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CASE STUDY

Psychosocial Considerations for Pediatric Care in Emergency Departments

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Abstract

When pediatric patients are admitted into emergency departments a different course of psychological care is required. Often, when admitted, children are scared and in pain. Fear and pain at any age introduces unexpected behavioral responses, and this is not an exception for children. This makes children quite vulnerable in emergency departments, regardless if caregivers are trained to work with pediatric patients. Within the urgency of delivering emergent medical care, as well as maintaining strong statistics noting minutes of care, there is little time for explanations or emotional containment for pediatric patients. Emergency medical caregivers can mitigate potential fear and reduce behavioral issues in their pediatric patients by implementing developmentally appropriate psychosocial interventions. The following case study focuses on choice-giving as a means of offering psychological safety to pediatric patients in the emergency department.

Case Study

A licensed therapist specializing in play therapy within the hospital system was paged to the emergency department (ED) to assist with an elementary school aged male patient who refused to take oral medication to calm him down. When the therapist arrived in the ED, outside the child's door stood ten hospital employees four of whom were holding restraints. This was the code gray team that had also been paged to assist with the potentially or actively combative patient. After multiple attempts for compliance prior to the therapist's arrival, the child was told he either needed to take the oral medication or have an injection. He was told that the medicine would make him feel better. Na-

turally, the child demonstrated a behavioral outburst at the thought of getting an injection.

During the therapist's quick assessment, it was clear that the child needed control in his environment. Although his chronological age was school-aged, developmentally, he was presenting much younger. Thus, it was important to approach him as such. Looking for developmental stage clues, it seemed as if this child was presenting as a three-year-old battling his will. He was striving for independence. He needed power and control by having a voice and choice.

The therapist immediately approached the attending physician and asked what the end goal was: administration of medication. Secondly, the therapist asked what had been tried to this point: bribery and threat. The examples given were, "You can have ice cream if you take your medicine." And when ice cream was not enticing enough: "If you do not take your medicine, we will hold you down and give you a shot." The child screamed in response to the threat, "I don't want to take that medicine!"

After the quick huddle with the attending physician, the therapist gingerly approached the child and he immediately slammed the door screaming, "Get out of my room!" It should be noted that the child was brought in by law enforcement due to disruption in the community. However, the officer was in the room with him and his social workers in the hallway. The therapist immediately asked the social workers if the child had a trauma history and briefly inquired about the severity



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of such trauma. It was unknown. Whenever trauma history is unknown, trauma informed care requires that caregivers assume a trauma history.

With that in mind, the therapist re-approached the attending physician and strongly recommended that the use of restraints as an intervention be aborted as a means of not causing trauma to the child. The physician then stated, "I will only do that if you have a better way. He is being way too disruptive and we need it quiet in here for our other patients." Being a child therapist and specializing in healthcare-induced anxiety and trauma in children, the therapist did have a better way.

Identifying the child's developmental stage as a 3-year-old, the therapist coached the nurse and physician in choice-giving in an effort to provide power in a powerless situation. Exasperated, and pressed for time, the team wanted a simple, quick intervention to dispense the medication. The restraints would indeed be faster, but the residual trauma of putting a young, scared child in restraints to administer medication could cause a lifetime of trauma. More importantly, it would communicate to the child that healthcare environments are not safe, potentially delaying future care if he feels unsafe with medical providers. The therapist strongly advocated for the emotional safety of the child.

The therapist quietly coached the physician in what choices to give the child: 1) "You can take the medicine on your own" 2) "Or, you can have us help." These options offered the safety of choice and control to a child who was scared and feeling helpless and out of control. His behavior was telling us that he was feeling out of control.

To the surprise of the physician as well as the code gray team, the intervention worked. With the therapist bedside with the patient, he chose to take the oral medication, choosing to take it slowly and not immediately when presented with it. Once he had taken the medication, he calmly invited the therapist to sit at the end of his bed and play dinosaurs with him. Curiously, yet intentionally, he played out a scene of power and control with the "big" dinosaurs and the "little" dinosaur. In the story that he created, the little dinosaur fought off the big dinosaurs. The little dinosaur felt powerful and in control. He was not left victimized. From a therapeutic perspective, his ability to "play out" the situation that just occurred using a projective measure (toys) allowed him to immediately process the situation and therefore prevent a trauma response.

From the arrival of the therapist in the ED, the whole process took approximately ten minutes. The team had been working with the child for nearly thirty minutes before the child therapist was paged. Ten minutes of intentional, developmentally-appropriate care to a child prevented him from having to go through the trauma of being put in restraints by adults and being injected with medicine.

Recommendations

When a pediatric patient is admitted into the emergency department of any hospital, they must be treated differently than adults [1]. Regardless of the presenting problem or circumstances requiring emergent medical care, medical or psychological, children require a different kind of care. For adults and children alike, when in an unknown environment, anxiety naturally increases [2]. Emergency caregivers can reduce psychological trauma in pediatric patients by offering choices, stating the agenda and expectations, focusing on resiliency from the past, and attuning to emotion [3]. By focusing on these four-steps of attunement, with concentrated attention given to giving power to children in powerless situations, the psychological impact of care, including anxiety and trauma, can be markedly decreased. Although these steps do require a few extra moments, and are not possible in true emergent situations, as demonstrated in the case study above, spending thirty-minutes forcing a child to do something that makes them feel powerless is futile and disrupts the flow in the department. Offering extra minutes for psychological care of a pediatric patient empowers the child and bolsters them with a feeling of control in a powerless situation. All caregivers can offer choices as a simple and direct way to offer emotional safety to a pediatric patient. Extra minutes of psychological care may offer a lifetime of significant psychological benefit to a pediatric patient.

Conflict of Interest

There is no source of support to disclose and no conflict of interest to disclose.

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