners with healthcare providers to manage the chronic illness or disorder. (Creer, 2000).

**Self Management** ‘is the successful outcome of the person and all appropriate individuals and services working together to support him or her to deal with the very real implications of living the rest of their life with one or more long term condition.’ (Long Term Conditions Alliance Scotland, 2008)

All of the above definitions support the idea that self-management is not simply adherence to treatment but includes the additional psychological and social implications of living with a chronic condition. With childhood chronic physical illness, children do not manage their condition by themselves but need help and support from all members of their family. As the child develops, the balance of self-care shifts from the carer/parents to the young person but with continued support.

Interventions which directly target aspects of children’s management of chronic illness are commonly referred to as self-management interventions (SMIs). If these interventions are to be more widely adopted in healthcare, training in skills such as group facilitation, problem-solving, goal selection, and cognitive-behavioural techniques need to be enhanced. If these interventions are to be delivered appropriately and effectively, training in the skills needed by healthcare professionals who deliver these programmes needs to be recognised and appropriate courses developed.(Newman et al, 2004).

Other terms include self-regulation, self-directed behaviour, self-control and self-care. These all define skills that children, young people and their families use to help control chronic illness.
The concept refers to improving wellbeing and strengthening self-determination and participation in healthcare.

Impact Variables to Consider in Self-Management

- **Condition Demands** – These vary between conditions. Some place a demanding burden on the family. For example, a child with cystic fibrosis will live with the demands of physiotherapy, exercise, the prevention of bacterial infection, enzyme replacement and consumption of a calorie-laden diet. This requires considerable continuous effort for the child and family. Other conditions have fewer demands.

- **Rhythm of the Condition** – Many conditions vary over time in terms of the intensity and frequency of symptoms. Periods of quiescence are often followed by an exacerbation of symptoms which may require management by additional treatments, surgery, hospitalisation and further investigation. Trying to predict and reduce the impact of a flare-up requires an awareness and control of the condition over time.

- **Treatment Expectations** – Often in the early stage following diagnosis of a chronic condition, much effort is placed in finding a cure. This may include trying many different treatments and approaches which when unsuccessful can leave the child and family with negative attributions about the condition and with feelings of reduced control. This may result in feelings of hopelessness and undermine confidence in managing the condition.

- **Illness Beliefs** – Differing and erroneous beliefs can be counterproductive.

- **Uncertainty** – Many conditions follow an unpredictable course and may have uncertainty regarding prognosis or the management of symptoms. Some conditions carry a life-limiting threat which children and families must adjust to.

Self-Management Issues to Consider

**From a Medical Perspective**

- Adherence – the relationship with parents and children and the relationship with the healthcare provider.
- Transition from paediatric to adult healthcare providers and settings.
- Developmentally appropriate healthcare.

**From a Parent Perspective**

- Younger children – the interaction is between healthcare provider and parent. Increasing calls for clinicians to pay more attention to children’s voices.
- Parents of young people remain legally responsible for their children but are expected to promote their independence and autonomy.
- With chronic illness, the challenge lies in maintaining a supervisory role while supporting the young person’s ability to independently manage their health. Parents may be overprotective.

**From a Young Person’s Perspective**

- Greater engagement with healthcare providers. May include wanting to be seen independently or wanting more confidentiality in healthcare.
- Important Issues – Negotiating relationships with peers, managing emotional responses to chronic illness, acceptance of illness and their efforts to find meaning out of having a chronic illness.
Communication Guidelines

• Although only one child within a family may have a physical health condition, the illness experience is felt by everyone.

• Children cope better when adults talk openly with them than when they are kept uninformed.

• Communication must be given at the child’s level of understanding.

• Include the child from the start to establish and maintain trust.

• When children are included appropriately they can form accurate and hopeful beliefs about their condition and related events. This forms a basis for adaptive coping strategies.

• Children are aware when adults are worried. What children don’t know, they will attempt to interpret themselves.

• Children are resilient, in particular in a supportive environment. Their adjustment is shaped by the quality of communication and how prepared they feel.

• It is helpful to have clarity from the onset about who is responsible for communicating with the child and what information is given.

• Communicate at a pace that suits the child. It may take time for the information to be assimilated.

• The means of communication may vary e.g. verbally, written materials, drawing, play.

• Allow communication to be guided by the questions children ask.

• Use language and words with which the child is familiar.

Psychosocial Assessment – Self-Management

Prior to considering which intervention if any is required to improve self-management an assessment of the presenting difficulties and the context in which they present is required. These assessment techniques are outlined in Chapter 3 and may include any of the following:

- Interview/Talk with child/family
- Talk with relevant others
- Observational Assessment
- Assessing Behaviour (Functional Analysis)
- Behavioural Recordings
- Self-Report Measures

Psychosocial Interventions – Self-Management

Based on assessment, a psychosocial intervention tailored to the individual child may be required. This intervention may include any of the following:

**Behaviour Change**
- Positive Reinforcement
- Reward Systems
- Modelling
- Omission of Positive Reinforcement
- Time-out from Positive Reinforcement
- Problem-Solving
- Goal Selection
- Motivational Interviewing Approaches

**Reducing Distress**
- Relaxation
- Progressive Muscular Relaxation - Young People
- Progressive Muscular Relaxation - Children
- Relaxation Exercises for Younger Children
- Relaxing Activities
- Visualisation
- Controlled Breathing
- Distraction
Scenario One

(Cara, aged 13 years)
Cara has Phenylketonuria (PKU) and she was seen together with her parents at a routine clinic appointment. They talk to staff about a situation which they are facing for the first time. Cara is going away with a friend and her family for a few days over the summer. She is going to be responsible for managing her diet over this period and has drawn up a chart with her parents’ help to enable her to monitor her exchanges while she is away. Cara’s parents are helping Cara to think through how she will deal with unusual situations such as eating in cafés / restaurants etc. Cara reported that she was sure she knew what to do as she had worked with school staff previously when she went away with the school for a weekend trip. Her parents stated that they are gradually giving Cara more responsibility for all aspects of self-care now that she is getting older.

Which Type of assessment has been used – Tick as appropriate

Interview/Talk with child/family
Talk with relevant others
Observation
Functional Analysis
Behavioural Recordings
Self-Report Measures

If Psychosocial Intervention is required – Tick which to consider

Positive Reinforcement
Reward Systems
Modelling
Omission of Positive Reinforcement
Time-out from Positive Reinforcement
Problem-Solving
Goal Selection
Controlled Breathing

Motivational Interviewing
Progressive Muscular Relaxation - Young People
Progressive Muscular Relaxation - Children
Relaxation Exercises for Younger Children
Relaxing Activities
Visualisation
Distraction

If Psychosocial Intervention is not required – Tick which to consider

Education and Reassurance
No further input Required
Refer to Specialist Service

Please record reasons for your choice(s)
.......................................................................................................................
**Scenario Two**

**Jack, aged 15 years**

Jack has had Asthma for 4 years and was seen at the respiratory clinic independently. He was talkative and relaxed throughout. Recently he has taken over the responsibility for his self-care (previously Jack’s mother managed this for him). Jack reported he often goes for days without taking his medication and admitted that he was really confused about what tablets and inhalers he should take and what to do when he forgot. He was also unsure of the exact functions of the various medications he takes and doesn’t really see the benefit as he has few symptoms. It has been noted that Jack is much more likely to omit to take medication and inhalers in the morning as he is usually in a rush for school. Jack rated his quality of life as good and there was little evidence that asthma impacts on his daily functioning.

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**Which Type of assessment has been used – Tick as appropriate**

- Interview/Talk with child/family
- Talk with relevant others
- Observation
- Functional Analysis
- Behavioural Recordings
- Self-Report Measures

---

**If Psychosocial Intervention is required – Tick which to consider**

- Positive Reinforcement
- Motivational Interviewing
- Reward Systems
- Relaxation
- Modelling
- Progressive Muscular Relaxation - Young People
- Omission of Positive Reinforcement
- Progressive Muscular Relaxation - Children
- Time-out from Positive Reinforcement
- Relaxation Exercises for Younger Children
- Problem-Solving
- Relaxing Activities
- Goal Selection
- Visualisation
- Controlled Breathing
- Distraction

**If Psychosocial Intervention is not required – Tick which to consider**

- Education and Reassurance
- No further input Required
- Refer to Specialist Service

---

Please record reasons for your choice(s)


Scenario One – Answers to Activity

Type of assessment undertaken:

Interview/Talk with child/family
Observation

Psychosocial Intervention

No further intervention required. Although this is a new situation, there is evidence that Cara and her family have the resources and skills necessary to cope.

Scenario Two – Answers to Activity

Type of assessment undertaken:

Interview/Talk with child/family
Observation
Behavioural Recordings
Self-Report Measures

Psychosocial Intervention

Goal Selection. As Jack has recently taken over the management of his healthcare, this is an excellent opportunity to discuss options and negotiate a schedule of self-management that fits in with his daily routine. A written contract of the exact details of the agreed goals could be drawn up to help reinforce implementation. Jack would also benefit from learning to self-monitor.

Problem-Solving. This intervention could help Jack to find solutions to enhancing self-management. It would enable him to look at options to improve time management in the morning which would enable him to attend to his medication and inhaler. Once agreed collaboratively, an action plan can be drawn up to help Jack implement his solutions.

Motivational Interviewing Approaches. Jack has been open about this ambivalence towards the benefits of his medication. Using motivational interviewing techniques such as agenda setting, discussing pros and cons or using a ruler will encourage Jack to elicit changes in the self-management of his asthma.

References


Adjustment
Policy Context & Outcomes

Getting it Right for Every Child (GIRFEC)
- Positive about self and confident and competent when faced by problems and adverse circumstances
- Receives additional support and care when they need it
- Provided with additional support when needed
- Does not feel discriminated against or demeaned by others
- Receiving appropriate healthcare and guidance from services
- Developing skills for coping with and managing disabilities and long term conditions

The Healthcare Quality Strategy for NHSScotland
- Caring and compassionate staff and services
- Clear communication and explanation about condition and treatment
- Effective collaboration between clinicians, patients and others
- Continuity of care
- Clinical excellence

European Association for Children in Hospital (EACH Charter)
- Article 1 – Children shall be admitted to hospital only if the care they require cannot be equally well provided at home or on a day basis
- Article 8 – Children shall be cared for by staff whose training and skills enable them to respond to the physical, emotional and developmental needs of children and families

Learning Outcomes

Be aware of the psychosocial impact for children and young people in relation to adjustment to physical health conditions and how to offer appropriate support when required.

- Define psychosocial adjustment to paediatric physical health conditions and demonstrate awareness of the variables which are correlated with it.

- Understand the adjustment tasks for the child, parents and siblings.

- Plan and implement appropriate psychosocial interventions when necessary based on comprehensive assessment.

- Understand the social and developmental context of the child and young person’s experience.

- Know the scope of own practice and be aware of situations where referral to a psychologist is required.
Background

Psychosocial adjustment to chronic physical health conditions includes emotional and social functioning. As children live within the context of their families, all family members will require to adjust to various tasks which living with a physical condition entails. Whilst acknowledging this, the focus here will be on the psychosocial adjustment of the child. From a developmental perspective, good adjustment results in the child meeting the developmental tasks of childhood and living as full and healthy a life as possible. Psychosocial adjustment encompasses a wide range in the level of functioning which is dependent on a number of variables. This range includes maladjustment which poses challenges for the child and family and can often require intervention.

A chronic physical condition is one which has been defined by Williams (1997) as a ‘medically diagnosed ailment with a duration of 6 months or longer which shows little change or slow progression’. These conditions include asthma, eczema, diabetes, epilepsy, cancer, juvenile idiopathic arthritis, chronic fatigue syndrome, cystic fibrosis, renal disease, metabolic disorders and heart disease. The severity of these conditions is correlated to adjustment and prevalence estimates suggest that 66% of children live with a mild condition, 29% with a moderate condition which limits some activity and 5% live with a severe condition which is frequently and intensely limiting. (Newacheck & Taylor, 1992).

Living with and adjusting to a chronic physical health condition is an enduring process which can disrupt children’s lives and place them at risk of disturbances in emotional and social functioning. Compared with physically healthy peers, children with health conditions experience higher levels of emotional and behavioural symptoms. Previous studies have investigated psychosocial adjustment across conditions and looked at the commonalities and differences which occur in all. These commonalities include visibility of the condition, life threat, demanding or intrusive care, involvement of sensory or motor systems and learning difficulties.

Correlated to Psychosocial Adjustment

Condition Factors

Condition Type - Studies examining psychosocial adjustment across condition type have resulted in mixed findings but have found that children whose conditions involve the brain have poorer social functioning and more behaviour problems than children with conditions which do not involve the brain.

Condition Course - Conditions with an unpredictable course or with a threat to life are associated with poorer psychosocial adjustment.

The Nature of the Condition - Conditions which require frequent trips to hospital, intensive treatment, time consuming management and disrupt daily living result in poorer psychosocial adjustment.

Child Factors

Gender - In studies exploring gender effects, the outcomes relate to who is doing the reporting. When children are asked to report on adjustment, girls reported more distress than boys. This may be due to girls being more willing to identify and report distress. On parent or teacher reporting, there are generally no gender differences.

Illness Perceptions - Children who perceive their condition as stressful in terms of negative life events and daily problems report more symptoms of anxiety and low mood and parents report that their children experience behaviour problems and poor self-esteem.
Family Functioning

Studies have examined the role of family functioning in relation to the psychosocial adjustment of children with physical health conditions. The dimensions of cohesion, expressiveness, organisation, independence and control within the family unit have been found to be correlated with adjustment.

Adjustment Tasks for the Child

- Dealing with the initial diagnosis.
- Coping with physical symptoms such as pain, changes to physical appearance, discomfort and disturbed sleep.
- Coping with healthcare systems such as clinic appointments, hospital environments and relationships with healthcare staff.
- Managing emotional well-being, anxiety, resentment and isolation.
- Preserving a positive self image.
- Preserving relationships with friends and family.
- Preparing for an uncertain future.
- Coping with interruption to school and academic performance.
- Managing transitions such as hospital to home, child to young person to adult services and specialist to local services.

Adjustment Tasks for Parents

- Coping with healthcare appointments and different healthcare staff.
- Becoming familiar with healthcare systems.
- Taking on a negotiating role for their child at home, school and in healthcare settings.
- Additional childcare responsibilities such as facilitating treatments, observing and managing symptoms.
- Balancing time demands invested in managing the condition with the parenting tasks of other children in the family.
- Balancing own work/career with additional healthcare tasks.
- Coping with their own thoughts and feelings about the condition and symptoms whilst being aware of the impact of their own emotional well-being on the child’s adjustment.
- Dealing with questions about the condition posed by the child or siblings.
- Balancing the developmental needs of the child with optimal condition management such as allowing a young person greater autonomy without risk to health.
- Coping with anxiety about their child’s future well-being and health.

Adjustment Tasks for Siblings

- Understanding the nature of the condition and the implications for them. For example, whether they will have the same condition, how to talk about it and changes in family life.
- Alternative care arrangements when parents are in hospital or clinic.
- Reduction in the quality and quantity of parental participation in their lives.
Responsibility for additional tasks due to the condition.

Supporting their sibling in adjusting to the condition, symptoms and other difficulties which may be encountered such as bullying, low mood or anxiety.

Coping with preparation and support when they are directly involved in treatment.

Symptoms of Adjustment Problems in Children

Internalising symptoms including anxiety, affective disorder, depression/low mood and social withdrawal.

Externalising symptoms including hyperactivity, aggression and oppositional behaviour.

Reduced or poor self-esteem.

Changes in self-concept.

What helps?

Social support.

Open and frequent communication about the condition in terms of physical and psychological well-being.

Maintaining hope.

Positive outlook and being optimistic.

Interventions aimed at improving psychosocial adjustment in this context aim to:

Increase awareness of the psychosocial impact that the condition has on the child and family.

From diagnosis, work with the child and family to ensure excellent communication, education and support structures are in place to prevent problems arising.

Regular and effective monitoring of psychosocial functioning and early identification of difficulties.

Reduce identified symptoms of emotional distress through interventions based on individual need.

Establish adaptive coping and patterns of behaviour which improve adjustment.

Communication Guidelines

Although only one child within a family may have a physical health condition, the illness experience is felt by everyone.

Children cope better when adults talk openly with them than when they are kept uninformed.

Communication must be given at the child’s level of understanding.

Include the child from the start to establish and maintain trust.
When children are included appropriately, they can form accurate and hopeful beliefs about their condition and related events. This forms a basis for adaptive coping strategies.

Children are aware when adults are worried. What children don’t know, they will attempt to interpret themselves.

Children are resilient, in particular in a supportive environment. Their adjustment is shaped by the quality of communication and how prepared they feel.

It is helpful to have clarity from the onset about who is responsible for communicating with the child and what information is given.

Communicate at a pace that suits the child. It may take time for the information to be assimilated.

The means of communication may vary e.g. verbally or through written materials for older children or through visual materials e.g. drawing or play techniques for younger children.

Allow communication to be guided by the questions children ask.

Use language and words with which the child is familiar.

Psychosocial Assessment – Adjustment

Prior to considering which intervention, if any, is required to improve adjustment, an assessment of the presenting difficulties and the context in which they present is required. These assessment techniques are outlined in Chapter 3 and may include any of the following:

- Interview/Talk with child/family
- Talk with relevant others
- Observational Assessment
- Assessing Behaviour (Functional Analysis)
- Behavioural Recordings
- Self-Report Measures

Psychosocial Interventions – Adjustment

Behaviour Change

Based on assessment, a psychosocial intervention tailored to the individual child may be required. This intervention may include any of the following:

- Positive Reinforcement
- Reward Systems
- Modelling
- Omission of Positive Reinforcement
- Time-out from Positive Reinforcement
- Problem-Solving
- Goal Selection
- Motivational Interviewing Approaches

Reducing Distress

- Relaxation
- Progressive Muscular Relaxation - Young People
- Progressive Muscular Relaxation - Children
- Relaxation Exercises for Younger Children
- Relaxing Activities
- Visualisation
- Controlled Breathing
- Distraction
Scenario One

(Clare, aged 12 years)

Clare has been living with Crohn’s disease for three years. She adjusted well to the diagnosis and her symptoms have been well controlled until recently. For the past two months, Clare has had a relapse in her condition and has regular hospital visits for treatment. Recently, Clare has refused to let nursing staff observe or dress a perianal abscess. She has been informed of the consequences of this choice and knows her parents are very worried. She has lost weight and there has been no evidence of tissue healing. Her consultant has suggested a period of nasogastric feeding but Clare refuses to contemplate this. There is concern at the change in Clare’s attitude and her current ambivalence towards her treatment as it is known that she has a good understanding of the condition and the consequences of her current choices.

Which Type of assessment has been used – Tick as appropriate

- Interview/Talk with child/family
- Talk with relevant others
- Observation
- Functional Analysis
- Behavioural Recordings
- Self-Report Measures

If Psychosocial Intervention is required – Tick which to consider

- Positive Reinforcement
- Reward Systems
- Modelling
- Omission of Positive Reinforcement
- Time-out from Positive Reinforcement
- Problem-Solving
- Goal Selection
- Controlled Breathing

- Motivational Interviewing
- Progressive Muscular Relaxation
- Progressive Muscular Relaxation - Young People
- Progressive Muscular Relaxation-Children
- Relaxation Exercises for Younger Children
- Relaxing Activities
- Visualisation
- Distraction

If Psychosocial Intervention is not required – Tick which to consider

- Education and Reassurance
- No further input Required
- Refer to Specialist Service

Please record reasons for your choice(s)

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Scenario Two

(Bob, aged 15 years)
Bob received a diagnosis of Diabetes 4 months ago. His family is supportive and Bob has been managing his diet and insulin regime well with his parents’ input. Despite managing these tasks Bob has started spending less time with friends outside school and has stopped a number of his afterschool activities including football and swimming both of which he particularly enjoyed. His teachers have noticed a change in his attitude to schoolwork with reduced concentration and uncompleted homework which is in contrast with his normal functioning at school. Bob reported that he has been increasingly withdrawn in the house, spending most of his time alone in his room. He stated that he has been sleeping poorly and has been noted to pay less attention to his appearance than previously. He reported that he hates having Diabetes and scored in the clinically significant range on a measure of emotional distress.

Which Type of assessment has been used – Tick as appropriate

- Interview/Talk with child/family
- Talk with relevant others
- Observation
- Functional Analysis
- Behavioural Recordings
- Self-Report Measures

If Psychosocial Intervention is required – Tick which to consider

- Positive Reinforcement
- Reward Systems
- Modelling
- Omission of Positive Reinforcement
- Time-out from Positive Reinforcement
- Problem-Solving
- Goal Selection
- Controlled Breathing

- Motivational Interviewing
- Progressive Muscular Relaxation
- Relaxation - Young People
- Progressive Muscular Relaxation - Children
- Relaxation Exercises for Younger Children
- Relaxing Activities
- Visualisation
- Distraction

If Psychosocial Intervention is not required – Tick which to consider

- Education and Reassurance
- No further input
- Refer to Specialist Service

Please record reasons for your choice(s)

.......................................................................................................................
Scenario One – Answers to Activity

**Type of assessment undertaken:**

Talk with relevant others
Observation

In this scenario, there is inadequate information to hold a shared understanding of the presenting problems. Further assessment is required prior to thinking about intervention. There is no evidence that Clare’s voice is being heard and little understanding of the reasons for making her choices. Talking with Clare about her thoughts and feelings is central to the assessment. As Clare has experienced a relapse in her condition and may have associated health anxiety or mood change, self report measures of mood and quality of life should be considered. Effective assessment is the start of the supportive relationship which is fundamental to any psychosocial intervention and the child’s perspective is fundamental. It is important not to be rushed into an intervention without a comprehensive assessment.

**Psychosocial Intervention**

**Motivational Interviewing.** An intervention using motivational interviewing approaches to explore ambivalence and elicit Clare’s reasons for making her current choices would be very effective here. Clare’s age, gender and positioning of the abscess may contribute to her decisions. There may be an issue of not being familiar with hospital staff as she has previously been in remission and did not require hospital treatment. She may also feel overwhelmed by the recent relapse in her condition, her parents’ emotional response and the urgency of decisions required by healthcare staff. Clare is also feeling physically unwell and is experiencing poor nutrition. This will impact on her emotional well being and ability to process and absorb information. Allowing Clare time and opportunity to explore her current circumstances and choices will be very helpful in eliciting behavioural change.

**Progressive Muscular Relaxation, Visualisation / Distraction.** Could well be helpful if further assessment reveals anxiety regarding treatments.

Scenario Two – Answers to Activity

**Type of assessment undertaken:**

Interview/Talk with young person/family
Talk with relevant others
Observation
Self-Report Measures

**Psychosocial Intervention**

Due to the clinically significant symptoms of depression, Bob requires to be referred to Specialist Services e.g. Paediatric Psychology.

**References**


Books and Resources
Books/Resources


Links

www.ascscotland.org.uk
www.cen.scot.nhs.uk
www.changingfaces.org.uk
www.children1st.org.uk
www.childreninscotland.org.uk
www.each-for-sick-children.org
www.handsonscotland.co.uk
www.healthscotland.com
www.nes.scot.nhs.uk
www.scotland.gov.uk
www.scotland.gov.uk/Topics/People/Young-people/childrensservices/girfec

Additional Policy


Scottish Government (2009b). Do the Right Thing: For People who Work with Children or Work on their Behalf.
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