Case Report

When Survival Hurts: A Case of Burn Trauma Complicated by Parental Grief and Displaced Guilt

Burn Trauma and Complicated Grief

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ABSTRACT

A young father with extensive burns following a house fire that killed his daughter displayed profound grief and emotional withdrawal, complicating his medical recovery. Despite surviving the event physically, he remained mute, refusing basic care and exhibiting signs of guilt, dissociation, and despair. His psychological state deteriorated rapidly, delaying wound care and rehabilitation. Psychiatric evaluation revealed overwhelming internalized blame and trauma, centered on his perceived failure to protect his child. A combination of bedside psychiatric engagement, family involvement, and trauma-informed care helped reestablish trust and emotional expression. This case illustrates the critical need for early psychiatric intervention in patients with complex grief and trauma, particularly when recovery hinges on motivation and adherence to care. It highlights the powerful role of mental health support in the acute management of burn patients and emphasizes the importance of narrative expression and therapeutic alliance in restoring a path toward healing.

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INTRODUCTION

Burn injuries often bring prolonged physical and psychological trauma.[1] In Indonesia, where more than half of burn survivors develop psychiatric symptoms,[2] the emotional toll is even more profound when the injury is coupled with family loss. The death of a child in a traumatic event presents unique clinical challenges, often leading to survival guilt, complicated grief, and emotional withdrawal that can interfere with recovery. This case illustrates the emotional complexity of a father recovering from burn trauma while grieving the loss of his young daughter, and the role of consultation psychiatry in facilitating treatment engagement.

Case Presentation

A 41-year-old man was admitted to the burn unit with deep partial-thickness burns involving 18 percent of his body, primarily the face and upper limbs, after escaping a house fire. His five-year-old daughter perished in the incident.

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His wife sustained minor injuries and was admitted separately. The patient was hemodynamically stable but displayed minimal emotional reactivity. On day two, the burn team requested a psychiatric consultation due to emotional withdrawal and reluctance to participate in care.

During assessment, he spoke in a flat tone and avoided eye contact. He reported persistent guilt, disrupted sleep, poor appetite, and passive thoughts of wishing he had died instead. *"It should have been me,"* he said. He described hearing his daughter's cries: *"I can still hear her screaming."* Though cooperative, he showed signs of emotional numbing and disengagement from treatment. He refused visits from family and declined participation in rehabilitation planning.

He repeatedly blamed his wife, who had also been in the house, for failing to rescue their child. He avoided discussing the moment he realized his daughter had died. Interviews with his relatives revealed a man deeply invested in his role as a father, though emotionally reserved. One family member described him as *"someone who always needed control."* This trait appeared to amplify his response to trauma, leading to displaced anger and an inability to tolerate helplessness.

Despite requiring daily wound care and dressing changes, he became increasingly resistant, sometimes refusing care altogether. His withdrawal placed him at risk of delayed healing and infection. The psychological burden of guilt, unresolved grief, and disrupted family dynamics was impeding his physical recovery.

Clinical Challenges

This case illustrates the often-overlooked phenomenon of psychiatric morbidity in acute burn care, especially

when compounded by loss. The patient met criteria for acute stress reaction with features of complicated grief and depressive symptoms. His emotional rigidity and need for control, coupled with severe guilt and avoidance, made it difficult to engage him in both medical and psychological care.

His refusal of family visits and projection of blame were barriers to emotional processing and support. The absence of early psychiatric intervention in such scenarios can lead to worsening distress, poor adherence to medical recommendations, and longer hospital stays. This case highlights the necessity of trauma-informed psychiatric input in the acute setting to support both mental health and physical outcomes.

Intervention

We used a crisis intervention framework based on the SAFER-R model (Stabilize, Acknowledge, Facilitate understanding, Encourage adaptive coping, Restore functioning, and Refer when needed).[3] Initial sessions focused on emotional containment and rapport-building. We validated his reactions without immediately challenging his guilt or blame, allowing space for silence and tears.

Supportive psychotherapy was gradually introduced, with an emphasis on helping him name his emotions and develop a coherent trauma narrative. Over time, we gently reframed his self-blaming thoughts. He began to speak of his daughter not just in terms of the fire, but of memories from before the trauma. This shift allowed space for grief to emerge without overwhelming guilt.

We involved the burn care team in daily discussions, ensuring a consistent and compassionate approach. As emotional engagement improved, so did his cooperation with wound care. We held a joint session with his wife, facilitated by psychiatry and nursing, which allowed them to share their perspectives. This session marked a turning point. The patient was able to acknowledge his wife's pain and begin reconciling with her emotionally, even while remaining deeply distressed.

Pharmacologic treatment was considered, but given the patient's gradual improvement with psychotherapy and his resistance to medication, we deferred antidepressants. By the second week, he showed improved affect, increased engagement, and fewer signs of avoidance. He was discharged with plans for regular outpatient psychiatric follow-up and bereavement support.

DISCUSSION

This case illustrates how acute medical recovery can be derailed by unresolved psychological trauma, especially in the setting of bereavement. The emotional collision of survival, guilt, and anger following the loss of a child presents profound challenges. Without psychiatric intervention, these emotions can manifest in care avoidance, family conflict, and prolonged hospitalization.

Few published case reports explore how burn injuries intersect with parental grief in the early inpatient phase.[4,5] This case demonstrates the importance of early psychiatric involvement and collaboration with medical teams to address both emotional and physical healing. It also shows the power of narrative reframing and family engagement in moving patients from paralysis to participation in care.

CONCLUSION

The death of a child during a traumatic event such as a house fire introduces profound emotional complications that can derail recovery. This case underscores the importance of early psychiatric intervention when grief, guilt, and trauma intersect in the acute care setting. Without timely support, such distress may lead to withdrawal, disrupted medical adherence, and prolonged hospitalization. By integrating psychiatric care with burn management, offering a safe space for emotional processing, and engaging the family in healing, clinicians can support both physical and emotional recovery. This case illustrates the value of early interdisciplinary collaboration in turning emotional paralysis into therapeutic engagement.

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