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Gender differences in resilience and psychological distress of patients with burns

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ABSTRACT

This research explored the gender differences in resilience and psychological distress of patients with burns. In Pakistan, psychological states of patients with burns have not been widely studied, women making up as the neglected section of society lag far behind in availing the needful health facilities. It was hypothesized that there would be significant gender differences in resilience and psychological distress of patients with burns. The sample of the study consisted of 50 patients with burns, obtained from four different hospitals of Lahore. In order to investigate resilience and psychological distress, the State Trait Resilience Scales (Hiew, 2007) and Kessler Psychological Distress Scale (Kessler, 2001) were used. In addition to these, self-constructed demographic questionnaire was administered. The data was analyzed using SPSS version 16.0. Independent sample *t*-test was conducted to find gender differences in resilience and psychological distress. The findings from the current research revealed that there were significant gender differences in resilience and psychological distress of patients with burns. The insightful findings from the current research carry strong implications for the clinicians, psychologists and policy makers who can help to develop and implement the rehabilitation programs for the affected population and can launch resilience promoting programs that would help them in coping with burns in effective manner.

1. Introduction

Major burn is one of the most severe traumas a person can endure, because skin is the largest organ of the body. Skin not only serves as defensive function but also maintains the shape and looks of the body. There can be many reasons to believe that survivors of massive burns are likely to experience a diminished quality of life, suffer much psychological pain and many symptoms of psychological ill health [1]. Clinically significant in-hospital psychological distress has been found to be common and tends to persist in in-hospital patients with burns [2]. There have been vivid findings on prevalent psychiatric and psychological issues among patients with burns [3].

First degree burns show redness; second degree burns show vesication, third degree burns show necrosis through the entire skin. Burns of the first and second degree are partial-thickness burns, those of the third degree are full-thickness burns [4,5].

Burn is often a devastating event with long-term physical and psychosocial effects. Burn scars after deep dermal injury are cosmetically disfiguring and force the scarred person to deal with an alteration in body appearance. In addition, the

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traumatic nature of the burn accident and the painful treatment may induce psychopathological responses. The risk factors, related to depression are pre-burn depression and female gender in combination with facial disfigurement [6]. Risk factors related to PTSD are pre-burn depression, type and severity of baseline symptoms, anxiety related to pain, and visibility of burn. Social problems include difficulties in sexual life and social interactions [7]. Quality of life initially seems to be lower in burn patients compared with the general population. From literature, it is concluded that cognitive (behavioral) and pharmacological (selective serotonin reuptake inhibitors) interventions have a positive effect on depression. Lawrence et al. [8] provide a more reliable study which shows that social stigmatizations experienced by burn survivors lead them to distress and depression Lawrence et al. [8]. In general, psychopathology and psychological problems are identified in a significant majority of burn patients [9]. ''Resilience refers to a dynamic process encompassing positive adaptation within the context of significant adversity. Implicit within this notion are two critical conditions: (1) exposure to significant threat or severe adversity; and (2) the achievement of positive adaptation despite major assaults on the developmental process'' [10]. ''Psychological distress is a nonspecific term that encompasses sadness, frustration, anxiety and a number of other negative mood states'' [11]. Resilience acts as significant factor when there are experienced harsh conditions, stress, infirmity and other unfavorable experiences, and also on maintaining personal health [12].

Correspondingly Roca et al. [13] investigated the pervasiveness, history, and psychosocial blow of posttraumatic symptoms among the adult burn survivors. While assessing the forty-three adult inpatients at a burn center, it was observed that the psychiatric symptoms were present. Thirty-one patients were evaluated 4 months after discharge. Posttraumatic stress disorder was diagnosed in 7% of patients at discharge and in over 22% of patients at follow-up. Symptoms of avoidance and emotional numbing tended to emerge after discharge from the hospital. While posttraumatic symptoms were associated with symptoms of depression, they were not strongly associated with psychosocial adjustment to illness; psychosocial adjustment was more strongly related to aspects of personality, the injury itself, and its treatment. Since adult burn survivors often develop new symptoms of posttraumatic distress after leaving the hospital, longitudinal surveillance is required to detect new cases and provide appropriate treatment. Survivors at risk for poor psychosocial adjustment after discharge may be identifiable during hospitalization, and preventive treatment strategies should be developed and tested for this population. A successful adaptation and adjustment after experiencing an adverse, hostile, or negative event is referred to as resilience which may be the protective shield and principle component of survival for survivors of a severe burn. Assessment of psychiatric outcomes with these patients may provide ways of measuring effects of acute burn care methods on later quality of life, specify more accurately their emotional needs during rehabilitation, and stimulate further research [14]. One such study from realm of western research shows that thirty children, aged 7–19, with severe burns were compared with 30 non-burned subjects matched for age, sex, SES, and parents marital status. The burned children had significantly higher levels of overanxious disorder, phobias, and enuresis, but they had the same rates of present depressive disorders [15].

There are certain reported clinical evidences that burn patients report impaired psychosocial malfunctioning but that is markedly reduced when a better resilient approach is undertaken. There have been multiple researches that have revealed that quality of life and psychological well-being is markedly different for the individuals who demonstrate better resilience [16,17]. Earlier research had focused on the intensity and impact of burn events as significant in determining quality of life and psychological well-being but recent decade has seen the trend of focusing more on self-based factors that enable one to cope well with distress Psychological resilience is the 'ability to adapt to stressful events with good outcomes', This has been one of such areas that have been ignored though the resilience appears to play significant role in determining the quality of life of adults with burns.

Although there is no agreed upon definition of resilience but generally it is defined as psychological process of coping and adapting to the phenomenon of stress [18]. Resilience is a psychosocial buffer that helps to lessen the impact of any disease in one's life. It is a dynamic concept and is assumed to be the ability to uphold healthy levels of functioning over time regardless of harsh conditions or to return to normal function after adversity [19]. Findings from physical disease resilience research may be used to develop approaches to reduce the burden of disease.

In the same way Brown et al. [20] determined whether variables associated with psychosocial adjustment to a burn varied by gender. 260 Male and female burned subjects were compared on their functional disability, disfigurement, coping responses, social resources, and psychosocial adjustment to a burn. Both men and women had adjusted psychosocially to their burn. Less functional disability for men and greater problem-solving for women were the most important variables in explaining psychosocial adjustment to a burn.

1.1. *Rationale*

Patients with burns have never been rigorously assessed as far as the gender differences in their psychological post states to burns are concerned. Current research is a pioneer attempt in Pakistan to unravel the dynamics of the recovery and psychological rehabilitation of such patients. Since recent medical and surgical advances allow many severely burned patients to survive who formally would have died. Thus there arises greater need to review the important dynamics of their distress and resilience. The current research study caters sound understanding into dimensions of distress and resilience and how it systematically varies across both genders. Everyone has the ability to cope with distressing calamities. This study would provide the greater understanding to the resilience and distress levels of patients. It can also help clinicians and especially health psychologists dealing with burn injured patients to enhance their resilience level and reduce their distress easily there be a guideline for psychologists to help the burn injured patients according to their distress and resilience level.