Minimizing Pediatric Traumatic Stress Through a Trauma-informed Approach in the Emergency Department

Author: Kathleen S. Jordan, DNP, FNP-BC, ENP-BC, ENP-C, SANE-P, FAEN, Charlotte, NC
Section Editor: Anna Maria Valdez, PhD, RN, CEN, CFRN, CNE, C-NPT, FAEN

CE Earn Up to 7.5 Hours. See page 338.

Crimes against children, particularly abuse and neglect, can lead to distressing lifelong physical, psychological, and social consequences for a child. The US Department of Health and Human Services reports that child maltreatment is one of the greatest threats facing the health, welfare, and social well-being of children.[1] In 2016, state and local child protective services received approximately 4 million referrals involving the alleged maltreatment of 7.2 million children.[1] Children who experience any type of abuse or neglect are vulnerable, defenseless, and powerless in the worst of situations.

Other traumatic experiences in the life of a child also can lead to a myriad of disturbing lifelong consequences. These experiences include childhood exposure to intimate partner violence, household substance abuse, or mental illness; parental separation or divorce; living in poverty; developing a significant medical illness; and sustaining a traumatic injury.[2] It is an unfortunate reality that an estimated 90% of children experience some form of trauma in their lives.[3]

Although no universal definition of trauma exists, the most commonly referenced definition is from the Substance Abuse and Mental Health Services Administration: "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[4]

The emergency department is frequently the point of entry into the health care system for children, particularly in an acute crisis situation. It is estimated that nearly 25% of patients evaluated in emergency departments in the United States are younger than 18 years.[5] All members of the ED health care team must have the knowledge and skill set to ensure that excellence in patient care, clinical outcomes, and performance measures are achieved for the safety and protection of children. Best practice through a trauma-informed approach can be attained only when all team members contribute their unique specialized knowledge and skill set in a collaborative effort to achieve the common goal of child safety and protection.

Childhood Trauma

Trauma in childhood differs from trauma in adulthood in significant ways. Notably, the brain of a child develops at an exceptional rate during the early years of life. Because of this rapid neurobiological development, when a young child is exposed to stressful events, serious physiologic outcomes can occur. A complex neuroendocrine response to stress exists, and when it is overwhelmed, disruption in the architecture of the brain occurs, with resulting serious developmental consequences. High levels of stress in childhood are viewed as a psychological assault on the mind and a physiologic assault on the brain.[6]

"Toxic stress" is the term used to described chronic, repeated, or sustained exposure to stress in childhood. Sustained activation of the stress response can result in impairments in learning, memory, and self-regulation. Manifestations most frequently observed in children include poor emotional self-regulation and impulse control, which include aggression against self and others, impairments in learning and memory, lack of a sense of self, and uncertainty about the reliability and predictability of others.[7] A child who has experienced trauma may be unable to cope and

Kathleen S. Jordan is Clinical Associate Professor, The University of North Carolina at Charlotte, and Nurse Practitioner/APP Fellowship Director at Mid-Atlantic Emergency Medical Associates, Charlotte, NC.

For correspondence, write: Kathleen S. Jordan, DNP, FNP-BC, ENP-BC, ENP-C, SANE-P, FAEN, 3839 Swanson Rd, Sherrills Ford, NC 28673; E-mail: ksjorda1@uncc.edu.

J Emerg Nurs 2019;45:319-22.
Available online 14 January 2019
0099-1767

https://doi.org/10.1016/j.jen.2018.12.008

have feelings of distrust, terror, and powerlessness. Childhood trauma can affect the way children view themselves, the world around them, and their future.

Trauma-informed Care

As health care professionals expand their awareness and knowledge about the detrimental impact of traumatic experiences on the life and well-being of children, the value of implementing a trauma-informed approach becomes more essential. A trauma-informed approach for vulnerable children requires that emergency care providers expand their knowledge base to recognize the impact of trauma and incorporate this insight into the child's current health status and the behavior that the child is exhibiting in the emergency department. Realizing and recognizing the impact that trauma has had on a child is the critical first step in becoming a compassionate and supportive trauma-informed care provider.

A trauma-informed care approach requires that the emergency care provider look through the lens of "What happened to this child?" rather than the traditional focus, "What is wrong with this child?" Through this paradigm shift the goal is to meet children where they are and not attempt to take them to a place outside their "trauma bubble." Children's mood, affect, and behavior may be due to the fact that they are unable to move outside their own safety net. As emergency care providers, we must fully recognize the effects that trauma can have on children's behavior, coping strategies, relationships, and ability to interact with health care providers and other professionals. We must be truly child focused from a developmental, linguistic, and culturally competent perspective and be mindful that what may be considered "problem behavior" is best interpreted as the child's response to, or way to cope with, the effects of trauma.[7]

Implications for Emergency Nursing

Successful initiation and maintenance of a trauma-informed approach to care in the emergency department requires that nurses advance their knowledge and skill set about the widespread impact of trauma, embed the framework guiding the approach to traumatized children into practice, and integrate evidence-based methods into clinical practice. Emergency nurses are in an ideal position to lead an interprofessional trauma-informed team approach involving both clinical and nonclinical staff. In a recent Cochrane Collaborative Review, it was stated that the integration of an interprofessional approach produces positive outcomes in ED culture, patient satisfaction, and collaborative team behavior.[8] For example, educating all clinical and nonclinical members of the emergency staff (eg, registration staff and security guards) to promote a welcoming, nonthreatening, trusting environment may help nurture feelings of safety for the child. Creating a safe and trustworthy ED environment for children is fundamental to successful implementation of trauma-informed care.[9]

TABLE 1
Messages to communicate to a traumatized child in the emergency department

It is not your fault, you did nothing wrong.
You are brave, and you did the right thing by telling what happened to you.
I am sorry that you had to (experience, see, hear…) this.
You can talk to me about your feelings if you want to, I will listen.
I care about you, and want you to be safe.
It is the job of adults to keep kids safe. There are adults who will work to keep you and your family safe.
It is OK for you to feel (angry, hurt, scared…).

Prevention of Retraumatization

Although it is never intentional, a critical component to trauma-informed care in the emergency department is the prevention of retraumatization (ie, iatrogenic harm) and the negative sequelae that may result. A trauma survivor who has not successfully processed traumatic memories can experience distress, dissociation, or other negative responses unrelated to the original insult as a result of common ED procedures. Memories of trauma can be triggered by routine care such as a physical assessment or other noninvasive procedures.[10] Common procedures that may precipitate retraumatization are the tightening of a blood pressure cuff around the upper arm of a child with a history of physical abuse or asking a child with a history of sexual abuse to undress. Another common trauma trigger is the requirement of physical restraint for a common ED procedure such suturing.

Children in the emergency department frequently feel a lack of control over the situation, which may lead to feelings of retraumatization. It is important that the emergency nurse provide the child with opportunities for shared decision making and control over the situation when feasible. For example, the nurse may offer choices regarding the position the child would like to be in for a procedure or distracting activities the child can engage in during a procedure.[11]

TABLE 2
Techniques for implementation of a trauma-informed approach to children in the emergency department

Decrease wait time, whenever possible.
Create a safety zone or private space for the child.
Interact with children at eye level.
Introduce yourself and explain your role; use developmentally appropriate language.
Acknowledge the child's pain, trauma, and stress.
Be aware of child's nonverbal cues, facial expressions, and body language.
Explain every step of the process and its rationale; ask if the child has questions.
Minimize multiple interviews, especially if related to trauma.
Allow children to take breaks from the conversation as needed.
Give choices whenever possible.
Ask if the child would like to have a supportive caregiver in the room.
Offer basic comfort measures such as warm blankets, beverages, and food.
Allow as much privacy as possible, especially if the child undresses.

Medical procedures are commonly viewed with fear through the eyes of a child, particularly if the procedures are associated with physical discomfort or pain. Managing the child's pain through medication and other modalities, such as allowing supporting caregivers to be present during procedures and engaging children in distracting activities, is of paramount importance. Evidence indicates that common verbal communication with a child such as repeating "You're ok, don't worry" actually exacerbates a child's discomfort and distress.[11]

Barriers exist to implementation of a trauma-informed approach that are inherent to the emergency care environment. The emergency department is typically a high-volume, high-acuity, and sometimes chaotic clinical setting. In addition, the interaction that emergency nurses have with traumatized children may be of very short duration because of rapid throughput. Despite these barriers, the messages we communicate to children are critical in promoting a safe and trustworthy environment.

A trauma-informed approach to a traumatized child may leave a lasting memory. Although the child may have only a short interaction with an emergency nurse and may not even know the nurse's name, he or she will know that someone cared enough to be present and listen. Several recommendations for interacting with a traumatized child are listed in Tables 1 and 2.

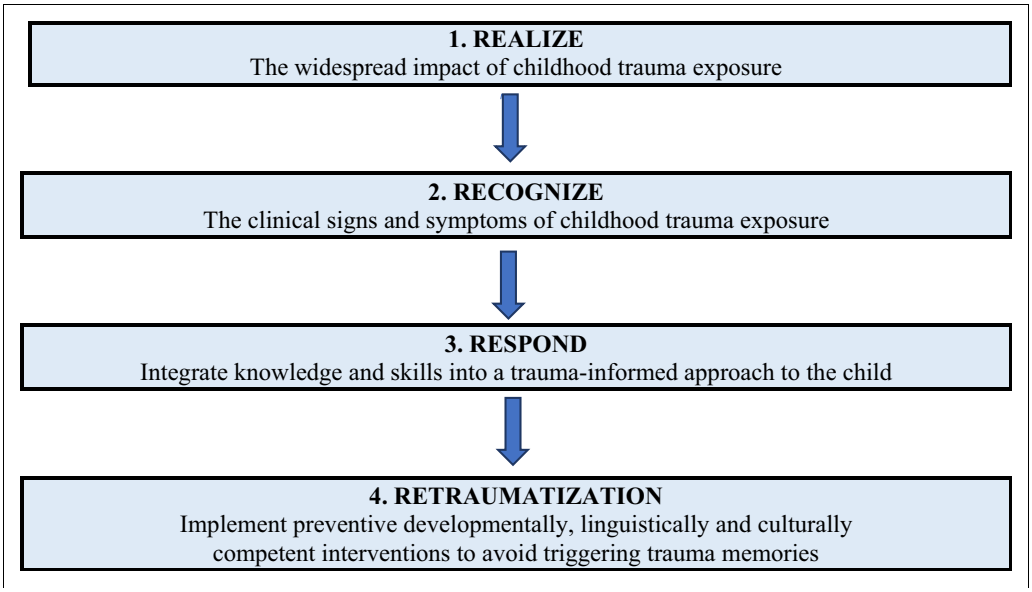

FIGURE
Principles of trauma-informed care. Adapted from Substance Abuse and Mental Health Services Administration (https://www.samhsa.gov/nctic/trauma-interventions; Accessed January 8, 2019).

Conclusion

Trauma exposure in childhood and the avalanche of associated long-term consequences are significant public health problems that demands attention. The concept of implementing a trauma-informed approach in the emergency department is relatively new, and more clinical research is needed for the successful transformation of this paradigm shift. What is known, however, is that emergency nurses can make a significant difference in the life of children who have been exposed to trauma by having a thorough understanding of the physiologic, psychological, and social effects of the experiences that have challenged the child. This knowledge base is a prerequisite for recognizing traumatized children, responding to them, and preventing retraumatization in the ED setting (Figure). As we move forward, a trauma-informed approach should be considered standard of care for the protection and safety of children in the emergency department.

REFERENCES

1. Children's Bureau, Administration for Children and Families, US Department of Health & Human Services. Child maltreatment; 2016. https://www.acf.hhs.gov/cb/resource/child-maltreatment-2016. Published February 1, 2018. Accessed December 7, 2018.
2. Felitti V. Adverse childhood experiences and adult health. *Acad Pediatr*. 2009;9:131-132.
3. Heinzelmann M, Gill J. Epigenetic mechanisms shape the biological response to trauma and the risk for PTSD: a critical review. *Nurs Res Pract*. 2013;2013:417010.
4. Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2014.
5. Wier LM, Yu H, Owens PL, Washington R. Overview of children in the emergency department, 2010: Statistical Brief #157. Rockville, MD: Agency for Healthcare Research and Quality; 2006-2013 Jun. https://www.ncbi.nlm.nih.gov/pubmed/24006551. Accessed December 7, 2018.
6. Child Welfare Information Gateway. *Long-term Consequences of Child Abuse and Neglect*. https://www.childwelfare.gov/pubpdfs/long_term_consequences.pdf. Published July 2013. Accessed December 7, 2018.
7. Nova Scotia Health Authority. *Recognizing and Responding to the Effects of Trauma*. https://novascotia.ca/dhw/addictions/documents/TIP_Discussion_Guide_2.pdf. Published May 2015. Accessed December 7, 2018.
8. Reeves S, Perrier L, Goldman J, Freeth D, Zwarenstein M. Interprofessional education: effects on professional practice and healthcare outcomes (update). *Cochrane Database Syst Rev*. 2013;3:1-47.
9. Menschner C, Maul A. Key ingredients for successful trauma-informed care implementation. https://www.chcs.org/resource/key-ingredients-for-successful-trauma-informed-care-implementation/. Published April 2016. Accessed December 7, 2018.
10. Reeves E. A synthesis of the literature on trauma-informed care. *Issues Ment Health Nurs*. 2015;36:698-709.
11. Kassan-Adams N, Butler L. What do clinicians caring for children need to know about pediatric medical traumatic stress and the effects of trauma-informed approaches? *AMA J Ethics*. 2017;19:793-801.

Submissions to this column are encouraged and may be sent to **Anna Maria Valdez, PhD, RN, CEN, CFRN, CNE, C-NPT, FAEN** Annav409@gmail.com