FLUCTUATION OF PSYCHOLOGICAL STATUS IN BURN PATIENTS DURING HOSPITALIZATION

Castana O.,[1] Makrodimou M.,[2] Katsaraki E.,[2] Apostolopoulou C.,[1] Alexakis D.[1]

Evangelismos General Hospital, Athens, Greece
[1] Department of Plastic and Reconstructive Surgery
[2] Department of Psychiatry

SUMMARY. This paper considers the fluctuations in psychological status that occur in burn patients in the acute phase, during hospitalization, and in the post-hospitalization period. The various disorders are reported. Psychiatric consultation is mandatory, along with psychological support, and appropriate medication should be prescribed.

Introduction

When an accident takes place, several losses occur, both material and physical. A burn stigmatizes both the body and the soul of the victim.[1] The physical appearance of patients with burns attracts more attention, although the psyche should also be attended to. When a patient arrives in the emergency room, the physiopathology caused by the burn injuries is addressed and action is taken to stabilize bodily function. This is of course of primary importance. But it is of equal importance to stabilize the patient's psychological status, starting in the emergency room and continuing in the ward.[2] Burn patients are isolated in order to eliminate the possibility of infection and visits are controlled. The medical and nursing staff confront the patient with pity, and the patient's relatives are usually appalled by the victim's physical appearance. This destabilizes the psychological status of a patient with a major disease and provokes sense of guilt for the accident that has occurred or a sense of grief at being involved in a fire accident responsible for family or economic loss.

Psychiatric symptoms in the acute phase, during hospitalization, and in the post-hospitalization period

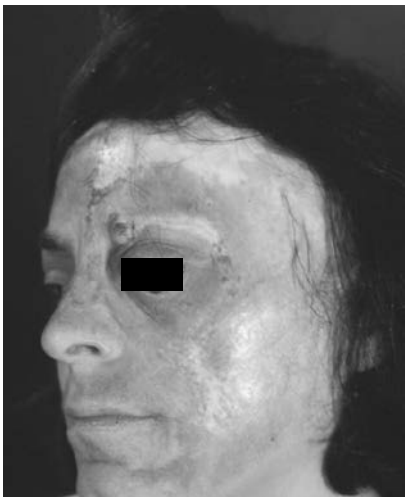
Several factors affect a burn patient's psychological status. The true causes are unknown and multifactorial. At the actual site and time of the accident, victims experience strong stress and pain. Panic evolves from the circumstances of the accident. Friends, family, or colleagues may be involved and the impossibility of providing help gives rise to considerable stress. There may also be economic loss of minor or major importance. The cause of the accident may be self-immolation[4] or a moment's carelessness, thus provoking a sense of guilt. A pre-existing psychological disorder, and medications taken, may lead to a post-burn psychological disturbance. The biochemical imbalance of burn patients can precipitate a psychological disturbance or reinforce the clinical presentation of a psychological disorder already under treatment, including drug abuse. Hypertension, hypoglycaemia, electrolyte imbalance, drugs administered, painkillers, and the presence of sepsis all play an important role.

Patients admitted to a burn care unit are isolated and deprived of the physical appearance of family members who could play a supportive role. Intensive care units are deprived of sunlight and illuminated by artificial means. The constant presence of alarms can be agitating. Patients lose their sense of time and date. The pity expressed by the medical and nursing staff,[5] along with patients' low self-esteem and depression (mainly caused by their incapacity to perceive their new body image)[6] and the fact that relatives express negative reactions towards their physical appearance, lead to the expression of psychological disorders (*Figs. 1,2*).

These disorders can be divided into those occurring in the critical care phase: delirium, organic psychoses and burn encephalopathy, post-traumatic syndrome, sleep disturbances, and depression and pain, in the hospitalization phase; and phobias and anxiety disorders, post-traumatic syndrome and nightmares, major depression and depressive disorders, and others in the post-hospitalization phase.[7-9]

Post-traumatic syndrome can be divided into three groups: acute (first three months), chronic (after first trimester), and delayed (more than six months).[10,11]

Patients present with hypervigilance and poor sleep.



Figs. 1,2 - Two patients.

The usual therapy is tricyclics such as imipramine and amitriptyline. Sleep disturbances follow this state of post-traumatic anxiety, mainly provoked by the environment of the burn care unit - room lights, monitor alarms, and even disturbance by caretaking staff. The usual therapy is imipramine and diphenhydramine. Delirium may be observed in patients with a history of substance abuse in combination with a burn injury > 30% TBSA.[12] Patients are agitated and combative. The use of benzodiazepines (diazepam, lorazepam, midazolam) can be of help. Burn encephalopathy presents as lethargy and coma, or as withdrawal syndrome. In such cases the organic causes should be addressed - in some cases phenothiazine (haloperidol, chlorpromazine, thioridazine) can help. Anxiety disorders and phobias need counselling and psychological support. Fluoxetine can be prescribed. It is worth noting that aggressiveness usually prevails over depression in the acute phase, while the contrary is the case in post-hospitalization. Cultural beliefs affect the patient's emotional state and set the basis of interpersonal interactions.

Confronting the problem

Psychiatric consultation is mandatory, along with psychological support, and appropriate medication should be prescribed. There are no words to stress the importance of the support of family, friends, and colleagues. The role of the psychiatrist and the psychologist is to guide and support both patient and relatives. Psychiatric consultations should follow stabilization of the patient in the acute phase. The social services should be at the disposal of the family involved. The plastic surgeon's role is to recognize any psychiatric disturbances and to try to restore functionality with the necessary operations or by applying appropriate physiotherapy. Aesthetic appearance can and must be improved in order to facilitate the patient's resocialization.

Conclusion

In conclusion, the psychiatrist should be integrated into the burn centre medical staff. Follow-up as a psychiatric out-patient will be of long duration, since most of these patients will have a strongly fluctuating psychological status for years to come, if not for life.[13]

RÉSUMÉ. Les Auteurs considèrent les fluctuations de la condition psychologique qui se produisent dans les patients brûlés pendant la phase aiguë, l'hospitalization et la période post-hospitalière. Ils rapportent les divers troubles des patients. La consultation psychiatrique est obligatoire, comme aussi le support psychologique, et il faut prescrire les médications les plus appropriées.

BIBLIOGRAPHY

1. Patterson D.R., Everett J.J., Bombardier C.H., Questad K.A., Lee V.K., Marvin J.A.: Psychological effects of severe burn injuries. Psychol. Bull., 13: 362-78, 1993.
2. Ilechukwu S.T.: Psychiatry of the medically ill in the burn unit. Psychiatr. Clin. North Am., 25: 129-47, 2002.
3. Charlton J., Gragliardi G., Klein R., Heimbach D.: Factors affecting pain in burned patients - a preliminary report. Post. Grad. J., 59: 604-7, 1983.
4. Stoddard F.J.: A psychiatric perspective on self-inflicted burns. J. Burn Care Rehabil., 14: 480-2, 1993.
5. Knighton J., Carrougher G.J., Marvin J.A., Bayley E.W., Rutan R.L., Weber B.: Research priorities for burn nursing: Report of the psychosocial issues group. J. Burn Care Rehabil., 13: 97-104, 1992.
6. Ye E.M.: Psychological morbidity in patients with facial and neck burns. Burns, 24: 646-8, 1998.
7. Kildal M., Willebrand M., Andersson G., Gerdin B., Ekselius L.: Personality characteristics and perceived health problems after burn injury. J. Burn Care Rehabil., 25: 228-35, 2004.
8. White A.C.: Psychiatric study of patients with severe burn injuries. Br. Med. J. (Clin. Res. Ed.), 13: 284 (6314), 465-7, 1982.
9. Blakeney P., Meyer W.J. III: Psychological aspects of burn care. J. Trauma, 11: 166-79, 1994.
10. Steiner H., Clark W.R., jr: Psychiatric complications of burned adults: A classification. J. Trauma, 17: 134-43, 1977.
11. Fauerbach J.A., Lawrence J.W., Schmidt C.W., jr, Munster A.M., Costa P.T., jr: Personality predictors of injury-related post-traumatic stress disorder. J. Nerv. Ment. Dis., 188: 510-7, 2000.
12. Moore D.P.: Rapid treatment of delirium of critically ill patients. Am. J. Psychiatry, 134: 1431-2, 1977.
13. Riis A., Andersen M., Pedersen M.B., Hall K.W.: Long-term psychosocial adjustment in patients with severe burn injuries: A follow-up study. Burns, 18: 121-6, 1992.

This paper was received on 20 October 2004.

Address correspondence to: Dr O. Castana, Department of Plastic and Reconstructive Surgery, Evangelismos General Hospital, Messogion Av., 154, 11527 Athens, Greece; e-mail: castana_ourania@yahoo.gr

Mediterranean Council for Burns and Fire Disasters (MBC)

WHO COLLABORATING CENTRE

On the INTERNET
http://www.medbc.com

for:

Notice board

WHO Section – Humanitarian Section – Annals – Medit-line – Search engine – Links to related sites