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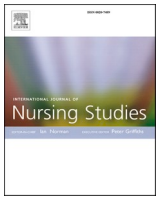

"Coming to terms" - the post-burn recovery journey of parent–child dyads: A constructivist grounded theory

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ABSTRACT

Background: Paediatric burn injuries pose a critical global health challenge, affecting millions of children annually. Beyond the immediate physical harm, burns disrupt developmental trajectories, leaving enduring psychological, physical, and relational impacts as children transition into adulthood. While advancements in acute care have improved survival rates, understanding the dyadic recovery process between parent and children remains underexplored. The prolonged and complex nature of post-burn recovery necessitates sustained caregiver support, emphasising the need to examine how parent–child dyads experience and collectively navigate this journey.

Objective: To generate a theory explaining how parent–child dyads experience and navigate through the post-burn recovery process.

Design: Constructivist grounded theory.

Participants: Paediatric burn survivors with a discharge status of up to 1 month or more and their informal caregivers who were present throughout the period of hospitalisation.

Methods: Initial purposive and subsequent theoretical sampling approaches were employed. Data were collected through face-to-face dyadic interviews at mutually agreed time and locations, supplemented by field notes. Concurrent data analysis utilised constant comparative approach to iteratively refine emerging codes and categories. To ensure congruence with the dyadic interviewing approach, the constant comparative approach employed did not only focus on uncovering categories, but also the content (emerging narratives) and interaction (how parents and children communicated noting areas of convergence and divergence in their narratives).

Results: Twenty-three (23) parent–child dyads participated in the study. The children and parents (19 mothers and 4 fathers) are aged 10–16 years and 33–49 years respectively. The core category, *Coming to Terms*, conceptualises the dyadic recovery journey from injury occurrence to acceptance and adaptation. Three interrelated categories characterised this process: (1) *Being with Each Other in a Trauma Bubble* (mutual emotional entrapment in acute distress), (2) *Living with the Scars* (physical and psychological marks shaping identity), and (3) *Navigating the Recovery Maze* (collaborative adaptation to post-burn realities). The *Theory of Coming to Terms* underscores post-burn recovery as an emotionally fraught negotiation marked by asymmetrical burdens for dyads, requiring reconciliation with lasting physical, psychological, and relational consequences. Although most aspects of the recovery journey showed commonalities across dyads, a notable divergence emerged in attitudes toward scars: while parents and older children tended to conceal these marks, younger children often chose to display them openly.

Conclusion: The findings highlight the dyadic interconnectedness in post-burn recovery, advocating for rehabilitative frameworks that prioritise both objective clinical outcomes and subjective experiences. A family-centered approach is critical to integrate ongoing support for children and caregivers.

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What is already known

- Paediatric burn injuries represent a global public health crisis, causing profound lifelong physical disfigurement, psychological morbidity, and developmental disruption.
- While medical advances have enhanced acute burn management, a critical knowledge gap persists regarding the dyadic nature of recovery, particularly the interconnected trajectories of children and parents during post-burn recovery.

What this paper adds

- This study pioneers a paradigm shift toward family-centered rehabilitative frameworks, synthesising subjective perspectives of caregivers and survivors to prioritise psychosocial/emotional well-being of parent–child dyads alongside clinical outcomes.
- This paper identifies three interrelated dimensions of post-burn dyadic recovery highlighting interdependence and interconnectedness between injured children's and their caregivers' experiences.
- This paper presents the *Theory of Coming to Terms*, as a framework explaining how parent–child dyads navigate post-burn recovery as an interconnected, emotionally charged journey toward thriving; and marked by asymmetric burdens and reconciliation with lasting impacts which can advance trauma-informed care.

1. Introduction

Paediatric burns represent a significant global health challenge, with millions of children sustaining burns annually (Mok et al., 2024; Wickens et al., 2024). According to the World Health Organisation Global Burn Registry (WHO GBR), burns are among the leading causes of injury-related morbidity and mortality in children (Lewis et al., 2025). These paediatric burns result from several causes including hot liquids, flames, chemicals, electricity, and hot surfaces with the majority occurring in the home (Lewis et al., 2025). Of the 9279 records registered in the WHO GBR from 2018 to 2022, up to 3336 represent paediatric burn patients of which 59.50 % (1984) are males and 40.5 % (1352) are females (Lewis et al., 2025). According to the 2023 WHO factsheet on burns, the majority of these occur in low- and middle-income countries and almost two thirds occur in the WHO African and South-East Asia Regions (WHO, 2023). While the burn death rates have been decreasing in several high-income settings, the rate of paediatric deaths from burns is currently more than 7 times higher in low- and middle-income countries (WHO, 2023). In Ghana, paediatric burns frequently occur in the home setting, and children make up more than half of all admissions to the burn unit (Bayuo et al., 2018).

The clinical management of burns proceeds through emergent, acute, and rehabilitation phases. Across the phases, the multidisciplinary burn care team play key roles in providing initial resuscitation, wound care, pain management, nutritional support, psychosocial support, rehabilitative care, and aftercare support. Though the duration of burns management usually depends on the extent and depth of the injury, the long-term sequelae of the injury suggest that hospital discharge is not an end to treatment as several aftercare needs such as itchiness and pain may be present. For children, burns represent a serious threat to their personhood as they grow into adulthood with the aftermath of the injury (McGarry et al., 2015). In addition to the wounds, children with burns may need to undergo invasive interventions and frightening procedures (Andrews et al., 2018; McGarry et al., 2014). While advancements in acute care have improved survival rates, the post-burn recovery journey for paediatric survivors extends far beyond initial medical treatment (Bayuo et al., 2020), encompassing complex physical rehabilitation, psychological adjustment, and social reintegration, all of which are profoundly influenced by the interplay between the child's resilience and their support systems (McGarry et al., 2014, 2015).

Burns disrupt developmental trajectories, often leading to chronic pain, post-traumatic stress, and social stigmatisation (Simons et al., 2016). The substantial psychosocial burden of paediatric burns is well-documented quantitatively, with studies showing that roughly 25–30 % of preschool children develop clinically significant stress reactions during recovery. While comparable to rates in older paediatric and adult burn patients, this prevalence is marginally higher than that observed in preschoolers following other traumatic events (Bakker et al., 2013; Duke et al., 2018; Willebrand et al., 2011). These reactions, characterised by avoidance and re-experiencing symptoms (Association, 2000), reflect neurodevelopmental vulnerabilities in younger populations. While these manifestations are concerning, longitudinal studies report that approximately one-third of school-aged children continue to demonstrate persistent stress-related symptomatology, with approximately 10–20 % progressing to meet diagnostic criteria for post-traumatic stress disorder (PTSD) (Bakker et al., 2013; Van Baar et al., 2011). Such findings highlight not only the acute psychological toll of burns but also the enduring psychosocial well-being risks persisting long after physical wounds have healed (McGarry et al., 2014; Simons et al., 2016).

Central to the support systems for children with burns are their caregivers, usually, parents who shoulder the burdens of caregiving (Bayuo and Wong, 2021). Informal caregivers/parents of children with burns often endure a multifaceted burden, marked by heightened risks of distress as they assume unexpected caregiving roles (Wang et al., 2023). Beyond the immediate trauma, parents grapple with profound emotional upheaval compounded by external blame (Padalko et al., 2019). This external attribution of fault may metastasise into internalised self-blame, which alongside external blame may manifest as pervasive despair (Van Niekerk et al., 2020). Post-discharge, these challenges may intensify as families transition to the home, often with minimal support (Bayuo and Wong, 2021; Bayuo et al., 2020). Additionally, caregivers may report hyperawareness of public scrutiny while simultaneously confronting their own fears of social judgement (Wang et al., 2023). The duality of advocating for their child's normalcy while navigating a stigmatising environment exacerbates emotional exhaustion and underscores the cyclical relationship between caregiver well-being and the survivor's recovery trajectory.

The experiences of children with burns and their caregivers reveal an interdependent trajectory: while the child bears the visible sequelae of injury, parents endure parallel yet distinct psychosocial agony, forging an entwined journey of trauma that transcends individual recovery (Ravindran et al., 2013a, 2013b). This duality necessitates a dyadic conceptualisation of post-burn recovery: one that examines how children and caregivers co-construct their recovery journey while navigating shared burdens (Tehranineshat et al., 2021). Critically, recovery extends beyond wound closure; it demands reconciliation with disrupted identities, relational dynamics, and existential meaning-making, implicating biopsychosocial processes that reverberate across parent–child dyads (Simons et al., 2016). However, extant research remains disproportionately anchored to acute biomedical outcomes, reflecting a persistent scholarly emphasis on acute management over the dyadic impact of burns (Bayuo and Wong, 2021; Bayuo et al., 2023).

Current healthcare systems and policies frequently adopt a fragmented approach, prioritising clinical outcomes over the holistic understanding of the recovery experiences of burn patients (Bäckström et al., 2018). This oversight not only undermines recovery outcomes but also perpetuates cycles of vulnerability. Existing research, where available, has predominantly analysed post-injury experiences in isolation (Abtan et al., 2021; Bäckström et al., 2014, 2018) rather than exploring how parent–child pairs collaboratively shape and navigate their recovery through mutual adaptation (Egberts et al., 2018). Indeed, the processes by which parent–child dyads experience, navigate, and derive meaning from their recovery journey remain underexplored (Killey et al., 2023; Lernevall et al., 2020). Investigating this dynamic could unlock insights into dyadic interventions that holistically support both individuals, rather than addressing them in isolation. To bridge this gap,

our study examined how parent–child dyads experience post-burn recovery, with the goal of constructing a theory that elucidates the nuances of their interconnected journey. The research question was "how do parent-child dyads experience and navigate the post-burn recovery process"?

2. Methods

2.1. Study design

Charmaz's constructivist grounded theory approach was employed (Charmaz, 2017) and reported according to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007). The constructivist grounded theory approach has a relativist ontology with a constructivist epistemology (Charmaz, 2017). With its emphasis on relativism, constructivist grounded theory emphasises the co-construction of multiple, subjective realities (Charmaz, 2017). The constructivist stance also emphasises that reality is constructed through social processes and interactions between the researcher and the study participants situated within specific social, cultural, and historical contexts. Additionally, the constructivist approach was considered well suited for this study as it allowed the researcher to possess prior knowledge or experience of the phenomenon (Bobbink et al., 2024), and in this instance, the lead author survived moderate scald during childhood.

2.2. Setting

The study was undertaken in the middle belt of Ghana, with recruitment from a large tertiary care facility which caters for all age groups. The tertiary care facility has an equipped 6-bed Burn Intensive Care Unit (BICU) and a 6-bed burns ward which serves as a step-down unit following successful resuscitation in the BICU.

2.3. Sampling and sample size

Purposive sampling approach was initially employed to recruit dyads parent–child dyads who met the inclusion criteria. Congruent with existing studies, a dyad comprised of two participants considered as a unit (Morgan et al., 2013; Szulc and King, 2022). A parent in this study is considered as either mother or father of the child with burns. A prior sample size was determined as 20 dyads based on existing methodological guidance (Thomson, 2011; Wutich et al., 2024). As the study progressed, theoretical sampling approach was employed to recruit more dyads who could contribute to the emerging theory till data saturation was attained (Ünlü and Qureshi, 2023). For instance, when we captured the diverging finding regarding how younger and older children preferred to show or hide their scars respectively, we focused on recruiting other younger children to explore this finding more.

2.4. Participants and recruitment

All paediatric burn survivors, operationalised as survivors aged 6 to 16 years (Krishnamoorthy et al., 2012), previously admitted to the burn unit (regardless of the depth or extent) with a discharge status of $\geq$1 month and their caregivers were eligible to participate. Children with burns who were treated on outpatient basis were excluded. Also, children who suffered concomitant injuries in that warranted transfer to other units were excluded. Caregivers/ parents were considered eligible if they stayed with the injured child throughout the hospitalisation period. Relatives who only visited occasionally were excluded.

For recruitment, the admissions and discharge books of burn unit were reviewed. Following an initial list of potential participants, a burn care nurse placed telephone calls to the caregivers to discuss the study and invite them to consider participating. Potential participants were encouraged to revert their decision to participate or decline to the assigned burn care nurse after a week. Once confirmation to participate was received, the burn care nurse followed up to answer any questions. Subsequently, mutually agreeable date, time, and venue were decided upon. On the scheduled interview days, both the child and informal caregiver were taken through the information sheet to reiterate the study details. Once they affirmed their participation, children completed an assent, and caregivers completed a consent form. Six parents declined participation due to their work schedules and lack of interest in the study.

2.5. Data collection

Semi-structured dyadic interviewing and field notes were employed as the main approaches to data collection (Bayuo et al., 2025). A guide which had been developed based on existing literature and the researchers' background experience in burn care was used to undertake the interviews. The guide was piloted before the main interviews. Piloting of the interview guide was carried out with three older children and their mothers following discharge the burns ward. The pilot data were not included in the final data set. All interviews were undertaken face-to-face in a quiet place with minimum interruption by the burn care nurses involved in recruitment. All interviews commenced with a 5–10-minute pre-interview chat to cultivate rapport and to offer an opportunity for the interviewer to dynamically evaluate communication styles, comfort levels, and potential power dynamics (Bayuo et al., 2025). The pre-interview chat included asking both the dyads about how their day/ week or work/ school had been. The children were asked if they felt comfortable with being interviewed with their parent at the same time. All children affirmed they would prefer to be interviewed with their parents as they felt comfortable with them present. The interviewer encouraged the child to talk freely about what they felt comfortable with. All pre-interview chat data were not included in the analytical process.

Once both child and parent expressed readiness to commence the interview, the process commenced with a broad question regarding how the injury occurred with the children encouraged to respond first followed by their caregiver. Thereafter, participants were asked about their recovery journey. To balance the interactions, the interviewer (a male burn care nurse with training in qualitative methods) served as a moderator ensuring the child's voice was not missing (Bayuo et al., 2025). All interviews were undertaken by the same person and were audio recorded. It is worth mentioning that both the interviewer and recruiter were not known to the participants. Following the initial round of interviews concurrently with analysis, repeat interviews were undertaken to clarify unclear statements. All transcripts were discussed with the participants following translation from the local dialect to English to confirm we have retained the meanings. In two instances, parents corrected few translated phrases.

2.6. Ethical considerations

The study was ethically approved by the institutional review board of the Hong Kong Polytechnic University (HSEARS20240318004) and administratively approved by the local healthcare facility in Ghana. Due processes regarding reviewing the information sheet and completing consent forms were undertaken. A clinical psychologist was sought to support participants if needed.

2.7. Methodological rigour/ trustworthiness

Lincoln and Guba's framework emphasising credibility, transferability, confirmability, and dependability was employed to achieve rigour (Lincoln and Guba, 1988). Credibility was ensured by piloting the interview guide. Also, only children with burns and their caregivers who met established criteria were invited. Prolonged immersion in the study settings and engagement with participants including undertaking repeat

interviews also helped to attain credibility. With the lead author as a burn survivor and a burn care nurse, we conceptualised this study aware of existing literature and personal experiences framing burns as a "family injury." While this lens sensitised us to systemic dynamics, we consciously guarded against overgeneralising family experiences or privileging clinical narratives over lived realities. Also, we remained alert to avoid minimising trauma by imposing optimistic frameworks onto participant accounts. All interviews were undertaken by the fourth author who is a burn care nurse. A reflexive diary was maintained throughout the data collection and analytical process. Triangulating the data collection sources via interviews and field notes was also helpful to attain credibility. The detailed description of the study process contributes to enhancing transferability. An audit trail was maintained to attain dependability. Returning to the participants to discuss the study findings helped to confirm the meanings and interpretations formulated.

2.8. Data analysis

Constant comparison approach was employed to analyse the data (Charmaz, 2017). All interview recordings were transcribed verbatim and translated to English. Transcripts were reviewed alongside the recordings by two members independently (JB and EAA) with ongoing team consultation. Once finalised and completeness confirmed, we proceeded to undertake coding in NVivo version 12. During open coding, two team members performed line by line coding inductively to identify phrases that reflected the post-burn recovery experiences. Considering the use of dyads, the open coding phase paid attention to both content (emerging narratives) and interactions. At the focused coding stage, the preceding codes were examined further to ascertain the connections/relationships between them to formulate categories. Theoretical coding was also employed to ascertain the relationships between the emergent core category and the categories. Following these, we reviewed the emerging categories to formulate a core category representing a highly inclusive abstract phrase or term that encapsulated the post-burn recovery process of children with burns and their primary caregivers. An iterative process was employed to review the core category against the preceding codes, concepts, and categories. Memos were used throughout the analytical process to ensure reflexivity. In the context of this study, our memos captured what happened and the ideas that emerged during the literature review, interviews, and data analysis processes.

3. Results

Twenty-three dyads participated. The paediatric burn survivors are aged 10–16 years with more males (n = 15) than females (n = 8). The informal caregivers (19 mothers and 4 fathers) are aged 33 to 49 years. Flames (n = 14) and hot liquids (n = 9) emerged as the main causes of burns. The post-discharge period ranged from 1 month to 4.5 months. All injuries occurred in the home setting. The first round of interviews lasted between 25 and 68 min. Follow-up interviews lasted between 4 and 11 min.

3.1. The Theory of Coming to Terms

The core category was conceptualised as "*Coming to Terms*" (Fig. 1). This core category and its categories (being with each other in a trauma bubble, living with the scars, and navigating the recovery maze) encapsulate the dual shock of both the injury's sudden onset and the nonlinear trajectory of dyadic recovery. The theory captures the burn event as a rupture in the child and family's assumed narrative of safety and control: an abrupt pivot into a reality where preparation was impossible, yet adaptation became mandatory as both parent and child worked toward acceptance. It reflects an iterative, emotionally fraught negotiation: not merely accepting the injury's occurrence, but reconciling with its enduring physical, psychological, and relational reverberations. The categories are discussed below.

3.2. Being with each other in a trauma bubble

3.2.1. Mutual guilt and self-blame

All dyads reiterated the sudden and unexpected nature of injuries, which triggered profound emotions. Dyads described a turbulent emotional journey as both the injured children and their caregivers grappled with the circumstances of the incident. Children recounted the initial physical pain as intensely excruciating; a sentiment corroborated by parents who witnessed their children's immediate distress. Parents reported a profound sense of mutual suffering, striving to comfort their

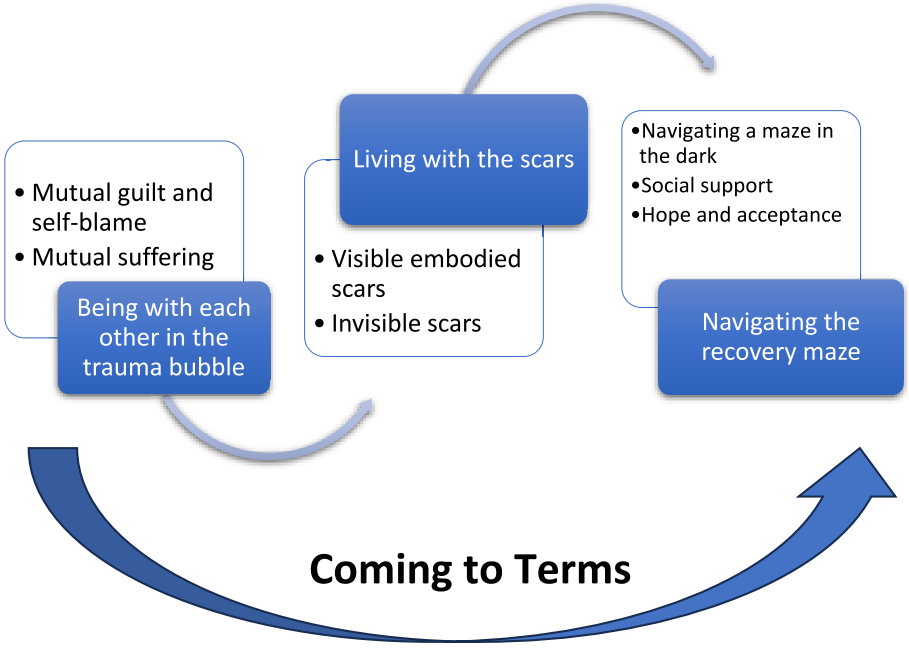

Fig. 1. The Theory of Coming to Terms.

children despite their own emotional turmoil. This mutual anguish was exemplified by accounts of parents weeping alongside their injured children in moments of mutual vulnerability. Additionally, parents expressed overwhelming guilt and self-blame, believing their actions (or inactions) might have contributed to the injury occurrence. This guilt compounded their emotional distress, as they felt ill-equipped to manage the complexities of caring for a child with burns. The children also blamed themselves as they felt something they did contributed to the injury. Together, self-blame and guilt resonated immediately following the injury as shown in the quotes from two dyads below:

"We were burning garbage at home and there was a container with hand sanitizer just by the site we were burning the refuse. We poured some of the sanitizer onto the refuse to light it up first. Some of the sanitizer leaked onto the bottle as we poured it. The hand sanitizer was close to the fire we had set. The leaked sanitizer came into contact with the fire and exploded and burned me. It all happened so fast I did not realise what was happening. I should have been more cautious with the sanitizer"

(Child, 11 years, Dyad 3)

"I felt it was a home accident that could have been prevented if we had kept the sanitizer away from their reach but we failed to do so hmm. I am the adult, more of my mistake than my child's mistake. It was a terrible scene which devastated us all. It is not something you can say you are prepared for, it just happened just like that, and you wished it had never happened in the first place"

(Father, 45 years, Dyad 3)

"When it occurred at first at home, the pain was unbearable for me. It was the worst pain I have ever experienced. It was very painful"

(Child, 13 years, Dyad 10)

"You see your own child in that state with the skin gone, it was a horrible scene. He was crying and I was also crying seeing him as young as he is to endure such pain. I felt the pain at that instance too and could not hold back my tears"

(Mother, 38 years, Dyad 10)

As acute care continued, mutual guilt and blame deepened. Parents grappled with self-reproach for failing to anticipate or prevent the injury, while children expressed guilt over the disruption their hospitalisation caused, that is, straining family routines and incurring unplanned financial burdens. The children voiced a desperate wish to return home and to normalcy quickly, believing their recovery was imposing undue hardship. This guilt intensified for children who recognised that their parent's hospital stay meant lost work opportunities, compounding their sense of responsibility. Parents agonised over the broader consequences of hospitalisation, such as their child's prolonged absence from school and social isolation, fearing these setbacks might irreparably harm their child's future. The experience of guilt fuelled and catapulted dyads into a phase of bargaining wherein both the injured child and their parents negotiated for better outcomes within the shortest possible time as shown in the dyadic quotes below:

"Seeing her with the wounds and bandages made me think about what I should have done to have prevented this whole thing. If I had not sent her on to light the gas stove, she would not have been burned like that."

(Mother, 41 years, Dyad 1)

"My mother was with me at the hospital and could not open her shop as she used to. If not for my burns, we will all be back home with my brothers and sister"

(Child, 15 years, Dyad 1)

"I prayed for all of it to be over; at least we could all return to our lives again."

(Mother, 43 years, Dyad 8)

"I prayed too, promising I will be a good child all the time if I got better quickly and left the hospital as soon as possible"

(Child, 12 years, Dyad 8)

3.2.2. *Mutual suffering*

The acute care phase further amplified shared trauma through exposure to clinical procedures. Parents described being unprepared when asked to view their child's wounds during treatments like wound care. Witnessing the injuries first-hand and hearing their child's cries of pain evoked distress, with parents wishing they could shoulder their child's suffering. Despite these harrowing experiences, dyads found solace in visible signs of healing, interpreting them as hopeful milestones toward discharge. Yet, recovery extended beyond the hospital. Post-burn sequelae like persistent itchiness disrupted daily life, often requiring parents to sacrifice sleep to comfort their child. Even as physical wounds healed, the emotional and practical toll of the post-burn sequelae lingered long after discharge. The shared emotional burden was compounded by uncertainties about the injury's long-term repercussions. Children primarily feared how their physical limitations might hinder participation in peer activities, while parents fixated on the potential for visible changes to shape their child's social acceptance and future opportunities. The notion of *being with* was evident in experiencing each other's physical presence: the child felt comfortable knowing they were not alone but supported by their parent, while the parent felt relieved knowing they are *being there for* and *with* their child:

"After I saw the wounds after the accident in our home, the nurses asked me to be present during dressing change to see the wounds again. I had to be a man and stand firm to see the wounds again. The wounds on the face were not covered but they were not that deep like what I saw on the body. The nurses removed the old bandages and washed the wounds. It felt really painful for me. I just wished I could be the one to bear the pain instead of my child. It is just a father's instinct."

(Father, 43 years, Dyad 11)

"On days I did not want to watch the wounds, the nurses showed me pictures. Sometimes they explained the edges looked okay. At least that was some good news because you know the wounds are healing gradually…with all that happened, just knowing I am able to be there all the time to help gave me some joy and relief"

(Mother, 39 years, Dyad 13)

"Since my mum was there [BICU] with me all the time, I was not afraid to be alone in the room. She stayed with me throughout. She was always there and all I needed to do was to call her."

(Child, 15 years, Dyad 13)

"After we returned home, he always wanted to scratch the healed areas. This is not like a simple wound that you can identify only a site but the legs, arms, and face all feeling itchy at the same time. We stay up at night to pat the area gently till he sleeps before we can also sleep."

(Mother, 38 years, Dyad 15)

"The itch is really bad, I feel it over my legs, arms and face all the time. I just want to scratch it"

(Child, 10 years, Dyad 15)

"I always worried if I can still play with my friends like I did before the burn. My arms were both bandaged and could not even run, how can I be the goalkeeper during football game."

(Child, 10 years, Dyad 22)

3.3. Living with the scars

3.3.1. Visible embodied scars

While the initial injury was described as sudden and traumatic, participants revealed that the psychological and emotional challenges following wound closure were equally unforeseen. Both survivors and their parents had anticipated that physical healing, that is, the closure of the wound would signify the end of the ordeal. Instead, the persistence of scars became a complex, enduring symbol of the trauma, reshaping identities and relationships after the injury itself had healed. The realisation that the injured child needed ongoing support even after discharge was a turning point for dyads since they had thought recovery ended following wound healing. This reality offered dyads a new frame of reference regarding the longstanding nature of the post-burn sequelae which begun the process of coming to terms and accepting the entire situation. The notion of *being with* and *for* each other was evident following discharge as highlighted by parent–child dyad 23 below:

> "For wounds I have seen in the past, the wounds heal and you are okay. I thought it would be the same in my child's case too. I was surprised that after the wounds healed, scars were now forming over the healed areas to the extent the surgeons had to do surgery to release contractures. Then there was the issue of blood too. There was even more work to do after the wounds healed that I did not expect. It just dawned on me I should be prepared for something longer than I initially thought. What more can I do than to be there for my child"
>
> (Mother, 49 years, Dyad 23)

> "I told my mother after the wounds heal, I will have my body and skin again but that was not what happened. The wounds healed and I noticed I was not the same again. My skin looked and felt funny and I could not move my hand. After discharge, I got home and after a while my blood level goes down and I had to be rushed to the hospital again for blood. At night, I struggle to sleep, and I still feel pain from the healing sites, but my parents are with me all the time"
>
> (Child, 16 years, Dyad 23)

For parents, scars functioned as a perpetual reminder of perceived failure. These marks evoked profound guilt, as parents internalised societal judgements, fearing that visible scarring would label them as neglectful or incompetent parents. Seeing the scars was as though it was a permanent accusation, reflecting how their visibility intensified feelings of responsibility for what was framed as a preventable home accident. This guilt frequently led parents to adopt strategies to conceal scars through clothing or avoidance of social situations in an effort to shield both their child and themselves from external scrutiny. The burn survivors' narratives were however mixed. While older children expressed self-consciousness, younger children reinterpreted their scars as emblems of survival, even sources of empowerment. Younger children described using scars as conversation starters with peers, framing them as a proof of surviving a challenging feat. This divergence in dyadic perspective often created tension within dyads: parents' protective instincts to minimise visibility clashed with younger children's desires to reclaim agency over their bodies and narratives:

> "I look at her and I think to myself what have I done to my child. You just cannot get over the guilt, can you? It is better to cover it so no one sees it thinks you are a bad mother"
>
> (Mother, 39 years, Dyad 13)

> "I just don't want anyone to see it [scars] and ask funny questions. You have to keep it [scars] covered all the time."
>
> (Child, 15 years, Dyad 13)

> "I try to make him wear clothes that can cover the burned areas. People just like to ask questions; some even look at you and you can tell from their faces that they are blaming you for allowing your child to be injured."
>
> (Mother, 43 years, Dyad 8)

> "When I tell my friends about the wound, I show them my arm and thighs and allow them to touch it. They tell me I am very brave"
>
> (Child, 10 years, Dyad 8)

To navigate and resolve the clash between parent-younger children's dyads, parents exerted their control to force the children to cover the visible scars, particularly in public spheres:

> "…oh, he just has to obey what I tell him to do and cover it up if we are going out"
>
> (Mother, 43 years, Dyad 8)

> "My mother makes me to wear long clothes to cover it when we are going to church"
>
> (Child, 10 years, Dyad 8)

3.3.2. Invisible scars

It emerged that both parents and children carried invisible scars from the trauma of hospitalisation. Children recounted vivid memories of procedural pain and the relentless ache of healing skin that lingered long after discharge. Parents, meanwhile, grappled with the psychological toll of witnessing their child's suffering, coupled with the stress of navigating unfamiliar medical environments and assuming caregiving roles. The home was occasionally viewed as a place of helplessness, where the parents presumed action (or inaction) and their inability to alleviate their child's pain compounded their guilt:

> "How can I forget the pain; it was just unbearable for me and the worst pain I can imagine. I still remember the pain back then."
>
> (Child, 15 years, Dyad 20)

> "I think it is right to say the pain was painful, and it is still painful. Seeing your child in that state, it is terrible and not easy at all. He is too young for all these… I was at the hospital and still managing the home alongside my husband."
>
> (Mother, 42 years, Dyad 20)

> "After we returned home, I became too strict with the home safety because I did not want another incident. It was like my eyes remained on the children all the time. The kitchen area always reminded me of that accident and wanted to avoided the place, but can I? I need to still cook for the family."
>
> (Mother, 38 years, Dyad 15)

> "The place [home] is supposed to be our place of refuge but it really feels strange after the accident. It brings back memories that we don't want to remind ourselves of."
>
> (Father, 45 years, Dyad 4)

3.4. Navigating the recovery maze

3.4.1. Navigating a maze in the dark

The abrupt and unforeseen nature of the burn injury catalysed a profound disruption for parent–child dyads and family systems, redefining their understanding of recovery as a collective, nonlinear journey wherein what they had was each other. Far from being confined to the physical healing of the injured child, the process of navigating the recovery maze with each other permeated the emotional, relational, and logistical fabric of the entire household. Early milestones such as wound healing, the return of a child's appetite, or tentative ambulation taken within the sterile confines of the burn unit were celebrated as silent shared victories. These moments, however, stood in stark contrast to the dyads' initial assumptions that recovery would follow a predictable, upward trajectory. Instead, dyads likened the process to navigating a

maze in the dark, marked by setbacks, unexpected plateaus, and fleeting triumphs that collectively underscored the complexity of healing:

> "My first concern is the pain, the wounds, and the patience you need to endure to get better. The recovery is slow, but it is still happening, and you need to be very patient. Sometimes, I can move with little efforts, other times I just cannot do anything at all. It is lots of patience, and not what I expected at all"
>
> (Child, 13 years, Dyad 10)

> "With all that happened, anytime I saw my child move around in the ICU, I felt some relief and hope that he was getting better. But sometimes he just wanted to remain in bed and did not want to move about or eat his meal. The whole process was back and forth. Today we are doing ok and tomorrow, we are down back to square one again."
>
> (Mother, 41 years, Dyad 10)

Parent–child dyads grappled with mourning the irretrievable loss of the child's pre-injury identity; a self they yearned to reclaim. The pre-burn persona became an idealised memory, while the scarred post-burn reality, marked by heightened bodily awareness and altered appearance, fuelled persistent anxiety about societal acceptance and self-perception. Both parents and children contended with intrusive mental imagery and cyclical rumination, repeatedly reliving the trauma of the initial incident. Yet, within this crucible of adaptation, a transformative identity emerged: one that integrated vestiges of the former self with the realities of embodied change, forging a reconciled sense of being that acknowledged loss while embracing resilience. *Being with* each other continued as dyads navigated the meaning of the loss and reconciling the remains of the old self with the emerging new self:

> "I was not born like this [points to the scars on the face and bandaged legs]. Every time I look at it when bathing or dressing and realise, I cannot wear the dresses I wore before, it hurts to know I was once like this [shows a picture on the phone] but not anymore with my legs, hands, and face burned."
>
> (Child, 15 years, Dyad 20)

> "Oh yeah, I look at her and you can see a lot has changed after the injury. Whenever I see her, it is the injury I remember especially since it could have been prevented. It is hard seeing she cannot wear her favourite dresses like she did in the past… We fear what might happen once she is much older. We just need to support her as much as we can"
>
> (Mother, 43 years, Dyad 20)

> "It is just what it is, there is nothing we can do about it but to remain supportive. We look at the family pictures and brings back memories how cute he looked. He is still cute, but I think you know what I mean, not as before."
>
> (Mother, 38 years, Dyad 15)

> "I just knew I would not be the same again, it changed for me. My hair has not grown and you can see the marks on my head."
>
> (Child, 14 years, Dyad 15)

3.4.2. Social support

Social support emerged as both a lifeline and a paradox. While financial aid and emotional reassurance from friends, co-workers, and extended family members alleviated immediate stressors, parents frequently described an undercurrent of isolation. This loneliness stemmed from the singular burden of decision-making such as managing long-term care plans and the unspoken pressure to project strength for their child. Children, conversely, rarely reported feelings of isolation or loneliness, as the constant presence of a parent at their bedside provided a tangible anchor. Yet this dynamic inadvertently deepened parental exhaustion, as caregivers suppressed their own emotions to maintain a facade of stability:

> "My school mates, the church, and my father's work colleagues all donated financially to help us cover the bills. They also visited us during the time we were admitted to Gee [hospital]. My mother was with me all the time too."
>
> (Child 12 years, Dyad 14)

> "Oh they [family members] visited us a lot, but they could only stay during visiting hours. After visiting hours, they were all gone, and you are left alone with your child. It is not like being at home when they can stay as long as they wanted. Even after discharge, they still visited us at home but once they leave, you are stuck with your thoughts all over again"
>
> (Mother, 41 years, Dyad 14)

3.4.3. Hope and acceptance

The acute hospitalisation phase and post-discharge period emerged as distinct yet interconnected chapters in the family's adaptation. During hospitalisation, the immediacy of survival, wound care, infection prevention, and pain management dominated daily life. Here, the relentless rhythm of medical routines created a paradoxical sense of structure amid chaos. Post-discharge, however, families confronted the nebulous challenge of reintegration. The reality of protracted recovery, ongoing physiotherapy, scar management, and psychosocial adjustments forced a reckoning with permanence. *Coming to terms* became an active, iterative process: a negotiation between mourning the pre-injury self of the child and redefining normalcy within new constraints. For parents, this meant relinquishing ideals of parental control. For children, it involved reconciling their changed bodies with evolving identities, particularly during adolescence, where visibility of scars intersected acutely with self-image. Notably, the concept of *making the most of what remains* took on multifaceted meanings. For some dyads, it sparked a reorientation toward gratitude, that is, a focus on the child's survival and regained mobility. For others, it fuelled advocacy efforts, with parents working actively to prevent a recurrence of the injury. Children, meanwhile, often displayed ongoing adaptability, reframing limitations as creative challenges. Dyads described periods of relapse into anger or despair, particularly when confronted with societal stigma such as public stares or insensitive/ intrusive comments about scars which reignited feelings of otherness. Despite these, dyads remained hopeful as they accepted the entire situation and continued to work collaboratively to shift from mere survival to thriving. The presence of hope despite the aftermath of the injury, willingness to keep moving on consistently, engage with others socially, and do things for oneself characterised thriving:

> "If I look at my injury and the other patients I saw on the ward, I felt mine was even okay. It gave me hope to continue getting better. Other people also encouraged me that issues like this are part of life, and we need to overcome them. That gave me hope to move on. Now I can play football again with my friends"
>
> (Child, 15 years, Dyad 11)

> "Well, it has happened. Some of the patients we saw on the ward did not survive but he survived and that is a good thing. Some patients also had more serious wounds than his, I think. We are sad it happened but grateful he survived it. What remains is the financial resources to continue taking care of him. Other people also encouraged me and helped me to cope with all the issues and back and forth with the burns. At least, he is back to the football game again with his friends"
>
> (Father, 43 years, Dyad 11)

> "He could not do anything for himself while on admission. To feed him and lift him all the time. I had to sit by his side all the time from morning to evening. We had to secure a loan to continue taking care of him while in the hospital. Some colleagues and the church also

helped to cover some costs. Now he looks better and goes to school without any issue."

(Mother, 39 years, Dyad 13)

"When I got to the hospital at first and I saw the extent of the burns, I knew I will not be the same again and will not be able to do the things I was previously able to do. But when I began to walk around, I felt things can get better for me. I just wanted to get better. I am back to school now and everything feels ok [smiles briefly]"

(Child, 15 years, Dyad 13)

4. Discussion

Burn injuries and their aftermath represent a profound bio-psychosocial trauma, extending far beyond the initial physical harm. Although burns are acute in nature, their aftermath mimics living with a chronic condition considering the longstanding nature of the post-burn sequelae. The *Theory of Coming to Terms* demonstrates that the dyadic post-burn recovery experience is not a solitary path for the injured child only, but a collective odyssey: one that binds parent and child in a web of guilt, uncertainties, mutual vulnerability, resilience, and redefined identities. By illuminating the dyadic nature of trauma and the psychosocial weight of scars, the theory challenges healthcare systems to evolve beyond biomedical models. That is, the dyadic post-burn recovery process is not merely clinical but a subjective, multifaceted, and arduous journey of negotiating identity, functionality, and societal reintegration. Also, the theory grounded in dyadic experience challenges existing assumptions regarding the existence of guilt and blame only among parents. Together, rehabilitation and aftercare programmes must adopt a family-centered multidimensional framework that prioritises not only measurable physical milestones but also the subjective, iterative journey of psychosocial and emotional adaptation, where individuals and families rebuild identity, agency, and resilience in the aftermath of trauma. By foregrounding the dyadic experience, the study findings challenge reductionist narratives that usually compartmentalise physical healing from psychosocial adaptation. Instead, the findings position the post-burn recovery process as a co-constructed journey marked by mutual vulnerability, resilience, and evolving identity renegotiation from surviving to thriving.

Traditional burn care frameworks often prioritise the injured child's physical healing, relegating psychosocial and emotional impacts to secondary concerns. However, this study reveals that trauma in paediatric burn cases is inherently relational, binding parents and children in a trauma bubble characterised by mutual guilt, self-blame, and emotional entanglement. Thus, rather than an injury affecting only the child, burn injuries can be described as a family injury with the potential to impact family dynamics (Bayuo and Wong, 2021; Bayuo et al., 2020). In line with this assertion, the notion of *being with each other in a trauma bubble* described by the dyads underscores how paediatric burns transcend individual suffering, becoming a collective crisis that destabilises familial roles and emotional ecosystems. The mutual guilt and self-blame reported by dyads: parents blaming themselves for perceived negligence and children internalising responsibility for familial disruption aligns with studies on paediatric trauma that highlight relational guilt as a barrier to adaptive coping (Li, 2023; van Eickels et al., 2025). By employing a dyadic approach, this study extends what is known by uncovering how guilt and self-blame operate bidirectionally: children's self-blame and their awareness of parental sacrifice intensified their own distress, while parents' hypervigilance and the permanent accusation of scars exacerbated self-reproach. Previous studies have reported guilt and self-blame among only mothers which seem to suggest a unidirectional experience (Padalko et al., 2019; Van Niekerk et al., 2020). The use of a dyadic approach in the current study not only affirms the existence of guilt and self-blame but also extends our understanding of mutual guilt and blame between parents and their injured children. The mutual guilt and blame experience suggest that interventions should be family-centered targeting the child and their parents. Family-centered options in this regard will reflect a collaborative care environment wherein significant others are provided with emotional and practical support. For instance, family-centered interventions can facilitate routine family assessment to screen parents/caregivers for signs of distress (in addition to the injured child), family functioning, and coping mechanisms. This approach can help to proactively uncover parental concerns which can be resolved to improve adaptation and healing. Also, the burn care team can facilitate *dyadic communication* through strategies such as narrative therapy sessions to afford families an opportunity to jointly reframe blame, mitigate the experience of reciprocal guilt, and foster a shared healing journey as both child and parents engage and dialogue through their guilt experiences (Cotter and Brestan-Knight, 2020; van der Wal et al., 2024). Support groups connecting families with shared experiences may also be helpful. Also, discharge preparation should include an assessment of the parent–child preparedness to return to the site of the injury occurrence considering the possibility of being re-traumatised.

Scars emerged as central motifs in the post-burn narratives, embodying divergent meanings. Uniquely, the scars served a dual purpose: an emblem of survival and a stigmatising marker. Undoubtedly, post-burn scars remain a significant concern for burn survivors due to their aesthetic impact. Comprehensive scar management, however, remains an ongoing issue and despite recent advances, burn survivors usually live perpetually with their scars (Finnerty et al., 2016). Parents' and older children's attempt to conceal the scars is in sync with Goffman's concept of stigma management, where the experience of stigma varies based on the capacity to conceal the stigmatised attribute (Goffman, 2009). Conversely, younger children's reinterpretation of scars as sources of agency aligns with emerging work on post-traumatic growth in paediatric populations (Park and Lee, 2022; Woolard et al., 2021). Yet the tension between parental protection and child autonomy revealed here complicates these frameworks: when parents prioritised concealment to shield their child (and themselves) from stigma, they inadvertently silenced their child's attempts to reclaim bodily narrative. This dynamic underscore the need for *family-centered psychosocial interventions* that mediate conflicting perspectives. For instance, burn care staff may consider implementing peer-led workshops where dyads collaboratively to explore scar visibility as a site of both vulnerability and resilience (Won et al., 2021). Also, aftercare support should not only focus on assessing physical outcomes of rehabilitative care but should also focus on the meaning children make regarding their scars.

This study dismantles the myth of linear post-burn recovery, revealing healing as a labyrinthine process marked by setbacks, fleeting triumphs, and unexpected plateaus as dyads navigate from surviving to thriving. While medical milestones such as wound closure were celebrated, they did not signal emotional resolution. Indeed, the dyadic post-burn recovery journey disrupts the conventional model of burn care that prioritises discrete phases. Though participants' descriptions of recovery as *navigating in the dark* seem to resonate with Bonanno's theory of nonlinear grief (Bonanno, 2008), the dyadic stance employed in this study highlights how familial interdependence and interconnectedness shape ongoing adaptation. For instance, parents' suppression of their own emotions to maintain a facade of stability for their child echoes the caregiver burden phenomenon often observed in chronic illness contexts (Javalkar et al., 2017; Toledano-Toledano and Domínguez-Guedea, 2019), but with added layers of moral injury tied to preventable accidents and subsequent aftermath. Similarly, children's adaptability in reframing limitations reflects resilience strategies (Beeler, 2020; Tillery et al., 2020), yet the cyclical relapse into despair amid societal stigma suggests that individual coping is insufficient without ongoing systemic support. In fact, ongoing professional support for burn survivors and their families even after discharge is greatly needed to facilitate their interconnected recovery journey (Bayuo et al., 2020; Shaygan et al., 2025). Notably, a flexible albeit comprehensive family-centered

programme of care that actively follows up on the dyad may be helpful to ensure that continuity of care and support when needed (Christiaens et al., 2015), ensure availability of professional support for parents the delivery of trauma-informed care.

5. Strengths and limitations

This study has some strengths worth highlighting. The inclusion of parent–child dyads to examine the phenomenon of post-burn recovery helped to capture both individual and co-created narratives. This dyadic approach offers greater utility for the development of interventions to support families rather than only the child. The methodological approach employed in this study helped to generate a theory regarding dyadic post-burn recovery which reveals the complexities and mutuality of the process. Also, the dyadic approach helped to capture both content and interactions between parents and their injured children to ascertain asymmetric burdens. While this study deepens our understanding of dyadic post-burn recovery, its focus on primary caregivers and children within a single cultural context may limit transferability. Future research should explore extended family dynamics such as siblings' roles and cross-cultural variations in guilt narratives and stigma. Longitudinal qualitative designs tracking dyadic experiences through developmental milestones (e.g., adolescence, adulthood) could further elucidate how shared trauma and recovery evolves over decades following the initial injury. Also, the need to include children who could offer information may have led to including more older children. Future studies can therefore target children below the age of 10 years to capture their experiences.

6. Conclusion

Post-burn recovery for parent–child dyads is not a solitary journey toward closure but a co-created relational reconfiguration and a continuous negotiation of guilt, visibility, and re-invention. By centering the dyad as the unit of care, the study findings suggest that burn care staff and healthcare managers may need to move beyond siloed physical and mental health interventions to foster ecosystems where scars (both visible and invisible) are not wounds to be hidden, but testaments to survival that bind families in collective resilience. The path to recovery after a paediatric burn is not merely physical; it is profoundly emotional and psychological for the child and their family. Consequently, burn care programmes cannot prioritise physical outcomes alone. They must be equipped with the resources, expertise, and sensitivity to provide continuous, tailored support for the evolving emotional needs that arise at different stages of this challenging journey– such as processing trauma and rebuilding identity. Burn care must be family-centered to proactively identify and resolve emerging psychosocial issues affecting parents and their injured children who are recovering through strategies such as ongoing family assessment, connecting them with support groups, and facilitating dyadic communication.

CRediT authorship contribution statement

Jonathan Bayuo: Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Arkers Kwan Ching Wong:** Writing – review & editing, Project administration, Investigation, Formal analysis, Conceptualization. **Frances Kam Yuet Wong:** Writing – review & editing, Supervision, Methodology, Conceptualization. **Eric Ampomah Adinkrah:** Writing – review & editing, Writing – original draft, Validation, Project administration, Investigation, Formal analysis, Data curation.

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Declaration of competing interest

All authors declare no conflicts of interest.

Data availability

Data sets are available on reasonable request to the corresponding author.

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