Childhood eczema treatment: the barriers

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- How the study findings could apply to children with other long-term conditions

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Childhood eczema affects more than 20% of children aged five or under (Williams et al, 2008) and can cause significant distress to the child and family, particularly due to sleep disturbance and itch.

The National Institute for Health and Care Excellence (2007) guideline on atopic eczema in children concluded that poor adherence to or non-use of prescribed topical treatments is the main cause of treatment failure. A Cochrane review found that most studies of parental education on childhood eczema have been small or of poor quality and lacking in theoretical underpinning (Ersser et al, 2014). Further understanding of the development of adherence practices in children with eczema is a necessary step in developing further interventions.

Questionnaire-based research among carers of children with eczema has shown that non-adherence may arise for several reasons, including poor understanding of the use of topical preparations and a fear of side-effects of topical corticosteroids (Beattie and Lewis-Jones, 2003; Charman et al, 2000).

Although qualitative studies have explored aspects of the therapeutic alliance between parents and health professionals in childhood eczema (Gore et al, 2005; Noerreslet et al, 2009) and carers’ views of eczema care (Santer et al, 2012), little is known about how the daily interactions between carers and children help or hinder adherence. We carried out a qualitative interview study to explore carers’ experiences of barriers and facilitators to regularly applying topical treatments for childhood eczema (Santer et al, 2013).

Method

Primary care staff at six general practices in the south of England searched their databases for children aged five years or under with a recorded diagnosis of eczema, and posted letters addressed to “parent or carer of [name of child]” inviting them to participate in the study.

Recipients were asked to return a reply slip to the research team; if they indicated that they would like to participate and their child’s eczema was still a problem, they were telephoned to arrange an appointment for a qualitative interview.

Results

Five key points

1. Barriers to adherence in childhood eczema include carers’ concerns around emollients and topical steroids, the time taken to apply treatments and child resistance.

2. Families employ a range of strategies to attempt to overcome child resistance.

3. Some carers described strategies of last resort, such as physically restraining the child.

4. Nurses and other health professionals can help families by acknowledging the difficulty of regularly applying topical treatments.

5. A choice of products should be offered to parents and children.
Interviews. Participants represented a range of urban/rural and affluent/deprived postcodes.

Qualitative interviews were semi-structured and followed an interview guide; they lasted 30-60 minutes and were carried out in participants’ homes, except for one where the participant preferred to be interviewed at her health centre. Interviews were audio-recorded, transcribed and checked against recordings. The study was approved by the Berkshire Medical Research Ethics Committee. All identifying information was removed from transcriptions and pseudonyms assigned.

Analysis was carried out thematically and iteratively using content analysis and a constant comparative approach. Participants were sent a summary of study findings and invited to comment. Those who provided comments said they felt their views were represented.

Results
Invitations were sent to 289 households and we received 70 replies; of these, 33 said their child’s eczema was no longer a problem, three declined to participate for other reasons and six could not be contacted. This resulted in a sample of 28 participants (10% of the mailing); all were parents, so we refer to “parents” rather than “carers” in our findings.

Participants identified their beliefs around eczema treatment, the time-consuming nature of applying topical treatments and child resistance as barriers to applying topical treatments. Parental beliefs (summarised in Box 1) have been presented in detail elsewhere (Santer et al, 2012).

This article explores the implications of the time-consuming nature of eczema treatment and the difficulties faced by families encountering child resistance to therapy.

Many parents spoke about the time taken to learn to incorporate the application of creams into family routines, while several described its negative impact on themselves in terms of stress or fatigue or themselves in terms of stress or fatigue or on siblings who became jealous of the child in treatment.

Families described a range of strategies aimed at overcoming child resistance, including:
- Explanation and involvement of the child in treatment;
- Distraction or games;
- Enforcing the routine, including “bribes” and force;
- Reducing the frequency of therapy or disguising therapy.

Some families found these techniques successful while others still encountered resistance.

Many parents saw establishing topical treatment as part of a daily routine as key to overcoming resistance, but strategies for dealing with this varied. Some parents expressed the view that topical treatment “had to be done” and incorporated it into the child’s routine, regardless of child resistance and with the use of force if necessary. This strategy of establishing routine by whatever means necessary was not without cost and was sometimes described as detrimental to the relationship between child and parent. A minority of parents took the approach of concealing treatment in an attempt to avoid conflict, by applying creams when their child was asleep, disguising bath additives in different bottles or, in one case, applying topical treatments under large dressings.

Some parents discussed deliberately reducing the frequency of emollient application in the face of resistance. This tactic was generally seen in parents who were more hesitant about the use of topical treatments, due to lack of perceived effects or side-effects such as stinging.

Discussion
Parents’ beliefs around eczema treatment, the time-consuming nature of applying treatments and child resistance were all barriers to adherence among interviewees. Families used a wide range of strategies to address child resistance, with varied success. These included:
- Involving the child in treatment;
- Distracting the child during treatment or making a game of it;
- Offering rewards;
- Disguising the cream;
- Applying the cream when the child was sleeping.

Some strategies seemed less desirable, such as forcing treatment on a reluctant child or reducing the frequency of applications, which could prove counterproductive in the longer term. Conflict over eczema treatments can negatively affect family relationships and can be a drain on carers’ physical and emotional resources.

These findings concur with research regarding carers’ poor understanding and concerns around the use of topical corticosteroids (Beattie and Lewis-Jones, 2003; Charman et al, 2000) and under-use of emollients (Cork et al, 2003). Although qualitative research has provided insights into the impact of eczema on families (Ellis et al, 2011; McKenna et al, 2005; Chamlin et al, 2004), there has been less qualitative investigation into barriers to use of topical treatments for eczema or strategies to overcome these.

Long-term conditions in childhood
Our findings have parallels with studies of adherence in other long-term conditions in children.

BOX 1. PARENTAL BELIEFS ABOUT ECZEMA

Parental beliefs about eczema management often differed from the medical model of eczema management. For example, families did not agree with health professionals that allergy testing is not usually helpful in eczema.

Many families felt that dietary avoidance might represent a potential “cure” and were frustrated with health professionals’ perceived lack of interest in this approach.

Some parents did not believe emollients to be effective and a minority viewed them as “unnatural” and potentially harmful if used in the long term.

Many families seemed unaware of the role of emollients in preventing flare-ups and there was widespread caution around the use of topical corticosteroids.

Source: Santer (2012)
Previous research in eczema has found that treatment adherence is more likely where carers report a strong relationship with their child’s healthcare provider (Ohya et al, 2001). The absence of this strong relationship may prevent concordance or the development of a common understanding of treatment goals.

The tension between establishing a routine by all means necessary as opposed to adopting some flexibility to side-step a child’s opposition has been found in other studies of treatment adherence for long-term conditions in children (Merzel et al, 2008). Neither strategy is without potential problems; rigidly enforcing a routine could be linked with a repetitive cycle of resistance, while deferring or skipping treatments may result in less treatment being applied.

Dermatology nurse follow-up with families and multidisciplinary educational sessions have been shown to improve outcomes in eczema (Gradwell et al, 2002) and nurse prescribing may increase adherence (Courtenay et al, 2011). However, the majority of families of children with eczema in the UK do not have access to such services as most eczema is managed in primary care.

Limitations
Although we sought to represent a range of views, the under-representation of single parents, fathers, ethnic minorities and low-income households means our interviewees may not be representative of other families.

Difficulties with topical treatment application in some families may have represented wider parenting issues not addressed during our interviews.

Conclusion
Establishing concordance through a clear explanation of the eczema treatment plan and engaging with carers’ beliefs are a necessary first step in addressing adherence to eczema treatments.

Child resistance forms a significant barrier to the regular application of topical treatments. The range of strategies adopted by parents in this study could usefully inform discussions between health professionals and carers when considering child resistance to topical treatment.