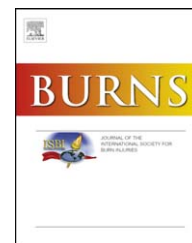


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BurnEd: Parental, psychological and social factors influencing a burn-injured child's return to education

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ABSTRACT

Childhood burns are painful and traumatic and impact the child and their family. For the child, part of the returning to wellness process involves successfully returning to school, a process in which parents play a vital role. This qualitative research aimed to examine how influential parental and other factors were in the return to school process. Data was collected through semi-structured interviews and was analysed using a social-constructivist Grounded Theory approach. The analysis revealed that parental confidence—in themselves, their children and their children's schools; role adaptation, skill acquisition and flexibility; and school receptivity, were pivotal in the return to school process.

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1. Introduction

Burns have been described as “one of the most traumatic, dehumanising injuries an individual can experience” [1, p. 8]. They are excruciatingly painful [2], physically threatening and psychologically and socially intrusive [3], and usually result in an increase in family disruption, trauma and distress [2,4].

Many studies have reported the psychological distress experienced by children and their families after a burn. For children, nightmares and enuresis have been reported to be common [5], as have fears of anesthesia, surgery and social rejection, which have been related to post-injury depression [6], and symptoms of traumatic stress [7]. Research has shown that children who experience more psychological difficulties adjusting to their injuries have been described as seeming insecure and withdrawn [8]. However, evidence also suggests

that 95% children adjust well psychologically to their burn-injury [9]. These well-adjusted children have been characterised as optimistic, outgoing and friendly [8].

For parents, burns can be one of the most stressful experiences [7]. After a burn in a child parents have been found to proceed through a process of guilt, anxiety and anger [10]. Research has shown that mothers have blamed their inattentiveness as a cause of the injury [11] and wished they had been able to prevent the injury through having taken a different course of action [11]. Such negative cognitions have been found to contribute to the development of low mood, anxiety and post-traumatic stress [7,11–13]. Research has demonstrated that in managing their stress and anxiety, parents may develop coping strategies including becoming very safety-conscious [10], overprotective [12,14], controlling [15] and restrictive of their child's activities in order to minimise the possibility of any further injury [7].

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These psychological reactions have been shown to affect families' capacities to adapt to situations [16]. Whilst coping with their psychological reactions family roles have been found to change dramatically to enable parents to deal with arising issues and promote the child's physical recovery [17]. Family support is often cited as having an important influence over child psychosocial adjustment [2,9,15,18,19], with greater family cohesion and expressiveness, and fewer family conflicts, promoting the best psychological adjustment and quality of life for burn-injured children [19]. Findings have shown that with continued family support, most burn-injured children recover socially and psychologically within a year [20]. This means that the children begin to integrate back into their normal environments including community activities and school [20].

Researchers also argue that "successful return to school is an essential part of the 'return-to-wellness' process and should be regarded as an important outcome measure" [21, p. 342]. Therefore, reintegrating into the school environment has been used as a measure of functional aptitude [22] as well as social and emotional adjustment of the child [23]. Nevertheless, returning to school after a burn can be a traumatic experience, even when the child has adjusted well to the home environment [10]. For example, children and their family members often feel anxious about how others in school will react to the child's new appearance, fearing that they might be rejected or ridiculed [24]. Additional research reports that for some children, returning to school after a burn-injury has resulted in social isolation, teasing and bullying [25]. This social isolation can affect a child's self-esteem and therefore lead to further isolation and withdrawal, complicating the psychological development of the child and potentially resulting in educational difficulties [26].

Previous research has shown that the success or otherwise of reintegration into school is influenced by whether the injury or scarring is visible (with visible scarring linked to bullying [27]); by the personal resources of the child (including their personality and coping skills [10]); and by the responses and support of school staff and peers [24]. Included within the child's personal resources is their new sense of self, which may have altered considerably as a result of their newly-found coping skills and change in appearance, including the use of pressure garments, rehabilitative appliances as well as possible scarring [28].

The child's adaptation to their new sense of self encompasses their body image, which may be influenced by the reactions of others to their new appearance. Recent research has focused on the impact of both body image and peer acceptance on the return-to-school process. Christiansen et al. [22] used retrospective quantitative techniques to determine whether body image and peer acceptance determined average school return time for children and adolescents. It was found that length of hospital stay, and patient's age and gender, were most strongly associated with delayed school return, with older boys (with a mean age of 12) taking the longest time to return. However, as the authors themselves admit, there may have been other factors that impacted the time of return to school that were not captured in this study owing to the use of a quantitative design.

Qualitative research techniques allow a more open and illuminating process than quantitative methods and therefore would be useful in exploring the effects of psychological aspects of the burn-injury experience, treatment, recovery and other, as yet unidentified, processes on the length of time it takes children to return to school after their injury. As has been demonstrated above, parents assume integral roles in promoting children's recovery after a burn-injury, influencing both physical and psychological functioning, and since returning to school is an essential part of the returning to wellness process [21], parents may also have a vital role to play in this process. Therefore, in the current paper, qualitative research techniques, namely a Grounded Theory approach, were used to examine how influential parental and other factors are in the return to school process.

Grounded Theory is a systematic, inductive and comparative qualitative research method that offers "a means of building conceptual bridges between real-life situations and formal theory" [29, p. 79]. To form a theory data is developed into abstract concepts and the relationships between these concepts are specified [30]. Through interviewing parents, Grounded Theory methods were used to develop a theory describing the relationships between psychological and other processes that facilitate and impede a child's reintegration in school.

2. Method

2.1. Participants

In total, eight mothers and four fathers, three of whom were couples, took part in the research. Their burned children included three girls and six boys who had suffered burns ranging from 1.5% to 13% Total Body Surface Area ($M = 5.4\%$) in size. The burns were located on different areas of the body including face, hands, chest, arms, torso, thighs, buttocks, and feet. Ages of the children at the time of injury ranged from 8 to 15 years old, with three children attending primary school and five attending secondary school. Length of stay in hospital varied from no overnight stay to 17 days ($M = 7.4$ days). Length of time since injury varied from 339 days to 893 days ($M = 681$ days).

2.2. The interview guide

The initial interview guide incorporated broad, open-ended questions based on existing literature that covered the period leading up to the burn-injury, the emergency period, acute care, returning home, rehabilitation and returning to school. To ensure reliability and validity of the interview guide, a university researcher and a consultant clinical psychologist experienced in the area of burn-injuries were consulted. The interviewer (a final year trainee clinical psychologist) used the interview guide alongside prompts, summaries, reflective and clarifying remarks to obtain a clearer and more holistic understanding of participants' individual experiences, and to develop important emerging information.

In accordance with the Grounded Theory approach [31], after each interview had been conducted, transcribed, and analysed, the interview guide was modified based on the

concepts that had emerged from the previous interviews, but the essence of the guide remained constant.

2.3. The Grounded Theory Method

Since the conception of Grounded Theory, reported by Glaser and Strauss in 1967 [32], several different approaches to Grounded Theory have emerged. Elliott and Lazenbatt [33] state that “research claiming to be a Grounded Theory study must follow specific Grounded Theory methodology” (p. 49). In this study, a more social-constructivist approach influenced by the work of Charmaz [34,35] was adopted. This approach is based on the principles that the research process is dynamic and interactive, meaning that the researcher is an integral part of the process. Accordingly, the researcher determines the direction of analysis through their interaction with and interpretation of the data [35]. Therefore, it is assumed that the researcher’s beliefs, prior knowledge and past experiences influence theoretical interpretations.

2.4. Procedure

Participant recruitment: Participant information sheets and opt-in forms were posted to the parents¹ of 50 burned children who had been under the care of a specialist paediatric burns unit located in the North of England. Their children had burns ranging from 1% to 27% in size, which were located on visible (head, neck, hands) and non-visible body parts. Parents were invited to take part in the research if their child was 7 years old or older at the time of injury, if their child was admitted to hospital prior to 1st January 2007, and if they were still in contact with the service.

Parents volunteered to participate in the research by returning an opt-in slip with their name, address and details of how they could best be contacted, in a pre-paid envelope. Volunteers were contacted by their preferred method and mutually convenient times and locations were arranged for the interviews.

Data analysis: The nine interviews ranged from 45 min to 75 min in length. Data collection and analysis was simultaneous, so that each process informed the other. The first four interviews were analysed at the sentence level, generating multiple interpretations of meaning for each sentence. This produced over one hundred concepts, which were compared with each other, refined and integrated to produce eleven main categories (injury experience; perceptions of treatment; psychological reactions to injury; coping with the impact of the injury; role of parent; psychological experience of physical recovery; time off school, practicalities and interpersonal interactions; perceived academic support; the decision-making process; experiencing the event; psychological reactions to the school return). Further data was interpreted in larger segments and was compared and contrasted with these initial categories. Furthermore, data was used to identify the relationships between categories and subcategories. Memos were written at all stages of the process to track the researcher’s thoughts regarding the data and model development.

¹ The term “Parents” is inclusive of carers throughout this document.

Analytical techniques and theoretical categories were discussed with a university researcher, with a consultant clinical psychologist who is experienced in burns, and at a Grounded Theory peer-supervision group. After seeking supervision and reviewing relevant literature, further analysis was performed to take the theory from a descriptive towards a more conceptual level. This resulted in the data being further analysed in a search for more abstract meaning and a subsequent reduction in the number of categories to five (injury encounter; parental emotional reactions; child’s psychological and physical state; parental role adaptation, skill acquisition and flexibility; school receptivity).

Ethical considerations: Ethical approval for the study was obtained from the Local Research Ethics Committee and Trust Research and Development.

2.4.1. Findings

The theory that was developed from the data encapsulates the process of returning to school from parental perspectives. Five main categories were developed to account for the process. Although children’s injuries healed with time the process was by no means linear, as unpredictable features including emotions, physical healing and demands of daily life were interwoven into the process. Fig. 1 displays a diagrammatic representation of the model, which is further explained below.

2.5. Parental emotional reactions

Parents often reported how they were engaged in everyday activities when their child’s burn occurred “It was half past ten at night and I’d gone up to read, so I was upstairs reading, and I always lock the door and say don’t open the doors” (Interview 2). This context of normality meant that parents were neither expecting nor prepared for the injury. Parents described how the occurrence of the injury was a complete shock and beyond the realms of imagination:

I was quite shocked because I’m quite a careful person really and I didn’t think, you know, I’m always careful around the bath and the hot water, like, when I use my kettle I always empty it out straight away so that no little child should get hold of it, and I’d heard about burns and how severe they could be and I was shocked that it had happened to me, that kind of accident (Interview 7).

In response to the injury parents explained how they reacted, in one of two ways: with panic and hysteria or, calmly and thoughtfully. Chaotic panic resulted in parents being unable to help their children:

I didn’t know what to do I was walking, my mum slapped me, and I was walking around back and forth saying ok he’s got to go under the water, and I’m walking to the sink, and I’m walking to the bathroom. . . I was walking to the car and back but I had the phone in my hand I was phoning an ambulance thinking I’ll get in the car and take him (Interview 4).

Contrastingly, parents who reacted calmly and thoughtfully were able to be more useful in the crisis situation “So I just shoved it straight under the tap and left it there for a bit,

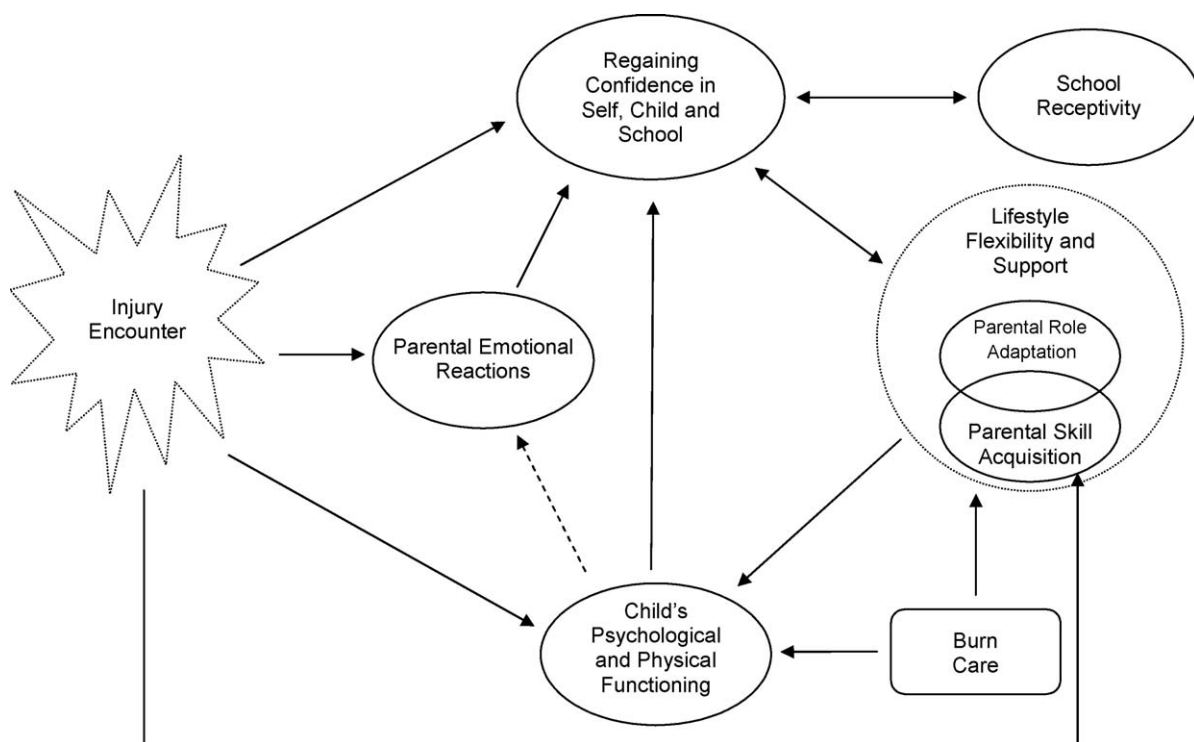


Fig. 1 – Factors contributing to the return to school process.

but then we took her down to [name of hospital] they dressed it and said to return the next day” (Interview 3).

The way in which the injury occurred was not reported to have any direct bearing on the return to school process, yet the resulting physical impact and psychological impact did. The ways in which the injury impacted parents emotionally was particularly important.

After the injury encounter parents described experiencing guilt, anxiety and stress. This reflected their helplessness at their inability to fulfil their parental role of protecting their child “If I hadn’t allowed him to be here, if I hadn’t have been waxing my mum’s legs and I’d had the kids in for their tea and they were watching a DVD, it wouldn’t have happened would it?” (Interview 4).

In addition to the injury encounter being a source of stress for parents, parents also worried whether their children would fully recover from their experiences both psychologically and physically. As parents witnessed their children’s recoveries this stress and anxiety decreased with time. However, during the recovery period these feelings, particularly anxiety, impacted upon parental confidence.

2.6. *Regaining confidence in the self, child and system*

A pivotal theme, that related in one way or another to most of the other themes, was that parents had to regain their confidence in three main areas after their child’s burn: in their abilities to protect their child; in their child’s abilities to take care of themselves and in the school’s ability to keep the child from harm.

The guilt, anxiety, stress and rumination that parents experienced in relation to both the burn and the healing

process led them to question their ability to be good parents. Parents described how they doubted their abilities to make what would usually be minor decisions; “But by the same token I wouldn’t have wanted to say I think he’s fit for school and then somebody turn round and say to me he’s not, look at him, you know” (Interview 5). In response to this self-doubt, parents explained how they overcompensated by becoming over-protective at the expense of the child’s freedom “Well I was very worried, I was giving it like, well text me at lunch time, is everything alright? I think on hindsight he coped very well and maybe I smothered him (Interview 5)”. This parental sense of anxiety and self-doubt may have been promoted by the sense of helplessness parents experienced in hospital when their child’s care was in the hands of professionals “It was like when any child or anybody was in hospital you feel like you’re not in control, that’s a big issue for any parent I think, you’re relying on other people making decisions” (Interview 8). Furthermore, parents received regular advice from professionals who told them what they needed to do to promote their child’s recovery, which prevented them from making independent decisions, thus further diminishing their roles as parents.

In lacking confidence in themselves, after being unable to effectively protect their children from the burn-injury occurring, parents became over anxious when allowing their children to be involved in activities that could be dangerous in some way. They needed to be confident that their child could be trusted not to put themselves in a dangerous situation both at school or elsewhere “I mentioned it about him still having something to do with them and he said ‘Do you think I’m daft enough to do anything like that again?’ But it worries me that he might be” (Interview 2).

Similar to parents needing to be confident that their children could be trusted to keep themselves safe, parents also needed to be confident that school staff would provide a safe environment for their child. When schools created a caring and proactive environment that bridged the recovery period with the normality of school, this allayed anxiety and increased confidence in the return to school process for both parents and children, "She said don't worry about anything and if you've got any concerns, any concerns whatsoever, come and speak to me. So she were really lovely like that. They were really good about it at school" (Interview 1). Whereas, when schools were perceived as unsupportive this bred parental anxiety and distrust of the school:

I thought well if you're not going to contact us I'm not fussed because if I'm not getting the support while I'm at home, he isn't going to get the support when he goes into school and he's on his own in there (Interview 5).

During this process of regaining confidence in themselves and others, parents also had the challenge of adopting new roles and learning new skills to support their children through the recovery and returning to school processes.

2.7. *Role adaptation, skill acquisition and lifestyle flexibility and support*

Within the context of low self-confidence and self-doubt, parents were further tested through needing to acquire an array of skills needed to care for their child. This often involved making large adjustments to their family lives to accommodate and care for their burn-injured child. They assumed new roles in supporting their child's physical and psychological recovery and to do this had to learn new skills "It was rubbing cream on, then almost like cling film over the top and then bandaging, then pressure and then bandaging" (Interview 8).

Managing their own emotions, changing their roles and routines, and learning new skills, all occurred within the context of "normal" life, which for all parents interviewed involved a job, other children and other commitments. Parents had to strike a balance between each of these components, which was described as particularly difficult if they had inflexible lifestyles because they worked full-time. A further factor that determined how flexible a parent could be was the quality and availability of their support networks. Parents who were better supported by their friends, families and communities were better able to cope with adapting their roles and learning new skills:

Well we have in our community something where people make meals and send it in and you just pay cost price for it so I used that service. So then I had my meals every day so I didn't have to cook, because I have a large family so it's a lot of work [smiles]. So then I had other help you know, just domestic help, like I normally do, and it was the winter holidays so my children were off school so they could help a little bit as well. It was really those first two weeks that were the most difficult and then things settled down, there were fewer appointments and he was moving around more so it was better (Interview 7).

In addition to being logistically difficult, this constant adaptation, learning and recovery process was relentless "It was so demanding, keep going to hospital, having a scan, having a massage and another scan. I didn't realise, I mean God is this ever going to give up" (Interview 6). Despite this constant pressure, parents were willing to undergo personal sacrifice to benefit their child's psychological and physical wellbeing.

2.8. *Child's psychological and physical functioning*

Part of the unrelenting nature of recovery was that there were no certain aspects to it. Living with the uncertainty as to how and when their child's physical injuries would heal further increased parental anxiety:

It was uncomfortable, you don't know what the next step is, you know, you've seen an injury and you think well that will be treated and we'll be sent home, and then you realise that you're going to stay in... and obviously you learn as you go...so it's a learning curve really and I suppose it still is (Interview 9).

Additionally, parents reported that seeing their children respond to their injury with stress reactions, including disturbed sleep, heightened anxiety, and depression, heightened their own anxiety "But, he stopped speaking though, he stopped speaking. The night we went in, the morning after he stopped speaking for about 3 days... Depressed. Very depressed, very, he'd just ask for something like 'I'm itchy' that was it" (Interview 4). Children and their parents both experienced stress responses to the injury including finding new dangers in old environments "She wouldn't brew up for about 5 or 6 months afterwards and she does that as part of her job so that was a bit difficult" (Interview 8).

However, these psychological difficulties became less pronounced with time as parents and children were able to come to terms with their experiences "We went from camping out to major... within the first week it was hard to digest what had actually happened and what you'd gone through" (Interview 5). Anxiety also diminished in response to professional care that promoted physical recovery. The way in which parents reported their children had been cared for in the hospital was almost as an idealised "perfect care". This was perhaps reflective of the gratitude that parents felt for the substantial recoveries that their children had made "Like I say, the treatment was absolutely outstanding at [name of hospital]. Without a shadow of a doubt his scars wouldn't have been what they are today without the treatment" (Interview 1).

Once children began to recover from their physical and psychological injuries the majority of parents reported that their children were motivated to get back to school; "He was desperate to get some normality back into his life and desperate to go back to school" (Interview 4). In order to get back to school, the negotiation of various obstacles was needed, including dealing with psychological changes such as a new self-concept, physical changes, including a new appearance, and the situational change of being academically behind:

He was wearing his pressure garments when he went back to school and he said I don't want to not do PE because I

suppose if I don't do it I'll look odd, but dressing and undressing for PE he got the mick taken out of him. They were calling him "Bernadette" because he looked like a girl because he had got tights on (Interview 5).

A further obstacle was that parents had to use their initiative and forward thinking to plan their child's return to school. This initiative and planning had to occur whilst parents concurrently dealt with normal life commitments, adjusted roles and were learning new skills. It is thus understandable why being proactive to make contact and arrangements with school was not the first item on their list of priorities. Therefore, when schools supported parents in considering a child's return to school, it had a sizeable impact on the return to school process.

2.9. School receptivity

Indeed, the largest factor that determined how quickly children went back to school after their burn-injuries was concerned with how receptive and supportive the school were during the child's period of absence. Parental ability to contact schools to make arrangements, in the way that they usually would have done in reaction to more normal circumstances of school absence, was hindered by their psychological reactions to their child's burn-injury, their lack of self-confidence and extensive role adaptation.

A lack of contact and academic support from school was seen as especially important when children were studying for their GCSEs. With parents being under pressure to adapt their roles, learn new skills and protect their child from further harm, they were unable to consider how to access support or improve the situation at that time "Until now I've not really thought about the education part of it. . .but if you think about it, if someone was to sit down and say he's going to get behind we probably would have thought of a tutor or something" (Interview 6).

One way of ensuring that returning to school is on parental agendas, without exacerbating parental stress, was inter-agency liaison between the burn care team and school professionals to create the initial bridge between the child and normality "When he actually came home, the hospital had contacted the education medical service or something like that, it's like a school, where they said they wouldn't over face him" (Interview 5).

2.10. Summary

In summary, the model displays how returning to school, from the parental perspective, is dependent upon many interwoven factors that must be negotiated in order to complete the process. An important factor for parents centred upon their ability to regain their confidence in themselves, their children and school staff after their child's burn-injury. A reciprocal relationship was observed between parents' confidence in themselves and their ability to adapt to their new roles and acquire new skills, which was impacted upon by the flexibility of their lifestyle and the availability of support. Parental emotional reactions also played a significant role in the process, as these influenced how confident parents felt about

themselves, their child and the school and, via this route, how proactive parents were able to be in contacting the child's school. The child's psychological and physical functioning influenced parental emotional reactions, as complexities here could cause further stress in an already stretched environment. However, this decreased as children recovered from their injuries, and therefore is shown diagrammatically with a dotted line. The child's functioning was affected by the support that they received from their parents and families and the medical care that they received from professionals, which although merited noting in the diagrammatical representation in the model was not a separate theme per se, and has therefore been represented using a different shape in the figure. Finally, the extent to which the school was approachable, receptive and supportive, seemed to be a major factor impacting the child's absence and return, especially given that depleted parental resources due to the psychological and practical constraints of the injury.

3. Discussion

The aim of this study was to develop a theory describing the relationships between psychological and other processes that facilitate and impede a child's reintegration in school. The analysis produced a non-linear model from the parental perspective, identifying regaining confidence in the self, child and school; parental role adaptation, skill acquisition and flexibility; and school receptivity as the most influential factors in this process.

Consistent with published literature [3], this study found that burns in children were psychologically intrusive for both children and their parents. Parents experienced emotional reactions including guilt, self-blame, anxiety and anger, which were consistent with published research [10,11,12,13]. Furthermore, in this research, parents blamed themselves for failing to protect their child from harm, as was also found by Fukunishi [11], and wished they had taken different action to prevent the injury, similarly to Rizzone et al.'s findings [12].

These parental emotional reactions and the injury experience led to parents losing confidence in themselves and their child. Whilst trying to manage this loss of confidence, parents became overprotective, controlling and restrictive of their child's activities in order to minimise the possibility of any further injury, which has also been found in previous studies [7,12,15,16].

The lowered self-confidence and emotional reactions provided a context within which parental roles had to adapt and new skills had to be acquired to support the child's recovery, thus corresponding to previous literature reporting that parents learned new skills [2,19] and adapted their roles [18] after their child's burn. Furthermore, the complex relationship between parents and the burn care team's help was interesting because on the one hand parents were very appreciative and grateful for the team's help, but implicitly the interactions could also threaten their sense of self efficacy through parents feeling deskilled. This has not been reported in previous research. As children's psychological and physical wellbeing improved in response to the support provided by parents and the burn care team, parental emotional reactions

began to alleviate. However, anxiety relating to the school return then came to the fore.

Previous research has noted that children and parents felt anxious about the ways in which others in school may react to the child's new appearance [24]. However, this study also found that parental anxiety was related to a lack of trust in the school environment and that parents needed to regain their confidence in their child's school, to be certain that their child would be protected from harm once they had returned. This has not been included in previous studies.

Finally, the research on parental perceptions and the subsequent model meant that unlike other studies [22,27] this study found no relationships between visibility of scarring, bullying, length of hospital stay, age and gender and the return to school process. This may be because the qualitative research methods employed by this study enabled parents to discuss issues that were most important to them, rather than having to answer inflexible questions about preconceived ideas.

The findings of this research, which are in line with previous claims [19,26,36,37], substantiate the need to provide sufficient support for both parents and schools to better enable them to support children during this time of crisis. This may include supporting parents in regaining their confidence or in adapting to their new roles as readily as possible through providing education and training in skill-based activities and problem-solving, so that parents have an adequate amount of resources to be able to make sense of their psychological experiences. However, owing to the possibility that parental confidence and self-efficacy may be threatened by help from the burn care team, professionals should be mindful of this and use an approach that allows parents to feel competent in their actions and whilst being responsive to provide parents with support when needed. Regular appointments in the post-burn period would provide an important opportunity to review parental and child psychological wellbeing in order to detect difficulties at an early stage and provide appropriate and acceptable intervention.

For those parents and children who are unable to make sense of their experiences alone, psychological support should be made available. However, it is hard to suggest an optimum time for this to occur, as the non-linear nature of this process means that parents and children will reach different stages of the process at different times depending upon the complexity of interwoven factors outlined above.

In addition to parental confidence and role adaptation, a central factor in determining how quickly children returned to school after a burn was how proactive, available and supportive school staff were towards parents and children. This finding suggests that burn care teams could support schools to be more proactive in helping children and their families, and is a novel approach. This would alleviate the need for parents to be proactive at this time, hence reducing the pressure for parents who have restricted support networks or inflexible lifestyles. Previous literature in the area thus far has suggested that the burn care team ought to help children and their families with the return to school process through initiating reintegration programmes [23,24,28,38]. This model suggests that a more useful school reintegration strategy would be for schools to initiate and support the return to

school process. This would better establish a sense of confidence and trust for parents, which the model indicates, will lead to a smoother reintegration for children, families and school staff and, a quicker return to school for the child. However, it is recognised that schools may struggle to fulfil this role due to the daily pressures that they are routinely challenged with in running a school. Accordingly, members of the burn care team may need to approach children's schools to explain the reasoning behind this and support the schools with the process where necessary. This would be a new development of the old style school reintegration programmes, that were based on promoting school understanding, and are used frequently in the USA as a means of optimising children's psychosocial adjustment when they return to school after a burn injury [21,29,38,39].

To summarise, the model indicates two main areas where clinical intervention could facilitate the return to school process for children and their families, firstly in supporting parents to regain their confidence and successfully adapt their roles, and, secondly in helping schools proactively contact parents to re-establish a parental sense of confidence in the school.

3.1. Methodological considerations

One limitation of this research was that only parental perspectives were considered in developing the model. Originally, it was intended to invite children to participate in the research with their parents; however, the local research ethics committee limited participation to parents and other adult family members only. Therefore, in the current study, the children who had suffered the injuries were unable to have their views heard. An area of further research should focus on the factors that children themselves perceive as important in the return to school process. Such research may uncover new priorities that have remained hidden within the current adult perspectives.

Furthermore, the current research found that parents felt that teachers might have experienced anxiety around the safety of the recovering burn-injured children in school. This may have contributed to additional time off school or parental beliefs that the school could be trusted. Therefore, a possible extension of this study might be to interview school-based staff to examine their views on facilitating factors and obstacles to school reintegration.

Future research should also focus on including families from different race and cultural backgrounds. Eight out of nine families participating in this study were of White British origin and this will have heavily influenced the model. It is hypothesised that this will have been particularly influential with regards to parental role adjustment, as in other cultures where extended families live together, changes may have been dealt with in different ways.

Additionally, the sample of participants in this research was self-selected and could therefore have consisted only of people who thought that they had a contribution to make in this area or because they had some very positive or very negative experiences that they wanted to share. If this were the case the applicability of the developed theory must be brought into question. One suggestion for improving the generalisability of the theory might be to use quantitative

methods therefore broadening the sample of participants over a wider population to examine the greater applicability of the research [40].

Finally, the mean size of burn for children included in the research was 5.4% Total Body Surface Area, which is relatively small. Therefore, the parents of children with large burn-injuries may have different experiences which would warrant further investigation.

4. Conclusion

In conclusion, the current research developed a theory detailing how child and parental psychological, physical and social factors influenced the return to school process. Parental confidence, role adaptation and school receptivity were identified as being pivotal to this process. Therefore it is suggested that interventions offered to families and schools should be focused in these areas to facilitate the reintegration process and therefore positively affect longer term potential outcomes for children.

Conflict of Interest

None.

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