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PSYCHOSOCIAL DEMANDS EXPERIENCED BY BURN VICTIMS DURING HOSPITALIZATION: A QUALITATIVE STUDY

DEMANDAS PSICOSSOCIAIS DE VÍTIMAS DE QUEIMADURA EM INTERNAÇÃO HOSPITALAR: ESTUDO QUALITATIVO

DEMANDAS PSICOSSOCIALES DE VÍCTIMAS DE QUEMADURAS DURANTE SU HOSPITALIZACIÓN: ESTUDIO CUALITATIVO

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Objective: to understand psychosocial demands experienced by burn victims during hospitalization. Method: qualitative research conducted with burn victims during hospitalization in a Burn Treatment Care Unit in the city of São Paulo. Researchers gathered data through in-depth interviews, analyzing results using the Meaning Interpretation Framework. Results: psychosocial demands experienced by burn victims stem from pre-burn experiences and amplify through interactions involving care and neglect during hospitalization, as well as through coping with burn sequelae. Insights gained from hospital practices pointed to potential strategies for improving patient experience throughout the hospital stay. Final considerations: the study highlighted psychosocial needs experienced by burn victims during hospitalization, encouraging the academic community and healthcare professionals to recognize the role this dimension plays in delivering comprehensive care.

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Descriptors: Burns. Burn Units. Psychosocial Functioning. Nursing. Nursing Care.

Objetivo: compreender as demandas psicossociais das vítimas de queimaduras na internação hospitalar. Método: pesquisa qualitativa realizada com vítimas de queimaduras durante a internação em uma Unidade de Terapia de Queimados no município de São Paulo. Os dados foram produzidos por meio de entrevistas em profundidade e a análise fundamentou-se no referencial da Interpretação dos Sentidos. Resultados: as demandas psicossociais das vítimas de queimadura integram suas experiências prévias à queimadura e intensificam-se com as experiências de (des)cuidado vivenciadas na dinâmica da internação hospitalar e com as repercussões por conviver com as sequelas das queimaduras. Ao observar a dinâmica hospitalar, identificou-se possibilidades de melhoria na experiência da internação hospitalar. Considerações finais: a compreensão atribuiu visibilidade à demanda psicossocial das vítimas de queimadura durante a internação hospitalar, favorecendo a sensibilização da comunidade acadêmica e os profissionais de saúde acerca da importância dessa dimensão na perspectiva da oferta do cuidado integral.

Descritores: Queimaduras. Unidades de Queimados. Funcionamento Psicossocial. Enfermagem. Cuidados de Enfermagem.

Objetivo: comprender las demandas psicosociales de las víctimas de quemaduras durante su hospitalización. Método: investigación cualitativa realizada con víctimas de quemaduras durante su hospitalización en una Unidad de Terapia de Quemados en la ciudad de São Paulo. Los datos se obtuvieron mediante entrevistas en profundidad y el análisis se basó en el marco de referencia de la Interpretación de los Sentidos. Resultados: las demandas psicosociales de las víctimas de quemaduras integran sus experiencias previas a la quemadura y se intensifican con las experiencias de (des)atención vividas en la dinámica de la hospitalización y con las repercusiones de convivir con las secuelas de las quemaduras. Al observar la dinámica hospitalaria, se identificaron posibilidades de mejora en la experiencia de la hospitalización. Consideraciones finales: la comprensión dio visibilidad a la demanda psicosocial de las víctimas de quemaduras durante la hospitalización, lo que favoreció la sensibilización de la comunidad académica y los profesionales de la salud sobre la importancia de esta dimensión desde la perspectiva de la oferta de atención integral.

Descriptores: Quemaduras. Unidades de Quemados. Funcionamiento Psicosocial. Enfermería. Atención de Enfermería.

Introduction

It is recognized that patient care during hospitalization involves biological, psychosocial, and spiritual dimensions. Care addressing biological factors, however, tends to receive priority in burn victim management. While these interventions are undeniably crucial for therapeutic success, it is essential to note that physical, psychological, and social sequelae from burns can last a lifetime, underscoring the need to integrate psychosocial needs early in the care process[1].

Psychosocial demands reflect emotional, social, and psychological needs arising from vulnerability, requiring interventions that support mental health and enable social reintegration. For hospitalized burn victims, they include emotional distress, self-image disruption, concerns about stigma, autonomy loss, and support for managing grief, pain, and adjustments to physical sequelae, as well as social support and advice for reclaiming social roles[2-4].

In this context, a study conducted at a specialized center in Iran showed that the most frequent Nursing Diagnoses (ND) among burn victims fall under the Safety and Protection domain, with Risk for Infection (23.09%) and Risk for Falls (20.81%) standing out. The Anxiety Nursing Diagnosis, associated with psychosocial requirements, appeared in just 16.03% of patient records[5]. Attention to psychosocial factors by nursing staff during hospitalization enables comprehensive care. Treatment effectiveness appears linked to the victim's psychosocial status before the injury and throughout the rehabilitation period; however, burn victims do not always maintain mental health given their health status, requiring professional support in this regard[1].

Burn victims referred to the Burn Treatment Unit (BTU) enter a psychologically critical stage, where death-related fear merges with pain-related and procedure-related fears, potentially triggering psychological symptoms[6]. Upon admission, burn victims and their support network often experience distress, stress, fear, and anxiety, which may challenge their ability to manage the situation and hinder their full rehabilitation[1].

Psychological distress is highly prevalent in this context. Approximately 30% of adult burn survivors experience moderate to severe psychological and/or social difficulties[6]. High psychological demands in burn victims may result in serious psychopathological symptoms. A retrospective study found a link between *delirium* onset and a mean patient age of 60 years (range 38–79), an average burned body surface of 22%, a 45-day mean hospital stay, and the frequency of dressing changes performed under anesthesia[7].

Given the important role psychological factors play in managing pain and anxiety[1], a generalist nurse with expertise in mental health care could take responsibility for attending to burn victims and their support networks. Improving both technical skills and emotional capacity among nurses in Burn Treatment Units (BTUs) is vital for responding to the psychosocial demands inherent to such settings.

In this regard, contributions stemming from competence in mental health care are extensive: they promote a close interpersonal bond with the burn victim, providing guidance during treatment to support personal growth and strengthen psychosocial, cultural, and spiritual aspects. Additionally, based on behavioral observation and mental state assessment, they contribute to developing therapeutic strategies, including pharmacological and non-pharmacological approaches, aimed at preventing and alleviating burn-related effects and sequelae[1,7].

Care for the patients' family members constitutes another central focus in mental health practice. These members hold a dual role: they are both directly affected by the shared experience with the burn victim and serve as significant individuals whose support is vital for the victim. Accordingly, interventions should address the needs expressed by this group while providing guidance that enables family members to actively participate in the patient's recovery process[1,7].

Care delivered in a hospital environment enables burn victims to confront pain and trauma, reclaim autonomy, and affirm their identity as survivors. Empirical evidence, clinical observations, and burn survivors' accounts indicate that comprehensive care, grounded in early and continuous attention to psychosocial dimensions, can support patients' psychological adjustment to trauma, facilitate coping during painful procedures, and foster resilience in the face of potential permanent disfigurement. Compassionate care, robust psychological support, and heightened sensitivity to patients' actual needs are essential to promoting their rehabilitation[1].

Research addressing burn-victim care remains limited. Current investigations aim to identify quality of life in relation to resilience and self-efficacy[8], assess dignity from the viewpoint held by nurses, family caregivers, and victims[9], examine the relationship between delirium symptoms and hospitalization[5] and examine how standardized Nursing terminologies are used in caring for burn patients[5,10]. Other approaches address mental health among Nursing students[11] and healthcare professionals working in BTUs[12].

Thus, a gap in scientific knowledge becomes evident when examining the psychosocial demands experienced by burn victims during hospitalization, thus raising the following question: *"Which psychosocial demands do burn patients experience during their hospitalization?* This investigation seeks to deepen the understanding of psychosocial demands experienced during inpatient care.

Method

This qualitative study is grounded in interpretive and material practices through which researchers examine people, objects, relationships, and the meanings individuals assign to their life experiences[13]. The research project met the requirements established by the Consolidated Criteria for Reporting Qualitative Research (COREQ)[14].

Data were collected in the burn treatment unit at a university hospital located in the city of São Paulo. The unit comprises ten beds, four dedicated to intensive care, as well as operating

and intake rooms staffed by a specialized multidisciplinary team.

The study included four individuals with burn injuries. The sample was formed using a purposive strategy with a homogeneous design, including cases that shared a common research focus. By employing this strategy, it was possible to explore the situation thoroughly, since the chosen information-rich cases provided insights that clarified the phenomenon being investigated[13]. Inclusion criteria included reaching legal age, demonstrating willingness or interest in participating, and having suffered burns, whether directly or indirectly, along with corresponding psychological demands. The exclusion criterion was intense pain reported by the participant, defined as a score ≥ 6 on the Visual Analogue Scale. No candidate declined participation.

Data collection occurred between July and August 2024 through in-depth interviews, defined as purposeful conversations[15] aimed at producing information relevant to the study's objectives. Participants were invited to share their views freely on the topic, while the researcher's questions facilitated a more in-depth exploration of the subject matter.

A two-part guide was created to structure data production. The first part included closed questions to describe participants regarding sociodemographic, occupational, and clinical aspects. Medical records were consulted to enrich clinical data, including burn date, causal agent, Burned Body Surface, burn depth, days in hospital, smoking habits (cigarettes/day), alcohol intake (frequency and average dose), psychiatric diagnosis, psychotropic treatment, comorbidities, and prescribed medication. The second part introduced the open question that anchored the interview: *Could you tell me how you have been perceiving your emotions during hospitalization?*

This instrument was reviewed by Nurses specialized in Psychiatric Nursing, and the data collection process was pretested with a participant fulfilling the previously established inclusion and exclusion criteria, after obtaining approval from the Research Ethics Committee.

Data production was carried out by the first author after completing training in in-depth interviewing and qualitative research. It should be noted that the researcher's prior presence in the unit helped her integrate with the team and establish initial contact with potential participants. Each participant was approached individually by the researcher, who explained the study's objectives and their participation terms. Once consent was obtained, the participant and researcher agreed on the most suitable time for the interview, which took place in the patient's private room behind closed doors.

During in-depth interviews, Nursing Therapeutic Communication strategies (Chart 1) were employed, representing a professional skill based on understanding human communication and intended to support personal development and cultivate individual abilities and potential[16-17].

Chart 1 – Therapeutic Communication as a technique for data production in qualitative research. São Paulo, São Paulo, Brazil – 2025

Expression
Strategies were employed to facilitate and encourage expression, allowing participants to share their experiences and feelings related to the topic under investigation. The opening question acted within this therapeutic approach, accompanied by deeper techniques such as reflective listening, verbal cues indicating interest and acceptance, thorough exploration into experiences and emotions, sustained participant focus on the topic, and participant-focused question redirection.
Clarification
Applied whenever it was necessary to elucidate messages from participants containing ambiguous or unfamiliar content, that is, when verbal and nonverbal messages required further explanation for the researcher's understanding. Examples include encouraging participants to make comparisons, requesting explanations for uncommon terms, and describing events in a logical sequence.
Validation

This approach aimed to confirm that participant and researcher attained mutual understanding, highlighting the interpretations and perceptions shared by participants. This process included creating a summary that reflected the main insights from the interactions, guided by participants' experiences.

Source: prepared by the author.

Considering the research topic's complexity and prolonged hospitalization, certain in-depth interviews were paused and resumed at later times. Accordingly, data collection was conducted over multiple sessions, each focused on the study topic. In-depth interviews, averaging 30 minutes, were audio-recorded and subsequently transcribed to form the qualitative corpus essential for analysis.

Data analysis followed the Meaning Interpretation Method, a framework highlighting the interplay between subjective experience and group stances; text and subtext; text and context; verbal expressions and broader actions; cognition and feeling, among other factors. Drawing on a theory integrating philosophical and social science perspectives, the method pursues both comprehension (hermeneutic stance) and critical evaluation (dialectical stance) on data emerging from research[15].

Data analysis unfolds in three stages: thorough reading of selected material, in-depth content exploration, and creation of an interpretative synthesis. It is understood that analysis begins with comprehensive reading, and that the researcher is expected to remain open to iterative movements, revisiting elements as necessary to develop an interpretation grounded in empirical data[15].

In the comprehensive reading phase, transcripts underwent a second reading to capture the overall content and detect specific features. This stage involved generating a description highlighting key material characteristics, serving as a foundation for interpretation, including classification by genre[15].

Through content exploration, researchers can recognize and question both explicit and implicit ideas embedded in the text. This stage establishes a dialogue with the produced content, creating opportunities for critical questioning and problematization. Insights from interviews[15] are contextualized through broader interpretations, covering sociocultural representations, theoretical frameworks, and relevant knowledge in the field.

The final analytical step, the interpretative synthesis, performs an integrative role by reassembling material that had been previously broken down. This stage involves refining the selected data to ensure alignment with the study's objectives, the chosen theoretical framework, and the empirical findings[15].

The Ethics and Research Committee of the *Universidade Federal de São Paulo* approved this project in accordance with Resolution No. 466/2012 on March 25, 2024, under Certificate of Presentation for Ethical Appraisal (Portuguese acronym: CAAE) No. 75779323.0.0000.5505. Each participant was allocated an alphanumeric code beginning with "E" and followed by a numeral corresponding to their entry order to maintain confidentiality and anonymity.

Results

All participants were male, aged between 32 and 59 years, self-identified as White, and had completed education from primary through secondary school. Additional details regarding participant characteristics appear in Chart 2.

Chart 2 – Participants' characteristics. São Paulo, São Paulo, Brazil – 2025

Participants	Length of Hospitalization	Burn Features	Clinical History
E1	30 days	Occupational accident resulting in second-degree burns to the face, ear, and right hand.	The participant exhibits no psychiatric conditions and does not use substances.
E2	15 days	Agent: boiling water. Second-degree burns on the face, cervical region, anterior chest, and left-hand thumb.	Schizophrenia diagnosis without ongoing treatment; the burn occurred following a suicide attempt.
E3	90 days	Motorcycle accident resulting in third-degree burns on the hip and left leg.	Past illicit drug user and current smoker.
E4	7 days	Agent: unknown. Second-degree burns on cervical area and face.	Illicit drug use, with ongoing care at the Psychosocial Care Center.

Source: prepared by the author.

I'll be honest, my past is somewhat complicated…: life stories and their impact on relationships marked by (lack of) care.

This theme is illustrated through excerpts from participants' life histories, emphasizing how healthcare providers may exhibit discriminatory or prejudiced behaviors when confronted with patients' past experiences. These behaviors by healthcare providers were reported by participants and supported by findings from the scientific literature.

> *I have a long history of criminal activity and have been serving time for many years. I was actually released on June 29, and the accident happened the following day, Tuesday, June 30, which was quite unfortunate. (E4).*

> *Today, I have come to understand that my condition, encompassing addiction, chemical dependence, and other compulsive behaviors, triggers relapse when I fail to manage my emotions. This inability to regulate emotions can trigger relapse, which, if unaddressed personally (my experience may not reflect others'), may lead to psychoactive substance use. (E3).*

> *I get emotional because being stigmatized is hurtful, and many do not understand that this is an illness. Someone said to me here, – Oh, but so-and-so is a chemical-dependent and is under treatment. To what I replied: – They are not chemically dependent… a genuine dependent, if deprived of the substance… whoa! They will make a fuss and cause serious trouble. (E3).*

From life history to burn hospitalization, individuals face a dual stigmatization risk - one rooted in personal experiences and another resulting from the biomedical hospital model's disregard for psychosocial considerations. Responses from participants revealed a missing psychosocial perspective in the research context, as emotional, psychological, and relational topics arose only in later interview stages, leading one participant to ask the following question after the research inquiry:

> *Can you repeat the question? It's mostly about the burns, isn't it? (E2).*

Is this what a patient's life is meant to be?: hospital context and (lack of) care experiences

According to participants, the hospital's structure and daily routines led to negative experiences, increasing their psychosocial demands.

> *You enter a hospital ward and hear things like "no, you can't do this, you can't do that…"; am I imprisoned? I'm not a prisoner! I'm here to be looked after! "But here you don't have that option, everything is restricted", okay, but what about downstairs! Staff members smoke, doctors smoke… so I feel very frustrated with these strict rules due to my powerlessness, because I cannot do anything. So, I see a primitive system that simply does not work. (E3).*

> *I went to the hospital, which had no burn specialization. Then the first transfer spot to Aricanduva appeared, which I refused. The doctor was extremely arrogant, he*

kept on talking, and at the end I asked him: – So, doctor, don't I have the right to say "no"? He replied: – You have no right to say anything. We are dealing with CROSS here. I swallowed my words, but I wanted to say, "You closet fag, I couldn't care less about motocross. My only concern is receiving proper care and maintaining my well-being. I have no family here. (E3).

This dialogue between a patient and a healthcare professional shows the impact of language in healthcare: the patient mistaking *CROSS* [a Brazilian public health regulatory and administrative tool for resource management] for *motocross* reflects the disconnect between those providing care and those receiving it.

Daily technical procedures essential to burn care further undermine the patient-caregiver relationship:

[I'm always] alone… The only time I do anything is during physiotherapy, when I get to have a chat and be out for a while, but once it's over, I'm alone again … then I watch TV, play on my phone…, yet it still tires me out… it gets boring… (E1).

Since I got here, I spend my mornings with the physiotherapist exercising my body. I wake up when they come to see me. Then there's blood tests, vaccines, medication… I need to follow all the doctor's instructions to get better. The rest of my day I spend watching TV. (E4).

By restricting care to procedural tasks, this experience heightens the participant's psychological suffering throughout hospitalization:

It certainly does! It causes distress, tension… I get restless not seeing anything or anyone, have no one to talk to… it makes me want to leave, to run away! Being alone is so distressing… Some days, being alone and not talking to anyone feels fine… but other days, it's just unbearable! (E1).

But the mental aspect is the most complicated… it's the most confusing… difficult to grasp… for example… I saw a record saying I wasn't sleeping, you know? Understanding this process and confronting the questions, "Why did I come here? Why am I here?" was challenging. While I was intubated, they told me I had removed the tube myself. These minor events and hallucinations I experienced were the most difficult for me to comprehend. (E2).

The sentimental aspect encompasses emotions, which in turn give rise to feelings. If I cannot manage them all, what are the consequences? If I can't handle anger well? I'll keep feeding it, and I might grab a knife and kill someone, because that happens. Femicide… or I might start harming myself. (E3).

I'm not trying to turn this place into chaos: perspectives on care

Building on the fragmentation created by the care model in the study setting, participants highlight individuality and holistic care, noting different approaches among professional roles:

It's about providing care through the lens of individuality. Each patient is unique. Approaching a human being with a holistic perspective is a serious responsibility. But there's more to it, you know? It's a multidisciplinary team. Doctors often miss many details that are obvious in daily practice, such as the conversation we are having now, which the doctor is completely unaware of! (E3).

Participants noted that gaps in hospital routines and organization could allow for external activities:

If I could take a walk around here, that would be nice, right? But I can't… (E1).

We could have an art workshop here. Not exactly here, to avoid disturbing daily routines and staff work, but in a room… even if it's a tiny one. Where everyone could sit or lie down if they can't sit… draw, express themselves… it would be extremely helpful! For sure! (E3).

Let's do something outdoors. By outdoors, I mean there should be some place out there. A garden, perhaps? (E3).

I looked like a burned Frankenstein: personal experiences with burn injuries

Directly lived in the body, burns cause multiple fragmentations that, according to the participants, became more pronounced during hospitalization. In addition, burns bring entirely new experiences, including pain from the injury itself and the anticipatory fear and discomfort linked to treatment procedures.

I had never experienced anything like this… a man saw me lying by the side of the road, rescued me, and brought me to the hospital. (E4).

Still… I felt pain. It was, how can I put it, quite recent, you know? Every time I moved, it hurt… They gave me medication, but it was just to keep the pain under control, right? Yet even so, I felt pain. (E1).

At first, yes… I had never experienced anything like this, never had surgery or anything similar, you know? For the first surgery, I was scared. I had never had… what's it called? General anesthesia… I was a bit scared. Then, for the second one, I was more at ease… for the second surgery. (E1).

While pain experiences among burn victims are well-established in the literature, the interpretation proposed here requires an ethical shift that treats burn pain as unprecedented, unique, and distinct from other pains previously experienced. The burn's intensity and sharpness led, among other ruptures, to experiences of forgetfulness, erasure, and absence:

> *After receiving care, I went to my cousin's place as soon as I left [the hospital] to find out what had happened, since I couldn't remember. (E4).*

> *So, I was coming back from work, and I was… well, technically, I still am, since I continue experiencing these processes. I was having obsessive thoughts, feeling a bit angry, so I sped up on my motorcycle to get home quickly. When I reached the curve, I just couldn't navigate it, so I fell six meters down… I think the motorcycle's exhaust landed on me because I can't remember anything, I passed out… (E3).*

> *The machine [that was clogged at work] exploded, and it all hit my face. My face, my arm, my neck… and I only woke up when I was here at the hospital… because it all blew up, you know? (E1).*

Upon regaining consciousness, waking up and recalling the burn, these victims confront disfigurements and bodily changes, as reported by participants from their own burn experiences:

> *Fear. I felt so much fear because my face wasn't like this before. I thought to myself, "Oh my God, what now? How will I look?". I was afraid and a bit worried about my face, about whether I would ever look the same. Afraid it might leave a lasting trauma. Because I know who I was and now look at me. I can't even speak properly, my mouth is completely burned, and my nose is burned inside. Experiencing this is awful. As I took photos with my phone and observed my appearance, I became extremely distressed. I felt terrified because I finally realized what had truly happened to me. (E4).*

> *A piece of the material got into my eye… Thank God it didn't affect my sight. My ear took the worst of it, you know? (E1).*

> *I feel a bit fragile, yet I'm seeking to reframe this experience and get back on my feet. (E3).*

Discussion

A patient cannot be dissociated from their previous history. While previous experiences may not directly relate to the burns, they shape the individual's essence and, as a result, are crucial for coping with hospitalization. Participants in this study reported a painful connection with their past, and sharing these experiences with healthcare providers can provide an opportunity for compassionate support, though in some cases, it may also heighten anxiety. Pre-burn mental health conditions affect rehabilitation and, depending on clinical handling, can contribute to poorer psychosocial adjustment and, consequently, influence physical recovery[1-2].

Acknowledging burn victims' life histories and promoting an emotionally safe environment should serve as foundational pillars for multiprofessional care teams. Psychological support through active, sensitive listening that honors individual differences is vital to the therapeutic process and, consequently, to rehabilitation. In this context, healthcare professionals must provide care that addresses each victim's uniqueness, integrating physical recovery with psychosocial rehabilitation, while fully respecting individual complexity and avoiding judgments or stigmatization[1,3].

Burn pain encompasses sensory aspects mediated by receptors present in the skin. While its intensity is closely linked to the extent and depth of the injury, other factors, particularly environmental, social, and psychological contexts, significantly influence the pain experience, as previously discussed. Social isolation, absence from work, physical dependence for basic daily activities, and anxiety regarding procedures are among the many factors influencing how burn victims experience pain[2,18].

Hospitalization imposes a rupture in the individual's daily life, frequently leading to diminished autonomy. Separation from familiar surroundings, routine disruptions, and restricted family visits contribute to a sense of dissociation in burn victims, as participants noted. Interviews highlighted insufficient staff communication, scarce activities during hospitalization, and limited mobility within the care unit[4].

Literature highlights resilience as a crucial element for effective recovery. Resilience in burn victims is fostered through family support, external support networks, and healthcare teams. In this context, care must go beyond technical procedures to incorporate psychological support

for victims and their families, providing guidance on the health condition and strategies to foster acceptance, coping, and resilience[2,19-20].

Recurrent complaints among study participants included idleness and social isolation. Providing patients with access to spaces and activities during hospitalization is key to reestablishing daily routines, regaining a sense of control, and fostering active participation in the care setting. These interventions strengthen treatment participation, aid in coping with burn-related psychological effects, and encourage decision-making autonomy[4,21].

Pain and the emotional ability to manage a new scar stand out among the many aspects of suffering[2]. These experiences are intense and enduring, often extending beyond the hospitalization period. As previously discussed, such aspects can be amplified by preexisting or treatment-emergent psycho-emotional factors.

It is crucial to emphasize the distress caused by potential changes in body image, such as scars that bear a negative symbolic weight and set the victim apart from others, creating substantial potential for social exclusion and prejudice. Such experiences pose a considerable threat to mental well-being during and after hospital care, requiring ongoing monitoring by the healthcare team. In this regard, the *American Burn Association* recommends routine screening for disorders such as depression and post-traumatic stress in burn patients, using tools like the *Patient Health Questionnaire* to ensure diligent and effective mental health monitoring[3,20].

The challenge in addressing physical and emotional pain arises from healthcare professionals' limited ability to fully consider multiple contributing factors, often resulting in care that is fragmented rather than integrated[3-4,22]. Recognizing the individual's particularity is vital, especially in relation to pain, which is central to the patient's coping process. Physical pain combined with the sight of one's own scar in the mirror highlights the dual physical-emotional suffering faced by burn victims.

Ultimately, the low staff turnover in the hospital unit where the study was conducted limited the ability to expand the sample size according to the planned strategy. Ongoing data collection at multiple time points was conducted in accordance with participants' availability and subjective conditions, while also improving data quality through the rapport established between researcher and participants.

The study provides nuanced qualitative insight into the psychosocial challenges encountered by burn victims during hospitalization. The study underscores contributions to clinical practice in BTUs, as the qualitative data highlight the need for strategies and interventions that assess psychosocial needs and diversify therapeutic practices in the hospital setting, pointing toward enhanced comprehensive care.

Final Considerations

The experiences reported by burn victims provided visibility to the psychosocial demands encountered during hospitalization. These demands encompass pre-trauma experiences, adverse encounters linked to hospital (lack of) care, and the difficulties arising from coping with burn marks and their physical and emotional impacts.

In this context, nursing professionals working within healthcare teams should address the full complexity of burn victims' experiences, promoting strategies that encompass both physical care and psychosocial support. Interventions such as attentive listening, ongoing psychological support, systematic screening for psychological distress, and patients' direct engagement in treatment decisions should be incorporated as essential components of comprehensive care.

It is recommended to implement occupational therapy sessions and social engagement groups during hospitalization to promote autonomy recovery and mitigate losses stemming from trauma. Building strong healthcare team–patient–family relationships, supported by external networks, is crucial for promoting resilience and facilitating rehabilitation adapted to each person's individuality.

In this way, the study's findings illuminate the psychosocial challenges experienced by burn victims while suggesting practical strategies for delivering care that is more compassionate, holistic, and responsive to the subjective dimensions of pain, body image, and each patient's unique journey.

Collaborations:

1 – project's conception and planning: Nathália Cristina Cará, Lucas Cardoso dos Santos, Alfredo Gragnani and Thiago da Silva Domingos;

2 – data analysis and interpretation: Nathália Cristina Cará, Lucas Cardoso dos Santos, Alfredo Gragnani and Thiago da Silva Domingos;

3 – writing and/or critical review: Nathália Cristina Cará, Lucas Cardoso dos Santos, Alfredo Gragnani and Thiago da Silva Domingos;

4 – final version's approval: Nathália Cristina Cará, Lucas Cardoso dos Santos, Alfredo Gragnani and Thiago da Silva Domingos.

Conflicts of interests

There are no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available in the article itself.

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