Suffering, depression, and the impact on self-image in individuals with burns

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ABSTRACT

Introduction: Individuals with burns suffer from self-esteem and depression. **Objective:** Analyze the participants' perception of the suffering caused by the burn, depressive symptoms, and interference in self-image and interpersonal relationships. Methods: Qualitative, longitudinal, descriptive study, with 36 participants seen at a reference center of care to burn people in a teaching hospital in southern Brazil. A semi-structured interview was conducted, and data were processed through Content Analysis. **Results:** The category about the suffering caused by the burn, and its impact on self-image emerged with three thematic units. Data suggest that participants dissatisfied with a self-image developed depressive symptoms in response to the difficulties that the burn caused in the life of a relationship; family support was decisive in coping with the new condition; affective links were rescued, benefiting the recovery. **Conclusion and implications for practice:** Participants' self-image perception damaged and associated with decreased self-esteem and depressive symptoms, impairment for the interpersonal relationship, and pointing out the importance of the family in the process of recovery and strengthening of family bonds during and after treatment of the burn.

Descriptors: Self-esteem, Self-image, Depression, Burns, Mental health.

INTRODUCTION

Burn injury is one of the cruelest conditions in a human being's life. The trauma causes several aesthetic problems, with vast repercussions in the context of life because it incapacitates the person concerning working, compromises autonomy, impairs daily life, affects the body's identity, and results in psychological suffering, with depression being a frequent diagnosis among burn individuals[1,2].

Among the global population, depression ranks first in the global burden of disease, causes loss of interest, raises feelings of guilt, and affects self-esteem. It affects about 350 million individuals worldwide, mainly female subjects. It starts at a young age and may be recurrent or chronic. Among its causes, one could mention social, psychological, and biological factors. It also impairs functional ability, socialization activities, and management of daily affairs, resulting in stigma and prejudice, thus hindering individual fitting, and resulting in suicidal behavior. In underdeveloped countries, treatment and follow-up of depressed individuals are scarce and not very effective[3,4].

In Latin America, about 12 million individuals of different age groups and incomes suffer from depression. Brazil is the country with the highest prevalence of depression. Health problems, such as burns, exacerbate depression, especially near hospital discharge when the burned patient's efforts focus on rehabilitation[5]. Aware that their body has definitely changed, a series of emotional, identity and relocation problems in society may arise, increasing the overall disease burden of burn survivors[6].

Suicide is a serious global public health problem and continues to account for one of the leading causes of death. In 2019, 703,000 people committed suicide worldwide, mainly in low- and middle-income countries and at a young age. Although suicide rates have decreased worldwide between 2000 and 2019, the rate grew by 17% in the Americas over the same period[7]. Depression is noted as the leading mental disorder related to suicide[3,7,8].

Every day, scars and contractures point out to the disfigured image "felt on the skin"

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and "seen in the mirror", and resuming social life is difficult due to damaged physical and emotional abilities. Therefore, exploring the perception of their new image and contributing to redefining their self-esteem is vital for the optimization of services that serve this audience[9,10].

Self-image is intrinsic to each individual and varies throughout life depending on the situations experienced. A study of burned individuals found a high prevalence of psychiatric disorders in most participants, with a higher rate of major depressive disorder and a significant relationship between self-image and psychiatric disorders, especially for major depression and suicidal behavior[11].

We reinforce the importance of investigating the burns survivors' mental health because when mental health is strengthened, it promotes changes of attitude to face adversities and suffering and provides information for burn care centers to develop effective strategies to assist in managing and coping with suffering[12.]

Considering the foregoing, the objective of this study is to review the perception of burn individuals assisted in a reference center about the suffering resulting from burns, depressive symptomatology, and their interference with self-image and interpersonal relationships.

METHODOLOGICAL PATHWAY

A larger study was developed, and we will present in this article the cutout of the qualitative, longitudinal, exploratory and descriptive study, using the theoretical framework of thematic content analysis[13] at a reference care center for burn individuals in a teaching hospital in a municipality of Londrina, PR.

The qualitative study provides important contributions about the experiences lived by individuals after the burn and the perception of the resulting interferences.

Data collection began after approval by the Ethics Committee on Research with Human Beings of the Universidade Estadual de Londrina (UEL) and the Universidade Federal de São Paulo (UNIFESP) under reports 1.794.796 and 1.707.282, respectively, in compliance with the recommendations by the Resolution 466/2012 of the National Health Council.

In order to determine the number of interviewees, we chose a non-probability convenience sample; the data collection phase was carried out from January 2017 to May 2019, having as study subjects 36 participants hospitalized in a reference center for burn care. The interval between the first and second moment was stipulated as four to six weeks by observation over the years in the unit regarding these returns; the same occurred regarding the period of data collection being ample due to the long period of hospitalization for treatment of these individuals. Participants aged 18 years or older, of both genders, hospitalized for at least 30 days, and cognitively able to participate in the interviews were included in the study. The cognitive evaluation was done by the researcher who worked at the unit through an interview where attention and concentration, memory, judgment, reasoning, and comprehension were evaluated, and whether there was any alteration in the state of lucid consciousness, based on the Mini-Mental State Examination (MMSE). One individual refused to participate in the second stage of the interview and was excluded from the study with no damage to treatment. Individuals readmitted to the unit for procedures were not included.

The first moment of the interview occurred at the moment of hospital discharge or the first return, and the second moment from four to six weeks after the first return. On both occasions, a semi-structured interview was carried out, lasting thirty to sixty minutes, based on an instrument prepared by the researchers, with sociodemographic characterization, questions about the psychological suffering caused by the burn, perception of self-image, self-esteem, and interference in the relationship life and with three open-ended guiding questions: Talk about the suffering caused by the burn; relate the presence of depressive symptomatology with the perception of your image and esteem; talk about how you perceive this interference of depressive symptomatology in personal and interpersonal life.

The evaluation in two moments occurred due to the verification of possible changes in self-image and interpersonal relationships after leaving the hospital because they remained hospitalized for a long time and after discharge, they began to have contact with other individuals in their social circle, such as family, friends, and coworkers.

Interviews were carried out at the outpatient care unit, in a private environment, only between the interviewer and the participant, without any external interference. On that occasion, doubts about the

research were solved, and the Informed Consent Form (ICF) was signed.

The participants were followed up and evaluated by the researcher as to psychic symptoms and, when necessary, the evaluation and intervention of the psychiatrist and psychologist of the institution were requested. After hospital discharge, these consultations continued at the discretion of mental health professionals or guidance, and referrals to the Psychosocial Care Network (RAPS) and other health services were made; the researcher left her telephone contact so that when necessary, the participants could contact her, which occurred for some time on the part of some of them, even after the research ended.

The speeches obtained from interviews were audio recorded with the authorization of the participants, and later transcribed in full, without considering behavioral or bodily aspects, and were labeled with the letter "E", followed by an Arabic number sequential to the chronological order of the interviews, in order to maintain anonymity. We intended to understand the characteristics and structures behind the fragments of the messages, grouped and established categories that comprised the themes identified[13].

RESULTS

Of the 36 participants, most were male, the age group 27 to 51 years old, common-law marriage, white, had finished high school, with income ranging from one to two minimum wages. Most accidents were occupational accidents caused by flammable products and resulted in second-degree burns.

The analysis of the specific data led to the constitution of a thematic category: the suffering caused by the burn, impact on self-image, and depressive symptomatology, with three thematic units described below.

Category 1: The suffering caused by the burn, impact on self-image, and depressive symptoms

In this theme, research participants mentioned the relationship between suffering and difficulties caused by burns.

As a result of the injuries, we noticed changes in the individual's lifestyle resulting from physical, psychological and social alterations that influenced their body image, lifestyle and self-acceptance. The difficulties faced by patients unveil the importance of emotional care to minimize as much as possible the problems arising from the adaptation process.

Psychic suffering in burn patients may cause emotional damage expressed by sadness, denial, fear, anxiety, pain, discouragement, irritability, easy crying, associated with difficulties in performing activities of daily life, and constant dependence on others, leading to depression.

The suffering caused by the burn, the impact on self-image, and depressive symptoms were expressed and didactically referenced in three thematic units, namely:

Thematic Unit 1: Impact on self-image

This thematic unit comprises a strong emotional impact on the participant due to the altered perception of self-image and self-esteem. Besides the many psychological and social problems, it caused insecurity and fear of the unknown due to the change in appearance, made the individual often feel attacked and invaded, thus building social stigma, made them feel different from other people, avoiding crowded spaces, ending up in isolation.

Participants reported that their current appearance was a shock compared to their previous appearance. Self-prejudice is clear, and points to inferiority, denoted by the lines below:

> *[...] I see it, and say it's ugly, and it's going to be like this for the rest of my life. Worse than that, I worry about people, someone may see me without a shirt, and I am ashamed to walk around without a shirt. What will they think? [...] I liked to walk around without a T-shirt because I had a nice body, I used to go to the gym, and I liked to show off. Now everything has changed, it has to be with a T-shirt, and I don't know how people will react, sometimes someone may look as if they are disgusted and think: look at that guy's back, look how bad it is. [...] suffering doesn't bring me. In the future, the issue of showing my body, exposing myself, brings me shame, I feel ashamed. [...] I look in the mirror and see my face, I turn my back and there is something missing to improve, it won't change, it won't improve, it will stay this way [...].* (E5)

[...] My body used to be nice, I exercised, everyone looked and commented. Now, try not to look, I don't like it. [...] it became ugly, I laugh. Crying won't help, now it is complicated, I don't look, I hardly wear shorts, I just wear pants. I am ashamed. [...] no need to show if you are ashamed, but there are times that I stay home without a shirt, and it is embarrassing. The burn is black, I want it to clear up and disappear quickly, the scar is no victory, so you have to laugh so as not to cry. (E14)

[...] It is difficult to come out naturally, and these scars on the face bother me a lot. I am making a sacrifice with my eye, every day I stretch my skin, imagine having my eye slanted. I am doing exercises for my eye and body, so as not to stand too much and not to gain weight. [...] I have no hair on one side of my head, a piece of my ear was cut off, and without the little piece of the ear it is very ugly, so I look at myself in the mirror and God forbid, it makes me sad. [...] I wear long-sleeved shirts, and my hand always has a little mitten that doesn't call attention. Now I wear a wig, I put on a little hat or cap to disguise it and not draw attention. If I have a tight scar on my face, it attracts attention and the whole town is aware of it. I get somewhere and people talk because they are curious. I've been out with my friends, and they stare at me. No short shorts. I will not wear them so soon, because of the scars that they took off to put somewhere else. (E23)

The suffering caused by the burn and the impact on self-image were expressed by physical, social, and psychological limitations imposed by the new condition.

Thematic Unit 2: Depressive trait related to hospitalization

In our study, depressive symptoms were permeated by reports of sadness, crying, loneliness, separation from family members, fear of having reparative procedures performed and not achieving the desired success, and inability to resume activities due to physical or emotional disability. Therefore, the health team must pay attention to the somatic and psychological manifestations associated with the burn, as reported in the statements below:

[...] I missed them, I felt sad, I wanted to go away, I missed my wife, my children. We used to spend twenty-four hours together, we don't see them here, it is worrisome, I cried a lot, nobody noticed, but I cried. (E1)

[...] the greatest suffering is in relation to treatment, there was pain, it bothered me, I was far from home; but I felt welcomed in the hospital, the staff was loving, welcoming, but suffering is the distance from family, it causes a lot of suffering. [...] I could overcome that sadness that comes. I try not to think too much, but from time to time I worry about what my situation will be. (E4)

[...] In the past, I could do everything, and now I am always depending on others. I was sad because before I could do everything I wanted, and now I don't, I feel sad, it took away my joy. [...] I feel I like living, but in the beginning, I was sad. In the beginning, when I found out that my legs were gone I was sad because I couldn't do anything. How would be my life without my legs? (E10)

[...] When I realized I was in the hospital, I woke up, I felt very sad, I felt discouraged, I couldn't walk, turn in bed, when I sat up, everything seemed to fall around me. [...] Before the accident I was worried about getting better, after the accident I felt sad because it was all over, I lost all my musculature. [...] Now I am more emotional, I cry more easily, if someone says something I feel like crying. (E24)

There are aggravating factors such as separation from a spouse:

[...] I am feeling sad, I can't work, my burns are starting to hurt. I broke up with my wife, she changed a lot because of this, she said she didn't want it anymore, and left home. [...] I spend almost a month without treatment at CAPS, and these days I have been feeling shaken, the psychological kind of down. [...]

There are things that I prefer not even start doing to avoid leaving it half done. (E18)

In a positive way, our findings indicated overcoming difficulties through family support.

Other participants reported that the depressive symptoms worsened and even triggered death ideation and suicidal behavior:

[...] My current boyfriend cracks the whip over me when I say I don't want to live. I think that life is still worth it, but there are days when we get depressed and feel like dying, I feel angry, and I have to cry to get some things off my chest, crying relieves. If they ask too many questions, I cry in the middle of everybody, but if there's something I can't say, I keep to myself, quietly, and then nobody notices. About the burn, if I get irritated, nervous, people start asking about it, and I don't like it. [...] I feel sorry for myself, imagine looking in the mirror, I knew I was not like that, it makes me sad. [...] today I feel irritated. If something goes wrong, I get mad easily. When I get depressed, I think I should have died, I didn't want to have these scars, these thoughts come, why didn't God take me. (E23)

[...] It took away the joy, because before I had satisfaction in doing things, and nowadays I go there to try to do them, and I can't, and I get discouraged because I have to ask others. My family is helping me to cheer up because otherwise I just want to lie down. [...] I think I'd better had not survived to not be a trouble for people, I think that death would be better because, as the doctor says, I will wait two years to recover, and not be as I was before, and if I had the opportunity I would do it. What I'm afraid of is not being able to finish it. [...] I almost don't go to physical therapy, I have thoughts that it won't get better, I haven't done anything because I think it won't work. The recovery of my neck is difficult. [...] I feel discouraged, sad, helpless, I have my family who is everything to me, but it is sadness, discouragement. (E30)

We highlight that there are participants in a vulnerable situation pointing to the accident as a punishment for distancing from God and changing their lives, but tied to guilt:

[...] I keep blaming myself; if I hadn't left the button on, the accident wouldn't have happened. My husband says I can't keep blaming myself, it happened because it had to happen [...]. (E8)

[...] This activity was not supposed to be done, but I went there and did it, I can say I could have avoided it. I always wanted to prove I could do it. They wouldn't do it, I went there and did it, that's why the accident happened, because I messed up where I shouldn't have. (E11)

[...] I believe that everyone has a purpose in life and that everything we do has a weight too; so, when we go astray from God's path, it may be that some things happen in our lives, for us to return to Him. (E25)

[...] (silence...) feeling of guilt because if I hadn't done anything that day I wouldn't be going through this. I have sadness [...]. (E30)

Thematic Unit 3: Dependency, loss of autonomy, and limitation

The participants in this study had to make adjustments in their lives due to the sequels and limitations that made them dependent on another person for help or to perform daily and instrumental activities. With that, autonomy was impaired, limiting them from performing activities.

[...] It changes because when you have your arms everything is easier. And when you don't have the arms you wait for who is treating you, who is doing it for you. I didn't learn, I didn't get it until today, she is the one who treats in the mouth. [...] I don't have my arms, but I am using her arms [...]. (E1)

[...] I am doing nothing, I don't wash dishes, clean, organize anything. I used to live by myself, I had to do everything. Now, I need my brother, my mother, because I am doing personal hygiene like bathing, get dressed. I

> *can't floss my teeth, my brother ties the dental floss on the finger of my right hand, then I bring it and floss the teeth, even flossing is complicated. My activities are reduced to almost zero, I'm stuck at home. [...] 80% dependent. I can't organize anything, fold clothes, clean the house, wash dishes, go down to the laundry room to turn on the machine and wash clothes [...].* (E28)

The reports indicate loss of autonomy, functional incapacity, and dependence on care at different levels.

In the statement below, the participant addresses the difficulty in performing tasks and the dependence on the family member.

> *[...] Before getting burn, I used to walk up to six kilometers a day, now I can't go out in the sun. I try to exercise at home, abdominal exercises, leg exercises, to keep it stiff, I do them without weight, with my body, in the morning and at night. I can't do it with weights because my left hand is hard, it doesn't move, so I can't do anything with it. [...] I used to do everything at home, and now I can't even drag water from the shower, I have difficulty to clean, wash dishes, iron clothes, I can't [...].* (E23)

DISCUSSION

The statements above make clear that injuries caused by the burn affected the physical image and well-being; therefore, the self-image, causing participants to avoid looking at the scars. It also made participants wear clothes to hide the lesions, and when that was impossible, they felt ashamed to go out due to the other's curiosity. The damage to the psychological condition is related to the deteriorating physical condition and to social and cultural aspects that facilitate the development of depressive symptoms. These data are similar to those of a study on the stigmatization of burned individuals pointing to depression and worsening of self-esteem[14].

A study[15] points out that the marks of each individual were evaluated in a unique way, and according to standards established by society. That was in agreement with the reports of our interviewees who pointed out the burned body as shameful and a cause of embarrassment, especially in our country where the cult of the beautiful body is projected by the media as synonymous with success. Thus, the burned body denotes shame and suffering.

Participants are aware of the damage the burn caused to their image and self-esteem, which are now out of social standards. However, the amazement of those with whom they interacted was also evident in their speeches and in their desire to minimize the embarrassment of the curious gaze and the questions about what had happened. This led them to change the way they dressed as a way to hide their physical deficiencies and their fear of socializing, as found in other studies[16-18].

Dissatisfaction with personal image, especially with injuries in more visible areas of the body, may cause irreversible damage to behavior, self-image, self-esteem, and result in social withdrawal[17,19]. The social support provided by the family and skilled mental health professionals may contribute to reduce the feeling of inferiority and incapacity, besides contributing to the participant's re-socialization and stimulus to the new life condition, to improve self-esteem and depression[14].

By needing hospitalization, the participant victim of burn not only suffers organic changes but was challenged by emotional stressors such as family homesickness, job loss, and body changes, developing anxiety and depression, affecting the quality of life, family, social, and work relationships, resulting in changes in personal identity, as found in other studies[20,21].

They described physical pain; however, the family distance and the concern with the uncertain future are also forms of pain that are reflected emotionally and need to be considered, as they reported that even though they were welcomed by the team, being distant from the family was the cause of suffering[15].

Individuals with burns may suffer from the disability resulting from the injury, becoming vulnerable to a series of problems such as intense pain, impaired appearance, isolation, economic difficulty, and physical and emotional limitations that can lead to worsening suffering and oscillate periods of improvement and worsening of symptoms[22].

Unfortunately, this center for burn treatment does not have an effective mental health team and does not carry out the subsequent emotional follow-ups of these patients; for this research, they were evaluated in two moments, but there was no

follow-up in the medium or long-term, which does not allow us to say anything about the evolution of the symptoms detected. The specific mental health care, when necessary, occurred in services external to the institution where the research was carried out.

Important stressors observed were separation from the spouse, lack of specific treatment for depression, and the difficulty in retaking work, as these facts end up hurting even more the person who already suffers from the after-effects of burns and can lead to depression. The burn sequelae cause the individual to reduce work productivity, thus worsening financial condition with implications in life, and feeding back the installed depressive symptomatology [4, 22].

Having the support of family and friends is extremely important for the burned individual, and positively affects how to cope and improve self-esteem; however, when not done effectively, it influences physical and mental health and even survival[23].

The physical damage and partial or total disability in participants' rehabilitation may be perceived in the reports of pain, anxiety, and denial to perform tasks. They serve as triggers for depression, followed by damaged autonomy and altered self-image, corroborating the findings of other studies[14,24].

The burn participants need physical aid and support during the rehabilitation phase, and the family's role in this context is crucial and decisive to curb the development of depression, besides influencing self-esteem[25].

A study[15] also pointed out that burn participants reported intense physical pain, compromising the execution of tasks, and psychological and emotional distress, in line with what was reported in our study.

Among burn patients, anxiety and depression are especially common and a European study[26] showed that burn individuals developed a more intense emotional state when the burn injury was potentially severe. In our study, the reports of the presence of depressive symptoms and damage to self-image highlights, regardless of the extent, depth, or severity of the burn, which was proven by the application of psychometric scales, with the majority presenting mild and moderate symptoms, and to a lesser extent, severe symptoms.

Depression, like other mental disorders, has a multifactorial etiology, and burnout can trigger this, but there are complexities of factors at play.

Social, economic, and cultural factors may contribute to the development of suicidal behavior. Depression is the factor most associated with suicide, and being in a vulnerable situation, such as reinsertion into society, causes damage to self-esteem, family relationships, work, and honor, and may develop stressors that lead to suicide. Therefore, any threat should be considered, and prevention strategies with a multifactorial approach are necessary[4,7,8].

In the melancholic statements of our participants, it is implicit the desire to end their own lives after the burn because of the suffering for feeling discriminated against and attracting looks of curiosity and repulsion that hinder recovery, and consequent re-socialization, the economic difficulties faced in some cases for the previous presence of depression and disruption in affective interpersonal relationships. However, in our context, we did not identify the occurrence of attempted suicide. The speeches of participants denote suicidal ideation due to the difficulty of coping with the damage to self-image and the life of relationships in society; however, we did not find a concrete plan of execution as found in another study[27].

Some research data also point to depressive symptoms in burned individuals, subsequent to countless difficulties, especially in the attempt to return to activities, which leads to the amplification of this suffering and can trigger suicidal behavior[28].

Having a condition that limits activities or movement is an additional factor that hinders social rehabilitation; however, the resulting development of depression exacerbates the functional and social impairment of the individual[29].

In the above-mentioned reports, depression is an evident problem among adults with physical dependence. A study on physical disabilities found that participants who developed their activities in a negative manner were unemployed, or belonged to a low social class, were the ones who presented the most depression that, added to a disability, predisposed them to suicide[30].

The barriers found in society should be minimized through information and policies on insertion that contribute to overcoming and facing disability.

The limitations of the study were related to the fact that the research was carried out in a single center, which does not allow generalizations, the participants were not followed up in the medium and long term, the number of variables to be studied and the subjectivity of the analysis. The study brings

contributions to the theme and helps in planning care for individuals with burns, especially for essential measures regarding prevention, diagnosis, and early interventions for depression and self-esteem.

CONCLUSION AND IMPLICATIONS FOR PRACTICE

The perception of the participants was for physical and psychological suffering, fear, and loss of autonomy, with direct consequences in social, affective, and work life; for damaged self-image associated with decreased self-esteem; for the presence of depressive symptoms and resulted in damage to interpersonal relationships. They pointed to the importance of the family in the process of recovery and strengthening of family ties during and after treatment for burns.

We emphasize the need for burned individuals to receive routine assistance from a trained professional regarding psychological suffering in order to detect and intervene as early as possible in psychic alterations and to alleviate and cease suffering. It is of fundamental importance that the institution where this research was conducted and other institutions that provide care to individuals with burns have mental health professionals on their teams. It is also important that adequate public policies are in place to prevent suicide and that burned individuals have support to cope with their deformities and limitations.

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