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Short Communication

Psychiatric Disorders in Burn Units

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Abstract

With the increased survival of patients with large burns comes a new focus on the psychological challenges and recovery that such patients must face. Most burn centres employ social workers, vocational counsellors, and psychologists as part of the multidisciplinary burn team. Physiological recovery of burn patients is seen as a continual process divided into three stages resuscitative or critical, acute, and long-term rehabilitation. The psychological needs of burn patients differ at each stage. Depression and anxiety Symptoms of depression and anxiety are common and start to appear in the acute phase of recovery. The antidepressants Mirtazapine and vilazodone hydrochloride are the most save antidepressants regarding to Hyponatremia Side effect of other antidepressants. Lorazepam has been found to lessen burn pain, largely by treating acute anxiety.

Keywords: burn; depression; anxiety; ptsd; hyponatremia; lorazepam; mirtazapine

Introduction

Recovery of burn patients is seen as a continual process divided into three stages resuscitative or critical, acute, and long-term rehabilitation.

Resuscitative or critical stage:

The psychological characteristics of this stage include stressors of the intensive care environment, uncertainty about outcome, and a struggle for survival. The intensive care environment can be both overstimulating and under stimulating with the monotony of lying in a hospital bed for weeks. Cognitive changes such as extreme drowsiness, confusion, and disorientation are common during this phase. More severe cognitive changes such as delirium and brief psychotic reactions also occur, usually as a result of infections, alcohol withdrawal, metabolic complications, or high doses of drugs. Patients may also be intubated, which greatly limits direct communication. In depth psychological intervention is of minimal value at this phase, since physical survival is the primary goal. Patients should be encouraged to cope with the frighteningly unusual circumstances of the intensive care unit through whatever defences are available to them, even primitive strategies such as denial and repression. Supportive psychological interventions should focus on immediate concerns, such as sleep, pain control, and protecting patients' coping strategies. Non-pharmacological approaches to pain control, such as hypnosis and relaxation, can be effective. Medical staff can also effectively intervene during this early stage of recovery by working with a patient's family members. Family members may be anxious and distressed while observing the patient undergo treatment, which fosters the same response in the patient. It is important to help family members understand this effect and help them to convey a sense of hope and calmness to the patient.Medical staff can also effectively intervene during this early stage of recovery by working with a patient's family members. Family members may be anxious and distressed while observing the patient undergo treatment, which fosters the same response in the patient. It is important to help family members understand this effect and help them to convey a sense of hope and calmness to the patient.

Acute stage:

The acute phase of recovery focuses on restorative care, but patients continue to undergo painful treatments. As patients become more alert during this phase, they face these procedures with less sedation. Also, patients are more aware of the physical and psychological impact of their injuries. Depression and anxiety Symptoms of depression and anxiety are common and start to appear in the acute phase of recovery. Acute stress disorder (occurs in the first month) and post-traumatic stress disorder (occurs after one month) are more common after burns than other forms of injury. Prevalence of depression and anxiety in inpatients with burns:Depression 23-61% - Generalised anxiety 13-47% - post-

traumatic stress disorder 30%. Patients with these disorders typically have larger burns and more severe pain and express more guilt about the precipitating event. The severity of depression is correlated with a patient's level of resting pain and level of social support. Sleep disturbance Central to both anxiety and depression is sleep disturbance. The hospital environment can be loud, and patients are awakened periodically during the night for analgesia or for checking vital signs. Patients' mood, agitation, and nightmares can all affect sleep. Premorbid psychopathology Compared with the general population, burn patients have a high rate of premorbid psychopathology. Patients with pre-existing psychopathology typically cope with hospitalisation through previously established dysfunctional and disruptive strategies. The most common premorbid psychiatric diagnoses are depression, personality disorders, and substance misuse. Prior psychopathology can have an adverse impact on outcomes, including longer hospitalisations and the development of more serious psychopathologies after injury.Grief Patients may now begin the grieving process as they become more aware of the impact of the burn injuries on their lives. Family members, friends, or pets may have died in the incident, and patients may have lost their homes or personal property. In addition to these external losses, patients may also grieve for their former life (such as job, mobility, physical ability, appearance). Mental health professionals and other staff should help patients to grieve in their own way and at their own pace.Brief psychological counselling can help both depression and anxiety, but drugs may also be necessary. When offering counselling, it is often helpful to provide reassurance that symptoms often diminish on their own, particularly if the patient has no premorbid history of depression or anxiety. Drugs and relaxation techniques may also be necessary to help patients sleep. Informing patients that nightmares are common and typically subside in about a month can help allay concerns. Occasionally patients will benefit from being able to talk through the events of the incident repeatedly, allowing them to confront rather than avoid reminders of the trauma. Staff often make the mistake of trying to treat premorbid psychopathology during patients' hospitalisation. Referrals to community treatment programmes should be made once patients are ready for discharge. Both procedural and background pain can be challenging for patients and staff. Some patients report that procedural pain is easier to cope with because of its transient nature, whereas with background pain there is no clear end in sight. It is important to conduct a thorough pain assessment in order to determine which type of pain is the greatest problem. A pain treatment plan that provides pharmacological and non- pharmacological approaches should be established. Opioid agonists are the most commonly used analgesics. Long-acting opiates are used for background pain, and short acting opiates are used for painful procedures such as wound care. It is crucial that drugs for background pain are provided on a fixed dose schedule to maintain control of the pain. Opioid analgesics may be supplemented with other drugs, including inhaled nitrous oxide and anxiolytics. Lorazepam has been found to lessen burn pain, largely by treating acute anxiety. Mirtazapine and vilazodone hydrochloride are the most save antidepressants regarding to Hyponatremia Side effect of other antidepressants. Non-pharmacological pain control techniques include cognitive-behaviour therapy and hypnosis.These have been shown to be effective in treating procedural pain. One exciting new distraction technique is virtual reality. Since attentional focus is limited and a person cannot attend to more than one stimulus at a time, virtual reality creates a realistic environment for patients to absorb themselves in during painful procedures, thus taking focus away from the discomfort.

Long term rehabilitation stage:

The long-term stage of recovery typically begins after discharge from hospital, when patients begin to reintegrate into society. For patients with severe burns, this stage may involve continued outpatient physical rehabilitation, possibly with continuation of procedures such as dressing changes and surgery. This is a period when patients slowly regain a sense of competence while simultaneously adjusting to the practical limitations of their injury. The first year after hospitalisation is a psychologically unique period of high distress. Physical problems—Patients face a variety of daily hassles during this phase, such as compensating for an inability to use hands, limited endurance, and severe itching. Severe burn injuries that result in amputations, neuropathies, heterotopic ossification, and scarring can have an emotional and physical effect on patients. Psychosocial problems—In addition to the high demands of rehabilitation, patients must deal with social stressors including family strains, return to work, sexual dysfunction, change in body image, and disruption in daily life. Many people continue to have vivid memories of the incident, causing distress. Patients may also develop symptoms of depression. There is evidence that adjustment to burn injuries improves over time independent of the injury size. Social support is an important buffer against the development of psychological difficulty. It can be helpful to make follow up telephone calls to patients after discharge or to continue to see patients in an outpatient clinic to screen for symptoms of distress and to provide psychotherapy. Adjustment difficulties that persist more than a year after discharge usually involve perceptions of a diminished quality of life and lowered self-esteem. Some studies suggest that burn disfigurement in general leads to decreased self-esteem in women and social withdrawal in men. “Changing Faces” is a successful programme for enhancing self-esteem. This includes a hospital-based programme for image enhancement and social skills plus a series of publications for patients dealing with aspects of facial disfigurement. Many patients face a lengthy period of outpatient recovery before being able to return to work. Some patients go through vocational challenges. In a recent study of patients hospitalized for burn injury 66% returned to work within six months of their injury, and 81% had returned by one year. As expected, patients who sustained larger burns took longer to return to work. About half of the patients required some change in job status. Ancillary resources such as support groups and peer counselling by burn survivors can also be important services to burn survivors. Major burn centres ideally have a network of burn survivors who are willing to talk with patients in the hospital.

Conclusion:

A burn injury and its subsequent treatment are among the most painful experiences a person can encounter. The emotional needs of patients with burns have long been overshadowed by the emphasis on survival. Patients undergo various stages of

adjustment and face emotional challenges that parallel the stage of physical recovery. Adjustment to a burn injury seems to involve a complex interplay between the patient's characteristics before the injury, moderating environmental factors, and the nature of the injury and ensuing medical care.

References:

1. American Burn Association (n.d.).(2014). Burn Incidence and Treatment in the United States: 2013 Fact Sheet.
2. Al-Mousawi AM, Mecott-Rivera GA, Jeschke MG, Herndon DN.(2009). Burn teams and burn centers: the importance of a comprehensive team approach to burn care. *Clin Plast Surg*; 36: 547-554.
3. Kroenke K, Spitzer RL, Williams JB, Löwe B.(2009). An ultra-brief screening scale for anxiety and depression: *the PHQ-4. Psychosomatics*; 50: 613-621.
4. Ursano RJ, Bell C, Eth S, Friedman M, Norwood A,et al.(2004) Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. *Am J Psychiatry;* 161: 3-31.

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