Incorporating psychological approaches into routine paediatric venepuncture

A J A Duff

Studies of paediatric procedural distress have flourished over the past two decades, with psychological intervention strategies showing consistently high efficacy in reducing pain and fear. This review concentrates briefly on the acquisition and treatment of fear, arguing that what is witnessed clinically is not needle fear or phobia, but anticipatory or procedural distress. The main focus is on how such procedures could be amended to incorporate psychological techniques routinely, outlining specific guidelines for clinical practice.

Children continue to view venepuncture as being the most fearful aspect of attending hospital. While most are able to tolerate the procedure using a wide range of coping strategies depending on their age and gender, a large proportion are unable to do so and display high levels of fear, pain, and behavioural distress. Typically, this results in needle insertion being abandoned or the child being restrained or sedated, leading to further distress for all involved.

THE ACQUISITION OF FEAR

The term “distress” refers to a combination of fear, anxiety, and pain. Relationships between these factors are complex and have been extensively reviewed. Although conditioning theories have long since been used to help understand how children acquire fear, contemporary explanations have attributed causation to interactions between genetically linked behaviour patterns, temperamental predispositions, normal developmental fears, parental psychopathology, and discrete learning experiences, either direct or vicarious, which over time, are maintained by irrational thoughts and attention biases. Such experiences themselves depend on a range of equally important factors.

Individual factors

Age has been consistently shown to co-vary with needle pain and fear, ratings decreasing with increasing age, and with children over 8 years old, especially girls, rating needles as more “unpleasant” than “intensely painful”. Individual temperament has also been shown to be important. Children who are rated by their parents as being either more active or intense or negative in mood, display higher levels of distress. Furthermore, temperament characteristics determine whether or not parents are willing to “prepare” their child and how long they believe they can leave their child to tolerate needle insertion.

Variations in children’s cognitive abilities affect how they perceive, understand, remember, and report pain and distress. There is good evidence of the Piagetian stages of thinking, showing that conceptualisation progresses from the concrete to the abstract (table 1). Although there are no reports of adverse effects arising from the quantity of venepuncture, children’s recollections are known to be vivid, the more negative the experience, the greater the subsequent anxiety, distress, and non-cooperation.

In a sample of 7–18 year old children and adolescents, 63% recalled having a very unpleasant and painful needle-stick, and of these, 46% rated their subsequent fear as being “very” or “extremely” high. Such memories are pivotal in leading to increased worry and anticipation (although not always), as sensory stimuli in the clinical setting become more intrusive.

Parental factors

Parents also find visiting hospital with their child an anxiety provoking experience. Not only does distress arise from their child being sick, but also from knowing that they may have to endure painful procedures. There are strong correlations between parental anxiety and child distress during venepuncture, and good evidence that parents have insight into this. Yet most parents do prefer to be present during venepuncture, and irrespective of pain intensity, almost all children perceive this to “help the most”. The benefits of parents being present during the procedure and taking active roles, have been repeatedly shown. Those taught explicit distraction and comforting techniques and encouraged to use them during venepuncture, found them useful and were “more satisfied” with their child’s care than those who were present but not taught such strategies.

Situational factors

The setting and conditions under which needle insertion is performed also influences levels of distress. Distinction needs to be drawn between children who present acutely and unwell (for example, in accident and emergency units), and those with chronic conditions who attend hospital regularly. Although children in the former two groups may only encounter brief venepuncture on a “one off” basis, they often have little familiarity and few pre-existing coping strategies. They have been财务管理...
Table 1: Variations in developmental understanding of pain, reporting of pain, and appropriate distraction techniques

<table>
<thead>
<tr>
<th>Age</th>
<th>Understanding of pain and responsesa</th>
<th>Measuring pain</th>
<th>Distraction techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–3 months</td>
<td>No apparent understanding of pain</td>
<td>Self rating—none possible</td>
<td>Oral glucose18</td>
</tr>
<tr>
<td></td>
<td>Memory for pain likely but not conclusively demonstrated</td>
<td>Biophysical methods</td>
<td>Oral pacifiers (“dummies”)22</td>
</tr>
<tr>
<td></td>
<td>Responses appear reflexive</td>
<td>Heart rate18</td>
<td>Visual and auditory stimulation [e.g., blowing bubbles, singing]14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Transcutaneous oxygen19</td>
<td>[Application of EMLA]29–32</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Palm sweat19</td>
<td></td>
</tr>
<tr>
<td>3–6 months</td>
<td>Response to pain supplemented with sadness and anger</td>
<td>Observations</td>
<td>As above</td>
</tr>
<tr>
<td>6–18 months</td>
<td>Development of fear of painful situations</td>
<td>Behavioural indices [e.g., Neonatal Facial Action Coding System (NFACS)21, Children’s Hospital of Eastern Ontario Pain Scale – CHEOPS22]</td>
<td>Interactions that involve active processing and motor responses13</td>
</tr>
<tr>
<td></td>
<td>Common words for pain evolve</td>
<td>Parental ratings23,24</td>
<td>[e.g., action rhymes25], kaleidoscopes, party blowers26,27</td>
</tr>
<tr>
<td></td>
<td>Loose localisation of pain</td>
<td></td>
<td>‘Mummy’s jewellery’26</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Touch, bubble-blowing14</td>
</tr>
<tr>
<td>18–24 months</td>
<td>Use of the word “hurt” to describe pain and non-cognitive coping strategies</td>
<td>As above</td>
<td>As above</td>
</tr>
<tr>
<td></td>
<td>Awareness of methods of alleviating pain</td>
<td></td>
<td>Simple cognitive strategies [e.g., counting, being read stories, listening to music]28</td>
</tr>
<tr>
<td>24–36 months</td>
<td>Beginnings of pain description</td>
<td>As above</td>
<td>Drawing29</td>
</tr>
<tr>
<td></td>
<td>External causes attributed to pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Threat of immediate pain is overwhelming</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Future benefit not understood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36–60 months</td>
<td>Using more descriptive adjectives and attachment of associated emotions [e.g., “sad”, “mad”]</td>
<td>Gross indications6 (no pain, a little pain, a lot of pain)</td>
<td>As above</td>
</tr>
<tr>
<td></td>
<td>Difficulty in understanding that needle pain will be over quickly</td>
<td>Can grossly mark site of pain on body outline6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spontaneous use of distraction</td>
<td>“Pieces of Hurt” (poker chips)6</td>
<td></td>
</tr>
<tr>
<td>5–7 years</td>
<td>Clearer differentiation of levels of pain intensity</td>
<td>Self rating</td>
<td>Guided imagery</td>
</tr>
<tr>
<td></td>
<td>Beginning to use cognitive coping strategies</td>
<td>Accurately mark on body outline6</td>
<td>Engagement in fantasy scenes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Faces Scale6,27</td>
<td>[e.g., playing on beaches, watching the biggest TV in the world, “you’re a super-hero”]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Pain ladders”25</td>
<td>Reality conversation</td>
</tr>
<tr>
<td>7–11 years</td>
<td>Additional explanations of why pain hurts</td>
<td>Self rating</td>
<td>Listening to music</td>
</tr>
<tr>
<td></td>
<td>Concerns about pain limiting present activities rather than future ability</td>
<td>Visual Analogue Scales (VAS) and Likert and numerical scaling now possible6</td>
<td>Reading</td>
</tr>
<tr>
<td>11+ years</td>
<td>Additional explanations of the value of pain</td>
<td>As above</td>
<td>As above</td>
</tr>
<tr>
<td></td>
<td>Pain acknowledged as a “feeling”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FEAR OR PHOBIA?

Given this range of aetiological factors, what is actually witnessed clinically—fear or phobia? Fear can be considered a normal response to threatening stimuli that involves three response systems: physiological arousal, covert feelings and thoughts, and overt behavioural reactions. Phobia on the other hand, is an unreasonable response to a benign stimulus, resulting in at least one of the three elements being persistently activated. While some investigations have attempted to delineate subtypes of needle phobia (for example, vasovagal-type and resistant-type), an entirely different argument exists altogether: that needles and venepuncture are not benign stimuli for children, but unpleasant sensory and emotional experiences which invade physical and psychological “space” and threaten loss of control. Therefore, what is seen clinically, is neither fear nor phobia of needles per se, but anticipatory fear and distress. It is rare that children and adolescents become frightened and upset on seeing needles outside the context of the procedure. Furthermore, ratings of fear are much higher prior to needle insertion, after which they sharply decrease and are no different when children are offered a needle-less injection system.

TREATMENT

Most psychological treatment packages are based on the seminal cognitive behaviour therapy (CBT) work of Elliot, Jay, Olsen, and colleagues involving a combination of modelling, relaxation training, guided imagery/distraction, graded exposure/active behavioural rehearsal, and reinforcement/incentive scheduling.

Modelling has been utilised in tackling needle related distress by showing filmed models prior to the procedure. It is based on the premise that observing another child (preferably of the same sex, culture, and age group) displaying some anxiety about needle insertion but overcoming it, will help the observer to utilise successful coping skills too.

Relaxation training involves teaching the child how to gain control over the symptoms of physiological arousal by breathing slowly and deeply and releasing muscle tension. This is usually done in conjunction with guided imagery where the child is encouraged to evoke pleasant imagery and engage in fantasy “scenes”. Such techniques are often referred to as hypnosis although arguments do exist that the latter is something entirely different, involving altered states of consciousness. (However, as the aim is to enable children to actively gain a sense of internal control over their reactions as opposed to being a passive recipient of “mystical” external forces, the use of the term “hypnosis” is best avoided in this context.)

Developmentally appropriate distraction is a well established and commonly practised intervention, which mediates reductions in pain and fear (table 1). The “golden rule” in utilising distraction is that, the more interactive and varied the technique and the more active processing and motor responses are invoked, the greater the chance of distress being reduced.

Graded exposure (to the feared stimulus) is achieved by establishing successive approximations of the procedure (for example, needles in packaging being held up to arms with sleeves down), quickly building up to full behavioural rehearsals in a treatment room. Clinical experience suggests that health professionals who are not qualified to undertake venepuncture can help children reach the latter stage quickly as the child’s knowledge that “this person can never stick a needle in me” produces insufficient anxiety to be overcome. Consequently, a “qualified” carer needs to become a co-worker as early as possible in the hierarchy.

Together relaxation training, distraction, and graded exposure are known as systematic desensitisation. Another important aspect of this is reinforcement scheduling, where each accomplishment in a graded exposure hierarchy is attended to positively (that is, rewarded), thus focusing on what the child is achieving as distinct from what remains to be achieved.

Several meta-analyses and reviews of these techniques exist showing them to be highly effective. Trials also show that combinations of CBT and pharmacological approaches (for example, topical application of the easily melted (eutectic) mixture of local anaesthetics lidocaine and prilocaine (EMLA), or conscious sedation using either oral valium, midazolam, or morphine sulphate) are effective; yet, despite this knowledge too few psychological strategies have been adopted routinely by too few carers. If venepuncture related distress is to be more consistently reduced, there needs to be greater scope for such approaches to be incorporated prior to needle insertion. While there is a scarcity of psychologically trained professionals working in paediatric settings, this would be an entirely different proposition aimed at encouraging a variety of paediatric health carers to use CBT techniques and reviewing how paediatric venepuncture is routinely administered. What follows are suggestions as to how this might be achieved. These are considered in two phases: what happens beforehand (prevention), and what happens after a child reacts adversely.

PREVENTION

Prior to the procedure there are five stages to consider: assessing knowledge and experience, preparation, actively involving parents, participation and giving permission to cry, and the procedure itself (fig 1).

Assessment of previous experience

As part of initial paediatric assessment, questions need to be asked about children’s previous experience with needles. Were these traumatic? Was restraint used? What was done to ameliorate their distress and what, if anything, was effective? (While the application of EMLA to the skin where needle insertion will take place, approximately one hour beforehand is known to be effective in reducing pain, for some children this can serve as an early signal that venepuncture is imminent, exacerbating anticipatory distress. Consequently, consideration needs to be given to whether or not this outweighs the potential pain relief that EMLA application offers.) Responses to these issues will then determine how many of the following phases need to be addressed.

Preparation

This part of the process need not be lengthy, perhaps lasting only 10 minutes. However, it must include addressing the expected sensory experiences and the actual steps of the procedure. This information needs to be given to both children and parents, and may be accomplished in a variety of ways (for example, showing equipment to be used and explaining “how it might feel”, and “what it might smell or sound like”). Explanations about the actual needle insertion also need to be given, enabling misconceptions and fears to be openly
addressed. Younger children in particular believe that the needle goes into the arm itself (and in some cases expect it to "come out the other side"). They typically find the idea of it being inserted into a vein difficult to grasp. If a child is particularly anxious, it is at this juncture that observing a filmed model may be most effective. Having a "library" of videoclips, with a mixture of age, sex, and cultural "models" is invaluable.

actively involving parents

Children are likely to experience less distress during venepuncture if a parent is present.\textsuperscript{45,46} Once "prepared", parents need to be encouraged to stay and given active roles to take,\textsuperscript{47} the exception being when they themselves have needle fears or show high levels of distress.\textsuperscript{48} This needs to be discussed as openly as possible in order to avoid causing blame or guilt.
Instructions, either written or spoken, should begin by explaining that parental presence is aimed at “helping their child master a stressful situation” and that they will be encouraged to not only soothe and comfort them, but also to distract them during the procedure using developmentally appropriate techniques (table 1). This is known to be more effective than if undertaken by a health care professional. Parents should be encouraged to sit close enough to their child so that they can both see and touch them and encouraged not to give false reassurances (for example, that the needle “will not hurt”). In the event of restraint being required, where possible parents should not be involved. They need to be present in the room as a resource for the child, not staff.

**Participation and giving permission to cry**

From a very early age, children can participate in venepuncture (for example, by unwrapping certain medical equipment, cleaning the insertion site, and choosing whether they want to lie down or sit up). With the emphasis on collaborating with children as opposed to doing something to them, the older they are, the more proficient co-workers they become.

Giving children permission to cry or shout out when the needle is inserted can result in them experiencing less distress than if they are told not to cry and to be brave. Indeed, it may be useful to actually plan in advance what kind of noise the child would like to make and for a parent or health care worker to make it too, validating and “normalising” the reaction.

**The procedure**

When it is known in advance that a child is to undergo venepuncture at an outpatient appointment, it should take place as soon as possible after they arrive. This is crucial in avoiding a prolonged period where the child is exposed to a range of procedure related “cues”, which may serve as reminders of the imminent event and/or of previous traumatic venepuncture(s). Of course, at times this will be impossible (for example, when decisions are only made during the consultation process itself).

Reviewing how and where the procedure takes place is also important. Do children really need to lie down? Are there alternative locations to treatment rooms? For children who are known to be fearful, should those in training be allowed to repeatedly attempt needle insertion? Sometimes, it may be less stressful if a known and trusted health carer inserts the needle. Wherever it takes place and with whom, having as few professionals as possible in the room is vital, as is minimising disturbances (for example, by switching pagers off when possible) and interruptions (for example, by putting up “engaged” signs). Further consideration should be given as to whether the child wants to look at the needle being inserted or not. Older children, particularly those who have experienced few needles and who expect pain, are more likely not to want to look.

Once the “scene is set”, children should be encouraged to engage in their “newly acquired skills”, breathing slowly and deeply, relaxing their muscles, and distracting themselves either individually or with their parents.

**Time management issues**

In clinics where children regularly attend, time restrictions may be less of an issue with preventative work occurring between appointments. However, where time is pressured, it may be sufficient to only include some of these stages, or indeed, only certain aspects of each one. A “short form” version of the above would include:

- Stocking as wide a range of distraction materials in the clinic area as possible
- Telling the child that it is okay to make a noise
- Ensuring that the procedure occurs as soon as possible during the consultation process.

However, children with extreme venepuncture related distress are inordinately time consuming in the long term, consuming a range of resources as their fears become more debilitating and their care, increasingly compromised.

**REACTIONS IF IT ALL GOES WRONG**

When a child reacts with such distress that needle insertion is impossible, avoiding conflict and coercion is as important as facilitating “trust” and “respect”. However, a response is clearly required and three sequential questions need to be addressed (fig 1).

Firstly, consider if the procedure really needs to be undertaken that day. Secondly, if it has to be, then is there time to take a rest and to reintroduce the procedure? If so, allow the child a break away from the clinic and on their return, reintroduce the procedure piecemeal and try again. If the procedure does not need to be undertaken that day, further in-house preparation and practice-only sessions could prove effective and result in success. Ultimately an onward referral may need to be made to a child health professional experienced in CBT (either “in house” or via local child and adolescent mental health services). However, waiting times may be long and interim plans for venepuncture may need to be made.

**SUMMARY AND CONCLUSIONS**

Children continue to find venepuncture one of the most frightening aspects of coming to hospital. This should not be considered as “phobic” fear but rather “anticipatory” or “procedural” distress. As such, there is an onus to amend the procedures, incorporating effective psychological techniques routinely to avoid conflict, reduce unnecessary anticipation, and promote effective coping strategies. Children and adolescents need assistance to develop trusting relationships with professionals and gain some control over what happens to them.

Much is known about the efficacy of psychological techniques in reducing venepuncture related distress but despite this, some research continues to focus more on replicating findings and less on changing clinical practice. Clinical effectiveness will depend on how such strategies are incorporated routinely. Although psychologically trained professionals are being increasingly employed in paediatric care, this problem will always be too large to remain exclusively in their domain. Other carers do already possess skills in this area (for example, play specialists and nurses), but more will need to acquire and utilise these if real change is to occur. Support from consultants and lead clinicians to include these strategies is vital too, as large general outpatient clinics would need to be restructured to a greater or lesser extent. Empirical evaluation of attempts to do so need to be undertaken.

Future research needs to focus on: practical screening tools to identify which children may be at risk of experiencing venepuncture related distress, which strategies work for whom, group work and peer support, sustaining improvements in the long term, and evaluating the potential for the use of topical anaesthesia to increase anticipatory anxiety in children who already have high levels of fear.

**USEFUL RESOURCES**

**Treatment manuals**

A Clinical Practice Guideline for “Acute Pain Management: Operative or Medical Procedures and Trauma” and also the “Clinicians Quick Reference Guide” (1992). US Department of
Health and Human Services (USDHHS). Document numbers 92-0019, 92-0820, and 92-0032 respectively. Obtainable from the Centre for Research Dissemination and Liaison, AH&CP Publications, Clearinghouse, PO Box 8547, Silver Spring, MD20907, USA.


Resource materials

“Being Yourself” (a range of books resource materials for working with children). The Old Bakery, Charlton House, Dover Street, Dover CT16 1ED. Tel: 01304 226 900.

Action for Sick Children. c/o National Children’s Bureau, 8 Wakley Street, London EC1V 7QE. Tel: 0207 843 644 (www.actionforsickchildren.org.uk)


Website

www.edc.org/PainLink/plpresents.html (excellent overview of techniques appropriate for use in alleviating children’s acute pain).

ACKNOWLEDGEMENTS

The author would like to thank Jack Cadranel, Dorothy Fielding, Keith Brownlee, and Steve Conway for their invaluable help and support during the preparation of this paper.

REFERENCES

What's in the next issue

Future content

See which articles have just been accepted for publication and preview the table of contents for the next issue a month before it is published

www.archdischild.com