***April 2025 Mary Elizabeth's Hospital – Rigshospitalet for Children, Adolescents, and Expecting Families**. Written by the MARYS' Research and Education Team based on literature reviews and research projects rooted in the perspectives of children and teens and an international Delphi study on the healthcare professionals' perspectives. Three psychologists were involved in drawing up this overview. The content was also discussed and refined at various steering group, working group and management meetings in 2023–2024. For further information please contact Jette Led Sørensen at jette.led.soerensen@regionh.dk*

**Overview of age and developmentally appropriate communication with children and adolescents in healthcare settings.** NB: Considerable caution must be exercised in terms of age and developmental stage. Children and adolescents who are ill may seem younger than their age or may possess extensive knowledge and understanding about their illnesses or other topics beyond what is expected.

| Age | Psychological/Cognitive development | Perception of illness and death | Verbal communication for staff | Strategies for staff |
|---|---|---|---|---|
| **0–1 year** | - Completely dependent and closely attached to parents<br>- Does not understand that parents still exist when out of sight<br>- Copies others' feelings, i.e. decodes body language and moods | - No perception of illness or death<br>- Uses parents' reactions and moods as a guide | - Speak calmly and take your time<br>- Briefly describe what you perceive the child is experiencing; even if the child does not understand the words, they will understand the tone of voice and feel the attention you give them<br>- Along with speaking calmly, change to a lighter pitch and use a happy tone to increase trust<br>- Use facial expressions and mirror emotions, i.e. recognize the emotional intensity of the child and regulate your intensity to be in tune with the child | - Skin-to-skin contact<br>- Swaddling<br>- Ensure that the child can see, hear and/or smell their parents |
| **1–3 years** | - Sees themselves as the centre of everything<br>- Beginning to develop language but cannot completely express feelings and needs verbally<br>- Reacts instinctively to the emotions and moods they experience, e.g. crying when in need of reassurance<br>- Memories are unconscious but influenced by past experiences<br>- Increasingly complex emotional register<br>- No concept of time<br>- Sensitive to separation from parents | - Often communicates with their body, e.g. by turning away, crying, reaching out<br>- Recognises experiences with illness<br>- Can express that something hurts but not how little or how much<br>- Believes that illness always happens by accident<br>- Use parents' reactions and moods as a guide<br>- Does not perceive death as permanent | - Use few, specific words<br>- Gather information about the child while they are playing<br>- Use primarily closed-ended questions<br>- Tell the child what to do instead of explaining it | - Combine verbal communication and gestures that support your explanation<br>- Have the child sit upright, preferably on their parent's lap or where the child feels safe<br>- Enter the child's sphere of attention, and talk with them about what is holding their interest (e.g. through play, clothes, digital device or book)<br>- Approach the child slowly and assess how close you can get and ask whether you can touch them<br>- Initiate touch where they are not in pain, e.g. during play before the actual examination |
| **3–6 years** | - Think concretely with no concept of time, unless explained in terms of familiar everyday routines<br>- May be driven by irrational emotional logic | - Magical thinking characterises their perception of illness, i.e. the child believes that their thoughts and actions can influence their illness<br>- Has difficulty understanding unseen illnesses<br>- Understands that some diseases are contagious and others are not<br>- Understands that you can get hurt and may be fearful of injury<br>- Use parents' reactions and moods as a guide | - Be aware of possible linguistic misunderstandings that lead to believing something is dangerous, e.g. "taking a blood test", "run over for an x-ray"<br>- Avoid sarcasm and irony<br>- Say the name of the disease and where it is located in the body<br>- Explain that the staff are there to help<br>- Explain time with child-like reasoning, e.g. that you have to sleep twice before Friday | - Have the child sit upright, preferably on their parent's lap or where the child feels safe<br>- Enter the child's sphere of attention, and talk with them about what is holding their interest (e.g. through play, clothes, digital device or book)<br>- Get the child to help with something practical, e.g. unpacking equipment<br>- Consider whether it would be a good idea to use stuffed animals, specific everyday objects, models, drawings/figures, books or similar when explaining things |

| Age | Psychological/Cognitive development | Perception of illness and death | Verbal communication for staff | Behavioural strategies for staff |
|---|---|---|---|---|
| **6–13 years** | - Language almost fully developed and understands the concept of time but can best relate to specific events such as birthdays and summer holidays<br>- Typically still needs parents nearby<br>- Has the ability to worry<br>- Has a strong ability to empathise<br>- Understands others' feelings and that what they do affects others, e.g. feeling guilt and responsibility<br>- Concerned with fairness<br>- Better at hiding their true feelings and has more strategies to regulate their emotions<br>- Identifies with peers and often does not want to be different, e.g. sick | - Understands cause and effect but primarily assumes that diseases are caused by external conditions<br>- Perception of illness becomes more detailed and precise but still has difficulty understanding that something is happening inside the body<br>- Beginning to understand that death is permanent | - Talk to the child and ask open-ended questions such as "Have you done this before?"<br>- Ask what they usually do to deal with difficult situations; discuss alternatives<br>- Ask what the child has or has not understood and correct any misunderstandings<br>- Use parallel stories to explain, e.g. "Some of the other children have mentioned ... is it the same for you?"<br>- Ask and continually assess how much information the child wants to receive | - Ask the child where they would like to be, e.g. sitting on a lap, in their own chair or holding hands<br>- Consider whether it would be a good idea to use specific everyday objects, models, drawings/figures, books or similar when explaining things |
| **13-18 years** | - Gradually thinks more abstractly, has the ability to plan and take a long-term perspective but often thinks more concretely and short-term when under pressure<br>- May need help regulating their emotions, planning, and structuring as their brains are still developing<br>- Gradually increasing their independence but still need parental support<br>- Being part of a community is essential, i.e. being like the others<br>- Serious / chronic illness can lead to a greater risk of loneliness and poor wellbeing<br>- Reflects more on existential issues | - Perception of illness and concerns about late effects become more adult-like, but adult experience is lacking<br>- May feel invincible; striving for normality and forgetfulness can make managing treatment difficult<br>- Need to have information repeated and continually adapted to their age and development<br>- Have increased understanding of hypothetical situations and can gradually relate to multiple possible solutions and outcomes<br>- May need shorter timelines and perspectives, e.g. weeks to months<br>- Illness affects entire existence, including education, social relationships and sexuality<br>- Tries to gain control over something difficult to control<br>- Progressive development of an adult identity may include engaging in risk behaviours like consuming alcohol, nicotine and illegal drugs | - Talk to them like an adult but expect them to understand like a child<br>- Use everyday language and incorporate in relationship building<br>- Ask what they think is important to talk about and what / how much they want to know<br>- Support health literacy, for instance by using the correct words about illnesses and medicines, and confirm that everything has been explained sufficiently and they have understood<br>- Provide time for reflection and processing information<br>- Provide support by asking questions using the HEEADSSS* dialogue tool<br>- Focus on their resources and strengths, not just problems and risk behaviour<br>- Involve them in all considerations and decision making in a developmentally appropriate way, and obtain informed consent<br>- Ensure that they are aware that healthcare professionals do not have a duty of confidentiality toward their parents; agree on how and when their parents should be informed and involved | - Want the same respect as adults but the same care as children<br>- Try to meet them on their terms and be curious about what they find important and difficult<br>- Involve them in decision making<br>- Have split-visit discussions so they spend part of the time alone<br>- Support their need for independence<br>- Use metacommunication about what you are doing and why<br>- Be curious about their views on treatment and their priorities<br>- Help them make sense of their treatment<br>- Do not assume that you know what they are thinking<br>- Ask what they think is currently important to achieve before telling them what is on the agenda, and then agree on a common agenda<br>- If necessary, use the HEEADSSS* format to touch on all aspects of their lives, including strengths, weaknesses and networks |

* Read more about HEEADSSS: https://stpn.uk/wp-content/uploads/2023/04/HEADSSS-by-Goldenring-2004.pdf