

Psychological Intervention for Caregiver Distress During Prolonged Pediatric Burn Hospitalization: A Consultation Liaison Psychiatry Case Report

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ABSTRACT

Severe pediatric burns often require prolonged hospitalization and are accompanied by significant psychological burden affecting both the child and caregivers. Despite this, structured psychological interventions for caregivers within inpatient settings remain underreported. We describe a case involving a 6-year-old boy with extensive burn injury affecting 57 percent of total body surface area and a complicated seven-month hospital course. His mother, the primary caregiver, developed marked parental stress and caregiver burden characterized by persistent guilt, intrusive recollections, anxiety symptoms, and anticipatory concerns about her child's recovery and future functioning. A brief structured cognitive behavioral intervention was delivered by the consultation liaison psychiatry team at the bedside, focusing on maladaptive guilt related cognitions, problem solving, and emotional regulation strategies. At follow up, the caregiver demonstrated clinically meaningful improvement across standardized measures of stress, anxiety, and caregiver burden, alongside reduced rumination and improved functional coping. This case highlights the potential value of integrating targeted psychological support for caregivers within pediatric burn care. Early intervention may reduce maladaptive guilt, improve caregiver resilience, and support sustained engagement in the child's recovery.

Key Words: Burns, pediatric, caregiver distress; liaison psychiatry; Psychological

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INTRODUCTION

Severe pediatric burns often require prolonged hospitalization and repeated procedures, creating sustained psychological strain not only for the child but also for caregivers.

Parents, particularly primary caregivers, frequently experience persistent anxiety, guilt, and emotional exhaustion during the treatment course, especially when

recovery is complicated by recurrent medical setbacks.^{1,2} Parental stress and caregiver burden, while related, reflect different dimensions of this experience. Parental stress arises from the perceived imbalance between caregiving demands and coping resources, whereas caregiver burden encompasses the broader emotional, functional, and socioeconomic impact of long-term care.³⁻⁵ Both are associated with impaired psychological well-being and reduced capacity to engage effectively in treatment. Despite growing recognition of caregiver distress in pediatric settings, structured psychological interventions during hospitalization remain limited.³⁻⁵ This case highlights the role of consultation liaison psychiatry in addressing caregiver distress through a brief, targeted cognitive behavioral approach integrated within inpatient care.

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CASE REPORT

A 6-year-old boy was admitted following scald injury from boiling broth, resulting in deep partial and full thickness burns involving approximately 57 percent of total body surface area. He underwent repeated surgical debridement and grafting procedures and experienced a prolonged and complicated hospital course marked by recurrent infections, graft failure, and intermittent readmission. At the time of psychiatric evaluation in February 2026, he remained hospitalized. Behaviorally,

the child showed a clear deviation from premorbid functioning. Previously described as cheerful and cooperative, he developed irritability, tantrums, aggression toward his mother, and sleep disturbance. These symptoms were closely associated with pain and febrile episodes. Psychiatric assessment supported a diagnosis of adjustment related emotional disturbance. The child's 42-year-old mother served as the sole caregiver throughout hospitalization. She reported persistent guilt related to the injury, intrusive recollections of the event, somatic anxiety symptoms, and ongoing concern regarding her child's future. Despite these difficulties, she remained actively engaged in caregiving and adhered to medical recommendations. There was no prior psychiatric history.

Psychometric evaluation revealed mild depressive symptoms, moderate anxiety, and moderate stress on DASS 21. Caregiver burden was elevated, with a ZBI score indicating moderate to severe burden, and parental stress was markedly high based on PSS assessment. Mental status examination demonstrated intact orientation, coherent thought processes, and preserved insight, though affect was dominated by anxiety and guilt. There was no evidence of suicidality. The clinical formulation suggested a stress related affective condition driven by prolonged caregiving demands, recurrent medical setbacks, and maladaptive guilt related cognitions.

A brief cognitive behavioral intervention was delivered across four sessions at the bedside. The intervention targeted maladaptive guilt, rumination, and anticipatory anxiety through cognitive restructuring, problem solving strategies, and behavioral techniques for emotional regulation and sleep. Psychoeducation was provided regarding burn recovery and normal caregiver responses to stress. Practical strategies were introduced to improve coping during medical setbacks and to support planning for the child's reintegration into daily activities.

At follow up, the caregiver reported reduced frequency and intensity of self-blaming thoughts, improved sleep, and greater ability to manage distress during clinical fluctuations. Objective measures demonstrated improvement across all domains, including reductions in anxiety, stress, and caregiver burden. Functional improvements included better concentration and more structured problem solving.

DISCUSSION

This case reflects a common but often under-recognized clinical scenario in pediatric burn care, where caregiver distress evolves alongside the child's prolonged medical course. The intensity of caregiving demands, combined with uncertainty and repeated clinical setbacks, creates conditions that reinforce maladaptive cognitive patterns such as guilt and catastrophizing.

Existing literature consistently highlights the association between caregiver burden and reduced psychological well-being, particularly in contexts of limited social support. In pediatric burn populations, the treatment phase itself often represents the period of greatest psychological strain, as caregivers assume active roles in care while managing emotional responses to the child's suffering.^{1,2} What stands out in this case is how central maladaptive cognition was in maintaining distress. The caregiver's belief that she was responsible for the injury amplified emotional burden and interfered with adaptive coping. Addressing these beliefs directly through cognitive behavioral strategies appeared to be a key mechanism of improvement. Although caregiver support is widely recommended, structured psychological interventions remain inconsistently implemented in inpatient settings. This case suggests that even brief, targeted interventions delivered within a consultation liaison framework can lead to measurable improvements in caregiver functioning. From a clinical perspective, supporting caregivers is not only beneficial for their own mental health but may also influence treatment adherence, communication with the medical team, and ultimately the child's recovery trajectory.

CONCLUSION

Prolonged pediatric burn hospitalization can lead to significant caregiver distress, even in individuals without prior psychiatric history. In this case, maladaptive guilt and sustained stress were key drivers of psychological burden. A brief cognitive behavioral intervention delivered within a consultation liaison psychiatry setting was associated with meaningful improvement in both emotional symptoms and caregiving capacity. These findings support the integration of early, structured psychological support for caregivers as part of routine pediatric burn care.

Conflict of Interest: The study has no conflict of interest to declare by any author.

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Authors Contributions: W.S. contributed to patient assessment, data collection, and drafting of the manuscript. A.K. conceptualized the study, supervised the clinical intervention, and critically revised the manuscript for important intellectual content. I.H. contributed to clinical management of the patient and provided surgical input relevant to the case. All authors reviewed and approved the final version of the manuscript.

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