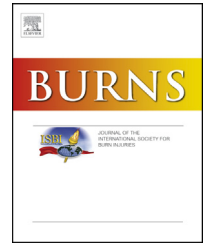


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The Fenix II study: A longitudinal study of psychopathology among burn patients

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ABSTRACT

Psychological symptoms are common among burn survivors. However, knowledge about epidemiology and predictors of psychopathology has shown great heterogeneity in this population. The Fenix-II Project was the first epidemiological study on the psychopathological consequences of burns developed in Spain, providing a detailed analysis of the progression of psychological symptoms during the first six months after injury. Three hundred and thirty-three patients were screened and 183 were included in this study. Posttraumatic, depression and anxiety symptoms showed a general decreasing tendency across time. At 6 months, 34 patients showed clinically significant Posttraumatic Stress Disorder (PTSD) symptoms (20.5% of 166 patients reached at 6 months) as assessed with the MINI Neuropsychiatric Interview. Within this group of patients, anxiety, depression and hyperarousal increased at 30 days, and avoidance 90 days after injury. The most accurate predictors of PTSD were found to be being burned in a Motor Vehicle Crash, risk of social exclusion, low body-image adjustment, anterior trunk location of the burn and life threat perception during the burn-shock period. Considering these factors, clinicians may identify patients at risk of PTSD development, allowing an adequate follow up and preventive interventions which may minimize the psychological consequences of burns.

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1. Introduction

The incidence of burns requiring medical care is nearly 11 million people a year throughout the World [1], producing significant morbidity, long-term disabilities and still in many cases, fatalities. Advances in the prevention and approaches

to fire extinguishment have reduced the extension of, and mortality caused by burns [2]. Furthermore, while about 60 years ago the survival rates of patients with a total burn surface area (TBSA) covering 40% of the body was 50%, currently people with a 70% TBSA have the same survival rates [3]. This increase in survival due to the improvement of

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medical treatments has enabled a specific focus on the mental health of burn survivors [4]. Within these new approaches, psychosocial assessment and interventions have made significant progress in the prevention, detection and treatment of the mental health consequences following a burn [5].

Psychological sequels of burns involve mainly affective and anxiety symptomatology [6]. Although diagnoses such as major depression and generalized anxiety are common in these patients [7-9], the emergence of acute and posttraumatic stress disorders (ASD and PTSD, respectively) as specific diagnoses allowed a more detailed analysis of the acute psychological consequences of burns and its risk of chronification [10,11]. However, literature in this field is still scarce.

Regarding its epidemiology, prevalence rates of PTSD in burn patients range from 3% to 45% [12]. In this regard, epidemiological studies on the progression of PTSD symptoms within burned patients have mainly been conducted in the U.S. and Nordic European countries where treatment is highly developed. However, there have been some studies coming from Mediterranean [13] and some emergent countries [14,15]; showing similar PTSD figures [12]. No major epidemiological differences should be expected from similarly developed areas, as the factors related to the incidence of PTSD are associated with the development of medical treatment at the time of the study, the type of population and the methodology with which the study was carried. However, as specific differences could be found in diverse clinical settings, we consider important to screen the occurrence of psychological symptoms, adding methodological developments to improve the understanding of the risk factors for its development and progression.

Regarding the possible predictors of PTSD occurrence among burn survivors, clinical variables such as the occurrence of a blast, the amount of TBSA affected, previous affective disorders, delirium, dissociative experiences, severe pain during acute treatment, and the length of stay (LOS) in medical settings, appear as good predictors of psychological distress, including PTSD [10,16,17]. However, personal and subjective variables such as age, female gender, life threat perception during the burn-shock period, and lower levels of perceived social support, also appear to affect the course of psychological adjustment after a burn [6,12,18-20]. Indeed, according to some authors, subjective and personal variables may have a more pronounced impact on distress than the clinical characteristics of the burn [13,21]. Nevertheless, until now, few studies have systematically included a sufficient set of clinical and subjective factors, neither meta-analytic evidence seems enough to effectively predict the occurrence and chronification of PTSD symptomatology, and therefore, which patients have a greater need to receive preventive interventions.

The aim of this work was to explore the progression of psychological sequels among patients included in the Fenix-II, a longitudinal study of psychopathology in burn patients admitted to a specialized unit in Barcelona, Spain. This paper will focus on: (1) the epidemiology and progression of posttraumatic symptomatology across the first 6 months after burn, and (2) the clinical and psychosocial predictors of PTSD during this period of time.

2. Methods

2.1. Participants

The Burn Centre of the Vall d'Hebron hospital system provides services for a total population of 8 million persons corresponding mainly to the Catalonia Region (an autonomous community with a total population of 7.5 million). The incidence of burns in Catalonia corresponds to the average in developed countries [22], with 31.2 per 100,000 person/year referred to specialized units [23]. Four hundred and eighty nine patients were admitted into the Plastic Surgery and Burns Department of the Vall d'Hebron University Hospital in Barcelona (Spain) between April 2009 and June 2011 (see admission criteria in Fig. 1).

From this initial pool, three hundred and eighty three patients between 18 and 75 years of age were screened, and 183 agreed to be included in the study after applying the following exclusion criteria: (a) not enough Spanish/Catalan language proficiency; (b) Mini-Mental State Examination <23; (c) exitus and, (d) recruitment limitations (i.e. short term admissions of less than 72 h or admissions for follow up of long-term sequels). No patient explicitly withdrawn consent once included in the study. A flow chart of the study can be seen in Fig. 1.

2.2. Study design and procedure

This study was a longitudinal follow-up across 6 months, in which 6 assessments were made, at 7, 14, 21, 30, 90 and 180 days after the burn. An ad-hoc structured baseline interview which included sociodemographic and relevant medical history data as well as characteristics of the burn was administered by two trained psychologists. Additionally, a battery of self-administered questionnaires was provided to participants in each assessment (please see instruments section below). The study was approved by the Clinical Research Ethics Committee of the hospital. Additionally, patients included in this study accepted participation in a voluntary and anonymous basis by signing an informed consent according to the Helsinki Declaration (amended in Tokyo, 2004).

2.3. Measures

As said above, an ad-hoc inventory was used to record the sociodemographic characteristics including age, gender, marital status, cohabitation, education, employment, access to housing and perceived social support (support from family, colleagues, and friends measured with a 1-5 Likert scale). Injury and clinical features included TBSA, LOS, degree of burn, body location, aetiology, place of occurrence (including home, work, street, camping/barbecue, vehicle, and a small amount of other settings such as public buildings), circumstance of occurrence (including occupational, suicide attempt, motor vehicle crash, aggression and other non-intentional incidents, i.e. incidents in which none of the previous circumstances were applicable, mostly daily activities which are supposed to imply low risk such as scald or steam burns),

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