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The dynamic experience of pain in burn patients: A phenomenological study

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ABSTRACT

Although pain is one of the main sources of suffering during the acute phase and rehabilitation in burn patients, it remains as a major challenge for burn care, and clinical management not always correlates with the experience felt by patients. The aim of this study was to understand the experience of pain from people who has suffered severe burns, to identify personal strategies used to cope with this challenging event. A qualitative phenomenological study with purposive sampling was carried out with severe burn patients admitted to a Burn Unit. Through individual in-depth interviews, verbatim transcription and content analysis, two main categories were isolated: a dynamic and changing experience of pain, from the onset to the hospital discharge, and diverse strategies developed by patients to cope with pain, being distraction the most frequently used. Pain experienced acquires its maximum intensity during wound care, and divergent patients' opinions about sedation are present. This study highlights how understanding subjective experiences is an invaluable aid to improve care in pain assessment and management. Furthermore, it points out the need to guarantee patient involvement in the organization and improvement of burn care, inasmuch as traditional professional centered approach is not ensuring an optimal management.

1. Introduction

The incidence of severe burns requiring hospitalization ranges around 11 million people in the world, although most burns do not result in death. However, the impact on disability and mortality is higher in countries with low incomes, where prevention programs and quality of acute care have a variable development [1]. Consequently, hospitalizations due to burns present high rates of variability among countries and regions, ranging from 3% to 10%, with an average ratio of 20% of body-surface area burned [2].

One of the consequences that generates more suffering during the acute phase and rehabilitation in burn patients is

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the presence of pain. Most studies place this symptom as the most important one that is referred to by patients and it is a major challenge for a health care team. The classical definition of pain as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage [3] has, in the case of burns, some singularities. There are many factors that affect the conscious perception of pain, such as cognition (attention, self-belief, appraisal), burn wound characteristics (dressing, infection, movement, donor sites), mood, predisposition (genetics, substance abuse), context (expectations, culture, past experiences, environment, relation with staff), or drug factors [4]. Thus, pain in burned people has an evolutionary character, both centrally and peripherally, and the classical classification depending on thickness and area affected does not always correlate clinically with the experiences felt by patients [5]. Subsequently, the same type of lesion can be perceived in a completely different way by different patients, in conjunction with the evolutionary changes of tissue regeneration, psychological factors, and the context of patient care [4].

This diversity and complexity of factors that determine the control of pain in burn patients require health care teams to recognize these difficulties as the first step to offering appropriate intervention and treatment to this unique patient group [6]. Optimal control of pain is not always achieved, despite the known adverse consequences of inadequate management of pain in burn patients [7]. For example, mental health problems are common adverse outcomes associated to a bad acute pain experience, including risk of suicide [8–10].

Due to the very subjective nature of the experience of pain, an approach with qualitative methods may contribute to a deeper knowledge in areas difficult to evaluate with quantitative methods, such as perceptions and experiences of patients with pain, the intrinsic mechanisms developed to handle these situations, and environmental factors that could modify their experiences. Some qualitative studies have reported patients' experiences and memories of pain such as becoming aware of pain, allowing oneself to feel pain, different pain experiences, fragile body surfaces, patients' experiences of pain control, patients' perceptions on burn-pain management, and patients' expectations of burn-pain management [11,12]. Moreover, the need for patient involvement in planning and improving care is another area that has been identified in patients with severe burns [13], so that qualitative methods offer an excellent framework for this purpose.

The aim of this study was to understand the experience of pain from people who have suffered severe burns to identify personal meanings given by the patients and which strategies they used to cope with this challenging experience.

2. Methods

2.1. Design

Due to the subjective nature of the experience of pain and the aim of the study, a qualitative phenomenological descriptive design was carried out.

2.2. Patients and study participants

A purposive sampling was conducted from patients who had been admitted into the Burns Unit of the University Regional Hospital of Malaga (Spain). To be included, patients needed to be over 18 years old, give their consent to participate, be able to maintain a fluent conversation in Spanish, and must have being admitted to the Burns Unit for at least three weeks so that they had enough time to face different pain experiences, regardless of the body-surface area burned. In this Unit, the criteria from the American Burn Association are used to classify severe burns for adults [14]. Gender was used as an additional criterion because of its influence on significance that men and women give to their health care events and experiences [15,16]. Additionally, women are more likely to experience psychosocial issues such as body image disillusionment secondary to burn [6], lower self-esteem, and heightened anxiety [17], and they also report more burn treatment and rehabilitation problems [18]. Finally, gender is a principal factor influencing burn patients' quality of life [19].

Moreover, an additional criterion for sampling was the time from hospital discharge. A maximum variation sampling was applied to maximize the diversity related to this issue. Initially, in accordance with sampling recommendations for phenomenological studies, six patients were planned to be recruited [20], although purposive selection continued until reaching information saturation. This principle was evaluated by calculating the frequency of categories obtained as the interviews were carried out. Once the analysis returned no significant new codes or categories, saturation was considered to be achieved.

2.3. Data collection

Patients were contacted by telephone to propose their participation in the study. Once accepted to participate, they were appointed at the Faculty of Health Sciences to conduct face-to-face interviews in order to carry them out in a place other than the hospital so as to avoid constraints derived from context, in case of developing interviews at the hospital. They were given verbal and written information about the reasons for doing the study, the interviewer's background, the members and interests of the research team, as well as the characteristics of a qualitative interview in which they could express openly any opinion that they considered opportune. The interview was guided by a script with open-ended questions that were developed from themes identified in the literature on pain in burned people, which had undergone discussion among members of the research team in order to agree upon the script's final contents (Table 3). A male member of the research team with 18 years of experience in qualitative research, and who has no therapeutic relationship with the participating patients, conducted the interviews. A female member of the research team was present during the interviews to take notes about non-verbal clues and the context of the interview, but with no verbal participation. The topics suggested during the interviews included their memories about pain from the beginning of the accident and along the whole process, the meaning of pain in those moments, thoughts, fears, emotions, and sensations that