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The acceptability of early psychological interventions for adults with appearance concerns after burns

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ABSTRACT

Introduction: Appearance concerns are common following burns. However, there is a lack of research investigating early psychological interventions for appearance concerns. This qualitative study explored the acceptability of early psychological interventions for appearance concerns after burns.

Methods: Fifteen adults (nine female; 18–56 years) with appearance concerns were interviewed within three months post-burn to explore their views about the acceptability of early psychological interventions for these concerns. Interviews were audio-recorded and transcribed. Template analysis informed data collection and analysis.

Results: Three themes represented participants' views about the acceptability of early psychological interventions for appearance concerns: (1) early psychological interventions are absent; (2) early psychological interventions are acceptable within a therapeutic relationship (to manage upsetting emotions and thoughts about appearance, with therapists who are experienced in supporting burns patients); and (3) ambivalence and obstacles exist (e.g., difficulties accepting help, minimising injuries or concerns, and time restrictions following hospital discharge).

Conclusion: Early psychological interventions for appearance concerns following burns are likely to be acceptable for some patients. However, ambivalence and potential barriers

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remain to be addressed. Embedding early psychological interventions for appearance concerns into routine burn care could increase acceptability through normalisation.
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1. Introduction

Appearance concerns, a term that incorporates feelings of anxiety, shame, and social avoidance, are common after burns because of wounds, scars and other changes to the skin [1,2]. This is not surprising given the psychosocial difficulties that individuals with visible differences, including burns, can experience due to stigma, including unwanted reactions from other people [3,4]. Appearance concerns have been reported in around one third of adults after burns during hospital admission [5] and after hospital discharge [6]. Effective psychological interventions to treat appearance concerns after burns are therefore needed.

However, systematic reviews of psychological interventions for appearance concerns in adults with visible differences (where appearance is visibly different from cultural 'norms') concluded that there were few high-quality studies [7,8]. The most commonly studied psychological interventions are cognitive behaviour therapy (CBT), which aims to modify unhelpful or negative thoughts/beliefs and reduce unhelpful avoidance or safety-seeking behaviours [9,10], and social skills training to help manage unwanted reactions from other people [7,8,11]. CBT is reported as the most used therapeutic approach by practitioners working with people with individuals with visible differences, including burns, across Europe [12]. In a survey of 166 burn care psychosocial professionals across the UK and United States of America, CBT was used by 82 % of practitioners [13].

Acceptance and commitment therapy (ACT) is a third-wave psychological therapy, which involves helping individuals to live a meaningful life with their distressing emotions and thoughts rather than trying to reduce them, by being more accepting and mindful as opposed to avoiding them [14]. ACT was reported as a therapeutic modality used by almost a third of psychosocial professionals working with those with visible differences across Europe, in addition to mindfulness being used by 40.5 % [12]. This compares to a survey of burn care psychosocial professionals working in the UK and United States of America, where acceptance and mindfulness-based approaches were used by 69 % of practitioners [13]. There is some evidence to suggest that ACT may be helpful in reducing appearance concerns in those with a variety of individual differences [15–17], including burns [18]. However, controlled studies are limited.

Evidence suggests that self-compassion [19] may be particularly beneficial for addressing experiences of shame and guilt, through third wave compassion-based interventions such as compassion focused therapy (CFT) [20]), compassionate mind training [21], or mindful self-compassion programmes [22]. One quarter of a sample of psychosocial professionals working with individuals with visible differences across Europe reported using compassion-based interventions [12]. There is also evidence for the benefit of compassion-based interventions for appearance concerns in individuals with skin conditions [23] and women following breast cancer [24,25]. As with ACT, controlled studies are limited.

Research investigating psychological interventions for appearance concerns in patients with burns at any stage post-injury is minimal. Only one of the studies included in the systematic reviews investigating psychological interventions for appearance concerns [7,8] included adults with burns . This study [26] evaluated a support group attended by 34 patients with burns over a three-year period. However, the group did not target appearance concerns specifically and was a support group rather than a psychological intervention, with the findings indicating that there was no evidence to support the intervention [7]. Additional studies have also investigated the impact of group social skills training with burn-injured adolescents [27] and adults [28,29], to try and help individuals understand and respond to other people's reactions to their burns, with positive effects reported on measures of anxiety and social confidence. Only one of these studies [27] included a control group and one study [29] had a mixed group of adults with a range of facial differences. The number of sessions/duration of the group ranged from eight weekly sessions [28] to a variety of tasks/activities over two [29] and four days [27].

Three other studies also investigated psychological interventions for appearance concerns after burns, with two of these aimed at reducing psychological distress more generally rather than appearance concerns specifically. One study examined the impact of an eight-session group CBT intervention in 86 patients with burns compared to treatment as usual, where one session focused on appearance concerns and two sessions focused on giving patients ways to manage social situations [30]. Improvements in psychological distress were noted for participants in the CBT group, but no outcome measure of appearance concerns was used [30]. An uncontrolled pilot study also explored the feasibility, acceptability and efficacy of a 14-session protocol delivered individually on a weekly basis to 10 adults following a burn injury [31]. CBT techniques targeted post-traumatic stress symptoms, depression, coping with scarring (three sessions) and community integration. The intervention was started on average three months (ranging from one to seven months) after injury, with the inclusion criteria being that participants were at least four weeks post-injury. This study found improvements in body image scores and community integration in the nine of the 10 participants who completed the intervention [31]. However, there was a lack of detail in the strategies used to target appearance concerns and this appeared to be limited to social skills training rather than techniques to manage emotions, thoughts or behaviours associated with appearance concerns. Lastly, in a case series of

three adults after burns and one patient with a skin loss condition, ACT techniques reduced appearance concerns and increased the ability for patients to live meaningful lives [18]. However, this study was not a single case experimental design, and therefore lacked a control condition. Despite this promising evidence, further research investigating psychological interventions for appearance concerns after burns is therefore warranted.

Research suggests that appearance concerns develop during hospital admission or in the early phase after discharge after burns [32,33]. Psychosocial professionals report that appearance concerns were most likely to manifest during the hospitalisation phase or early after discharge from hospital, with problems around social interactions and social anxiety starting within the first six months post-injury [13]. There is also evidence that appearance concerns remain stable in the first year following a burn [34]. Therefore, early psychological interventions to support the adjustment to appearance changes, and help patients cope with appearance concerns, in the initial post-burn period could be invaluable. Research is currently limited to the study by Cukor et al. detailed above [31].

In addition, there is a lack of qualitative research exploring the acceptability of early psychological interventions for appearance concerns after burns at any stage post-injury. More generally, there is a dearth of literature on what psychological interventions for appearance concerns individuals with visible differences would find acceptable [35]. Acceptability is important to explore as there is evidence that stigma in seeking help for appearance concerns may exist and psychological support may be difficult to access [12]. Although acceptability of (early) psychological interventions for appearance concerns after burns has not been explored, acceptability has been investigated in relation to accessing psychological support more widely. One study found that psychosocial professionals working in UK burns services experience challenges delivering psychosocial care for a range of psychological difficulties, including limited time and resources, geographical distance that patients live from services, appointments not being prioritised as much as wound-related appointments and the prevalence of pre-existing mental health conditions [36].

One recent qualitative study explored the acceptability of psychological support for any burns-related difficulty [37]. Eleven patients were interviewed two years post-burn, particularly aiming to identify barriers and facilitators to accessing support. Findings suggested that increased psychological presence within inpatient burns services was required, so that psychological care felt familiar and available. This study also found that patients perceived accessing psychological burn care as stressful once they were discharged from hospital, and negative beliefs about mental health or psychological therapy impacted engagement. Misunderstanding about what psychological therapy is/can offer, previous negative experiences of wider psychological or mental health services, a desire to cope independently and stigma were identified as barriers. For outpatients, time and financial pressures and, when in hospital or during early discharge, acute priorities (e.g., pain and physical recovery), were additional barriers to engagement [37]. Therefore, various obstacles to engaging in psychological interventions for any difficulty following burns likely exist, albeit some of these barriers (e.g. stigma) may be generic to psychological therapy and seeking mental health support in general, rather than specific to burns-related concerns [38].

Exploring acceptability is a vital early stage of intervention development, prior to investigating effectiveness or outcomes [39]. If interventions are considered acceptable, they are more likely to be successfully implemented and create beneficial outcomes [40]. Research focused on providing insights into whether early psychological interventions for appearance concerns are acceptable to individuals after burns is lacking but is important for informing intervention development and implementation. The current study aimed to address this gap, as part of a wider project exploring early appearance concerns after burns.

2. Materials and methods

2.1. Design

A qualitative study was conducted using semi-structured interviews. Adults (aged 18 years or over) experiencing appearance concerns from a burn injury in the last three months were eligible to participate. Individuals were excluded if they had sustained their injuries due to a suicide attempt, self-harm or assault or had a known cognitive impairment. Cognitive impairment was defined as a temporary or permanent impairment in cognition (including learning disabilities, dementia and delirium). This was assessed by hospital medical records for the eleven participants who had participated in another research study during their hospital admission and self-report from the other four participants. Participants were offered the choice of in-person or remote (video or telephone) interviews. The study obtained ethical approval from the South Birmingham NHS Research Ethics Committee (REC) and Health Research Authority (IRAS ID: 292292; REC ref. 21/WM/0144).

2.2. Data analysis

Template analysis, a form of thematic analysis, was used to develop a priori themes to guide initial coding of the interview transcripts, guide the interview schedule and conduct analysis [43]. A priori themes were identified and these are displayed in the supplementary materials. However, as recommended, these were used tentatively with the awareness that, along with any other themes that are generated, they may not necessarily prove relevant, useful or meaningful and may need to be refined or discarded [43]. Seven recommended stages [43] were followed: 1) familiarisation with the data; 2) preliminary coding; 3) clustering; 4) producing an initial template; 5) developing the template; 6) applying the final template; and 7) final interpretation. Stages were completed sequentially and iteratively. NVivo version 1.7.1 was used to assist with analysis. The development of the final template was reached when the iterative process of template development reached saturation: when all data could be

coded using that version of the template [43] and no new themes were being developed [47].

The semi-structured interviews were conducted by the first author, who has doctoral level knowledge/training in qualitative research methods. In addition, the first author is an experienced clinician with experience of interviewing people with regards to sensitive and emotive topics. Interviews were audio-recorded and the first author made notes and wrote case summaries, documenting key interview dynamics and reflections from the interview [43]. The last author reviewed the interview audio-recordings in order to provide a check on quality control and rigour, as detailed further below. Coding and theme development was completed by the first author and the inter-subjectivity of the researcher was seen as integral to the process of analysis [52,53]. This is in contrast to more positivist assumptions underlying some versions of thematic analysis that might seek to measure about 'coding reliability' [48–51].

2.3. Participants

Fifteen adults (nine female) with a mean age of 40.5 (range: 18–56) years participated. Twelve participants described themselves as White British, one as British Indian, one as White European and one as Black African. Self-reported socio-economic status ranged from four to 10 ($M = 5.87$, $SD = 1.85$; where one equates to 'Worst off' and 10 to 'Best off') on the *McArthur Scale of Subjective Social Status – Adult Version* [41]. Total mean scores on the *Appearance Subscale of the Body Esteem for Adolescents and Adults* [42] ranged from 0.1 to 2.7 ($M = 1.43$, $SD = 0.82$). Possible scores range from zero to four, with higher scores indicating increased appearance esteem (therefore lower appearance concerns). Time since burn ranged from just over two weeks to just under eleven weeks.

Participants had sustained scalds ($n = 9$), flame burns ($n = 3$), a friction burn ($n = 1$), a contact burn ($n = 1$) and a flash burn ($n = 1$). Total body surface area (% TBSA) ranged from 0.5 to 28 %. Depths of burn included mixed thickness ($n = 6$), full thickness ($n = 4$), partial thickness ($n = 3$), deep dermal ($n = 1$) and unknown ($n = 1$). Body location of burns included the legs ($n = 11$), chest/abdomen ($n = 6$), arms ($n = 5$), hands ($n = 4$), back ($n = 4$), buttocks ($n = 3$), feet ($n = 2$) and face ($n = 1$). For eleven participants, demographic and burn injury information was collected from medical records. The remaining participants self-reported the information. Those who self-reported the information did not appear different in terms of demographic and burn injury variables compared to those where the information had been obtained from medical records. However, one participant who self-reported demographic information did not have information about the % TBSA or depth of their burn.

2.4. Measures and materials

Interview schedule. As detailed above, a priori themes based on template analysis guided the interview schedule [43]. Questions were open-ended, aimed at exploring views about early psychological interventions for appearance concerns. It included questions about whether interventions would be helpful (e.g., Do you think some psychological, or emotional, support would be helpful to you at this stage, to manage your experiences about your changed appearance or body?'), experiences of psychological interventions for appearance concerns (e.g., 'Has any psychological, or emotional, support been available to you already? If so, who was this by and what did it involve?'), what interventions should aim to achieve (e.g., 'If psychological, or emotional, support could be available to you, what would you want to gain from it?'), what would make interventions more acceptable (e.g., 'What would have made / make it easier or more acceptable for you to have taken up psychological support (if it had been offered to you) for how you felt about your appearance?'), and what barriers exist for taking up interventions (e.g., 'Can you think of any reasons that would make it difficult for you, or would make it difficult to other people after burn injuries, to take up psychological support for this difficulty?'). Prompts were used to provide deeper understanding of participants' responses and views. The interview schedule and a priori themes are available in Supplementary Materials as well as at the Open Science Framework (https://doi.org/10.17605/OSF.IO/FBQUY).

To contextualise the sample, two self-report measures were completed prior to the interviews. The *Appearance Subscale of the Body Esteem for Adolescents and Adults* [42], a 10-item self-report questionnaire, was used to measure body esteem, particularly focusing on appearance. The authors of the scale [42] report very good internal consistency (Cronbach's $\alpha = .93$ and $\alpha = .89$ for females and males, respectively) and three-month test-retest reliability ($r = .89$) [42]. It has been used in research exploring psychological variables and appearance concerns in adults following burn injuries, with an alpha coefficient of.95 reported [44]. Responses to items fall on a scale ranging from 0 ('Not at all') to 4 ('Always'). An example item is, 'I'm pretty happy about the way I look.' The total mean score of this measure has a possible range of values between 0 and 4. Lower scores are suggestive of poorer appearance esteem, therefore higher appearance concerns. The *McArthur Scale of Subjective Social Status – Adult Version* [41] is a well-known single-item scale to measure self-reported socio-economic status that has been found to correlate significantly with an objective index of socio-economic status ($r = .40$) [41]. Research has also shown that this scale predicts health outcomes above objective indicators and is often a stronger predictor of health compared with objective socio-economic status [45,46]. Participants rank themselves on a ladder from one ('Worst off') to 10 ('Best off'), representing their socio-economic standing in the UK.

2.5. Procedure

Convenience sampling was used. The first fifteen participants interested in taking part and meeting inclusion criteria being recruited. Fifteen participants was expected to be sufficient to answer the research question and ensure diversity within the sample in terms of demographic and burn injury variables. Eleven participants had participated in another research study during their hospital admission and expressed interest in this study. Three participants responded to fliers in hospital burns services and one was recruited through social media. Ten interviews were conducted over

video-calls, three were held in person and two were telephone interviews. Interviews lasted 79 min, on average (range: 41–112 min). Interviews were transcribed verbatim and pseudonyms were assigned.

2.6. *Quality control and rigour*

Credibility and rigour can be established using a variety of methods, including auditing the analytic process, keeping detailed audit notes and reflexivity [54,55]. Transparency was explicit and an audit trail with detailed notes was kept. An audit checklist was developed prior to the study commencing and completed at the end of the study by the first and last authors. A reflective diary was maintained throughout the study and used to inform reflection as to the concepts evident in the data.

2.7. *Reflexivity*

The first author kept a reflective diary throughout recruitment and analysis. In particular, the first author was aware of her ongoing clinical role as a Consultant Clinical Psychologist in a burns service and previous experience of working with patients after burns who experience appearance concerns. Other authors (AT, DH) also have experience of conducting research and providing clinical services (AT) with people who have sustained burn injuries. In addition, all authors have conducted prior work on the roles of psychological flexibility and/or self-compassion. In keeping with utilising reflexivity in qualitative research [52–54], the research team continually reflected on the relationship between preconceptions and the emerging findings during team meetings and through field notes.

3. Results

Three main themes were identified: *Early psychological interventions are absent; Early psychological interventions are acceptable within a therapeutic relationship;* and *Ambivalence and obstacles*. The main themes and their subthemes are described below with illustrative quotes. It is important to note that all participants identified themselves as experiencing appearance concerns due to their burns scars or skin pigmentation changes and spoke about their self-consciousness/shame and desire to conceal their burns from other people.

3.1. *Early psychological interventions are absent*

This theme captured participants' experiences that early psychological interventions for appearance concerns were largely not available within burns services. Many participants described feeling that, if they had accessed psychological support or engaged in psychological interventions following their burn, these had been focused on other areas of distress such as post-traumatic stress or painful procedures (e.g., dressing changes). There was the perception that appearance concerns had not been fully explored. This was often spoken about with a sense of confusion or disappointment. For example, Jake reported receiving psychological support from the psychologist for his post-traumatic stress symptoms, which indeed felt like a priority, but that his appearance concerns had not been focused upon. He stated,

> "That was focused more around the emotional response to the trauma rather than appearance change…that doesn't address longer term psychological issues around appearance because most of it has focused, as I said, around the trauma, far less on the appearance."

Similarly, Elaine spoke about her experiences of accessing psychological support from a psychologist attached to her regional burns service for anxiety following her accident leading to her burn injuries and said,

> "Um…we haven't really hit on how my legs look, it's more just going more on the head side of it, the anxiety and everything."

3.2. *Early psychological interventions are acceptable within a therapeutic relationship*

This theme represented participants' views that early psychological interventions for appearance concerns would be acceptable and helpful to support them in their difficult journey associated with their appearance change. Participants described thinking that interventions would have helped them adjust to their changed appearance and manage the upsetting emotions and thoughts they had been experiencing associated with how their burn looked or may look in the future. For example, Leanne said that they could "help you re-evaluate how you think about yourself, and [pause] erm, guide you to sort of look at different ways of doing situations and scenarios." In addition, participants felt that interventions would have supported them with the uncertainty surrounding their possible future appearance at a time when this felt unknown. Many participants reported that they would have accepted such interventions if they had been offered to them. For example, William stated,

> "Like I say, with the help itself, if I could have spoken to somebody, you know, if the help had have been there it might have made me journey a lot easier. Or at least took away some of the anxiety etc. that I've been experiencing."

Similarly, Elaine said,

> "Yeah. Because if you've got pain you can get tablets for that. If you've got something wrong with your head you can get tablets for that, do you know what I mean, I mean the hospital's been absolutely brilliant, you know what I mean, this has got nothing to do with them, it's just that… It's just…yeah as I say the hospital's been brilliant but… and they couldn't have done anymore…and I don't suppose they can do any more, but if there was something… yeah, I would have accepted it."

For Joanie, interventions to develop self-compassion also seemed important. This is likely to be linked with the psychological barrier described below, in that a small number of participants described low self-compassion for their

appearance concerns due to blaming themselves for the accident happening. She said,

"Just understanding how to [pause] process it. Like, the other emotions that would support being kind to myself or understanding how to channel the thoughts. So instead of just going all the way down be like going 'oh stop being so cruel to yourself.' It's also like having other avenues you can think, and it's opening them up and understanding how to do that, to know that actually I have been through something quite tough, and I'm not – you're not just over exaggerating about the whole situation."

Related to the delivery of early interventions, participants thought that these should be delivered within a therapeutic relationship. Feeling listened to and understood with an objective and non-judgmental stance was important for participants. Participants commented that a therapeutic relationship is different to those with family and friends, who may provide advice or reassurances about appearance. David explained this through the quote,

"I think having someone to talk to that I've never met before, having that someone who's not going to pre-judge me. I think that is – because if you talk to a family member they're going to react in a way because they know you, they know the core you, and I think their answers or their advice would be biased, same if you're talking to a friend, having that independent impartial person is – you can open up and to them and say stuff that you probably wouldn't say to most other people."

Alexei explicitly spoke about the importance of early psychological interventions being delivered by psychological professionals who were experienced in burn injuries who could understand what they were experiencing and had experience of helping other patients after burns. He said,

"Hmmm that would be helpful to talk to someone who have experience and talk with people what previously was in the same situation as me. So I would say probably would be helpful because, like, maybe, especially if they had experienced the same as I did, like in this kind of situation, but he already knows what other people experience…."

3.3. *Ambivalence and obstacles*

Despite the positive views around the acceptability of early psychological interventions, this theme reflected obstacles around the uptake of these. Whereas some participants expressed ambivalence about whether they would accept (or would have accepted) an intervention, all participants described obstacles. This theme includes four subthemes: *Ambivalence; Psychological barriers; Contextual barriers;* and *Timing*.

3.3.1. *Ambivalence*

Some participants expressed ambivalence towards early psychological interventions. Participants would present arguments for engaging versus not taking them up, suggesting an unease about making a decision due to different or contradictory beliefs (cognitive dissonance) [56]. Interestingly, Nicola had the contact details of the psychologist at her regional burns service and knew she could phone them to ask for an appointment but her ambivalence about the acceptability of this was conveyed by the following,

"And maybe it might help. But I don't know. Unless I try, do I, that's what I'm thinking. I don't know. In my mind, who can make this go away? Nobody. But I could have reassurance and more understanding maybe. I don't know. I don't know, maybe I should phone her and just have one session and maybe I'll change my mind about it."

Ambivalence and cognitive dissonance was also evident in this quote by John:

"It sounds as though I've got a, you know, that kind of mental block just to say, 'do you know what, it's only a burn for goodness sake, I don't need any help at all,' and then on the other hand to say, 'well, obviously there is an issue because you've blurted out for the last two hours all these emotions and things so you've done it for a reason."

3.3.2. *Psychological barriers*

This subtheme highlighted a number of psychological barriers to engaging in early psychological interventions. These included negative beliefs about talking therapies generally or accepting help. Difficulties in opening up about distressing experiences was described. Some participants also appeared to believe that they should be able to cope by themselves, which seemed to be caused by an underlying stigma around mental health difficulties and needing emotional help. A small number of participants described a lack of self-compassion for their appearance concerns, seemingly due to self-blame surrounding the accident, which was described as a barrier to taking up early interventions. Some participants expressed beliefs that psychological interventions would not be able to help with appearance concerns, due to either past unhelpful experiences of psychological therapy or a belief around psychological interventions being unable to change the objective appearance of the wound or scar seemed important. However, some could also appreciate interventions might be helpful. For example, Nicola said,

"To start, I don't think that psychologist can make my wounds look fader can she? She can't make the wounds heal any quicker than what they need to be. She can't make the healing process quicker. Nobody can take it away. No-one can make it not happen. That's what I would like in a realistic world but it doesn't work like that. But I know talking is good. I understand that."

Participants expressed beliefs about levels of distress associated with their appearance concerns not being severe enough, or the burn injury not being severe enough, to warrant a psychological intervention or to take resources away from other patients with more significant distress or more severe injuries. Aadan perceived his burn injury as relatively minor compared to other patients' injuries and that

psychological interventions would not be acceptable to him unless his mental health was significantly suffering. He said,

> "For someone who's got a major injury, maybe psychological support would be important because there's a psychological damage attached…I must say, unless I consider something really extremely, you know, doubting to my physique, something that really damages my mental status, something extreme, very extreme, something life threatening [pause] – or that would have been life threatening."

3.3.3. *Contextual barriers*

This subtheme represented contextual barriers that contributed to ambivalence about engaging in early psychological interventions. These included practical issues, including limited time and travel requirements if interventions were offered face-to-face after hospital discharge. Participants talked about the need for flexibility in delivery of interventions after hospital discharge (e.g., video-appointments). For example, Nina said,

> "If it was online – like this, I don't mind, because it's after work and, you know, it's – there's no travel and you don't have to leave your house. Obviously sometimes you do need to speak to someone in person because you know, they need to see what's wrong, but I do feel like video appointments are quite handy, just being like more accessible – not accessible because you can access hospital – more convenient."

One participant expressed concern about a possible lack of privacy if early psychological interventions were delivered during hospital admission (e.g., if patients were in hospital bays).

Participants appeared to perceive psychological burn care in general, and therefore early psychological interventions, as not sufficiently normalised or embedded within the burn care pathway. Related to this, participants also spoke about the need for psychological burn care to be more proactive, rather than reactive (e.g., to referrals). Accessing psychological care was considered to fall on the patient to seek out (e.g., by contacting the service or asking for a referral) which felt effortful and off-putting. Proactive, routine, attempts to explore appearance concerns by the psychological care team was suggested. For example, Nicola said,

> "Maybe one of you phone me to chase it up and then I might have initially done it – does that make any sense? Rather than having the leaflet option. Maybe the psychologist I seen in hospital could have catched me on a phone call, maybe like six weeks later to see how you are. I know you haven't got the facilities, it's just a suggestion in my mind, I thought because I was talking to her originally, if she rang me and asked how I was I could be honest and then she could say 'do you want me to put you on the waiting list?', that maybe, because I think a leaflet isn't the same, it's not the same."

Participants suggested normalising early interventions, and psychological burn care in general, by clearly embedding it into the burn care pathway, in order to enhance acceptability. For example, John said,

> "If it came, I suppose, as part of the care package, you know, part of the whole package. So whether you would actually see, as in my case, see the triage nurse, then get transferred over to the burns unit and then after the burns unit you would then – or as part of that – speak to somebody about your experiences, how you feel, you know…It's not 'do you think you need to speak to somebody?' if they say 'this has been booked for you so you have to go,' and I think that would probably be better for somebody like me because otherwise you wouldn't choose to go and talk to someone."

3.3.4. *Timing*

This subtheme represented participants' views about when psychological interventions for appearance concerns should be introduced. During hospital admission was often considered to be an optimal time to start early interventions, or at any early stage in outpatient care for those who had not been admitted to hospital with their injuries. Participants believed that coinciding early interventions with initial dressing changes or hospital showers would be useful. Typically, these events are when patients see their injuries for the first time, when they are confronted by the reality of their injuries. For example, Lauren said,

> "I think that the best psychological support wise would be once the dressings come off or at least once they're kind of coming off, like preparing somebody for how they might feel, preparing, almost like it's normal but I kind of know it is from other situations and injuries, try and be reassuring and then I think it's then as the dressings are coming off, say, is when somebody needs to kind of assert themselves because that's when the reality stage starts, at least from my point of view, and it's not happening if you can't see it – when the dressings are there."

In contrast, Alexei held a differing view. He believed that early interventions would be better starting a few weeks after discharge from hospital, to allow time for an initial focus on physical recovery, attempts to re-establish normality and time for patients to learn whether their appearance changes are likely to be longer lasting or permanent. He said,

> "When I first got back (home), I couldn't even get a proper shower, I couldn't even look at my body how it's changed because I didn't know which parts are going to be like fully healed, which parts could be scarred, you don't really know it before you start, yeah, I would say six or seven weeks, that's probably the time when you could talk to someone and then just, like, you can hear someone because at that stage probably you feel more down than at the stage where you've been dismissed from the hospital, that's when you start looking at yourself, you start analysing, you start thinking."

4. Discussion

This study aimed to explore the acceptability of early psychological interventions for appearance concerns after burns in a sample of individuals who were experiencing these concerns within three months of their injuries. Participants perceived that early psychological interventions for

appearance concerns were missing from burn care, but the idea of these were acceptable to many participants. The finding that participants wanted help for their distress within a therapeutic relationship is not surprising given the importance placed on the therapeutic alliance in psychological therapy [57,58]. In the context of appearance concerns after burns, the therapeutic relationship might be particularly important to individuals because of the stigma associated with being visibly different and the unwanted reactions from other people [3,4]. Although not a focus of this paper, participants did speak about their self-consciousness, shame, and desire to conceal their burns from other people. Therefore, a therapeutic relationship with someone who is authentic, empathic and accepting (unconditional positive regard) [57] may be vital when considering early psychological interventions. However, some were ambivalent and all identified either psychological or contextual barriers to engaging in early psychological interventions. This is the first study to focus on the acceptability of early psychological interventions specifically for appearance concerns after burns, extending the literature from that of a previous study that explored acceptability of an early psychological intervention for a variety of psychological difficulties after burns [37].

The current results are consistent with findings from a recent study where patients with burns were interviewed two years post-burn to identify barriers and facilitators to accessing psychological support for any burns-related difficulty [37]. That study found that increased psychological presence within burns services was required, so that psychological care felt familiar and available [37]. The current findings also highlight the importance of normalising early psychological interventions into routine burn care. The current findings identified both psychological and contextual barriers to engaging in early psychological interventions for appearance concerns, which also aligns with previous findings of negative beliefs about mental health or psychological therapy, time and financial pressures for outpatients, and acute physical health priorities when in hospital and during early discharge [37]. Indeed, there are likely to be general obstacles to engaging in any psychological interventions following burns for a variety of difficulties. Some of these barriers are generic to psychological therapy or seeking mental health support due to stigma [38]. However, stigma accessing psychological support for appearance concerns in individuals with visible differences do appear to exist [12].

The current findings also extend previous research by identifying additional psychological barriers to engaging in (early) psychological interventions for appearance concerns specifically. These are beliefs that: 1) appearance concerns, or the burn injury itself, were not severe enough to warrant a psychological intervention or take resources away from other patients who have increased levels of appearance concerns or more severe injuries; and 2) psychological interventions cannot change the physical appearance of a wound/scar, thereby limiting the utility of a psychological intervention.

4.1. *Study strengths and weaknesses*

The findings from the current study should be considered in light of several strengths. Both female and male adults after burns were included, and there was diversity in age, socioeconomic status and burn injury factors (severity, mechanism and areas of body affected). There was also a diverse range of appearance-related distress. In order that the transferability of the findings can be judged, the characteristics of the sample are clearly described. Nevertheless, it is important to acknowledge that the majority of participants were White British, and clearly the findings will not be transferrable to all individuals following burn injury, including those from Black/Asian/other ethnic minority groups. Further, as convenience sampling was adopted the population was self-selecting and this may represent some specific bias. Furthermore, the sample differed in the time post-burn (ranging from just over two weeks to almost eleven weeks), and so were at different stages in terms of wound healing and scar development. Similarly, some participants had required hospital admissions for their burns whereas others had only needed outpatient burn care.

The current study focused solely on the acceptability of early psychological interventions for appearance concerns. Future research may therefore benefit from exploring the acceptability of education and information materials related to appearance changes (e.g., wound healing, scarring, pigmentation changes and treatment options) and how these could be usefully combined with, or form part of, early psychological interventions. Similarly, a small number of female respondents spoke about receiving support (or considering accessing) support from other burns survivors, and future research could also consider the acceptability of embedding peer support into early psychological interventions. Finally, individuals in the current study did not talk about or infer that social skills training may be acceptable or useful. But given its evidence base [27–29] and the possibility that patients may not be explicitly aware of social skills training and what it might offer, future studies should also consider whether this would be an acceptable part of early psychological interventions.

4.2. *Clinical implications*

The study has important clinical implications. Offering and delivering early interventions for appearance concerns should be a clear focus for burns services. The findings suggest that early interventions should likely be introduced during hospital admission or initial outpatient burn care appointments, coinciding with initial dressing changes or hospital showers. However, the timing of early interventions likely needs further consideration, and interventions likely need to be adaptable to individuals who focus on physical priorities initially, perhaps having a preventative focus. Indeed, a period of psychological adjustment to appearance concerns after burns occurs [59,60], and individuals are likely to experience these at different rates. Early interventions should focus on helping patients to manage their distressing thoughts and feelings related to their appearance, and be delivered within a therapeutic relationship by those who have understanding of, and experience in, helping other individuals after burn injuries. Psychosocial professionals working within burns services would be ideally placed to deliver interventions. Other

healthcare professionals have been found to lack knowledge and confidence in communicating with patients around appearance concerns when this has been explored across a variety of visible differences [61]. Furthermore, self-help interventions may not meet the needs of patients after burns , given the absence of a therapeutic relationship. The value of face-to-face psychological support for appearance concerns in those with visible differences has indeed been reported in a previous study [17].

The current study suggests that some individuals will be ambivalent about early interventions, and that contextual and psychological barriers will be prevalent. Delivering early interventions during hospital admission would alleviate some of the contextual barriers and flexibility in delivery (e.g., in person versus remote) may be useful for those receiving outpatient care. Embedding early psychological interventions into routine burn care may increase acceptability through normalisation, and this has been considered important in other long-term conditions [62]. Indeed, proactively offering early interventions for appearance concerns to all patients may reduce stigma and the impact of beliefs about self-blame about the accident, and the level of distress or injury severity. However, this would have clinical resource implications that would need to be considered. Education when offering early interventions may also be important. Specifically, being informed that whilst a psychological intervention cannot change the appearance of a wound/scar, it has the possibility of helping patients respond to or manage any distressing experiences they have about appearance. Finally, acknowledging and normalising that some individuals find it difficult to 'open up' and talk about their experiences and/or experience challenges being self-compassionate after an accident and when in distress would be useful.

Further research focusing on the acceptability of specific early psychological interventions for appearance concerns should be conducted, in line with recommendations for the development of healthcare interventions [39]. This could identify and address ambivalence and barriers to engaging in interventions, prior to being investigated for effectiveness in controlled trials. Once an early intervention is developed, further research may benefit from applying a specific framework of acceptability for the specific early intervention being investigated for thoroughness. For example, the theoretical framework of acceptability which comprises seven components: affective attitude, burden, perceived effectiveness, ethicality, intervention coherence, opportunity costs and self-efficacy [40].

5. Conclusions

Early psychological interventions for appearance concerns following burns may be acceptable for some patients. However, ambivalence and potential barriers are apparent and need to be addressed. The timing of introducing early psychological interventions should also be considered. Nevertheless, normalising early interventions for appearance concerns by embedding them into routine burn care is likely to be important for their acceptability.

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CRediT authorship contribution statement

Laura Shepherd: Conceptualisation, Methodology, Formal analysis, Investigation, Writing – Original draft, Writing – Review and editing, Visualisation, Project administration, Funding acquisition. **Fuschia Sirois**: Conceptualisation, Methodology, Formal analysis, Writing – Review and editing, Visualisation, Supervision. **Diana Harcourt**: Conceptualisation, Methodology, Formal analysis, Writing – Review and editing, Visualisation, Supervision. **Paul Norman**: Writing – Review and editing, Visualisation, Supervision. **Andrew Thompson**: Conceptualisation, Methodology, Formal analysis, Writing – Review and editing, Visualisation, Supervision. All authors have approved the final article to be submitted.

Data Availability

The data that support the findings of this study are openly available in the Open Science Framework at https://doi.org/10.17605/OSF.IO/FBQUY.

Declaration of Competing Interest

None to be declared.

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Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.burns.2024.07.038.

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