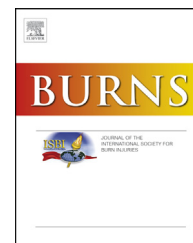


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Coping styles and quality of life in adults with burn



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ABSTRACT

Objective: The purpose of this study was to examine the pattern of connections between coping strategies and indices of burn-related quality of life (BRQOL).

Method: Burn patients ($n = 83$) were recruited from an outpatient burn clinic in the critical care hospital of a South Atlantic medical college. Participants completed measures of coping and BRQOL while in the waiting room before or after their medical appointment.

Results: A canonical correlation found that coping strategies and BRQOL were highly correlated with 47.6% overlapping variance. Within this canonical correlation, body image and dysfunctional coping had the largest loadings, suggesting that individuals with burn who exhibit negative perceptions of their body tend to engage in more dysfunctional coping styles. A multiple regression then found that a set of dysfunctional coping styles explained 39.2% of the variance in body image, with self-blame and self-distraction as independent predictors of negative perceptions of their body.

Conclusions: Targeted intervention research that focuses on the reduction of psychological distress related to body image, self-blame, and self-distraction may have the potential to increase quality of life among individuals with burn.

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1. Introduction

Burn-related injuries are a prominent public health issue as approximately 11 million individuals worldwide experience burns each year that receive medical attention [1], and in the United States, this figure is approximately 450,000 individuals [2]. Burns result from multiple etiologies and frequently occur on visible portions of the body such as the arms and hands [3]. One important aspect of health among individuals with burn is burn-related quality of life (BRQOL). BRQOL centers on physical, social, and role functioning in addition to current

psychological state and general health perceptions [4]. Among individuals who have sustained a burn, multiple psychosocial and physical difficulties may be present. One of the most frequent and distressing complaints among individuals with burn is pain [5,6]. In addition to pain, psychological issues are common, as 13–23% of individuals with burn exhibit depressive symptoms, while a larger portion (13–45%) are diagnosed with posttraumatic stress disorder [7–11]. Additionally, nearly 20% of individuals with burn experience delirium, while 33% experience alterations in current mental status (indicating a reduced level of cognitive functioning on the Mini Mental Status Exam) [12]. 27.2% of individuals with burn in one

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sample met criteria for a substance use disorder six months after injury, which was also associated with greater burn severity [13]. Individuals with burn also commonly experience sexual dysfunction [14] and difficulty with social interaction as a result of their scars and public responses [15,16]. In addition to overall mental health, body image is often an issue among individuals who have sustained a burn [15]. Although burn scars by themselves do not predict individuals' perceptions of their body [17], coping strategies play a large role in how individuals manage and cope with their scarring or other visible differences [17]. Without adequate coping strategies, patients with burn who have negative views of their body can exhibit difficulties with psychosocial adjustment, self-esteem, and depression [18,19]. Therefore, an understanding of the role of body image in BRQOL is important to investigate.

To cope with physical and psychosocial problems, individuals with burn may employ multiple strategies. Generally when psychological difficulties such as depression, anxiety, and PTSD have been studied after burn [7–11], there are more and less adaptive coping strategies that typically emerge. Enlisting social support [20] is common and has been associated with more positive outcomes including a sense of belonging [21] and better rehabilitation [22], especially through the use of family and friends, professional, and peer support [20]. Additionally, acceptance of injury and spirituality/religious beliefs have been found to be associated with better outcomes [20]. Avoidant coping strategies, which involve cognitive and behavioral efforts oriented toward denying, minimizing, or deliberately suppressing distressing feelings/experiences [22], are associated with increased psychological distress, depression, and PTSD among individuals with burn [23,24]. Therefore, it does appear that different methods of coping following a burn can influence psychological reactions. Despite the research that has linked coping strategies broadly with mental health in individuals with burn, no research has yet taken a more nuanced approach to examine which specific aspects of coping are most related to unique factors of quality of life following a burn. As a result, the purpose of the current study is to examine the pattern of connections between various problem-focused, emotion-focused, and dysfunctional coping strategies and specific indices of quality of life following a burn.

2. Method

2.1. Participants

Burn patients were recruited from an outpatient burn clinic located in the critical care hospital of a South Atlantic medical college. This visit to the outpatient clinic may or may not have been the first visit since hospital discharge and was varied in time since hospitalization among the participants. To participate in the study, patients needed to have experienced an acute burn, be at least 18 years old, and be able to read and write in English. Of the initial 89 patients who completed the Brief COPE and Burn-Specific Health Scale (BSHS), 6 cases did not have at least 50% of data present for both the Brief COPE

and the BSHS and were excluded from the current analyses, resulting in 83 participants. Sixty-four of the remaining 83 had complete data. Fourteen of the 83 participants had incomplete but at least 50% of data on both scales, so missing values were imputed using a linear trend-at-point procedure. Four additional participants did not have at least 50% complete data for the 9 subscales of the BSHS, but did have more than 50% of the data for the Brief COPE; these participants were retained, and only their missing values for the Brief COPE were imputed. Only one participant had less than 50% complete data on the Brief COPE, and thus only that one participant's BSHS values were imputed. In the end, data for 19 of the final 83 participants included some level of imputation, but never to amount to more than 50% imputation for any one scale for a participant. See Table 1 for patient demographics. In particular, participants were generally assessed outside of the acute phase of injury ($M = 4.25$ months, $SD = 6.27$).

2.2. Measures

The Brief COPE [25] is used to assess different coping strategies across multiple domains of coping using 14 two-item subscales. Item responses range from 1 – “I haven't been doing this at all” to 4 – “I've been doing this a lot” in relation to how individuals deal with problems they face. This measure was derived from the COPE [26] inventory using factor analytic procedures. The shorter version is a highly reliable measure with good validity demonstrated across multiple samples [25,27–30]. Brief COPE subscales were turned into composite scores of emotion-focused (acceptance, emotional support, humor, positive reframing, and religion), problem-focused (active coping, instrumental support, and planning), and dysfunctional coping (behavioral disengagement, denial, self-distraction, self-blame, substance use, and venting) [29]. Higher scores on these subscales are associated with increased use of these coping strategies.

The Burn Specific Health Scale-Brief [31] is a shorter, 40-item version of the original BSHS [32]. The BSHS-B was derived from an exploratory factor analysis of the BSHS [31] yielding 9 subscales that encompass aspects of burn-related quality of life (BRQOL). These include heat sensitivity (“being out in the sun bothers me”), affect (“I often feel sad or blue”), hand functioning (“signing your name”), treatment (“taking care of my skin is a bother”), work (“my burn interferes with my work”), sexuality (“I feel frustrated because I cannot be sexually aroused as I used to”), interpersonal relationships (“I would rather be alone than with my family”), simple abilities (“bathing independently”), and body image (“the appearance of my scars bothers me”). Items on the BSHS-B are scored on a 5-point Likert scale ranging from 0 – “extremely” to 4 – “not at all.” These ratings are associated with the level of agreement on each item (for emotional questions) or difficulty with completion of the task (physical items). Good internal consistency for each of the 9 subscales has been demonstrated [31], as well as good validity in multiple samples of patients with burn [33,34]. To account for multicollinearity between hand functioning and simple abilities, ($r = .90$) both variables were averaged together to create a composite score.

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