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AN OCCUPATIONAL THERAPY COMMUNITY-BASED SELF-ESTEEM PROGRAM FOR ADOLESCENTS WHO HAVE EXPERIENCED BURN INJURIES

by

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A Scholarly Project

Submitted to the Occupational Therapy Department

of the

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in partial fulfillment of the requirements

for the degree of

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Approval Page

This Scholarly Project Paper, submitted by Karla Beck and Kathryn Miller in partial fulfillment of the requirement for the Degree of Master's of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

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Faculty Advisor

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Date

PERMISSION

Title: An Occupational Therapy Community-Based Self-Esteem Program for Adolescents Who Have Experienced Burn Injuries.

Department: Occupational Therapy

Degree: Master's of Occupational Therapy

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ABSTRACT

Self-esteem is a problem that adolescent burn survivors deal with on a daily basis. Yet, there is limited research regarding adolescent burns and the psychosocial aspect within their daily occupations. The purpose of this scholarly project was to develop and provide occupational therapists with interventions and outcome measures to utilize in a Self-Esteem Program for implementation in both inpatient and outpatient settings. This program focuses on helping adolescents to regain their self-esteem and confidence when returning back to their communities. Burns have an emotional and behavioral effect on children/adolescents, causing anxiety, pain, distorted self-image, and depression (Pardo, Garcia, Marrero, & Cia, 2008). Occupational therapy would be beneficial to adolescent burn survivors in facilitating a smooth transition back into the community.

A comprehensive literature review was conducted focusing on adolescents 10-21 years of age who experienced a burn injury that affected their daily activities and social participation. A literature review, including occupational therapy theoretical and practice literature, guided the Self-Esteem Program developed for adolescents who have experienced burns and are returning back into the community. The articles included in the literature review were retrieved from PubMed, CINAHL,

Google Scholar, The American Journal of Occupational Therapy, and selected professional textbooks.

A Self-Esteem Program based on the Occupational Adaptation Model (Schkade & McClung, 2001) was developed for implementation by occupational therapists employed by inpatient or outpatient burn care settings. The target audience is adolescents who have experienced burns and are returning back into the community. In this program, occupational therapists provide client and caregiver education so both audiences may have a better understanding of burn injuries and the recovery process.

Occupational therapy (OT) offers many benefits to adolescents who have been injured by burns. Goals for interventions that OT provides within the program include: increasing adolescent's self-esteem, social interaction, assertiveness, and successful reintegration back into their communities. This program is expected to assist adolescents in the realistic analysis of life situations, application of the self-esteem techniques provided within the program, with the anticipation of an improved psychosocial outcome following burn injury. Interventions and outcomes are directed toward increasing the adolescents' psychosocial skills for adaptation following burn injury.

CHAPTER I

INTRODUCTION

A burn injury hospitalizes approximately 24,000-40,000 adolescents annually (Piazza-Waggoner, Butcher, Adams, Goldfarb, & Slater, 2004). There are a total of 125 specialized burn treatment centers in the United States (U.S.). Many burns are non-life threatening, however, any temperature above 120 degrees fahrenheit can severely burn a child's skin and result in surgery if in contact for more than 3 seconds. Approximately 450,000 people receive medical treatment for burn injuries annually (American Burn Association, 2010).

The skin is the largest organ of the body. It serves multiple functions including thermal regulation and prevention of fluid loss by evaporation, a barrier against infection, and sensory receptors that provide information about the environment. The skin consists of three layers: epidermis, dermis and hypodermis. The epidermis is the outermost layer of the skin whose main function is protection. The dermis is the middle layer composed of primarily connective tissue providing nourishment for the skin, nerve endings and hair follicles. The hypodermis is the innermost layer of the skin consisting of adipose tissue between the skin and other underlying tissues. Burns can be measured by the percentage of the body damaged and by the thickness of the burn, as will be explained in the following paragraphs (Pessina & Orroth, as cited in Radomski &

Trombly, 2008).

Burns are typically classified in three categories: first degree/superficial, second degree/partial thickness and third degree/full thickness burns. First degree burn is a superficial burn affecting the surface of the skin leaving the epidermis, the outermost layer of the skin, intact. Symptoms of a first degree burn include skin that is red, sore, swollen or itchy. First degree burns are often caused by sun damage, chemicals, steam, hot water, friction and cigarettes (Pessina & Orroth, as cited in Radomski & Trombly, 2008).

Second degree burns damage through the epidermis and into the dermis, the second layer of skin. When suffering from a second degree burn, symptoms include red and blistered skin. If the burn covers a larger area, an individual may experience fainting, weakness, nausea, or moist skin. Second degree burns are often caused by hot flames, severe sun burn, grease and extremely hot liquids (Pessina & Orroth, as cited in Radomski & Trombly, 2008).

Third degree burns, most severe type, destroy all layers of the skin, epidermis, dermis, and hypodermis. Symptoms of a third degree burn include skin appearing white and leathery, extreme pain, rapid heartbeat and breathing, shock, chest pains, and blistering skin. Third degree burns can cause nerve damage leaving the victim with a loss of sensation in the burn area. Third degree burns are often caused by fire, electricity, or explosive chemicals (Goodis, 2010).

Pardo et al. (2008) found that the most common type of burn injury is scalding occurring in the home in the presence of any or both of their parents, the majority of

admits including boys five years or less. Examples of thermal burns include flame, scald (hot/molten liquid/steam), and touching a hot pot on a stove. The type of burn depends on the layers of the skin affected.

Determining the severity of a burn and if hospitalization is needed can be calculated using the *rule of nines*. This rule involves the percentage of the body affected by the burn and the depth of the burn. *Rule of nines* includes 9% for the face, chest (front and back), abdomen (front and back), right upper extremity, left upper extremity, right lower extremity (front and back), left lower limb (front and back), and 1% for genitalia, totaling 100 %.   Hospitalization is recommended for any burn that has affected more than 25% of the body, third degree burns, and burns due to chemicals or electric shock, preferably in an approved burn center (Pessina & Orroth, as cited in Radomski & Trombly, 2008).

Psychosocial aspects and self-esteem are a lifelong process for adolescent's pre/post burn injury that can affect their daily occupations. During the transition from childhood to adulthood, adolescents' self-esteem fluctuates across this timeline (Robert et al., 1999). Therefore, each adolescent may need continued services (i.e., self-esteem building, assertiveness training, and community reintegration services) depending on the impact of the psychosocial issues present throughout their daily occupations.

The purpose of this scholarly project was the development of a self-esteem program and manual entitles *Building Self-Esteem One Adolescent at a Time.* This program is intended to be implemented by occupational therapists with adolescents recovering from burn injuries during their hospitalization and community phases. The

target population is adolescents ages 10-21 years. The manual consists of interventions focusing on: building positive self-esteem, assertiveness/social interaction, community reintegration and adaptation, family/community education, assessments, and outcome measure. The Coping with Burns Questionnaire (CBQ) was used as the pre/posttest (Bras, Loncar, Brajkovic, Grekurek, & Mickovic, 2007). The CBQ consists of 33 items divided into six scales: emotional support, optimism/problem solving, avoidance, revaluation/adjustment, self control, and instrumental action. The program also consists of a series of selected self-esteem assessments appropriate for the adolescent population. In the *Building Self-Esteem One Adolescent at a Time* manual are reproducible handouts to serve as an interactive form of learning and increase application of the intervention strategies provided.

The structure of the interventions was influenced and guided by the Occupational Adaptation (OA) frame of reference. The main goal of OA is to achieve relative mastery over the environment by encompassing a highly interactive self-organizing process developed by an individual. "OA focuses on the interactive process between a person and their occupational environment" (Schkade & Schultz, p. 107, as cited in Cole & Tufano, 2008). According to OA, individuals desire to behave in a masterful way and the environment demands mastery of the person; these influence the results of the press for mastery (Schkade & McClung, 2001). All three aspects (demand, desire and press for mastery) are present throughout an individual's life.

The following chapters of this book are organized in a manner to guide the reader through the *Building Self-Esteem One Adolescent at a Time* manual. Chapter II

provides a literature review of the extensive findings pertinent to this scholarly project, regarding psychosocial aspects of adolescents who have experienced a burn injury.

Chapter III contains methodology utilized in conducting the literature review and developing the product. The product is presented in Chapter IV to provide the reader with a detailed manual of interventions and assessments that may be used in a building self-esteem program for this adolescent population. Chapter V contains a brief summary of the project, the limitations, strengths, proposal of implementation of the project, and future recommendations.

CHAPTER II

REVIEW OF LITERATURE

Introduction

Research regarding adolescent burn injuries and the recovery process is limited overall with a larger emphasis on the psychosocial aspect. Adolescents who have experienced a burn injury may inquire many different challenges throughout their daily lives. Challenges may include decreased self-esteem, assertiveness and social interaction, physical appearance, care of burns, community reintegration and education. There are many assessments and tools that can be utilized during an inpatient and outpatient stay for a client who has experienced a burn injury. There are many standardized assessments; however, minimal research studies have been conducted to support these assessments within the burn population.

Burn Centers and Quality of Life

Quality of life (QOL) is an important aspect when treating children who have experienced a burn injury. QOL includes physical symptoms, functional status, role/lifestyle activities, social functioning, emotional status, cognition, sleep and rest, energy and health perceptions (Cromes, Holavanahalli, Kowalske, & Helm, 2002). Outcomes for recovery after burns also correlate with lifestyle prior to burn injury, burn injury characteristics, burn treatment intervention/activities, and environmental factors.

According to the American Burn Association (ABA) as cited in Reimel, Klein, Nathens, and Gibran (2008), burn centers designation includes director qualifications, subspecialty availability, and existence of a quality assurance program, however, criteria for a burn center does not provide standards, parameters or protocols for the burn intensive care unit (ICU) where critically ill burn patients receive their care nor are there practice guidelines for burn care. Reimel et al. (2008) states that care in ICU's have improved in outcomes and resources in some burn centers due to the implementation of the "intensivist model of care." This model includes the following criteria according to Reimel et al: 1) the burn ICU physician-director is board-certified in critical care, 2) more than 50% of attending physicians providing critical care services to burn patients are intensivists, 3) attending physicians providing critical care services do not have responsibilities outside the burn ICU, 4) an independent intensivist team (other than the burn team) has the authority to write orders.

Dealing with a burn injury can have an impact not only on the individual but family members as well. Moi, Vindenes, and Gjengedal (2008) stated that if clients and family members are given thorough information about what to expect and possible ways of dealing with their current situation, it would help significantly in enduring the worst phases of recovery and also providing reassurance that professional assistance is available. Kaplan (1985) stated that client education plays a large factor in recovering from a burn injury. Not only patient education, but family training as well can speed up the recovery process. Education in areas such as proper positioning, passive exercise, skin care, pressure garments, next appointment dates, and a contact person in case of

an emergency assist the patient and family during this process. Kaplan (1985) found that educational methods are most effective when geared toward the client's understanding of the injury, their specific needs, problem areas, cognition, and motivation towards therapy.

Problem Areas with Adolescents and Burns

Blakeney et al. (2005) found that 20-30% of individuals who have experienced a burn injury demonstrate mild-to-moderate difficulties with behavioral problems, especially competence. Competence is the possession of required skill, knowledge, qualification or capacity to complete or engage in a task. Social incompetence is most common among child burn injuries due to the failure of adolescents to develop the proper skills, techniques, and strategies to facilitate successfully in the social environment (Blakenley et al., 2005). Liber, Faber, Triffers, and Van Loey, (2008) also stated that children with burn injuries suffer difficulties in their developmental tasks that put them at risk for other kinds of distress. Piazza-Waggoner, Butcher, Adams, and Slater (2004) found that children with facial disfigurements and lower social competence also reported higher social anxiety and loneliness. Conversely, "studies show that good social competence is related to more frequent companionships with peers and positive self-regard in academics, athletics, and physical appearance" (Piazza-Waggoner et al., 2004).

Blakeney et al. (2005) discussed that the most important aspect for a child who has experienced a burn injury is the psychosocial domain. Burn injuries can lead to mental instability and severe emotional distress. Liber et al. (2008) found that major

factors with psychiatric outcomes in this population include the size of the burn, the child's developmental stage at the time of the burn injury, and the time post burn. However, the age of the child at the time of the burn has no effect on the outcome psychiatrically. Yet age matters in terms of ability to cope after burn injury, adolescents who suffered a burn injury, in comparison to adults who suffered a burn injury, have a harder time coping with their disability both physically and mentally. Mentally, adolescents struggle with social interaction, scar disfigurement, confidence, and isolation due to physical and mental difficulties (Liber et al., 2007). Surprisingly Liber et al. (2007) found levels of depression to be significantly lower in children who have experienced a burn injury in comparison to children who have not.

Anxiety is the most prevalent disturbance in young adult survivors of pediatric burn injuries (Meyer et al., 2007). According to Pardo et al. (2008) boys scored higher in levels of anxiety in correlation to the cause of the burn; the most common cause being fire. The older the client, the higher the score in regards to social and thought problems. McGourty, Givens, and Fader (1985) found that children who suffer from severe wounds may receive long term hospitalization, therefore separated from family and friends for an extended amount of time. This experience significantly affects an individual's life style and may develop emotions such as anxiety, fear, guilt, and anger. Pardo, Garcia, Marrero, and Cia (2008) found that self-image and depression are more prevalent in the rehabilitation stage, as well as difficulties with reintegration into the community. These all have an effect on an adolescent's body image, self-esteem and social competence. Bras, Loncar, Brajkovic, Gregurek, and Mickovic (2007) found that

individuals scored higher on the mean scale, average scores of participants, when surrounded with positive emotional support, therefore related to better health status and quality of life.

Children who have experienced a burn injury may have some physical disfigurement or scar visible to their peers. This may cause individuals to feel insecure and different from their peers as well as isolating them due to the emotional domain. According to Rimmer, Fornaciari, et al. (2007), visible scars or disfigurements can lead to negative feelings such as low self-esteem, self-image, and self-confidence. Rimmer Fornaciari, et al. (2007) found that children with lower self-esteem have greater levels of anger and hostility, which may lead to anxiety and defensiveness. Rimmer, Foster, et al. (2007) found that 63% of children who have experienced a burn injury reported bullying as a problem. Children with visible scars reported bullying to be a greater problem than those children with non-visible scars. Physical appearance has long been identified as a major contributing factor in terms of a child's acceptance with their peers.

Blakeney et al. (2005) and Rimmer, Fornaciari, et al. (2007) both found that an intensive social skills program offered to adolescents who have experienced a burn injury to be substantially beneficial, especially with those who suffered interpersonal difficulties. The programs are designed to assist children in overcoming the particular challenges their illness and treatment have brought them and provide them with the opportunity to experience as many normal aspects of child development as possible (Gaskell, 2007). Programs also provide a safe environment where the individuals felt well accepted and comfortable.

Rimmer, Fornaciari, et al. (2007) found that burn camps overall had a positive effect on self-esteem for pediatric burn survivors, yet showing no statistical significance in self-esteem between comparison group and individuals who have experienced a burn injury post camp. Also attending camp and participating in certain activities allowed children to enhance their abilities to better adjust to new environments, enhance personal satisfaction, and be able to make healthier lifestyle choices. Although Rimmer, Fornaciari, et al. (2007) found a social skills camp to be mildly beneficial in increasing self-esteem, however, the study was only completed over a one week period. Piazza-Wagonner et al. (2004) found that campers prior to camp showed deficits in self-esteem, where in posttests some campers demonstrated an increase in self-esteem, some a decrease, and others demonstrated no change at all.

It has been found that individuals who have experienced a burn injury have difficulty developing relationships with peers of the opposite sex and certain family members (Pardo et al., 2008). Family support is an important influence in a child's psychosocial adjustment after a burn injury. With increased family cohesion, fewer family conflicts arise, thus providing a more positive atmosphere in promoting the best psychological adjustment and quality of life for burn-injured children. Findings have shown that with continued family support, most children who suffered from a burn injury recover psychologically and socially within one year, and begin to integrate back into their normal environments such as school and community activities (Horridge, Cohen, & Gaskell, 2009). Horridge, Cohen, and Gaskell (2009) stated that not only does the burn injury affect the child, but the parents/adults as well. Parents had to regain

their confidence post burn injury including their abilities to protect the child, the child's ability to take care of themselves, and the school's ability to keep the child from harm. If the parent/adult is having difficulty in these areas, it can inhibit or slow the recovery process for the child. Parents may become overly anxious and not allow their child to participate in certain activities due to intensity of activity. "Psychiatrist, psychologist, and social workers assist the burn team in helping survivors and their families with interventions that assist patients during hospitalization as well as with the transition back into society" (Rimmer, Fornaciari, et al. 2007, p. 335).

Effects of Self-esteem and Burn Injuries with Adolescents

Self-esteem is define as "the level of global regard that one has for the self as a person" (Robert et al., 1999, p. 581). Self-esteem is part of a person that is not fixed, therefore self-esteem changes during daily or experiences throughout life. During the transition from childhood to adulthood, adolescent's self-esteem fluctuates across this timeline (Robert et al., 1999). Individuals who have experienced a burn injury develop a set of coping mechanisms for stressful situations and circumstances experienced post burn injury. "Coping refers to a person's cognitive and behavioral efforts to manage stressful situations and accompanying negative emotions" (Bras et al., 2007, p. 159). Bras et al. (2007) found statistical significance between avoidance, as a mechanism to handle stress, and levels of depression and hopelessness. They found that individuals who used avoidance as a defensive mechanism displayed higher levels of depression, post traumatic stress disorder (PTSD) symptoms, and lower QOL.

Role of Occupational Therapy and Burns

"Occupational therapist functions as an integral member of the burn care team and assists clients in achieving an optimal level of independence and a satisfying life style after a burn injury. With early assessment and ongoing occupational therapy intervention, an individual recovering from a burn injury should be able to return to a functional life style more rapidly" (McGourty, Givens, & Fader,1985, p.793). Occupational Therapy would be beneficial in facilitating a smooth transition into the community. Occupational therapists play a significant role in the recovery of adolescence after burn injuries. Occupational therapists view adolescence as a crucial time where the main focus is on identity and social roles within their environment. Occupational therapists not only have the responsibility of dealing with the physical aspects such as the scarring, strength, and joint mobility but they also keep in mind the psychosocial aspects of the clients as well (i.e., self-esteem, community involvement, social interaction and assertiveness).

Occupational Therapists do not work alone; they are joined by a burn care team that could consist of doctors, physical therapist, speech pathologist therapists, psychologists, psychiatrists, school teachers, etc. The team members work closely together and keep everyone on the team updated with progress of the patient.

Types of Assessments

There are many different types of assessments an occupational therapist can do with a client in order to gather the necessary information that is needed to start the

treatment process. With clients after burns, assessments are critical because occupational therapists are not only looking at the physical limitations of movement but they are also looking at the psychosocial aspect of the client as well. The type of information therapists want to gather from their clients and how much time their clients can sustain to answer or perform can be a key element with assessments and interventions. The type of assessment also depends on the phase a burn survivor is in such as; intensive care unit (ICU), acute care, inpatient rehabilitation or outpatient rehabilitation. The following series of assessments are examples of evaluations that can be used with clients who have experienced a burn injury.

Self-perception profile for adolescents (SPP-A).

The SPP-A is 45-item questionnaire assessment that was developed by a man named Harter. This assessment was designed to measure adolescents' judgments of their overall competence. There are eight subdomains of competence which include scholastic competence, social acceptance, athletic competence, physical appearance, behavior conduct, job competence, close friendship and romantic appeal as cited in Robert et al., 1999. This assessment looks at the importance of each subdomain and difference between the level of competence and the level of importance. Psychometric properties of the SPP-A have been studied and found to be reliable and valid. "The SPP-A is based on William James' theory of self-esteem" (Robert et al., 1999, p. 582). Williams (believed) that people with a high self-esteem believed they were competent in areas they viewed important and therefore disregarded the importance of the domains they were not competent in. People with low self-esteem, Williams believed,

were unable to identify the importance of each of these subdomains and the impact they had on their life and therefore were more likely to become depressed or anxious (Robert et al., 1999).

Robert et al. (1999) found differences in the subscales of the assessment between those who had been burned and the normative group. The study showed that burn survivors scored lower on athletic competence and physical appearance, meaning they perceived themselves as being less competent athletically and less physically attractive then their non-burned peers. The study also showed that burn survivors appeared to be more socially competent and in the work place compared to their non-burned peers. In the other areas of the subscales of scholastic competence, romantic appeal, behavioral conduct and friendships, the two groups had no significant differences (Robert et al., 1999).

Rosenberg self-esteem scale.

"Rosenberg Self-Esteem Scale is a valid, reliable, self-report measure of global self-esteem" (Rimmer, Fornaciacri, et al., 2007 p. 337). The Rosenberg Self-Esteem Scale consists of 10 questions which are answered using a four-point scale, ranging from strongly disagree to strongly agree. The questions relate to people's feelings of self worth and self acceptance (Rimmer, Fornaciacri, et al., 2007). The Rosenberg Self-Esteem Scale is a good tool to use for a pre- and post-effects of treatment, distinguishing how a client feels about oneself prior to treatment and how they feel post treatment.

The study by Rimmer, Fornaciacri, et al. (2007) used the Rosenberg Self- Esteem Scale with those adolescents who attended a burn camp. The participants were given the assessment before camp and after camp. Those who attended the camp both years maintained the same level of self-esteem from the first burn camp into the second burn camp. During year two of the burn camp the burn surviving children reported to have a significantly lower self esteem score compared to the comparison group of non-burned children. However, the burn surviving children reported to have a similar and comparable score to the group of non-burned children (Rimmer, Fornaciacri, et al., 2007).

Coping with burns questionnaire (CBQ).

The CBQ is a questionnaire that consists of primarily burn-related or trauma-related questions. The CBQ has 33 items that are further divided into six scales. The six scales includes: emotional support, optimism/problem solving, avoidance, revaluation/adjustment, self control and instrumental action (Willebrand, Anderson, Kildal, and Ekselius, 2002). Avoidance looks at the characteristics of putting forth effort to divert attentions away from the accident or difficulties a person may be experiencing. Self-control looks at having control over a person's expression of feelings. Emotional support is when one seeks out social support of the emotional kind. Instrumental action looks how a person actively seeks out support or actively problem solves for one's self. Revaluation-Adjustment is when a person makes statements about changing/adjusting and limiting their thoughts about the accident in order to feel better. The last subscale Optimism-problem solving looks at how a person puts forth effort in

making things work by using cognitive strategies and having a positive outlook for their future (Bras et al. 2007). These constructs are important because high levels of emotion-focused coping with low levels of acceptance coping have been found to be correlated with Post Traumatic Stress Disorder (PTSD) and with emotional stress. Avoidance of coping has been found to also be related to PTSD and with a lower quality of life (Bras et al., 2007).

The study by Willebrand et al. (2002) looked at the coping patterns, health status and personality traits of 161 adults who had been burned. The results of the CBQ were divided up into 3 clusters: extensive copers, adaptive copers, and avoidant copers. The extensive copers were found to use the most coping and they were in an intermediate role with the health status and the personality trait of neuroticism. The adaptive copers used strategies of emotional support and optimism/problem solving and they showed the highest health status ratings. The Avoidant copers used the strategy of avoidance the most and showed low evidence of using emotional support and optimism/problem solving and the highest rates of neuroticism and aggression (Willebrand et al., 2002).

Cognitive emotion regulation questionnaire (CERQ).

The CERQ is a 36 item self-report scale that is used to assess cognitive coping strategies. The CERQ questionnaire is measured with a five-point likert scale ranging from almost never to almost always (Liber et al., 2008). The questionnaire was "specifically designed to look at the cognitive components of emotion regulation" (Jermann, Van der Linden, Acremont, and Zermatten, 2006, p. 126). The questionnaire is broken down into nine subscales consisting of: self-blame, acceptance, rumination,

positive refocusing, refocusing on planning, positive reappraisal, putting into perspective, catastrophizing and blaming others (Liber et al. 2008). Liber et al. found that there were two factors involved which were active coping styles and passive coping styles. The results showed adolescents to be higher in the passive coping styles that they were in the active coping styles.

Beck depression inventory.

In the article by Bras et al. (2007) used the Beck Depression Inventory assessment. In this article the assessment was used to assess depression among adolescents within 2 weeks after a burn injury. Depression is measured by scores ranging from 0 to 63, the higher the score equals the most depression experienced. If a score is less than 4 it is considered as denial and scores over 40 would suggest characteristics of histrionic or borderline personality disorder. The study found higher levels of anxiety was correlated to higher levels of depression. The study also found that higher levels of hopelessness were correlated with higher levels of anxiety and higher levels of depression; researchers also found a significant correlation between avoidance and depression. Overall “51.43% reported not being depressed, 20% reported mild depression, 21.43% reported moderate depression and 7.13% had severe depressive symptomatology” (Bras et al. 2007, p. 161).

Youth self-report (YSR).

The YRS is a self-rating questionnaire of adolescents’ self-perception of “personal adaptive functioning and emotional and behavioral problems in the past 6 months” (Liber et al. 2008, p. 777). The questionnaire contains 112 items that can be broken into

two categories of internalizing and externalizing and are scored on a three-point scale (Liber et al. 2008).

Liber et al. (2008) joined the CERQ and the YSR together with the Child Behavior Checklist (CBCL), Children's Depression Inventory, and the Quick Big Five in order to assess the psychological effects of 62 individuals who had experienced a mild to moderate burn injury eleven years prior to the study. Results showed that the levels of depression and problem behavior were significantly lower than the average adolescent population. Overall, adolescents who suffered a mild to moderate burn injury were more likely to overcome the barriers or challenges that burns are thought to create. A small percentage of participants were fully healed after 10 years and no longer receiving any treatment (Liber et al., 2008).

Occupational Therapy Interventions

Burn protocol.

In order for a client with a burn injury to recover and reach the maximum amount of self-esteem they can, they have to receive proper care and treatment of their burns. Occupational therapy interventions differ depending on which phase the client with burn is in (ICU, acute, inpatient rehabilitation or outpatient). When a client with burns is in the ICU (initial injury to about 72 hours post burn), the therapist concentrates on splinting and positioning the most (Pessina & Orroth, 2008).

A client with a burn injury who has any joint that is a superficial partial-thickness injury (first degree) or worse is a candidate for wearing a splint. Splints would preferably be fabricated and applied in the initial visit. The time a splint is worn is very dependent

upon the clients' ability to function and movement of the extremity that is splinted. If a client is unable to actively move the extremity throughout daily tasks, a splint should be worn at all times except for when they are in therapy sessions or changing their dressings on the wounds. On the other hand, a client who is able to actively move their extremity may be asked to only wear their splint at night. Splints may be applied directly over the dressing of a wound and usually secured with gauze wrap or a Velcro strap (Pessina & Orroth, 2008).

Occupational therapists also focus on positioning while clients are in the ICU. Positioning is important for persons with burn injuries as it is helpful for preventing contractures and pressure ulcers (Pessina & Orroth, 2008).

In the acute phase of a client's stay, the occupational therapist focuses on range of motion (ROM) and strengthening through multiple interventions. Therapists still continue to splint and position but they also include exercise/activity, pain management, environmental adaptations, and patient and family education in their intervention process. During the acute phase, splinting and positioning are often used with preoperative care (which is the time line of 5-10 days post skin grafting procedure). Occupational therapists use splinting and positioning to immobilize the areas that have been grafted to allow the grafts to adhere and heal properly in order to continue in the recovery process (Pessina & Orroth, 2008).

When a burn survivor is in an inpatient rehabilitation facility they still require 24 hour care which could be because they are unable to care for themselves, need more strengthening or have decreased activity tolerance, etc. Occupational therapists in this

setting focus their interventions on ROM, strengthening, activity tolerance, sensation, coordination, scar management, massage, pressure dressings/garments, self-care and home management skills, patient and family education, and being supportive with psychosocial deficits. Interventions like these all help a client to regain their function and return to their prior level of functioning (Pessina & Orroth, 2008).

Outpatient occupational therapy focuses on many of the same interventions that inpatient rehabilitation, however, the client does not require 24 hour care. They are now able to function independently and are stable enough to return to their home. Clients may still be in need of assistance throughout the day from aids such as family members in occupations like bathing, showering, dressings, garments or cooking for example (Pessina & Orroth, 2008).

Self –esteem building.

Self-esteem plays a large factor in adolescents' lives, as it is an emotional aspect that defines a person's perspective of how they feel towards themselves. Self-esteem may be difficult for an adolescent who has received a burn injury as the burn may hinder their thoughts and feelings towards themselves. Not only do individuals who have a burn injury worry about their self-esteem, they also worry about how their peers view them. Many burn survivors feel self-conscious, guilty, awkward or stigmatized by their disfigurations caused by the burns (Rimmer, Fornaciari, et al., 2007). Unwanted stares from their peers may come from their disfigurations, scars, pressure garments, or splints. Although pressure garments and splints are provided to help heal and protect the skin they still create unwanted attention from others. Severity of one's burns may

also affect how a person views themselves as a person. In a study by Lawrence, Fauberach, Heinberg, and Doctor (2004), it was found that the severity of a burn on one's body had a high correlation with their body esteem and how they viewed themselves externally.

Gaskell (2007) showed that burn camps are helpful for adolescents to improve on their self-esteem, confidence, and coping skills. The participants reported they felt better about themselves after they had seen others who were also burned and formed a relationship with those peers who were going through the same struggles they themselves were going through. One participant stated they learned "there are people who are worse off than me who are beautiful people inside and are not bothered-this is how I should be" (Gaskell, 2007, p. 152).

Parents also play an important role in the development of an adolescent's development of self-esteem and involvement. In the study by Horridge, Cohen, and Gaskell (2010), parents were found to have an effect on their child's development. Parents were found to make decisions for their children, therefore the children were becoming more passive and not given a chance to make their own decisions independently and live like a normal adolescent.

Social support is also important to provide to an adolescent when developing self-esteem. Social support is related to the concept of hope, which is a positive attribute that should be cultivated in those who are suffering from either physical or psychological scars resulting from a burn injury. Research has shown those who receive social support from friends, family or their community develop a more positive way of

thinking and therefore increase their self esteem and decrease their depression as well (Cox, Call, Williams, and Reeves, 2004).

Social interaction.

Social interaction can be a significant struggle for those adolescents who have suffered a burn injury. Adolescents face an even greater battle than adults who have been burned in terms of social interaction. As adolescents go from childhood through high school, acceptance is based on multiple factors including: appearance, attire, and family income. For those adolescents who have been burned, many struggle with being accepted based on their outward appearance. They are expected to return to their lives with their family and friends and learn how to be social in a world that highly discriminates against differences that are visible. Parents may also hinder their children's social interaction skills as demonstrated in the article by Morridge et al. (2010) where they found the parents were less likely to allow their children to participate in more dangerous activities, thus decreasing social interaction for their child.

Adolescents with scars from burn injuries also face being bullied at school which can also discourage their thoughts of social interaction and not wanting to be involved or interact with their peers. In the article written by Rimmer, Fornaciari et al. (2007), the authors looked at bullying with adolescents first by having them watch the Harry Potter and *The Sorcerer's Stone* movie and then having a small discussion on what bullying consists of. The group consisted of 250 burn survivors. After the preview of the movie along with the discussion, a total of 61% reported being bullied at school, 25% reported

getting headaches or stomach aches, and 12% reported staying home from school due to the bullying (Rimmer, Fornaciari et al., 2007). When looking at the high percentages of adolescents who have reported being bullied, staying home from school, or avoiding the problem, shows the importance of a program that could be implemented. This program could help those who have a burn injury to overcome the lack of acceptance they feel from their peers with the stares and the gestures they have to go through on a daily basis.

Blakeney et al. (2005) implemented a 4-day intensive social skills program with adolescents who had a burn injury 2 years prior. The interventions used were a psychoeducational group focusing on learning skills from observing others who had disfiguring scars and how they interacted, practicing the skills learned in a supportive atmosphere, and focusing on their goals. After the 4-day program, the participants who had been burned showed a significant improvement compared to the control group of the study. The adolescents who participated in this program improved on two separate levels of internalizing, (i.e. which is how they feel), and externalizing, (i.e., which is how they behave with others).

Education for family and community.

Individuals who have experienced a burn injury go through phase of burn care in the recovery process. In occupational therapy, clients receive treatment including dressing, garments, positioning, pain management, scar massage, strengthening, ROM exercises, coordination, ADLs, and psychosocial evaluations focusing on self-esteem, social interaction, assertiveness, and reintegration back into the community. Clients and

family are educated with all aspects of burn care in order to return home and increase their independence and participation in occupations for an optimal quality of life (QOL). The community is another key population for education regarding burn rehabilitation and self-esteem building.

There are many educational resources available to individuals who have experienced a burn injury, their families and communities. These resources may be easily located on the internet, journal articles, text books and pamphlets through a local hospital or rehabilitation facility. These resources may include examples of where to find burn units, insurance questions, available clinics, therapy programs, research on burns, and different types of burn care equipment. Therapist, support groups, physicians, nurses and the majority of healthcare professionals can provide proper resources for those patients recovering from a burn injury.

Summary

In summary this chapter provides an overview of the research that has been done thus far for burn survivors. The psychosocial and physical aspects can inhibit/hinder daily occupations that one may inquire throughout their life. The next chapter will provide a brief overview of the self-esteem program and its manual. This manual will contain intervention strategies, education techniques with family members and community, and community reintegration.

CHAPTER III

METHODOLOGY

The self-esteem program and manual for occupational therapy (OT) practitioners to utilize with adolescents who have experienced a burn injury was created to provide practitioners with the tools and resources needed during the evaluation, intervention planning and implementation and discharge process. One-page synopses of selected assessments were created to assist the practitioners in finding the best assessments to use with their clients. The authors felt the best assessment for a pre- and post-test was the Coping with Burns Questionnaire (CBQ) and therefore is provided at the front of the *Building Self-Esteem One Adolescent at a Time* manual. The CBQ was chosen based on its variety of categories included on the questionnaire. The CBQ consists of 33 items and is divided into six scales: emotional support, optimism/problem solving, avoidance, revaluation/adjustment, self-control and instrumental action (Bras, Loncar, Brajkovic, Grekurek, & Mickovic, 2007). Practitioners are encouraged to use the interventions and relevant assessments based on the clients' individual needs. The interventions may need to be modified in order to meet these needs and OT practitioners are given permission to do so.

The self-esteem program and manual is intended to be implemented with adolescents between the ages of 10 and 21 who have experienced a burn injury. Those who are younger than 10 and older than 21 were not included in the target population

as the therapeutic approaches addressed psychosocial issues and viewed the ages between 10 and 21 as a critical time where adolescents develop their own personal identity.

The need for such a product was established by conducting a thorough review of literature regarding psychosocial issues such as: behavior, self-esteem, assertiveness, social interaction, physical appearance, community integration, education and prolonged nature of burn care and overall quality of life. A literature review, including occupational therapy theoretical and practice literature, guided the Self-Esteem Program developed for adolescents who have experienced burns and are returning back into the community. The articles included in the literature review were retrieved from PubMed, CINAHL, Google Scholar, The American Journal of Occupational Therapy, and selected professional textbooks. Common themes in the literature review were identified, particularly in relation to psychosocial issues, multi-disciplinary intervention approaches and occupational functioning of adolescents who have experienced a burn injury.

Based on the emergent themes, the literature review in Chapter II was structured in a logical manner that supported these themes and findings. Chapter II focused on psychosocial aspects related to adolescents who had experienced a burn injury, assessment measures for self-esteem and psychosocial issues, and intervention approaches from both an OT and interdisciplinary healthcare perspective. Multiple authors explored the effects of burns and self-esteem, social skills, self-confidence, burn protocols, and overall quality of life following a burn injury. Assertiveness and

community involvement were two areas that were lacking in the literature regarding adolescents recovering from a burn injury. These two areas are important aspects that also play an important role in adolescent's development of self-esteem and self-confidence.

For that reason assertiveness and community involvement are two areas that are incorporated into this self-esteem program and manual entitled *Building Self-Esteem One Adolescent at a Time*. OT interventions focusing specifically on assertiveness skills were developed along with activities provided for burn survivors to be involved in the community. The activities within the community are intended to help burn survivors not only practice assertiveness skills but also practice their social interaction which will lead to an increase in their self-esteem and self-confidence. The findings support the need for OT practitioners to play a greater role in addressing these areas as there will be a significant positive impact on an adolescent's occupational performance.

Prior to the development of the product, an occupation-based theoretical model was selected to guide the structure and content of the program and manual. The Occupational Adaptation (OA) model was utilized to outline and organize the format of the self-esteem program and manual. The OA model looks at the occupations which focus on actively involving the person and providing meaningful, client-centered, therapeutic sessions to the person that are either tangible or intangible (Cole & Tufano, 2008). OT practitioners are encouraged to modify and adapt the interventions provided in the program to the needs of each adolescent.

The main goal of OA is to achieve relative mastery over the environment by encompassing a highly interactive self-organization process developed by an individual. The OA model allows adolescents to develop relative mastery in response to the challenges that are presented to them after experiencing a burn injury.

The OA model was also utilized when structuring the interventions provided in the *Building Self-Esteem One Adolescent at a Time* manual focusing on the needs of the adolescent clients who are receiving therapeutic services from OT practitioners. Adolescents who have experienced a burn injury are faced with many life-altering occupational challenges, which in turn affect their psychosocial functioning. The effects of psychosocial functioning may also impact the quality of occupational performance of the adolescents. By utilizing the OA model, adolescents are able to work through their challenges they may face when out in their community with the guidance from the OT practitioner. Working and learning to adapt to the situations adolescents face after experiencing a burn will result in effective, efficient, and a more satisfying role performance across their lifespan and also increase their overall self-esteem.

The reader is directed to Chapter IV for more specific information on the structure and content of the product. Detailed information about the assessments and interventions is provided as well. Chapter IV explains the importance of each section provided in the *Building Self-Esteem One Adolescent at a Time* manual and its relation to the psychosocial aspects of adolescents who have experienced a burn injury.

CHAPTER IV

PRODUCT

In comparison with the literature, there is little emphasis on the psychosocial aspects of interventions by occupational therapists (OTs) with adolescents who have sustained burn injuries. Adolescent burn survivors may experience a wide range of maladaptive issues such as concerns with: behavior, self-esteem, assertiveness, physical appearance, community integration, education and prolonged nature of burn care. Guided by the Occupational Adaptation (OA) frame of reference (Schkade & McClung, 2001; Schkade & Schultz, 1992a, 1992b), a self-esteem program and manual developed by the authors, is meant to assist OT practitioners through the evaluation and intervention process with adolescent burn survivors. More specifically, the manual focuses highly on the psychosocial aspects of burn injuries pertaining to self-esteem and reintegration into the community.

The self-esteem program and manual is intended to be utilized by OT practitioners working in inpatient and outpatient burn care settings who provide therapeutic services to adolescent clients between the ages of 10 and 21 who have sustained a burn injury. The purpose of this program will be for occupational therapists to assist adolescent burn survivors in developing and regaining their self-esteem and confidence as they return back to the community. This will assist adolescents in realistic

analysis of life situations, application of the techniques provided within the program, and experiencing an improved psychosocial outcome following burn injury.

The program that has been developed here includes activities focusing on: client and family education, self-esteem with peers and acquaintances, assertiveness/social interaction, rehabilitation equipment worn and the reasons needed, and community education and outreach.

The Occupational Adaptation Model

The OA model has two concepts that have helped guide and implement the making of this program and manual. The two guiding components of Occupational Adaptation are that it describes a normal human phenomenon called adaptation and it allows occupational therapists to plan, guide, and implement interventions within the OT scope of practice (Cole & Tufano, 2008). “OA focuses on the interaction of the person, the environment, and the internal adaptive processes that occur when individuals engage in their daily occupations” (Schkade & Schultz, p. 464, as cited in Schultz, 2009). The main goal of OA is to achieve relative mastery over the environment by encompassing a highly interactive self-organizing process developed by an individual.

OA proposes six guiding assumptions about the relationship between human occupational performance and human adaptation:

1.) Competence in occupation is a lifelong process of adaptation to internal and external demands to perform.

2.) Demands to perform occur naturally as part of the person’s occupational roles and the context (person-occupational-environment interactions) in which they occur.

3.) Dysfunction occurs because the person's ability to adapt has been challenged to the point at which the demands for performance are not met satisfactorily.

4.) The person's adaptive capacity can be overwhelmed by impairment, physical or emotional disabilities, and stressful life events.

5.) The greater the level of dysfunction, the greater is the demand for changes in the person's adaptive processes.

6.) Success in occupational performance is a direct result of a person's ability to adapt with sufficient mastery to satisfy the self and others. (Shultz, 2009, p. 463)

The above six assumptions guided the development of this program and manual by helping prioritize the challenges and difficulties that adolescents face after experiencing a burn injury. In regards to assumption number one, adolescents are at a crucial age where adaptation will be a lifelong process during engagement in their daily occupations. Interventions focus on the context or environment which enhances adolescents' performance and daily activities, enhancing the ability for successful adaptation. Interventions also focus on the psychosocial/emotional disabilities (i.e. self-esteem, assertiveness, social interaction, etc) an adolescent post-burns faces when returning back to their community.

The OA model looks at the occupations which focus on actively involving the person, providing sessions that are meaningful to the person and finally including a product that may be tangible or intangible (Cole & Tufano, 2008). Adaptive capacity is the capability an individual has to perceive the need for change, modification, or

adaptation of an occupational response in order to respond with positive relative mastery (Schkade & Schultz, 2003).

A desire for mastery includes the internal factors that occur within a person and for the adolescent recovering from a burn injury, specifically, sensorimotor, cognitive and psychosocial systems. These three systems are unique to each individual and can be affected by genetics, biological and phenomenological influences (Schultz, 2009).

Demand for mastery includes the external factors that affect the person. Occupational environment represents the overall contexts within which the person engages in their occupational role. Three aspects of the environment include work, play/leisure and self-care. For the adolescent recovering from a burn injury each of these areas can be affected by the physical, social and cultural influences on the individual's experiences (Schultz, 2009).

Components of the Self-Esteem Program

Self-esteem is vital to a person's daily living; without self-esteem individuals struggle to make it through their day and can become depressed. In order to increase adolescents' self-esteem, worksheets have been made to be incorporated into the OT intervention sessions. The worksheets were made specifically keeping the Occupational Adaptation model in mind. Adolescents who have suffered a burn injury will use these worksheets to see the progress of how they have improved throughout the program.

Social interaction/assertiveness activities have been incorporated in this program to enhance an individual's desire and demand for mastery in all contexts of work or school, play/leisure, and self-care. The worksheets included in the program

focus on the challenges adolescents may encounter in order to create positive adaptive responses.

Patient/family education is an important concept to the program. The family often can supply a natural and supporting environment for the individual in the recovery process. This component will enhance meaningfulness to the interventions, activities, and development of goals during the duration of program. Therapeutic use-of-self is an important aspect of therapy when developing OT goals and interventions as it provides evidence-based client-centeredness.

Burn care education is also important to the program. In discussing reasons for wearing garments, splints, masks, etc., with an occupational therapist, an individual will have a better insight into the recovery process. Therefore, through education and discussion with the OT, individuals have the capability to adapt more easily to challenges faced during daily occupational tasks and situations.

Community reintegration is a major part of the recovery process of an adolescent as this is the most crucial time in their lives to establish their own personal identity. It is difficult for adolescents who have suffered a burn injury and are now facing self-esteem issues along with the potential lack of social interaction and assertiveness skills to return back to their community comfortably. There are many pertinent aspects of community reintegration including: home, school, work, peer/social interaction, and daily occupations. Many adolescents may worry about what people will think about them or say to them. In order to make adolescents feel comfortable in returning back to

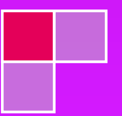
the community it is important to not only have activities that involve community outings but to also prepare the individual's community and school for what may occur.

After completion of the OT self-esteem program, an individual will be able to distinguish their adaptive capacity and their occupational challenges faced throughout their daily lives. The adaptive responses developed throughout the program will become the beginning of a lifelong process as a person who has suffered a burn injury will continue to face and overcome occupational challenges.

Summary

Chapter IV includes interventions and assessments for adolescents focusing on self-esteem, assertiveness, social interaction, coping with a burn injury, and community reintegration. Chapter V will summarize the purpose of the program, key information regarding the implementation of the product, and future recommendations. All intervention activities provided within the self-esteem manual were developed by the authors and their original work. The authors give OT practitioners full permission to copy pages with credit provided to the authors.

Building Self-Esteem One Adolescent at a Time!



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Introduction

This section contains occupational therapy (OT) interventions in relation to the psychosocial aspects of adolescents, ages 10-21, who have experienced a burn injury. The interventions are guided by the Occupational Adaptation (OA) model (Schkade & McClung, 2001).This manual consists of an overall outcome measure, selected assessments, and interventions that may be implemented and facilitated by occupational therapists during OT intervention sessions.

OT Interventions include: self-esteem, assertiveness/social interactions, and community reintegration. The goals of these interventions are to enhance these areas and develop the skills required for an appropriate adaptive response regarding occupations of daily living for a positive sense of self-esteem and relative mastery. This program is designed to be implemented in congruence with the typical burn care treatment where clients will receive the sensorimotor aspect of OA.

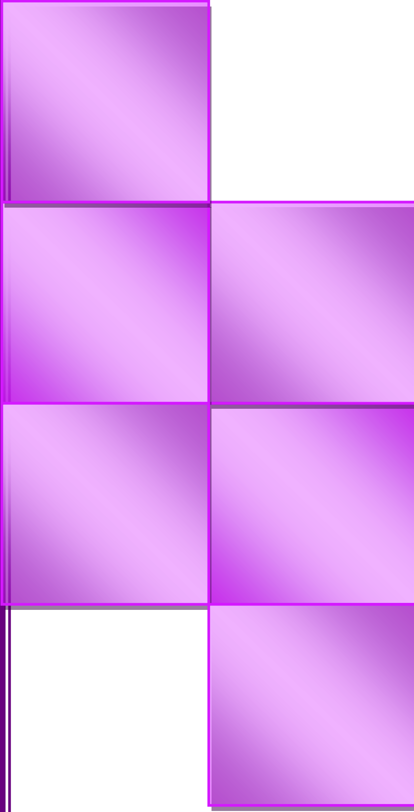
For additional resources on interventions related to psychosocial aspects and occupational therapy:

Carrell, S. (2000). Group exercises for adolescents: A manual for therapists (2nd Ed.). Thousand Oaks: Sage Publications, Inc.

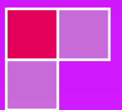
Occupational Adaptation Model

The Occupational Adaptation (OA) model has two concepts that have helped guide and implement the making of this program and manual. The two guiding components of OA are that it describes a normal human phenomenon called adaptation and it allows occupational therapists to plan, guide, and implement interventions within the OT scope of practice (Cole & Tufano, 2008). The main goal of OA is to achieve relative mastery over the environment by encompassing a highly interactive self-organizing process developed by an individual.

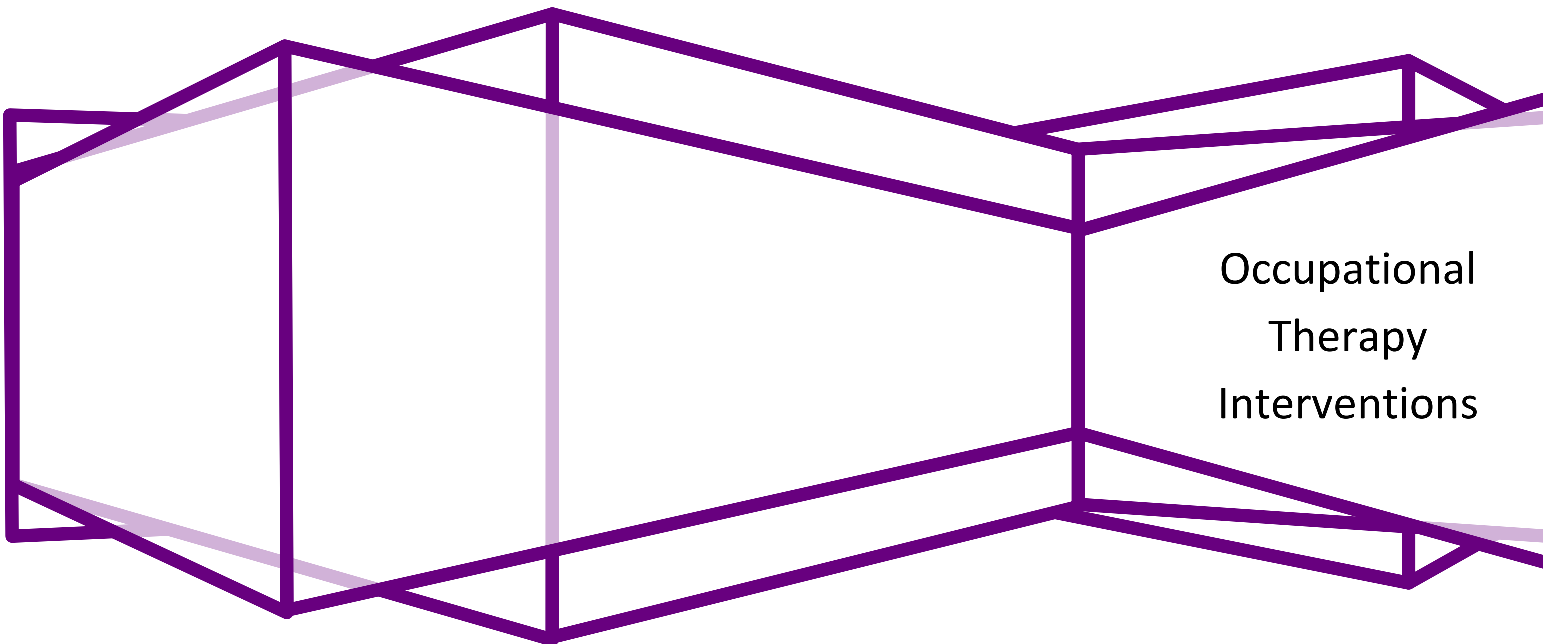
The assumptions of OA guided the development of this program and manual by helping prioritize the challenges and difficulties that adolescents face after experiencing a burn injury. Occupational Adaptation assumes that every person system is present in every response. A person system includes: sensorimotor, cognitive, and psychosocial. The three aspects of the person system develop the plan for the occupational response called adaptation gestalt which is seen as the overall process inherent for the adolescent participants in this program (Schkade & McClung, 2001).



Psychosocial Interventions Provided by Occupational Therapy



Outcome Measure



Pre/Post Test

Coping with Burns Questionnaire (CBQ)

The CBQ is a questionnaire that consists of primarily burn-related or trauma-related questions. The CBQ has 33 items that are further divided into six scales. The six scales include: emotional support, optimism/problem solving, avoidance, revaluation/adjustment, self-control and instrumental action (Willebrand, Anderson, Kildal, & Ekselius, 2002). The scale used in the CBQ is based on the theory of coping as a process. The participants are instructed to think about how much they used the strategies presented in front of them and rate them on a 4 point scale. Ratings are as follows: 1-does not apply/not used; 2-used somewhat; 3-used quite a bit; and 4- used a great deal (Bras et al., 2007).

Authors: Mimmie Willebrand, Morten Kildal, Lisa Ekselius, Bengt Gerdin & Gerhard Anderson.

Purpose: The Coping with Burns Questionnaire (CBQ) was designed to measure coping after a severe burn injury and discharge.

Description: The CBQ consists of 33 items divided into six scales: emotional support, optimism/problem solving, avoidance, revaluation/adjustment, self-control and instrumental action. The participants are instructed to think about how much they used the strategies presented in front of them and rate them on a 4 point scale. Ratings are as follows: 1-does not apply/not used; 2-used somewhat; 3-used quite a bit; and 4- used a great deal.

Setting: All settings

Time Required: Less than 10 minutes

Population: Adolescents and adults age 13 and older.

Reliability/Validity: Internal consistency is moderate to high with alpha values ranging from 0.56 to 0.83.

Cost: No cost

Source:
The Morris Rosenberg Foundation
Department of Sociology
University of Maryland
2112 Art/Sociology Building
College Park, MD 20742-1315

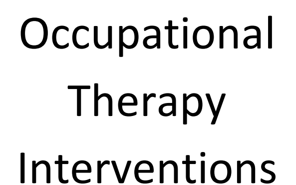
Additional Resources:

Willebrand, M., Andersson, G., Kildal, M., & Ekselius, L. (2002) Exploration of coping patterns in burned adults: Cluster ananlysis of coping with burns questionnaire (CBQ). *Burns, 28,* 549-554.

Bras, M., Loncar, Z., Brajkovic, L., Gregurek, R., & Mickovic, V. (2007). Coping with severe burns in the early stage after burn injury. *Coll. Antropol. 31, 1,* 159-163.

Building Positive Self-Esteem

This section entails worksheets and directions regarding self-esteem with adolescents who have experienced a burn injury.



JOURNAL WRITING FOR SELF-ESTEEM

Directions:

- Each week, give the client a copy of the Journal Worksheet presented on the following page.
- Ask the client to fill out the items and bring the worksheet back to the first OT session/meeting of the following week.
- Discuss with the client how they felt the past week and if there was anything else that they wanted to write down but didn't.
- Discuss how the client feels they are progressing each week when faced with these situations. For example:
    - Do they feel more confident?
        - If yes, why do they feel more confident (did something happen in the past week to make you feel this way)?
        - If no, why do they not feel more confident and what can they do for the following week to help their confidence?
    - Do they feel they are improving with their responses?
        - What have they done this past week to make them feel they are improving? What changes have they felt they have made in their responses in the past week?
        - If they do not feel they are improving in their responses what changes can they make in order to help them with this process?

A situation that hurt me emotionally this week was…

____

____

____

I responded to the situation by…

____

____

____

After the situation was over I felt…

____

____

____

A situation that made me feel good this week was…

____

____

____

I responded to this situation by….

____

____

____

After the situation was over I felt…

____

____

____

*This is an authentic work of the authors of this manual: Beck, K., & Miller, K., UND, 2011.

"I" STATEMENTS

"I" statements are an important part in the recovery process as it allows the individuals to become aware of how they feel when they encounter different actions throughout their day.

When I am made fun of I feel…

____

____

When I am yelled at I feel…

____

____

When I am stared at I feel…

____

____

When I am asked about my scars I feel…

____

____

When I am in public I feel…

____

____

*This is an authentic work of the authors of this manual: Beck, K., & Miller, K., UND, 2011.

I AM A UNIQUE INDIVIDUAL

Something unique about me is…

____

____

The thing I do best is…

____

____

Something I have accomplished…

____

____

Something I am talented at is…

____

____

My best characteristic about myself is…

____

____

I am most proud of myself when I…

____

____

I want to improve this about myself…

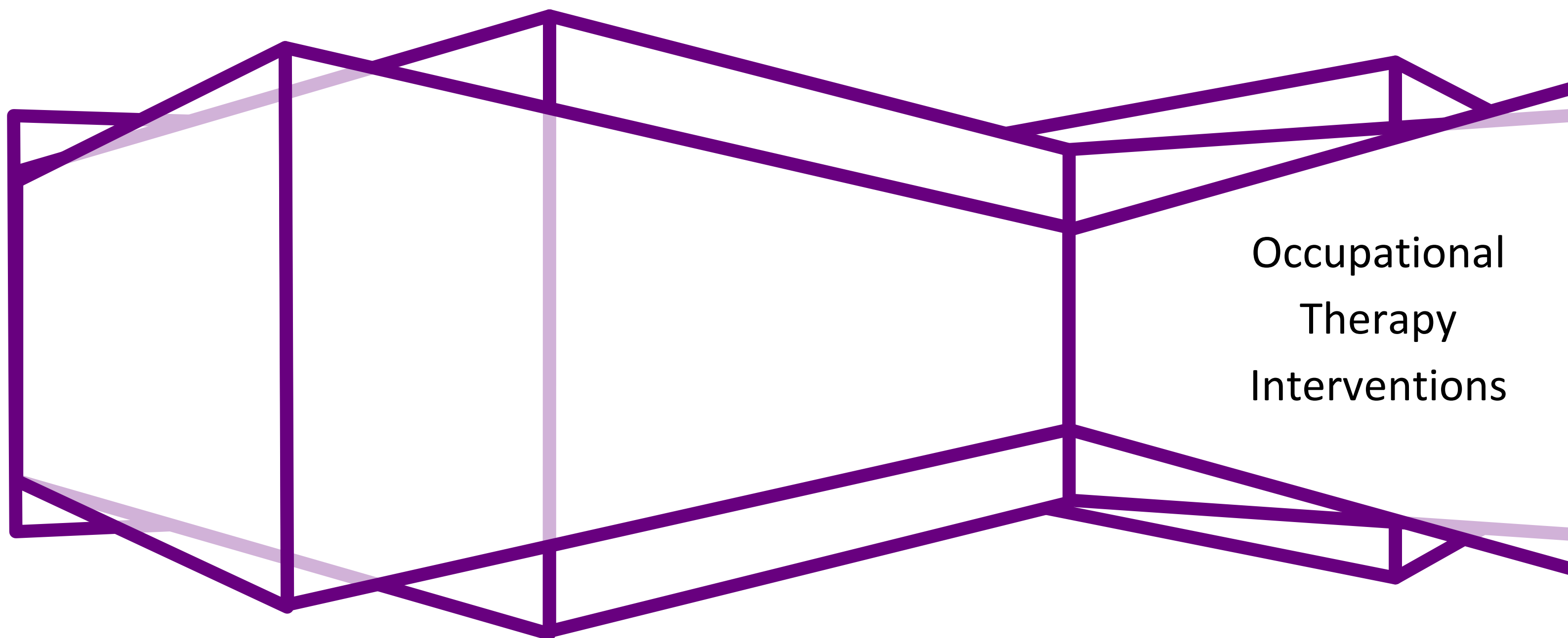
____

____

*This is an authentic work of the authors of this manual: Beck, K., & Miller, K., UND, 2011.

Assertiveness/Social Interaction

This section entails worksheets and directions regarding assertiveness for adolescents who have experienced a burn injury.



DEFINITIONS OF AGGRESSIVENESS

Before beginning the worksheets following this page go over each phase of assertiveness. The overall definitions will help give the client a better understanding of what type of assertiveness they are currently using and what type they think is best to use.

Aggressive

- Aiming to win regardless of the other person
- Standing up for your rights in such an aggressive way that the others rights are violated
- Manipulation, tricking others, getting revenge in subtle ways
- Humiliating, overpowering others to win
- Yells at others and points out the flaws in others

Passive

- Avoiding conflict
- Not standing up for yourself
- Not expressing your feelings or thoughts in an honest and truthful way
- Not making decisions for yourself
- Speaks quietly, avoids eye contact and may slump posture

Assertive

- Being true and expressing your thoughts and feelings
- Having a feeling of control in what you say and do
- Standing up for your rights and choices in a way that doesn't threaten/violate others rights
- Making clear, direct decisions about the appropriate way to behave.

Reference:

Dowling, T. (2000-2010). Career article 106: Assertiveness skills for women. *Articles and Guides.* Retrieved on April 18, 2011 from http://www.seekingsuccess.com/articles/art106.php

RESPONSE SITUATIONS

For the example provided below, give examples of the different types of responses.

Example:

You hear other people talking about your scars.

What would you say/do?

Aggressive Response:

____

____

____

Passive Response:

____

____

____

Assertive Response:

____

____

____

Once you have written down your responses to the situation find a partner and role play each response. After you have role played each response, discuss how each response made you feel and which response you felt was most effective in this situation.

*This is an authentic work of the authors of this manual: Beck, K., & Miller, K., UND, 2011.

RESPONSE SITUATIONS

For the example provided below, give examples of the different types of responses.

Example:

If someone tells you that you can't play on their team during Phy. Ed. because of the way you look.

What would you say/do?

Aggressive Response:

____

____

____

Passive Response:

____

____

____

Assertive Response:

____

____

____

Once you have written down your responses to the situation find a partner and role play each response. After you have role played each response, discuss how each response made you feel and which response you felt was most effective in this situation.

*This is an authentic work of the authors of this manual: Beck, K., & Miller, K., UND 2011.

RESPONSE SITUATIONS

For the example provided below, give examples of the different types of responses.

Example:

If someone tells you that no one will ever love you because of your scars.

What would you say/do?

Aggressive Response:

____

____

____

Passive Response:

____

____

____

Assertive Response:

____

____

____

Once you have written down your responses to the situation find a partner and role play each response. After you have role played each response, discuss how each response made you feel and which response you felt was most effective in this situation.

*This is an authentic work of the authors of this manual: Beck, K., & Miller, K., UND 2011.

RESPONSE SITUATIONS

In the space given to you below, write down one situation you have experienced in the past week that was **challenging** to you. Give examples of the different types of responses and put a star next to the response you used when faced with this example.

Example:

Aggressive Response:

____

____

____

Passive Response:

____

____

____

Assertive Response:

____

____

____

Once you have written down your responses to the situation find a partner and role play each response. After you have role played each response, discuss how each response made you feel and which response you felt was most effective in this situation.

*This is an authentic work of the authors of this manual: Beck, K., & Miller, K., UND, 2011.

RESPONSE SITUATIONS

In the space given to you below, write down one **positive** situation you have experienced in the past week. Give examples of the different types of responses and put a star next to the response you used when faced with this example.

Example:

Aggressive Response:

____

____

____

Passive Response:

____

____

____

Assertive Response:

____

____

____

Once you have written down your responses to the situation find a partner and role play each response. After you have role played each response, discuss how each response made you feel and which response you felt was most effective in this situation.

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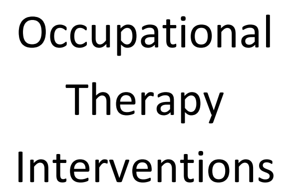
Community Reintegration and Adaptation

This section entails worksheets and directions regarding community reintegration for adolescents who have experienced a burn injury.



It is difficult for clients who have experienced a burn injury and are now facing self-esteem issues along with lack of social interaction and assertiveness skills to return back to their community comfortably. Many clients may worry about what people will think about or say to them. In order to make clients feel comfortable in returning back to the community it is important to not only have activities that involve community outings but also prepare the individuals community and school for what is to be expected.

It is important for clients to inform their communities about the recovery process (i.e. what the individual has gone through) and the successes they have gained during their hospitalization. Following this page are instructions for adolescents to use when creating a Microsoft™ PowerPoint® to present to the community. This activity is beneficial to the client as it allows them to gather information they would like their community/school to know about their recovery process before returning back into the community. The client is in charge of putting together information they would like to include in their *Microsoft™ PowerPoint®*. It is important for the therapist to work side-by-side with the client when creating the *Microsoft™ PowerPoint®* as the client may need assistance with proper wording and possible definitions. The following activity may take longer than one session and can be implemented into multiple sessions throughout the program.

What to include in the Microsoft™ PowerPoint®:

- Collaborate with the client on concerns they have about returning back to the community.
    - Discuss areas of concerns that the client wants to make notice to their school and community and include these in the presentation.
- Pictures of burns (if client agrees)
- Pictures of equipment that the client will be wearing.
    - If possible bring the equipment with for the community to look at
        - This includes splints, garments dressings and any durable medical equipment that they might need.
- The progression of the client from day one until the day you present.
    - What treatments were like and the interventions the client participated in.
    - What the interventions helped the client to do.
- The types of treatments the client has or is receiving and how they helped the client
    - Occupational therapy, physical therapy, speech language pathology therapists, nursing, physicians, socials workers, etc..
    - Purpose of skin grafting and where
- Conclude with any questions that the community or school might have.

*This is an authentic work of the authors of this manual: Beck, K., & Miller, K., UND, 2011.

Planning an Outing

Write down 3 places you would like to go in your community

1____________________________

2____________________________

3____________________________

Give a reason as to why you would like to go to these places

1_____________________________

2_____________________________

3_____________________________

List the possible barriers you might face at each of these places

1______________________________

2______________________________

3______________________________

List all the pros you can think of for going out into the community

1______________________________

2______________________________

3______________________________

4______________________________

5______________________________

6___________________________

7___________________________

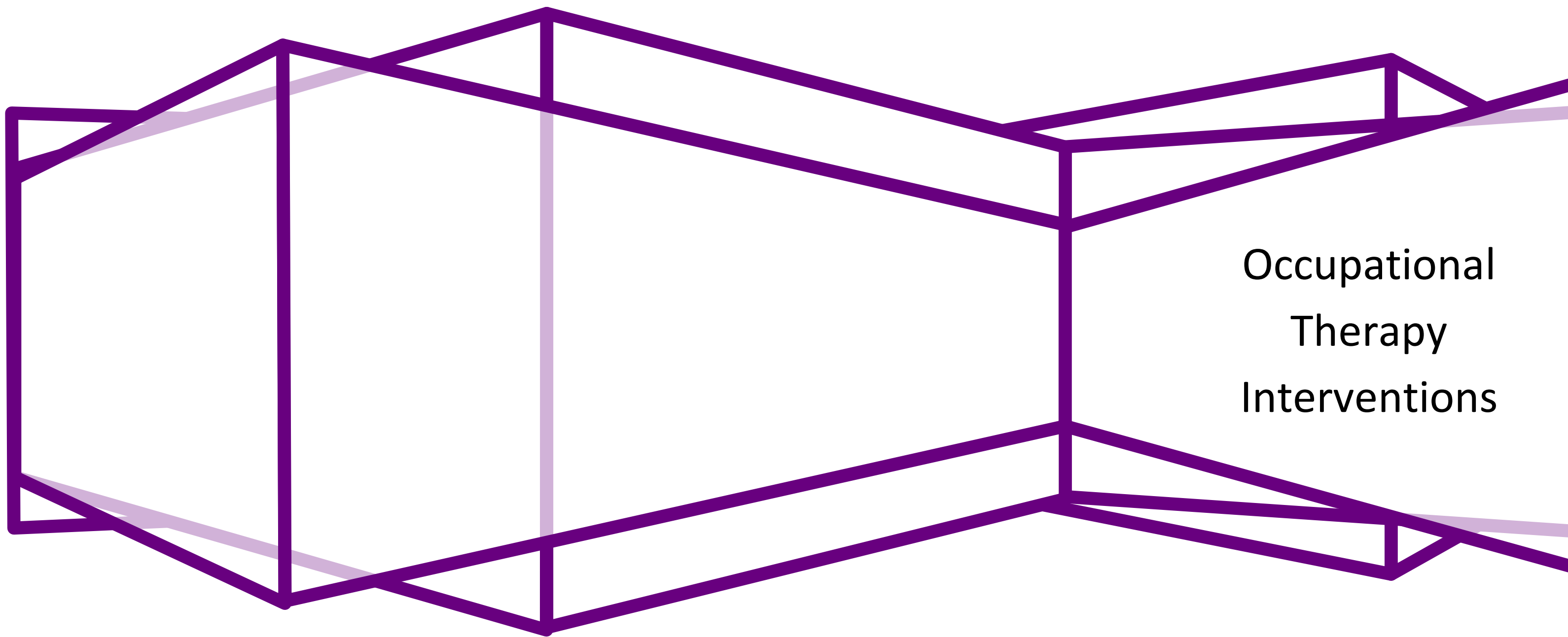
8___________________________

9___________________________

10__________________________

*This is an authentic work of the authors of this manual: Beck, K., & Miller, K., UND, 2011.

Family/Community Education

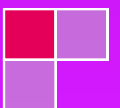


Family/Community Education

Individuals suffering from a burn injury go through phases of burn care in the recovery process. In occupational therapy (OT), clients receive treatment including dressing, garments, positioning, pain management, scar massage, strengthening, ROM exercises, coordination, ADLs, and psychosocial evaluations focusing on self-esteem, social interaction, assertiveness, and reintegration back into the community. Clients and family are educated with all aspects of burn care in order to return home and increase their independence and participation in occupations for an optimal quality of life (QOL). The community is another key population for education regarding burn rehabilitation and self-esteem building.

Additional Resources: internet websites (American Burn Association, etc.), journal articles, text books and pamphlets through a local hospital or rehabilitation facility.

Selected
Assessments



Authors: Mary Law, PhD, OT (C); Sue Baptistes, MHS, OT (C); Anne Carswell, PhD, OT (C); Mary Ann McColl, PhD, OT (C); Helene Polatajko, PhD, OT (C); Nancy Pollock, MSc OT (C)

Purpose: Individualized, client-centered measure designed to detect changes in a client's self-perception of occupational performance over time. The COPM facilitates collaboration between the client and the therapist in developing intervention plan.

Description: Standardized instrument involving a semi-structured interview divided into three subareas: self-care, productivity and leisure. Clients describe occupations performed on a daily basis and rate satisfaction with performance in each area in addition to performance problem in all three areas. Each activity is rated on a 1-10 point scale (1-not important, 10- extremely important). The client is than asked to identify the five most important problems to be addressed during treatment and to rate them on the 1-10 point scale. The COPM was originally published in 1999, with the latest fourth edition released in May 2005.

Setting: All settings

Time Required: Administration time is typically 20-40 minutes.

Populations: 7+ years of age and with all disabilities.

Reliability/Validity: Test-retest reliability at 1- and 2- week intervals ranging from 0.63 to 0.89 for performance and from 0.76 to 0.88 for satisfaction.

Cost: Electronic Manual $34.18, & Electronic Workbook $29.23

Source:
Canadian Association of Occupational Therapists
CTTC Building
3400-1125 Colonel By Drive
Ottawa, ON K1S 5R1
Canada
lawm@mcmaster.ca

Additional Resources:

Krohn, W.S. (2007). Assessments in occupational performance. In E. Asher (Ed.), *Occupational therapy assessment tools: An annotated index* (3rd ed.) (pp 31-54). Bethesda, MD: AOTA Press.

Authors: Jeanne M. Landgraf, L. Abetz, & J.E.Ware

Purpose: Measures unique physical and psychosocial concepts in health and well-being

Description: Parent/proxy version and self-report. Two patent/proxy versions: CHQ-PF50, CHQ-CF85. Fourteen physical and psychosocial concepts rated on a 4-point scale over the past 4 weeks.

Setting: Clinical Setting

Time Required: CHQ-PF50 10-15 minutes, CHQ-CF85 16-25 minutes

Population: 5-18 years of age. All diagnoses.

Reliability/Validity: Internal consistency established. Content, discriminate, and construct validity established.

Costs: $250 for user manual

Source:
HealthAct
Two International Place
16th Floor
Boston, MA 02110
Website: www.healthact.com

Additional Resources:

Healthact chq (2011). CHQ: *Child health questionnaire.* Retrieved on February 25, 2011, from http://www.healthact.com/chq.html

Letts, L., & Bosch, J. (2005). Measuring occupational performance in basic activities of daily living. In M. Law, C. Baum, & W. Dunn (Eds), *Measuring occupational performance: Supporting best practive in occupational therapy* (2nd ed.) (pp. 200-201). Thoreofare, NJ: SLACK, Inc.

Authors: Shirley Zeitlin

Purpose: Assess adaptive coping habits, skills and behaviors a child utilizes in daily activities. It also assists children with disabilities to develop intervention plans to improve coping skills in school, daily activities and the community.

Description: Coping Inventory is composed of a 48-item questionnaire divided into two categories: Coping with Self, and Coping with Environment. Each category is further subdivided into three dimensions to reflect the child's coping style. Each item is rated from 1 to 5, reflecting child's behavior.

Setting: Clinical setting

Time Required: Varies (Average = 30 minutes)

Population: 3-16 years

Reliability/Validity: Moderate to strong internal consistency. Adequate criterion validity.

Costs: $58.20 for Started Set (1 manual, 20 forms). $26.75 for a Sample (1 manual, 1 form).

Source
Scholastic Testing Services, Inc.
Administrative and Editorial Division
480 Meyer Road
Bensenville, Illinois 60106-1617
Website: http://www.ststesting.com

Additional Resources:

D' Amica, M., & Mortera, M.H. (2007). Assessments of coping and adaptive behaviors. In E. Asher (Ed.), *Occupational therapy assessment tools: An annotated index* (3rd ed.) (pp. 633-671). Bethesda, MD: AOTA Press.

Authors: Mimmie Willebrand, Morten Kildal, Lisa Ekselius, Bengt Gerdin & Gerhard Anderson.

Purpose: The Coping with Burns Questionnaire (CBQ) was designed to measure coping after a severe burn injury and discharge.

Description: The CBQ consists of 33 items divided into six scales: emotional support, optimism/problem solving, avoidance, revaluation/adjustment, self-control and instrumental action. The participants are instructed to think about how much they used the strategies presented in front of them and rate them on a 4 point scale. Ratings are as followed: 1-does not apply/not used, 2-used somewhat, 3-used quite a bit, and 4- used a great deal.

Setting: All settings

Time Required: Less than 10 minutes

Population: Adolescents and adults age 13 and older.

Reliability/Validity: Internal consistency is moderate to high with alpha values randing from 0.56 to 0.83.

Cost: No cost

Source:
The Morris Rosenberg Foundation
Department of Sociology
University of Maryland
2112 Art/Sociology Building
College Park, MD 20742-1315

Additional Resources:

Willebrand, M., Andersson, G., Kildal, M., & Ekselius, L. (2002) Exploration of coping patterns in burned adults: Cluster ananlysis of coping with burns questionnaire (CBQ). *Burns, 28,* 549-554.

Bras, M., Loncar, Z., Brajkovic, L., Gregurek, R., & Mickovic, V. (2007). Coping with severe burns in the early stage after burn injury. *Coll. Antropol. 31, 1,* 159-163.

Authors: Phyllis L. Newcomer, Edna M. Barenbaum, Brian R. Bryant

Purpose: Identify major depression and anxiety to determine the need for further assessment and intervention.

Description: Norm-referenced questionnaire and self-report. The student form has 22 items rated using a 4-point Likert-type response. The teacher form consists of 20 items in a true/false format. The parent form consists of 28 items in a true/false format.

Setting: Clinical setting, quiet, and comfortable environment.

Time required: 20-30 minutes

Populations: 6-19 years of age.

Reliability/Validity: Internal consistency 0.89 for student scale, 0.86 for parent scale, and 0.87 for the teacher scale. Test-retest reliability assessment of total anxiety and depression scores with a 4-day interval yielded adequate to high Pearson coefficients of 0.75 for the student scale and 0.97 for the teacher scale. Correlation coefficients for criterion-related validity were moderate with a median of 0.53.

Cost: $163 for a kit (Manual, Student Rating Scales, Teacher Rating Scales, Parent Rating Scales, Profile/Record Forms and Scoring Keys)

Source:
Pro-Ed, Inc.
8700 Shoal Creek Blvd.
Austin, TX 78757
info@proedinc.com
Website: www.proedinc.com

Additional Resources:

Cooke, D.M., & Finkelstein Kline, N. (2007). Assessment and process skills and mental functions. In E. Asher (Ed.), *Occupational therapy assessment tools: An annotated index* (3rd ed.) (pp 489-614). Bethesda, MD: AOTA Press.

Authors: Ralf Schwarzer, & Mathhias Jerusalem

Purpose: Assesses individual's perceived self-efficacy during stressful situations and ability to cope or adapt to life changes.

Description: Ten item comprehensive questionnaire rated on a 4-point self-rating scale ranging from 1 (not at all true) to 4 (exactly true). Responses are added up to a total score ranging from 10-40.

Setting: Not specified

Time required: Less than 10 minutes

Populations: 12 years to adulthood

Reliability/Validity: Moderate to strong internal consistency. Adequate criterion validity.

Cost: Printing costs

Source:
Prof. Dr. Ralf Schwarzer
Freie Universitat Berlin, Psychologie
14195 Berlin, Germany
health@zedat.fu-berlin.de
Website: http://www.healthpsych.de/

Additional Resources:

Cooke, D.M., & Finkelstein Kline, N. (2007). Assessment and process skills and mental functions. In E. Asher (Ed.), *Occupational therapy assessment tools: An annotated index* (3rd ed.) (pp 489-614). Bethesda, MD: AOTA Press.

Authors: Kathi Baron, MS, OTR; Gary Kielhofner, DrPH, OTR, FAOTA; Anita Lyengar, MS, OT; Victoria Golhammer, OTS; Julie Wolenski, OTS

Purpose: An assessment and outcome measure based on the Model of Human Occupation (MOHO) designed to collect data on an individual's self-perception of occupational competence, the importance of occupational functioning, and environment adaptation.

Description: Client completes a questionnaire about perceived competence and the importance of occupational performance and environmental adaptation. Each item is rated on a 4-point response scale based on perceived competence (from "I have a lot of problem doing important to me" to "this is most important to me"). After completing the questionnaire, client prioritizes items and goals are generated collaboratively to address specific item responses. The OSA (version 2.2) was originally published in 1986; however the latest edition was released in 2006. The COSA was published in 2005.

Setting: All settings

Time required: 10-20 minutes

Populations: 12+ years of age capable of reporting occupational performance and environmental situations; COSA is designed for children ages 8-13.

Reliability/Validity: Reliability is not reported; however both OSA and COSA adopted a 4-point scale to improve reliability. Rasch analysis supports internal validity; no item misfits were noted. OSA and COSA were both determined to be valid measure of occupational self-assessment.

Cost: OSA: $38.50, COSA: $35.00

Source:
Model of Human Occupation Clearinghouse
University of Illinois at Chicago
Department of Occupational Therapy (MC 811)
College of Applied Health Sciences
1919 West Taylor Street
Chicago, IL 60612-7250
Website: www.moho.uic.edu
Moho_c@yahoo.com

Additional Resources:

Krohn, W.S. (2007). Assessments in occupational performance. In E. Asher (Ed.), *Occupational therapy assessment tools: An annotated index* (3rd ed.) (pp 31-54). Bethesda, MD: AOTA Press.

Authors: Joseph Fava

Purpose: Asses stress and coping abilities to assist in understandings one's own stress and coping skills in order to develop appropriate goals and interventions.

Description: 12 item checklist that describes perceptions of one's current stress and coping skills. Client's rate how often each statement is true for them in the last month on a 5-point Likert scale ranging from 1 (never) to 5 (frequently).

Setting: Not specified

Time required: 5-10 minutes

Populations: 12 years through adulthood

Reliability/Validity: Internal consistency demonstrated by Cronbach's coefficient alphas of 0.85 for the Stress scale and 0.87 for the Coping subscale.

Cost: No cost

Source:

Fava, J., Ruggiero, L., & Grimley, D. (1998). The development and structural confirmation of the Rhode Island Stress and Coping Inventory. *Journal of Behavioral Medicine, 21*(6), 601-611.

Additional Resources:

D'Amico, M., & Mortera, M.H. (2007). Assessments of coping and adaptive behaviors. In E. Asher (Ed.), *Occupational therapy assessments tools: An annotated index* (3rd ed.) (pp 633-671). Bethesda, MD: AOTA Press.

Authors: Morris Rosenberg, PhD

Purpose: This scale provides a quick, simple methods of measuring the degree of positive and negative attitudes towards one's abilities and accomplishments.

Description: The self-esteem scale (SES) consists of 10 self-descriptive statements rated on a 4-point Likert scale ranging from strongly agree to strongly disagree. No training or special materials are required this assessment, which is scored manually by the examiner.

Setting: All settings

Time required: Less than 10 minutes

Populations: Adolescents and adults age 13 and older.

Reliability/Validity: Test-retest reliability ranged from 0.82 to 0.88; Cronbach's alpha correlations ranged from 0.77 to 0.88, indicating low-adequate internal consistency. Construct validity based on a significant association ($p < .05$) between SES scores and self-reports of nurses and other related constructs.

Cost: No cost

Source:
The Morris Rosenberg Foundation
Department of Sociology
2112 Art.Sociology Building
College Park, MD 20742-1315

Authors: David Lachar, PhD; Sabine A. Wingenfeld, PhD; Rex B. Kline, PhD; Christian P. Gruber, PhD

Purpose: Identify school-specific behaviors that reflect socially disruptive behaviors and problems in emotional or behavioral adjustment. The student behavior survey focuses on the students functioning relative to his/her peers and the school environment regarding academic achievement, adjustment problems, and behavioral assets needed for classroom success.

Description: Teachers rate 102 items related to classroom performance and behaviors of children compared with normative behaviors or "regular education students." Ratings include: academic performance and academic habits, parent participation, and health concerns. Items are rated on a 4-point Likert scale.

Setting: School setting

Time required: 15-20 minutes

Populations: 5-18 years of age

Reliability/Validity: Mean internal consistency of scale scores was 0.88; test-retest reliability was 0.86; mean interrater correlation was 0.73. Criterion validity was based on differentiation of 97% special education student versus the normative population ($p < .001$).

Cost: $99.00 for the Kit (25 AutoScore Answer/Profile Forms; Manual).

Source:
Western Psychological services
12031 Wilshire Blvd.
Los Angeles, CA 90025-1251
Website: www.wpspublish.com

CHAPTER V

SUMMARY

Due to the limited research of psychosocial aspects after experiencing a burn injury, the self-esteem program and manual is intended to be beneficial to this population. This product allows the client and OT practitioner to collaborate throughout the therapy sessions and work through challenges and difficulties that the client may face during the recovery process. Guided by the Occupational Adaptation (OA) model (Schkade & McClung, 2001; Schkade & Schultz, 1992a, 1992b), this self-esteem program and manual are provided to address psychosocial issues such as: building positive self-esteem, assertiveness/social interaction, family/community education, and community reintegration during each stage of the recovery process.

Reproducible handouts are provided in the *Building Self-Esteem One Adolescent at a Time* manual to assist the OT practitioner when implementing strategies during therapeutic sessions with clients. The handouts focus on psychosocial aspects that adolescents may face after experiencing a burn injury. Handouts focus specifically on the areas of: self-esteem, assertiveness/social interaction, family/community education, and community reintegration; they are provided for the OT practitioner to incorporate into their occupational therapy sessions. One-page synopses of assessments that could be utilized during the occupational therapy process have also been provided to assist

the OT practitioner in finding the best assessments for their clients based on the needs of the individual.

The self-esteem program and manual are intended to be implemented with adolescents who have experienced a burn injury and are between the ages of 10-21. This population was chosen as it is the most critical time when adolescents develop their own personal identity and face multiple challenges throughout their everyday occupations. The self-esteem program and manual are also designed to be implemented in both inpatient and outpatient settings in congruence with standard burn rehabilitation.

There are limitations during the development process of any product. A potential limitation of this product may be the compliance of adolescents working with the OT practitioner. Adolescents may be difficult to work with as this is the age when they become more independent and reluctant, withdrawing from new surroundings or experiences.

Future recommendations for this product include adapting this manual for implementation with a variety of other populations such as: children, adults, older adults, and psychiatric populations. Two other recommendations would be: to incorporate other healthcare professionals in order to provide an interdisciplinary approach and also conduct evidence-based research regarding the effective outcome of this program on adolescents.

A burn injury hospitalizes approximately 24,000-40,000 adolescents annually (Piazza-Waggoner, Butcher, Adams, Goldfarb, & Slater, 2004). Approximately 450,000

people receive medical treatment for burn injuries annually (American Burn Association, 2010). Due to the large number of people receiving medical treatment for burn injuries it is imperative to implement a program and manual such as this in order to help build positive self-esteem. A burn injury is a lifelong process that individuals deal with on a daily basis. This program will further enhance OT services in working with adolescents who have experienced a burn injury.

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