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Original article

# Perceptions of adult patients about the experience of hospitalization in a burn treatment center*

Percepções de pacientes adultos acerca da vivência da internação em centro de tratamento de queimados

Percepciones de pacientes adultos acerca de la vivencia de la internación en centro de tratamiento de quemados

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## Abstract

**Objective:** to analyze the perceptions of adult burn victims about hospitalization in a referral center. **Method:** qualitative research developed from December 2021 to March 2022, in a Burn Treatment Center in the North of the State of Paraná, Brazil. Corpus composed from 16 testimonials collected through individual semi-structured interview in depth, whose data were transcribed and submitted to the analysis of the Collective Subject Discourse. **Results:** there were four categories: "Interpersonal relationships and prolonged hospitalization"; "Pain during the hospitalization itinerary"; "Burn beyond the physical aspects" and "Coping strategies during hospitalization". **Conclusion:** the integral and humanized care, the presence of a support network, the inclusion of the patient in the recovery process and the faith were considered as factors that alleviate the anguish of the burn and promoters of positive post-hospitalization perspectives and hope.

**Descriptors:** Burns; Burn Units; Hospitalization; Qualitative Research; Interview

## Resumo

**Objetivo:** analisar as percepções de adultos vítimas de queimaduras acerca da internação em um centro de referência. **Método**: pesquisa qualitativa desenvolvida de dezembro de 2021 a março de 2022, em um Centro de Tratamento de Queimados no Norte do Estado do Paraná, Brasil. *Corpus* composto a partir de 16 depoimentos coletados por meio de entrevista semiestruturada individual em profundidade, cujos dados foram transcritos e submetidos à análise do Discurso do Sujeito Coletivo. **Resultados**: houve a emersão de quatro categorias: "As relações interpessoais e a internação prolongada"; "A dor durante o itinerário da internação"; "A queimadura para além dos aspectos físicos" e "Estratégias de *coping* durante a internação". **Conclusão**: o cuidado integral e humanizado, a presença de rede de apoio, a inclusão do paciente no processo de recuperação e a fé foram considerados fatores amenizadores das angústias do queimado e promotores de perspectivas pós-internação positivas e de esperança.
**Descritores:** Queimaduras; Unidades de Queimados; Hospitalização; Pesquisa Qualitativa; Entrevista

## Resumen

**Objetivo:** analizar las percepciones de adultos víctimas de quemaduras acerca de la internación en un centro de referencia. **Método:** investigación cualitativa desarrollada de diciembre de 2021 a marzo de 2022, en un Centro de Tratamiento de Quemados en el Norte del Estado de Paraná, Brasil. *Corpus* compuesto a partir de 16 testimonios recogidos por medio de entrevista semiestructurada individual en profundidad, cuyos datos fueron transcritos y sometidos al análisis del Discurso del Sujeto Colectivo. **Resultados:** surgieron cuatro categorías: "Las relaciones interpersonales y la internación prolongada"; "El dolor durante el itinerario de la internación"; "La quemadura más allá de los aspectos físicos" y "Estrategias de *coping* durante la internación". **Conclusión:** el cuidado integral y humanizado, la presencia de red de apoyo, la inclusión del paciente en el proceso de recuperación y la fe fueron considerados factores amenizadores de las angustias del quemado y promotores de perspectivas post-internación positivas y de esperanza.
**Descriptores:** Quemaduras; Unidades de Quemados; Hospitalización; Investigación Cualitativa; Entrevista

## Introduction

Burns are the result of contact between external agents with the skin, and may be of a thermal, chemical, electrical, radiant or biological nature, capable of causing damage to both the lining tissue, the muscular and bone systems, according to the extent of the injury. The consequences of this trauma can be various, such as pain, the risk of infection, as well as possible impairment of the functionality of body segments and volume depletion, which can generate hypovolemic shock and death. Therefore, they usually require long periods of hospitalization and comprehensive care, which is a significant public health problem.[1]

The Hospital Information System of the Unified Health System (SIH/UHS) reveals that, in Brazil, 49,439 burn admissions occurred from January 2021 to September 2022, of which 4,520 were in the State of Paraná.[2] Despite the high it is also relevant to consider the sub-notifications that inevitably occur.[1]

In this context, the institutionalized patient due to burns experiences painful moments even in the usual situations, such as the bath, which requires specific technique added to the use of analgesics, the exchange of dressings and recurrent indications for surgical procedures.[3]

The loss of autonomy, even in everyday activities, integrates the setbacks that the burned patient needs to face. Allied to this, the feeling of loneliness may arise, as well as afflictions regarding your life outside the hospital space, your job, your obligations and your family, which can incite feelings of anguish, anxiety and impotence.[3] However, neglect of emotional distress by the care team often persists, whether deliberately or not. Thus, it is essential to make use of this complex experience, because, if not administered in a multidisciplinary way, it may be marked by a lack of voice and, especially, by a lack of hope.[4-5]

It is necessary to consider that the skin fulfills multiple physiological functions, such as thermoregulation, the protective barrier function against external elements, the regulation of blood flow and the mediation of sensory functions, in addition to granting body aesthetics to the individual.[6] In this sense, when damaged by the burn, the patient can experience a process of mourning the old body, which covers the conflict between a recent past and the present, a situation that may give rise to questions related to his self-image and his value, as well as bitterness before memories and comparisons, disturbing their self-esteem. In addition, the long time of hospitalization strengthens such feelings, which will have a direct impact on resilience and disposition during treatment.[1]

Although the official data show high morbidity due to burns, Brazil has only 56 centers of specialized treatments in these injuries, with heterogeneous distribution in the territory.[7] However, this clientele can remain in treatment in different institutions until there is a vacancy in the specialized service. Therefore, the professionals of the institutions of origin need to offer qualified assistance, covering all spheres of the human being and not only the technical part of the burn treatment.

Thus, knowing the perceptions of this clientele allows the professionals involved in their care to expand the planning of their assistance beyond the physical damage caused by burns. This can contribute to the development of strategies that contemplate multidisciplinary and humanized therapeutic approaches that collaborate with the social reintegration of the patient, in order to minimize the emotional sequelae that a trauma of this nature can cause.

Therefore, this research is based on the following question: how does the adult burn victim perceive hospitalization in a reference treatment center? In order to elucidate this question, it was conceived as an objective: to analyze the perceptions of adult burn victims about hospitalization in a reference center.

## Method

This research has a qualitative approach and occurred in the Burn Treatment Center (CTQ - *Centro de Tratamento de Queimados*, in Portuguese) of a large university hospital, located in Brazil, in the North of the State of Paraná. The institution corresponds to a tertiary care center that welcomes patients from more than 100 municipalities in other states, in addition to about 250 cities in Paraná. It was inaugurated in August 2007 and is a reference in burn care, currently comprising 16 beds, six of which are assigned to intensive care and 10 to wards, as well as two exclusive operating rooms and own ambulatory.

Patients who were hospitalized in this sector during the months of December 2021 to March 2022 were invited to participate in this study. For inclusion of the participants, the criteria were used: to be aged 18 years or older and to be hospitalized in the wards of the CTQ for seven days or more. When, at the time of the interview, there was a case of convergence with some procedure (change of dressings in bed, balneotherapy, surgeries or examinations), this was suspended and new approach provided later. People with limited communication (emission, decoding and response) were excluded due to the process of recovery after face procedure or use of a specific device, such as vacuum dressings.

The proposed time lapse - seven days or more of hospitalization - is justified by the greater probability of submission to several balneotherapy and at least one surgical

procedure, when indicated, a context that extends the therapeutic experiences in the treatment of burns.

The information was collected by the main researcher, in the form of an individual interview in depth, semi-structured, audio-recorded and consented by the participant through the signature of the Informed Consent Term. The interlocutions happened in the dependencies of the CTQ and had minimum duration of 12 and maximum of 20 minutes, time established in the sense of not hindering the assistance directed to the patient.

Participants who could walk were interviewed in the study room of the sector. Those who were bedridden and who were not in the company of another patient in the ward were interviewed in their own bed. However, in order to preserve the participant, in cases of wards whose neighboring bed was occupied by another patient, it was decided to approach the respondent taking advantage of the moments of absence of the partner, when he underwent surgery, for example.

The guiding instrument consisted of questions of characterization of the participant, data related to injury/ hospitalization and four open questions: 1) How do you perceive this period of hospitalization since the burn happened until today? 2) Tell me about your feelings during this period. 3) Has there been a change in any internal/subjective aspect of you since the burn? If so, explain. 4) Tell me about your plans after being discharged from hospital.

As there was no pre-established number of patients surveyed, the interviews were closed when the data showed sufficient quality to respond to the objective of the study. This parameter was proposed through careful and intentional selection, which privileged two aspects: that the source of information of the condition studied was composed of those considered most relevant social actors (stakeholders) and corpus consisting of diversified profiles.[8]

Of the 131 patients admitted during the data collection period, 86 were adults, of whom 54 remained hospitalized for seven days or more. Of these 35, 15 refused to participate in the interview. Thus, of the 20 potential participants, 04 were excluded from the study because the interview was interrupted for examination or invasive procedures and, when proceeding later attempt to approach was found hospital discharge.

From the thirteenth interview it was evidenced the repetition of speeches, as well

as the identical pattern of answers to the guiding questions, without the presence of new significant elements related to the proposed objective for this study. Thus, based on this recurrence, data collection persisted until the sixteenth participant.

After the collection, the interviews were transcribed considering strictly the verbal aspects, being maintained the proper language of the individuals, but were disregarded pauses during the speech body expressions or behavioral signs. These data were treated through the mobilization of the Discourse Analysis of the Collective Subject Discourse (CSD), a technique of data processing whose purpose is to rescue collective ways of thinking of the most different groups. In other words, in the CSD, verbal data are processed with a view to the emergence of collective opinions.[8]

A preliminary analysis of the transcriptions of the speeches allowed the identification of key expressions and, in the sequence, the central idea expressed by them, which can be understood as a name or a linguistic expression that describes, in a synthetic and precise way, the meaning(s) of the discourses analyzed. Then, the key expressions and central ideas (CI) listed were categorized and, subsequently, the respective CSD were organized, summarily written in the first person singular.[8]

In more detail, the analysis, as well as the organization of the data collected, occurred as follows: a) a worksheet with six columns in Microsoft Excel; b) in the first column were inserted the speeches of each participant, transcribed in full; c) the second column housed the key expressions copied, which were identified after repeated readings of the transcripts; d) in the sequence, each key expression was analyzed separately, identifying the central idea expressed in each of them. 26 central ideas emerged from the key expressions, arranged in the third column and identified as IC1 to IC26; and) then, according to similarity, the central ideas were grouped into categories and subcategories, respectively in the fourth and fifth column; e f) finally, in the sixth column, the CSD were organized, whose wording was composed by the union of key expressions that were part of the IC belonging to each category.

The ethical aspects followed the recommended by Resolution n. 466/2012 of the National Health Council, with approval of the institution's Research Ethics Committee, under opinion n. 4.416.099 and CAAE 40087520.7.0000.5231, on 23 November 2020.[9]

## Results

The study consisted of 16 participants, of which 11 were men and five were women, aged between 69 and 20 years, mostly self-reported black or brown, married or in a stable union. As for the level of education, the respondents were thus distributed: one with complete higher education, one with incomplete higher education, six with complete high school, three with incomplete high school, four with complete elementary school and one with incomplete elementary school. As for the type of injury, six had suffered burns in domestic accidents, one in traffic accidents and nine during their work activities.

Regarding the etiology of burns, two cases were of electrical nature and the others of thermal character. The percentage of burned body surface ranged between 5 and 50%, all with mixed depth of 2$^{nd}$ to 3$^{rd}$ degree, predominantly covering areas of upper and lower limbs, trunk and neck. All interviewees had already undergone balneotherapy, dressings and debridement. As for the autologous skin graft, two patients had not yet done so at the time of the interview. Three individuals were submitted to hyperbaric oxygen therapy.

The analysis of the interviews allowed the emergence of 26 central ideas that were grouped into four empirical categories, category 1 and category 3 presented subcategories (Chart 1). Subsequently, the respective CSD were constructed, considering the key expressions that originated the central ideas, demonstrated in subsequent sections.

**Chart 1 –** Composition of empirical categories. Londrina, PR, Brazil, 2022.

| Categories | Subcategories | Main ideas |
|---|---|---|
| 1) Interpersonal relationships and prolonged hospitalization | A) Polarities in the relationship and communication with the multidisciplinary team | Appropriate treatment with encouragement, positivity, good humor and zeal from the multidisciplinary team. |
| | | Nursing listening as a strengthening factor in the care process. |
| | | The scarcity of information generating insecurity and anxiety. |
| | B) Relationship with other patients versus presence of a companion | Social relationships built with other burn patients to support recovery. |
| | | Prolonged hospitalization as a negative point and the expectation of returning home. |
| | | Loneliness and isolation as obstacles to hospitalization. |
| | | The support and comfort provided by the presence of a companion. |
| 2) Pain during the hospitalization itinerary | ----- | Non-appreciation of the patient's pain and delay in attending to pain complaints by the team. |
| | | Pain as a negative point. |
| | | Inadequate management of pain experienced outside |

| | | |
|---|---|---|
| | | a specialized service. |
| 3) The burn beyond the physical aspects | A) Positive feelings | Satisfaction and happiness for the resolution of the board. |
| | | Gratitude and the flowering of altruism. |
| | | Happiness awakened by the concern of loved ones. |
| | B) Negative feelings | Burn hospitalization as a precursor to emotional implications. |
| | | Initial reflections after institutionalization. |
| | | Awakening from feelings of frustration and impotence and preoccupation with external responsibilities. |
| | C) Reframing and changes in thinking | Positive coping from the perspective of learning and starting over. |
| | | The understanding of the seriousness of the burn and the recognition of human finitude. |
| | | Awakening of an alert and cautious conscience because of the burn. |
| | | The expansion of perspectives and the promotion of new thoughts. |
| | | Hospitalization as a means of exercising patience. |
| 4) Coping strategies during hospitalization | ----- | The value of faith, discipline and optimism for the recovery of burned patients. |
| | | The presence of spirituality and the intention to cultivate it. |

Interpersonal relationships and prolonged hospitalization

This category was composed of a total of seven central ideas arranged in two subcategories and the respective CSD, which can be seen in Chart 2.

**Chart 2 –** Category 1 speeches in their respective subcategories. Londrina, PR, Brazil, 2022.

| Subcategory A) Polarities in the relationship and communication with the multidisciplinary team |
|---|
| *I have been treated very well here most of the time and when we receive good treatment, recovery tends to be faster. The team does not allow me to be 'down' and, when professionals realize that I am discouraged, they encourage me, give encouragement to improve, treat with positivity. When I talk to the nursing staff, they listen to what I need, something that I did not have in the service in which I was hospitalized before being transferred here, because there I did not have the autonomy to express my opinion about my treatment. When I was there, I just wanted it to be over so I could leave. In this sector, everyone treats me with education, good humor and sincerity at work, trying to raise my self-esteem and valuing me as a human being, which gives a huge comfort and a lot of confidence. I realize that there is empathy on the part of professionals, even with all these good things, there are some of them who are intolerant, not able to work with the public and this cannot become habitual in this service. Another negative point I noticed was the lack of communication, more specifically about information regarding the procedures I was going to do, what was happening to me, especially information passed on by the doctor. I miss the doctor passing by and saying a word. Also, when I questioned, each one passed me a different information and I ended up getting kind of lost in the events. When I learn what is actually happening in the treatment I can sleep* |

| |
|---|
| *peacefully.* [CSD] |
| **Subcategory B) Relationship with other patients versus presence of a companion** |
| *I made good friends inside, good companions and companions and it was their willpower added to mine that has contributed to my rehabilitation. Still, I need a relative by my side. I know I'm not alone in a room, but for me, it's like I'm used to being around the family. A professional will do everything to help you here, but there is always discomfort and, having a family member together, I feel more comfortable, especially for physiological needs. So, if a family member can keep up with me, at least during the day, it would help me a lot in recovery. Added to this, it has the long period of hospitalization, because a burn is something painful, it is not like a fracture, which has a certain recovery time in most cases; the burn is more time consuming. Since it happened to me, I was very apprehensive, afraid to be away from my family; I began to think a lot about my family [...] and there are days that I do not feel well, it is a kind of despair and I alone here, with no one beside me, something will happen.* [CSD] |

Pain during the hospitalization itinerary

The second category was structured from three central ideas and the discourse constructed was as follows:

> *The burn causes unbearable pain and the pain is a strong point. It discourages you, it ends with you, it's horrible! I do not wish anyone this pain, because it makes everything more difficult even to make the needs. In the hospital where I was previously hospitalized they did not medicate me properly; the cleaning of the wounds was done without anesthesia and I felt a lot of pain. Here in this service this has improved, because during the balneotherapy and dressings I am anesthetized and I found it much better. But there was a situation where I woke up at five o'clock in the morning with a lot of pain in the arm, warned the nursing about it and the person in charge took a long time to meet me; lacked love for the next!* [CSD]

The burn beyond the physical aspects

This third category consisted of 11 central ideas and Chart 3 scales its three subcategories and the respective CSD.

**Chart 3 –** Category 3 speeches in their respective subcategories. Londrina, PR, Brazil, 2022.

| **Subcategory A) Positive feelings** |
|---|
| *Shortly after I was admitted to this service, my injuries were already progressing well and I feel very happy that my graft areas are working. When I heard about the success of the graft I was excited like a child; it can be a very simple thing for those who work in this area, but for me, it was a great victory my recovery and being able to walk again. Soon after the surgery I felt a lot of pain, but after controlled, I realized that it was well performed, I realized how good this institution is and I had a very good feeling that everything is going well. A feeling of gratitude to God that I survived; to those who took care of me here in the hospital, remembering that these people should be valued for the work they do; to all who prayed for me, friends and family.* |

| |
|---|
| *From now on I want to be more grateful, humble, supportive, give more and be able to help people, because before I was very selfish, I only thought about myself and my family, without caring about others. Here in the hospital I had the chance to meditate, to recognize myself as a human being and to realize that there are more humans on the outside, that I need to help others more. With all this, I feel my chest open and happy to realize that so many care about me. The prayer and concern of loved ones contribute much to my mood to the point of getting emotional. It is an inexplicable joy!* [CSD] |
| **Subcategory B) Negative feelings** |
| *What happened to me was very fast and I never imagined it would happen. I spent some time trying to understand how this happened to me and I was very disappointed with myself, because I think it was a silly thing of mine, an oversight. I feel frustrated that it happened because I have a lot to do outside the hospital. Since I got burned I've been so scared, especially of having sequels. At the beginning of the treatment I worried a lot, questioning: 'will I be normal again? Will I be able to go back to work or not?' The burn left me very badly emotionally also, more fragile and cry often when I remember the accident. I've been so scared I've had dreams about it. Initially, at the first call here, I thought I would leave after the consultation, which was nothing so serious, that I would leave soon. However, my life stopped because I'm here and my family is out there. So it's very negative not to be working, not to be with my family, not to be doing what I needed to be doing.* [CSD] |
| **Subcategory C) Reframing and changes in thinking** |
| *The burn taught me a lot, will always be remembered and will 'burn' throughout my life, in the soul, in the look, in the things I will talk about. She lit an alert for me and I think from now on I will be a different person, less stressed and more patient. I was always very agitated and 'burst, however, during hospitalization, my perspectives changed and I changed my thoughts, gave me time to think, which I did not have. Before, I thought only about working, I didn't think others around me existed and I will value people more now. I learned that we have to love each other intensely while we are here on Earth. I could stop and see life, feel life, then is a new life, a new birth. I think the experience of the burn will make me take more care to do things, because we can be talking and in a few minutes, you can die if you're not careful. I saw so many people worse than me, a lot more burned than me, a lot of people fighting and I came to see a person who was admitted here and was even able to feed alone, but after complications, died. So I'm not taking hurt or remorse from the burn. This process contributed to the change of thought also of some family/friends, I could feel their concern and this love was also an important source for me to recover.* [CSD] |

Coping strategies during hospitalization

The fourth and category was built on two central ideas, which originated the CSD below.

> *The burn is very dangerous and, for its cure, it is necessary to have discipline and maintenance of calm, in addition to following the guidelines of the health team. If the person surrenders and does not do what the professionals guide, he does not succeed in treatment. One must believe in recovery, have faith and perseverance. Here in the hospital there are people from the chapel who come to visit and pray with us and this is very positive. I always believed in God, but after this period here, a lot will change in my daily life, in the religious part, at home, in my whole life. I intend to seek more God, thanking him, regardless of religion, because He was wonderful with me. I will always pray that this no longer happens to me or other people. If He is giving*

> *me one more opportunity to live, it is because there is a plan for me and I will pursue this plan by being more religious and loving.* [CSD]

## Discussion

The results of the first category revealed considerations about the relevance of interpersonal relationships during the long recovery process of the burn victim. In subcategory A, the speech was supported by perceptions about the posture of the multidisciplinary team during hospitalization, qualifying it based on criteria such as effective communication and the nature of the doctor-patient relationship. When reflecting about the discourse, it is noted that it is consistent with what is said in the literature, which emphasizes humanized assistance. This is translated by the use of light technologies in care, so that the patient recognizes that his feelings are legitimized and that his dignity is preserved, generating beneficial repercussions on his emotional state and willingness to advance in treatment.[10]

Communication was reputed as a matrix for the prosperity of bonds, presenting greater depth before the attitudes of empathy and active listening by the team. It is important to emphasize that interpersonal relationships between professionals and patients are built through communication processes, including on the progress of treatment. When communication is not effective, such relationships become incipient and can provide feelings such as insecurity and anxiety. In convergence with the data, an integrative review of the studies showed that providing information to the patient validates their role as a participant in the therapeutic process and, in addition to encouraging self-care and ensuring their safety, allows stillness to the state of mind of the burned.[10]

Still in the initial category, the discourse associated with subcategory B denoted how social relations, as well as their lack, impact on the maintenance of mental state and patient perseverance. Prolonged hospitalization promotes rupture in the circle of relationships of the individual, abruptly removing him from his daily social life and making this situation remain for a long period. In the meantime, the patient is faced with a restrictive routine and is away from the comfort offered by family life, which can arouse feelings of isolation and loneliness, aspects that, combined with other stressful factors of hospitalization, can cause psychic disorders.[10]

Since the removal of their loved ones can cause difficulties in their readjustment in society and that a stable support network supports adherence to treatment, it is important that professionals broaden their perspective of the health-process disease beyond the curative sphere and that recognize the beneficial effects of the companion and social relations in the patient's coping capacity. In addition, the nurse, as a constant personality in the patient's coexistence, is essential in the identification and mediation of such adversities, which occurs through the nursing process and the application of light technologies.[4]

The second category showed one of the main discomforts that permeate the context of recovery of the burned patient: pain. In certain research, the reports presented coincide with the discourse of this category, since the narratives of both have as intersection pain as persistent discomfort, so that it is undesirable for any human being.[11]

Pain is an abstract and relative concept, being its threshold subject to affective-emotional characteristics of previous experiences, as well as cultural. The role of psychology in coping with burn afflictions is valued here, among them pain, since it causes physical and emotional marks, however the emotional ones cannot be repaired through the practicality of surgeries.[11]

Authors argue that the burn permeates four patterns of pain: 1) the pain of background, constant and independent of manipulation, until the moment of complete reepithelialization; 2) disruptive pain, which is mostly linked to manipulation and movements and has an acute and sudden nature; 3) pain in the procedure, which is related to the execution of medical interventions and, despite being acute, can resonate for hours and even days afterwards; 4) postoperative pain, which is one of the most intense pains.[12]

Pain, as a continuous physical and psychological stressor in the patient's recovery process, is not always valued as it should by care providers,[11-13] as mentioned in the CSD. By keeping in mind the predominance of the biomedical model, health workers can confuse their objective strictly with the act of proving the presence of pain, quantifying it and judging, by itself, if it is worthy of interventions.[13]

It is still possible that, in the same way that some professionals are sensitized to being exposed to suffering repeatedly, others naturalize this demand as a coping

strategy. Therefore, it is essential that caregivers are trained to act in a humanized way, recognizing the patient's claims and emphasizing ethics, without projecting judgments of their own value, in addition to offering planned and organized care.[13]

The third category emerged from the data shows the impact of the burn on the victims, passing through the physical injury itself. In its first subcategory, the CSD signals positive feelings experienced during hospitalization, being the contentment for the evolution of the clinical picture one of the angles brought. During hospitalization, the patient is in autonomy deficit, a situation that subjects him, even when it comes to the most basic care, to the availability of others. Added to this, uncertainties may arise as to the possibility of sequelae and the resumption of their previous capabilities.[1]

This framework can be motivated by cultural values, based on the understanding that crafts are the mainstay of a life socially accepted as natural. Thus, the human being, with his tendency to modify the environment around him to provide resources and make himself evident in the community, links its essence and value to them.[1] In this sense, the internees have the potential to relate their well-being to be restored to its previous performance, experiencing distress when considering the chance of having to assume a new social position.[4] This relationship emerges in the discourse when the patient expresses intense happiness when he recovers his abilities, even the most basic ones.

In addition, interpersonal relationships, more specifically the most significant family connections for the patient, beneficially interfere with the hospitalization process. The dimension of social support is directly proportional to the well-being of the individual, restraining feelings of anguish and stimulating adherence to treatment. Thus, family support proves to be an important coping device, contributing to avoid the emergence of emotional disorders and to facilitate the acceptance of their current condition.4

Moreover, when faced with threats to their longevity, the imminence of giving oneself intensely to their relationships and their principles is awakened in the individual, a condition manifested by the will to resolve pending issues and express feelings that were previously repressed. In this context, the experience generated by the burn triggers meditations about existence and, combined with prolonged exposure not only to one's own, but also to the suffering of others, it is plausible that the patient

recognizes his vulnerability, newly discovered in the people around him. Such a picture allows him to admit the value of the assistance offered to him at this very troubled moment, longing to help as well,[14] as mentioned in the speech.

In contrast, the thematic axis addressed in subcategory B emphasizes negative emotions, especially regarding frustration, disability and concern. Trauma is a subjective experience that has meanings and coping mechanisms influenced by previous values, judgments, beliefs and perspectives. Given the fact that the burn originates more than physical changes, the patient can be swallowed by a series of stunning emotions, which can follow his entire trajectory. This situation can generate difficulty of assimilation by the patient, and the two eventualities indicate emotional instability.[15]

In addition to the issue of physical and psychological health, the burn reveals a socioeconomic aspect, since, when institutionalized and removed from his scenario, the patient is compelled to leave his duties provisionally, whether financially dispensable or not. In cases where the burn occupies the position of provider, he experiences concern for his dependents and the possibility of not resuming his old skills, which can affect adherence to the therapeutic plan. Frustration and impotence are sensations that can incite in the patient an optics based on the belief of growth suspension, while the others around them continue with their lives.[15]

Subcategory C was designed based on the conception that the burn causes the individual to rethink their convictions. In the course of the hospitalization process, the perspective of death hovers over the patient, felt in their own experience or observed in other patients.[1]

Thus, closeness to death is accompanied by fear and grief caused by the perception of loss of one's own dreams, goals and loved ones. Naturally, the human being is inclined to ignore his finitude, due to lack of control over this phenomenon, which often does not allow planning.[15] Because they are prolonged in an environment that fosters considerations about the essence of life and what is after it, the individual can contemplate ethical and moral dilemmas that reverberate in behavioral and identity aspects.[16]

This possibility can be authenticated by the statements in the discourse about the changes in the peculiarity of the patient, concerning the greater exercise of patience, the more cautious behaviors and the desire to express their feelings more openly. The

adversities faced can be perceived in different ways depending on the individual, but it is plausible, considering the constructed discourse, that the patient is able to transform the meaning of the traumatic experience, especially if it receives resources that cover the entire biopsychosocial sphere.[15]

In turn, the speech corresponding to the fourth category deals with the methods of coping used by the patient, which were judged as essential to face hospitalization for burns. Institutionalization can cause emotional repercussions capable of affecting the resilience of the individual and, in search of restoring his balance, he develops tactics that suit his principles.[1]

It is in this context that the patient exercises self-reflection, obtains new perspectives or reinforces the previous ones. One of the highlights of the narrative presented is the patient's perception of the importance of his determination and discipline to comply with the therapeutic plan developed by the health team, the benefits of recognizing yourself as a participant in the recovery process and care based on transparency.

Equally to other studies,[1,15] this discourse alludes to the esteem of perseverance, dedication and especially faith in the patient's daily life, manifested by the feeling of gratitude to God. The presence of spirituality in the day to day of the sector of treatment of burns operated as a foundation in the reestablishment of the individual, producing sensation of tranquility. Feelings of sadness, loneliness and fear for life are indications of the longing for the dimension of religiosity, and faith becomes one of the few comforts in a context in which all bonds of affection were abruptly and temporarily interrupted. In this sense, faith has the office to appease the anxiety generated by the various uncertainties of hospitalization and the patient often clings to the perception that what happened is a small piece of a larger plan designed by forces such as fate and God, possibly from the feeling of powerlessness and lack of control over your own life.[1]

In view of the aforementioned conjunctures, care professionals can intervene through the provision of recreational activities that offer distraction and well-being. The application of these activities can provide the patient with relief from negativity and relaxation effects, as well as a milder understanding of their current circumstances.[1]

Although the results of this study and its discussions may provide information to increase knowledge about burn victims, it should be mentioned as a limitation that the

data reflect perceptions during hospitalization, since there was no verification after hospital discharge. Thus, it is suggested that other investigations learn how such perceptions occur in a scenario of return to society, which can modify the conceptions about the initial period of burn treatment.

The contribution of this work lies in the fact that, when giving voice to the experiences of the burn during hospitalization, efforts can be used so that the process of care can be understood as something multifaceted, looking beyond the biological impairments provided by this injury. It is hoped that the results of this research can foster reflections in multidisciplinary teams that deal with the clientele in question, so that they seek, increasingly, to base their practices not only valuing the treatment of the pathophysiological aspects of the burn, but also considering the individual in its entirety, which includes psychic and social impairments added to physical impairment.

## Conclusion

The integral and humanized care, the presence of a support network, the inclusion of the patient in the recovery process and the faith were considered as softeners of the anguish of the burned and promoters of hopeful future perspectives. Thus, the identified support points have repercussions pertinent to the socio-emotional sphere and act to appease negative feelings, such as loneliness, impotence and anguish

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