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Early assessment and identification of posttraumatic stress disorder, satisfaction with appearance and coping in patients with burns



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ABSTRACT

Background: The first year after severe burn is a psychologically challenging period for the patient. Patients may still struggle with burn-related physical and psychological problems such as posttraumatic stress disorder (PTSD) and body image dissatisfaction (BID).

Aim: This study investigates the presence of PTSD, BID and coping, at three, six and twelve months after discharge for early identification of patients in need of focused support during rehabilitation.

Methods: Fifty-two adult patients with different degrees of burns were followed at three, six and twelve months after discharge and 36 patients completed all assessment points. A standardized clinical protocol was used for systematic assessment of PTSD (IES-R), BID (SWAP-Swe) and Coping (CBQ). The follow-up included an intervention with a burn nurse as a complement to the existing program.

Results: Approximately half of the patients had a risk of developing PTSD three months after discharge from hospital, and body image dissatisfaction was found to potentially predict risk of PTSD during follow-up.

Conclusions: The findings suggest that it is important to include patients with less extensive burns in follow-up as this group is at risk of development of PTSD. Using standardized questionnaires in early follow-up along with assessment of body image dissatisfaction may facilitate detection of psychological problems.

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1. Introduction

Burn patients are a heterogeneous group with broad variation in age and characteristics of injury with an over-

representation of individuals with a history of pre-injury psychopathology [1,2]. Burn patients are confronted with excessive challenges in their recovery process on a physical, emotional and social level. The first year after hospitalization is a psychologically unique period for the patient. During this

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time, patients may still be coping with memories and flashbacks of the trauma, and struggle with daily problems related to burn-related physical limitations [2].

Posttraumatic stress disorder (PTSD) is a significant problem among burn patients, and the prevalence varies between 3–35% at 1 month after-burn, 2–40% at 3–6 months and 9–45% one year after-burn, depending on the type of measure used [3]. Another source of stress after burns is body image dissatisfaction (BID) which is an important predictor of long-term psychosocial functioning disorder [4]. A person's ability to cope with and manage stressful situations affects their adaptation and burn-related health [5].

Most burn centers have outpatient clinics with a multidisciplinary burn team, but guidelines for structured follow-up programs are not commonly used [6]. Structured programs for the identification of patients with severe psychological problems, such as PTSD, BID and problems with coping after burns, are uncommon.

In this study we restructured and further developed the burn follow-up program to take place at three, six and twelve months, by adding the assessment and support of trauma-related symptoms by a specialized burn nurse as a complement to the existing program. The authors have recently validated the Satisfaction with Appearance Scale (SWAP-Swe) to Swedish-speaking burn populations [7] and that questionnaire was used in this study.

The aim of the study was to investigate the presence of PTSD, BID and coping strategies up to 12 month after hospital discharge for the identification of patients in need of support during rehabilitation.

2. Material and methods

2.1. Participants

The study was conducted at the Karolinska University Hospital, in the Department of Reconstructive Plastic Surgery. Burn patients in the Stockholm area who had been admitted to the Karolinska University Hospital or other university hospitals, between February 2011 and December 2013 were consecutively invited to participate in the follow-up study if they were: 18 years of age or older, Swedish-speaking, without documented mental illness or dementia, and had a length of stay in the inpatient burn care of more than one day.

2.2. Data collection procedure

The patients were invited to attend a follow-up visit at the outpatients' clinic at three, six and twelve months after discharge from the hospital. Information, an invitation to participate in the study and the questionnaires were sent by mail to patients who met the inclusion criteria. Patients were asked to bring the completed assessment questionnaires to the visit. Patients also had the opportunity to ask questions and complete the questionnaires during the visit, if any questions had arisen related to the questionnaires at home. Patients were instructed to give an evaluation of their present situation when responding.

At the three- and twelve-month follow-ups, assessment included the Impact of Event Scale-Revised (IES-R), the Swedish version of the Satisfaction with Appearance Scale (SWAP-Swe) and the Coping with Burns Questionnaire (CBQ). At the six-month follow-up, assessment included only the IES-R. The clinical protocol during the visit was the same for all follow-up visits. Data about the injury (burn size, injury severity, length of hospital stay, surgery), age and gender were assembled from the patients' medical records. Burn severity, according to the Swedish National Board of Health [8] and Tobiasen's Abbreviated Burn Severity Index score (ABSI) [9] was confirmed by an experienced plastic surgeon. The classification of burn by the Swedish National Board of Health was used. The total body surface area (TBSA %), the extent of full thickness burns (TBSA-FT %) and co-morbidity conditions that influence the severity of burns were included in the evaluation. The Regional Ethical Review Board of Stockholm approved the study and informed consent was obtained from all individuals. The study was performed according to the principles of the Helsinki Declaration, 2004 [10].

2.3. Clinical follow-up and assessment of the patients

Follow-up care was based on the existing multidisciplinary approach. The burn team consists of the plastic surgeon, a specialized burn nurse and an occupational therapist. If the patients have need for physical therapy, intervention by a psychologist or pain treatment, this is provided. During the follow-up visit the plastic surgeon focuses on symptoms and problems related to the burn: evaluation of the healing of wounds, control of scar tissue, pruritus, pain, functionality and corresponding medical conditions. As a complement to this regular follow-up care, an intervention provided by the burn nurse focused on lifestyle issues, symptom experience and the patient's ability to perform self-care, for example, wound care.

For the nurse follow-up, a standardized clinical protocol was used for systematic assessment of symptoms and problems. The protocol included questions about daily life (e.g. about exercise and eating habits), self-care needs, quality of sleep, presence of nightmares and pain intensity. Using a numeric scale ranging from 0 to 10, where 0 represents "no pain" and 10 "worst imaginable pain", assessed the intensity of pain. An important component of the nursing intervention was to provide psychosocial support by establishing a relationship with the patient. The patients could also contact the burn nurse by phone when needed. Patients also had the opportunity to ask questions and discuss any possible problems or questions related to the burn. If any physical or psychological difficulties related to the injury were present, these were discussed with the plastic surgeon and the patient could be referred for further treatment.

2.4. Questionnaires

2.4.1. Impact of Event Scale-Revised (IES-R)

The Swedish version of the Impact of Event Scale-Revised (IES-R) was used to assess symptoms of PTSD. IES-R has been validated by Sveen et al. [11] to be a sensitive tool for the discovery of PTSD in burn patients and to have good properties as a screening tool for follow-up after burns. The questionnaire

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