

# De dolor a esperanza: afrentando el estrés postraumático y cultivando el crecimiento postraumático en víctimas de quemaduras

*From pain to hope:  
facing post-traumatic stress  
and cultivating post-traumatic growth  
in burn victims*

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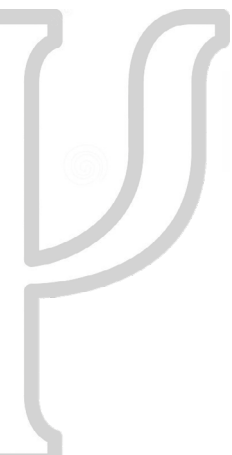
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## Resumen



Las quemaduras constituyen un problema de salud pública debido a las consecuencias del accidente, que repercuten en la vida del sujeto, además de secuelas físicas irreversibles, pudiendo desarrollar Trastorno de Estrés Postraumático (TEPT). Sin embargo, también pueden experimentar Crecimiento Postraumático (CPT), con una nueva resignificación de la vida, las experiencias y los valores. La presente investigación tuvo como objetivo comprender las experiencias de TEPT y CPT en sujetos que sufrieron quemaduras graves. Se realizó un estudio de métodos mixtos con la participación de tres personas que sufrieron quemaduras. Estas respondieron a un guion de entrevista semiestructurada mediante un encuentro presencial. Los datos fueron analizados mediante el software IRaMuTeQ (Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires). Los resultados se organizaron en tres clases: 1) "Trastorno de Estrés Postraumático", que muestra las dificultades enfrentadas al sufrir una quemadura, pudiendo desencadenar TEPT; 2) "Crecimiento Postraumático", que aborda el crecimiento personal después del trauma; y 3) "Red de apoyo", que presenta la importancia de las relaciones interpersonales para la recuperación. Tras experimentar un evento traumático, el individuo puede desarrollar la experiencia de Crecimiento Postraumático que, entre diversos factores, puede favorecerse mediante la red de apoyo.

**Palabras clave:** quemaduras, trastorno de estrés postraumático, crecimiento postraumático, red de apoyo, sobrevivientes de quemaduras.

## Abstract

Burning is a public health problem, due to the consequences of this accident that echo throughout the subject's life, through the trauma resulting from the incident and the therapeutic hospitalization, in addition to the irreversible physical sequelae, developing Post Traumatic Stress Disorder (PTSD). However, they can also experience Post-Traumatic Growth (PTG), with a new meaning of life,

experiences and values. To uncover this reality, this research aimed to apprehend the experiences of PTSD and PTG of subjects who went through severe burns. A mixed-methods design study was carried out, which had the participation of 3 people who suffered burns. They will respond to a semi-structured interview script, via a face-to-face meeting. The data were analyzed using the IRaMuTeQ (Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires). The results consisted of three classes: 1) "Post-Traumatic Stress Disorder", which shows the difficulties faced when suffering a burn, causing PTSD; 2) "Post-Traumatic Growth", which addresses personal growth after trauma and 3) "Support Network", which presents the importance of interpersonal relationships for recovery. After experiencing a traumatic event, the individual can develop the experience of Post-Traumatic Growth which, among several factors, can develop through the support network.

**Keywords:** burns, post-traumatic stress disorder, post-traumatic growth, support network, burn survivors.

## Introduction

Every day, people are exposed to various risks of burns in their routines, often without realizing it. A second inattention can begin a new chapter in their lives. Small oversights, such as failing to notice that the wind has extinguished the stove flame or handling hot pans without protection, can easily cause accidents with severe and irreversible consequences (Hoveidamanesh *et al.*, 2024; Nascimento *et al.*, 2025; Sen *et al.*, 2026).

A burn is a tissue injury resulting from contact with thermal, electrical, chemical, biological, or radioactive agents, and it can lead to significant physical, psychological, and social repercussions for victims (Barbosa *et al.*, 2024; Merchant *et al.*, 2025). Estimates from the World Health Organization (WHO) indicate that these injuries are responsible for approximately 180,000 deaths annually worldwide (World Health Organization [WHO], 2023). In Brazil, approximately one million burn accidents are recorded each year, resulting in about

100,000 hospitalizations and 2,500 deaths (Oliveira *et al.*, 2024). This scenario also generates substantial costs for the health system due to the need for prolonged treatments and specialized hospitalizations (Araújo *et al.*, 2023).

Accidents resulting in burns may occur through different agents, such as scalds, contact with flames or heated surfaces, chemical substances, excessive solar radiation, and electricity (Junior *et al.*, 2023; Nidhi *et al.*, 2025). Clinically, these injuries are classified according to their depth into first-, second-, and third-degree burns. First-degree burns affect only the epidermis; second-degree burns involve the epidermis and part of the dermis, usually with blister formation and intense pain; whereas third-degree burns compromise the entire thickness of the skin and may reach subcutaneous tissues, with destruction of nerve endings (Rodrigues Neto *et al.*, 2023).

Given the different severities of burns, the therapeutic plan varies according to the extent and depth of the injury. Patients with moderate or severe burns generally require hospitalization and undergo intensive skin care, including dressing changes, balneotherapy associated with debridement of necrotic tissues, escharotomies, and reconstructive surgeries. After the acute phase, interventions aimed at skin rehabilitation may also be indicated, such as the use of fractional CO<sub>2</sub> laser and compression garments for scar management and the functional recovery of the skin (Barbosa *et al.*, 2024; Souza *et al.*, 2021).

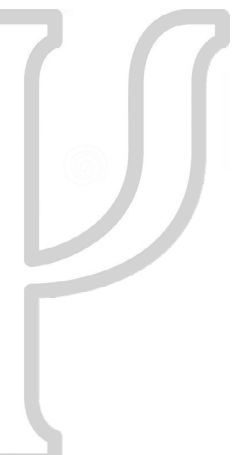
In this context, both the nature of the incident and the extent of the injuries influence the levels of stress experienced by patients. More severe burns often require prolonged treatments and invasive procedures –such as therapeutic baths, dressings, debridement, surgeries, grafts, and physiotherapy– which can intensify the experience of pain and suffering throughout the therapeutic process (Kornhaber *et al.*, 2025; Sarda & Hingway, 2024; Tracy *et al.*, 2026).

As a result, patients frequently experience intense levels of pain that reverberate across different dimensions of their experience. In this sense, the patient's experience can be understood through the concept of Total Pain, which encompasses four complex dimensions: physical, psychological, social, and spiritual. The physical dimension refers to bodily sensations of pain and discomfort resulting both from the

injury itself and from therapeutic procedures. Psychological pain involves emotional reactions associated with trauma and hospitalization, such as fear, sadness, insecurity, distress, and feelings of hopelessness. Social pain, in turn, relates to changes in autonomy and interpersonal relationships, which may include experiences of dependence, isolation, or perceived rejection. Finally, spiritual pain is associated with spiritual fragility, loss of or questioning about the meaning of life, existential crises, reduced hope regarding the future, and feelings of guilt related to one's own religious beliefs (Gomes & Melo, 2023; Melo *et al.*, 2023).

To address the complex demands of these individuals, beyond immediate intervention, it is essential that victims receive continuous care from a multidisciplinary team. Health professionals should be attentive to the nature of the incident and the extent of the burn, factors that can intensify psychological suffering, especially when the event occurs suddenly, violently, or unpredictably. In such situations, the accident may leave marked memories associated with the traumatic experience and may sometimes trigger re-experiencing of the event. Thus, the role of the team becomes essential to promote the patient's physical, psychological, and social adaptation, addressing aspects such as self-esteem, fear, distress, and guilt, which may interfere with the rehabilitation process and increase the risk of developing Post-traumatic stress disorder (PTSD) (Dmitry *et al.*, 2025; Fauerbach *et al.*, 2026; Kashkary *et al.*, 2024; Teófilo *et al.*, 2023; Tian *et al.*, 2025).

PTSD constitutes a frequent psychological complication among burn survivors, with an estimated prevalence of approximately 20.5% of patients in the first two years after the trauma (Boersma-van Dam *et al.*, 2025). It may develop after exposure to potentially traumatic events involving threats to life or physical integrity, and its main manifestations include intrusive thoughts related to the traumatic event, avoidance behaviors, persistent cognitive and emotional changes, and hyperarousal symptoms such as sleep disturbances and hypervigilance (American Psychiatric Association [APA], 2023). In the case of burn patients, such symptoms may be associated both with the experience of the accident and with the physical and emotional demands of the treatment and rehabilitation process (Ford *et al.*, 2025; Nascimento *et al.*, 2025).



On the other hand, despite the impacts associated with burns and the risk of developing PTSD, the traumatic experience may also favor processes of meaning-making and personal transformation. In this context, some individuals may develop processes of Post-traumatic growth (PTG), characterized by the construction of new perspectives on life arising from the experience of suffering (Nascimento *et al.*, 2025). This process involves the re-evaluation of personal beliefs and meanings in the face of the traumatic event, such that the more individuals reflect on the trauma and reorganize their beliefs in relation to it, the greater the likelihood of experiencing positive changes associated with this growth (Kazemi-Sufi *et al.*, 2024; Mapa *et al.*, 2023).

PTG can be understood from different theoretical models. Some studies classify it into three distinct categories, highlighting: (1) changes in the meaning of the self - the person begins to perceive themselves as stronger and more confident, developing greater resilience to face adversity; (2) transformations in interpersonal relationships - the individual becomes more open to sharing feelings with others and demonstrates increased empathy toward others; and (3) changes in life philosophy - modifications in spirituality and religion that lead to a re-evaluation of personal beliefs and values (Ng *et al.*, 2021; Silva *et al.*, 2024). Other authors, especially in the field of positive psychology, propose a more detailed organization of the phenomenon, describing PTG across five dimensions: (1) increased appreciation of life in general, (2) more meaningful interpersonal relationships, (3) an increased sense of personal strength, (4) changes in priorities, and (5) a richer spiritual and existential life (Campos *et al.*, 2021; Ellena *et al.*, 2021; Exenberger *et al.*, 2019; Silverstein *et al.*, 2018).

Therefore, PTG is configured as a multidimensional phenomenon that may emerge in different ways in each individual's experience. In this process, some factors have frequently been associated with its development, including religious and spiritual beliefs, which may offer symbolic frameworks and coping strategies in the face of traumatic experiences (Kazemi-Sufi *et al.*, 2024). Likewise, social support also plays a relevant role, since the presence of care, attention, and strengthened interpersonal bonds may favor coping with the stressful event. Thus, the support received from others tends to contribute to

the development of feelings of security and personal strengthening (Oliveira *et al.*, 2023; Tian *et al.*, 2025; Tracy *et al.*, 2026).

Despite advances in understanding the physical and psychological impacts of burns, scientific production is still limited to research on the experiences of PTSD and PTG in these patients. Although burns constitute a frequent traumatic event in different contexts, much of the research focuses on clinical outcomes or specific psychopathological symptoms, such as changes in self-esteem and depression after the accident (Kazemi-Sufi *et al.*, 2024; Woolard *et al.*, 2022). This focus may restrict the understanding of the complexity of psychological responses to the traumatic experience, particularly regarding coping processes and possible reinterpretations of life after the event. Thus, deepening knowledge about how individuals who have suffered burns experience PTSD and PTG is relevant both to expand the field of scientific investigation and to support care practices that more comprehensively consider the different psychosocial dimensions involved in the rehabilitation of these individuals.

Thus, unveiling the experiences of PTSD and PTG in people with burns may contribute to a deeper understanding of the psychosocial dimensions involved in coping with traumatic events, offering insights to support therapeutic practices focused on comprehensive and patient-centered care. To address this demand, the present study aims to understand the experiences of PTSD and PTG among individuals who have experienced severe burns.

## Method

### *Research Design*

A mixed-methods study of an exploratory and descriptive nature was conducted.

### *Participants*

The study included three people who had experienced burns. The number of participants was defined to preserve the depth of case

analysis (Crouch & McKenzie, 2006; Ting *et al.*, 2023). The inclusion criteria considered individuals who had suffered burns affecting more than 10% of their body and whose injury had occurred at least 3 months earlier. As an exclusion criterion, individuals without availability or conditions to discuss the accident were not considered. Table 1 presents the participants' sociodemographic characteristics. The study was conducted with adult women residing in Fortaleza, Ceará, Brazil, recruited through social media platforms. The sample consisted exclusively of women due to the characteristics of the recruitment process and the voluntary nature of participation, reflecting the accessibility and willingness of individuals who met the inclusion criteria. It is important to note that gender, age, and geographic context may influence the experience and expression of trauma, coping strategies, and post-traumatic growth, as these factors are associated with differences in psychosocial development, life experiences, and available support resources (Hokes & Adams, 2022). In addition, the relative homogeneity of the sample in terms of gender, similar age range, and shared regional context may have contributed to the convergence of reported experiences, potentially limiting the variability of perspectives captured.

**Table 1**  
*Sociodemographic data of the participants*

No.	Gender/ Age	Profession	Religion	Education	Number o people living with
P1	F/ 42	Salesperson	Adventist	Higher education completed	2
P2	F/ 30	Physiotherapist	Buddhist	Higher education completed	3
P3	F/ 41	Entrepreneur	Christian	Higher education completed	5

Note.  $N = 3$  participants. Abbreviations used in the table: "No." (participant identification number).

Source: prepared by authors.

### *Instruments*

Two instruments were used: 1) a sociodemographic questionnaire—to outline the participants' profile through information on gender, age, education, religion, and housing conditions; and 2) a semi-structured interview guide addressing six main points: 1) the experience of the traumatic event; 2) the rescue; 3) hospitalization and treatment; 4) post-traumatic stress disorder; 5) Support Network and coping strategies; and 6) post-traumatic growth. The interview guide was developed based on the literature on post-traumatic stress disorder, post-traumatic growth, coping processes, and social support in burn survivors (Kazemi-Sufi *et al.*, 2024; Mapa *et al.*, 2023; Oliveira *et al.*, 2023; Tian *et al.*, 2025), aiming to explore the subjective meanings attributed to the traumatic experience and the rehabilitation process.

### *Data collection*

During data collection, posts were made on social media to publicize the study. After confirming the participants' profile and inclusion criteria, the interviews were conducted individually at a scheduled time via Google Meet, with the aid of an audio recorder, and lasted an average of 30 minutes. All interviews were conducted by the researchers, following a semi-structured script, and were audio-recorded with participants' consent and fully transcribed for analysis.

### *Data analysis*

The content that emerged from the interviews was analyzed using the software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires (IRaMuTeQ) and complemented by Bardin's (2015) content analysis. The software analyses were conducted in three stages. Initially, classical lexicographic analyses were performed to verify statistics on the number of text segments (TS; text excerpts of approximately three lines), evocations, and forms.

Subsequently, Descending Hierarchical Classification (DHC) enabled the identification of the dendrogram with the classes that emerged, considering that the higher the  $X^2$ , the more associated the word was with the class, while disregarding words with  $X^2 < 3.80$  ( $p < .05$ ). Next, Bardin's (2015) content analysis was conducted on the material that emerged in each class in search of greater depth in understanding the material.

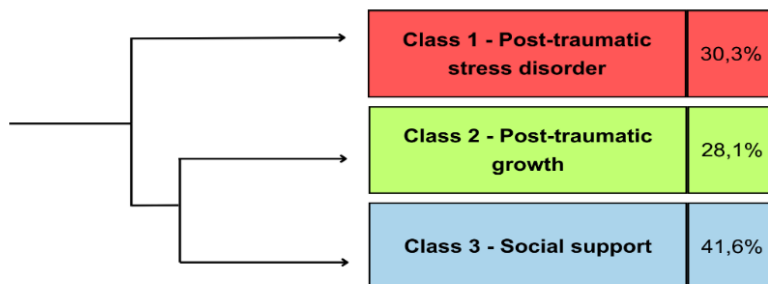
### *Ethical aspects*

The research project was approved by the Research Ethics Committee under opinion no. 43053521.8.0000.5052 and complied with the ethical aspects proposed by Resolutions No. 466/12 and 510/16 of the Brazilian National Health Council. People were able to come forward autonomously and volunteer to participate. The online format ensured privacy and confidentiality during data collection.

## **Results**

### *Classical lexicographic analyses and descending hierarchical classification*

The corpus containing the entire discursive material from the interviews consisted of three texts, divided into 178 text segments. A total of 6,342 occurrences emerged, including 1,238 distinct words and 638 with a single occurrence. The analyzed content was classified into three classes: Class 1 - "Post-traumatic stress disorder," with 27 TS (30.34%); Class 2 - "Post-traumatic growth," with 25 TS (28.09%); and Class 3 - "Support Network," with 37 TS (41.57%), as shown in Figure 1.

**Figure 1***Dendrogram of descending hierarchical classification*

Source: Prepared by the authors based on a dendrogram generated in IRaMuTeQ.

To achieve a faithful representation of the material, Table 2 was prepared describing the classes established through Descending Hierarchical Classification (DHC) in IRaMuTeQ and their subcategories, created by the authors based on content analysis.

**Table 2***Thematic classes and their subcategories*

Classes	Subcategories
Class 1 - Post-traumatic Stress Disorder	<ul style="list-style-type: none"> <li>- Traumas related to hospitalization and treatment</li> <li>- Burn sequelae</li> <li>- Re-experiencing, fear, and guilt</li> </ul>
Class 2 - Post-traumatic Growth	<ul style="list-style-type: none"> <li>- Coping strategies - physical activity, support from health professionals, spirituality, and gratitude</li> <li>- Appreciation of life</li> </ul>
Class 3 - Support Network	<ul style="list-style-type: none"> <li>- Relevance of social support</li> <li>- Acting as an agent of prevention and social support for burn survivors</li> </ul>

Source: prepared by authors.

*Class 1 - Post-traumatic Stress Disorder*

This class comprises 30.34% ( $f = 27$  TS) of the total corpus analyzed. It is composed of words such as "Difficult" ( $\chi^2 = 60.0$ ); "Treatment" ( $\chi^2 = 80.0$ ); "Physiotherapy" ( $\chi^2 = 80.0$ ); "Skin" ( $\chi^2 = 100.0$ ); "Burn" ( $\chi^2 = 100.0$ ); "Bath" ( $\chi^2 = 100.0$ ); "Psychological" ( $\chi^2 = 100.0$ ); and "Healing" ( $\chi^2 = 100.0$ ). It addresses the traumatic aspects of experiencing a burn, from the moment of the accident, through hospitalization, to its physical and psychological sequelae.

Another aspect highlighted in this class concerns the sequelae of burns. Pain, for example, may persist for years, even after discharge from treatment. This produces a sudden change in life, as tingling sensations and discomfort, still present in the body affected by the burn, ends up taking away the individual's freedom, making it impossible to exercise mobility as before. It is also observed that this experience can leave trauma that affects not only the individual who suffered the burn. Family members and friends involved in the incident and who accompany the patient's struggle during recovery are also susceptible to suffering as shown in Table 3.

**Table 3**  
*Participants quotes in class 1*

Participant	Quotes
P1	"And I tried my best to stay well so I wouldn't lose control. There, the most difficult moment is the bath. It was a lot of suffering and it lasted, on average, 2 hours."
	"[I have limitations] in moving, in sitting, in not staying on my feet for long. I still have a lot of pain, because the burn, in addition to the skin, affects the muscles, and I still have problems with my left knee, so I still cannot squat to this day."
	"And I still do physiotherapy, so going out is complicated for me. Especially on hot days, which are very difficult."
	"It took me a long time before I could cook again. I'm afraid. Barbecues, I'm terrified of them. So, the trauma of the environment remains. You become much more cautious wherever you are. I don't like being close to any barbecue grill."
	"It took me a long time before I could cook again. I'm afraid. Barbecues, I'm terrified of them. So, the trauma of the environment remains. You become much more cautious wherever you are. I don't like being close to any barbecue grill."
P2	"At the beginning, my friend's husband kept blaming himself. Then I told him: 'No one is to blame, it could have happened to anyone.'"
	"So I had no mobility. I felt a lot of pain, from going to the bathroom to eating. Besides everything I had already been through, there was also the issue of dependence."
P3	"I suffered a lot from not being able to move forward, because I only thought about it—about pain and loss, about why it happened to me."
	"I suffered a lot. My skin became very thin, it did not close by primary intention, which led to skin and nerve shortening, so it was quite complicated."
P3	"When it happened, I thought several times about taking my own life, because I said: 'My husband is so handsome and young, how will he stay with someone ugly and burned?' So my mind went crazy at the beginning. During the first six months, it was the worst time for me. [...] At first I was afraid to pass in front of the place where it happened. I felt sick"

Source: prepared by authors.

### *Class 2 – Post-traumatic growth*

This class comprises 28.09% ( $f = 25$  TS) of the total corpus analyzed. It is composed of words such as: "Good" ( $\chi^2 = 100.0$ ); "Place" ( $\chi^2 = 100.0$ ); "Avoid" ( $\chi^2 = 80.0$ ); "Association" ( $\chi^2 = 75.0$ ); "Walking" ( $\chi^2 = 66.67$ ); "I can" ( $\chi^2 = 60.0$ ); and "Talk" ( $\chi^2 = 47.83$ ). It addresses coping with trauma, portraying Post-traumatic growth (PTG), highlighting life re-signification and coping strategies.

As shown in Table 4, patients experiencing PTG also highlighted positive memories from the hospital that were important in coping with the situation. They recalled that, despite moments of pain, they felt welcomed by health professionals. Additionally, in this class, feelings of gratitude and spirituality are also very present, demonstrating significant coping in some personal areas of life, as illustrated in the participants' statements.

Participants also reported a significant appreciation of life after the trauma, accompanied by rediscovering themselves and restructuring their life philosophies. The accident began to be seen as a difficult but temporary event that remained in the past. In addition, many became references for other people, both for other burn survivors and for friends and family members.

In this Table, it is observed that, after the traumatic experience, the participants reconstructed their concepts of life, demonstrating greater strength and empathy. In addition, new purposes emerged, reflecting a greater appreciation of life and feelings of duty and gratitude for being part of an organization that seeks to support people who have gone through this traumatic event.

**Table 4**  
*Participants Quotes in Class 2*

Participant	Quotes
P1	"I had support during hospitalization and afterwards as well."
	"I have seen several people tell me that I was an inspiration, because they were going through something that was so small compared to what I went through."
	"As we say in the association, we are prevention agents."
P2	"As soon as I started exercising, it brought me a sense of well-being. I try to stay busy. Lack of concentration is something I struggle with a lot."
	"It reminds me of humane care. Every time I remember it, I remember it with great affection."
	"I still keep in touch with the physiotherapist from the hospital, with the psychologist, and with the doctor who operated on me several times. The affection I received reminds me of good things".
	"I can be grateful and take something good from that situation, so that helped me a lot."
P3	I can appreciate things more, look at situations and take something good from what happened. Today I don't panic so much about things; I don't think it's the end of the world. I know I have been through worse"
	"That was a turning point in my life. Physical exercise, walking—these were things that changed everything"
	"When we started going for walks, it opened my mind. That's why I always tell people to walk in places with nature."
	"We have to live life and go through everything. I cannot stop my life because of this. I cannot keep avoiding things; I can achieve whatever I want."
	"God and family were my foundation. Otherwise, I don't think I would be here today."
	"Because if I hide, I have no voice, and I have to tell people that it is dangerous. I cannot hide."

Source: prepared by authors.

### *Class 3 – Support network*

This class comprises 41.57% ( $f = 37$  TS) of the total corpus analyzed. It is composed of words such as: “Friend” ( $\chi^2 = 88.89$ ); “Burn survivor” ( $\chi^2 = 87.5$ ); “Family” ( $\chi^2 = 87.5$ ); “Go out” ( $\chi^2 = 100.0$ ); “Support” ( $\chi^2 = 100.0$ ); “Help” ( $\chi^2 = 75.0$ ); and “Fear” ( $\chi^2 = 80.0$ ). In this class, it is indicated how the Support Network is essential for the healing process of a burn victim.

Just as they recognize the importance of their Support Network during treatment, participants also expressed satisfaction in being able to provide support to others. In this way, they participate in organizations aimed at burn prevention, sharing information about everyday risks, focusing on the rights of burn survivors, and offering support to other victims of this traumatic situation as shown in Table 5.

**Table 5**  
*Participants quotes in class 3*

Participant	Quotes
P1	“I felt Much more welcomed by family and friends”
	“The association where I am doing volunteer work. I never imagined that I could be helping other people.”
	“Whenever I have the opportunity –when I’m talking to someone, in physiotherapy clinics, among friends –any opportunity I have, I talk about the precautions.”
P2	““I relied on people I got to know, like my husband, who was my friend before. He was my first friend here in Curitiba. That strengthened me a lot. When I managed to build this network again from scratch, that was what helped me the most”
	“On weekends when I was sad, I had friends who supported me. That was fundamental.”

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"It was family –my family always supporting me– and friends. One friend came and took me out of the dark room and took me for walks every day. Until then, I stayed locked in the room."

P3

"They were always supporting me, helping me, encouraging me, saying: 'It will pass, let's take it calmly, with other means.'"

"I went to sleep and woke up burned and injured; it was very difficult. But it passed. Today I will speak about the accident with authority. I tell it openly, because I think we need to talk about it."

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Source: prepared by authors.

### Discussion and conclusions

In Class 1, it is observed that experiencing a burn constitutes a traumatic event of great magnitude, since, in addition to the loss of physical integrity, the patient must deal with prolonged hospitalization, invasive therapeutic procedures, and uncertainties regarding life after the accident (Borges *et al.*, 2024). Participants reported intense pain associated with dressing changes and baths performed in bed, as well as suffering related to the loss of autonomy to perform daily activities such as eating or going to the bathroom. Thus, pain is described as an experience that begins at the moment of the accident and continues throughout the process of treatment and recovery (Díaz *et al.*, 2021).

This suffering also extends to the patient's Support Network, including family members and friends who accompany the period of hospitalization and rehabilitation (Moraes & Marcolan, 2023). Faced with the profound changes imposed by the trauma and the need to reconstruct meaning in their life trajectory, patients and their families may present manifestations associated with PTSD (American Psychiatric Association [APA], 2023).

In Class 2, it is observed that the experience of trauma may mobilize coping strategies that favor positive changes in the way individuals perceive their own lives. This movement may drive PTG processes through which the patient not only overcomes the traumatic event but also undergoes transformations in personal development and in the way they position themselves in relation to the world. The literature

indicates that this process may contribute to strengthening personal resources and to a greater appreciation of life from new perspectives (Silva *et al.*, 2024).

In this context, participants reported the need to share their experiences, doubts, and fears throughout the recovery process. When they find social support in family members, friends, and health professionals, as well as employ strategies that facilitate coping with the situation experienced, they become more likely to attribute new meanings to the traumatic experience (Borges *et al.*, 2024; Tian *et al.*, 2025). Among these strategies, spirituality was mentioned by all participants and was understood as an important coping resource capable of offering emotional support in situations of intense suffering (Kazemi-Sufi *et al.*, 2024).

In Class 3, the findings highlighted the centrality of social support in the recovery process following the experience of burns. The presence of family members, friends, and other significant people proved essential to reduce feelings of fear, sadness, and isolation, facilitating the reconstruction of daily routines and coping with the difficulties imposed by the trauma. The literature has indicated that strengthened interpersonal bonds can act as important psychological protective factors, contributing to individuals' adaptation to the changes resulting from the accident and to the reorganization of their lives after hospitalization (Oliveira *et al.*, 2023).

In summary, the present study aimed to understand the experiences of PTSD and PTG among individuals who experienced severe burns. The results showed that, after suffering a burn accident, individuals may present trauma resulting from the incident, hospitalization, treatment, and irreversible sequelae, which make them vulnerable to the development of PTSD. After overcoming the traumatic process, individuals may find different coping strategies, such as engaging in physical activity, receiving support from health professionals, spirituality, and gratitude, which help them become more resilient and develop a new perspective on life. In this process, the social Support Network is fundamental. Likewise, assuming the role of an agent of prevention and social support for people with burns may help them find meaning

in the past incident and in their lives, highlighting the importance of social, family, and hospital support in the process of overcoming and recovery of patients.

Like any scientific endeavor, the present study, despite bringing significant contributions to the topic, has limitations. These are particularly related to the cross-sectional design and the small number of participants, all of whom were women, presented a similar age range, and were from the same geographic region, which may have limited the variability of experiences captured, particularly considering the influence of gender, age, and context. Therefore, further research is suggested, with insertion in institutions that provide care and coexistence for these groups, to conduct longitudinal studies capable of following the process in the long term, with a larger number of participants and more diverse sociodemographic profiles.

It is hoped that the results presented here may support decision-making for the development of more targeted and effective interventions for burn survivors, particularly by integrating psychological assessment and care throughout the treatment trajectory, from hospital admission to the post-hospitalization period. The findings highlight the importance of addressing not only post-traumatic stress symptoms but also processes of post-traumatic growth, reinforcing the need for comprehensive and person-centered care approaches. From a theoretical perspective, this study contributes to expanding the understanding of the coexistence of distress and growth in the context of burn trauma, emphasizing the role of psychosocial factors such as social support and meaning-making. From a practical standpoint, the results underscore the importance of multidisciplinary teams prepared to identify psychological demands early and to promote interventions that consider both vulnerability and potential for positive transformation.

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