Trauma-Informed Care: Pediatric Intensive Care Nurses at the Root of Children's Safety and Trust

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Any experience that a child perceives as threatening or detrimental and has long-term consequences for the child's holistic health and welfare qualifies as trauma. Whether an experience is traumatic depends on the 3 *E*'s of trauma: the event, the experience of the event, and the effects. Traumatic events can affect an infant's or child's development and have lifelong repercussions. Because of the prevalence of pediatric trauma, trauma-informed care has become the standard of care. Nurses are perfectly positioned to lead trauma-informed care in the pediatric intensive care unit. This article explores the components of trauma-informed care and the application of this standard of care to children in the pediatric intensive care unit. The nurse providing trauma-informed care understands the impact of trauma on the child, the family, and the staff and responds by integrating knowledge about trauma into care, both individually and systemwide, seeking to actively avoid retraumatization. This article presents the 6 principles of trauma-informed care and 3 case examples illustrating the application of these principles in the pediatric intensive care unit. Additional resources are provided to equip critical care nurses to fully implement this standard of care for critically ill children. (*Critical Care Nurse*. 2022;42[6]:66-72)

What do hospitalization in the PICU (pediatric intensive care unit), living through a tornado, experiencing a pandemic, hearing a fight between one's parents, and death of one's pet all have in common? Each of these situations can be traumatic for a child. Any experience perceived by a child as threatening or detrimental, with long-term consequences for the child's holistic health and welfare, qualifies as a trauma.[1] Powerlessness, hopelessness, and stress may be outcomes of a single traumatic event or repeated exposure to such events. Additionally, the COVID-19 pandemic has placed additional stressors on children. Potentially traumatic events occurring during childhood are known as adverse childhood events and may precipitate mental and physical health issues and even early death.[2,3] Whether an experience is traumatic depends on the 3 *E*'s of trauma: the event(s) itself, the experience of the event(s), and the effects.[1]

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Consider trauma from the perspective of a "trauma tree." Traumatic events have detrimental effects on children's development, similar to the effects of root damage caused by drilling or soil compaction on a tree's structure.[4] Specifically, trauma during childhood can negatively affect brain development. Normal brain development is like an inverted triangle with survival efforts at the bottom point and cognition at the top plateau. With trauma, the brain development hierarchy is reversed, with most effort going to survival at the triangle's base and little attention to cognition at the apex. The bottom point (brain development) is critical but precarious before trauma, and the apex (cognition) is critical but vulnerable after trauma. In essence, traumatic events literally rewire the developing brain.[4]

Physical trauma is easily identifiable and well understood and yet, despite this awareness, unintentional injuries such as falls and other physical mechanisms continue to be the leading cause of death for children between the ages of 1 and 14 years. Physical trauma is also the leading cause of nonfatal injuries requiring treatment in emergency departments among all pediatric age groups.[5] Other categories of trauma include physical abuse, sexual abuse, human-induced or natural disasters, emotional trauma/loss, and treatment-related or medical trauma.[6] If physical trauma results in hospitalization, the child's experience of that hospitalization can be further impacted by trauma-inducing situations in the PICU, including pain, fear, anxiety, and loneliness, among others.[6-10] Thus, medical trauma fits in the "other injuries" category of hospital-acquired conditions, resulting in prolonged stay, increased cost, and long-term sequelae.[4]

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Trauma-informed care is quickly becoming the standard of care in response to the prevalence and impact of trauma on children. To skillfully, or perhaps even artfully, provide trauma-informed care, the critical care nurse must have a foundational awareness and understanding of the impact of trauma on the child and family unit. With this awareness the critical care nurse can be poised to fully respond to the 3 *E*'s of trauma (event, experience, and effect) while avoiding retraumatization.[1,11] Table 1 provides a glossary of terms specific to trauma-informed care.

Principles of Trauma-Informed Care

Multiple disciplines use trauma-informed care.[3] The organizational framework that acknowledges the prevalence, seriousness, and long-term consequences of trauma for the patient, regardless of age or location, is that of trauma-informed care.[11,14] The basis for incorporating trauma-informed care is centered on 6 principles: (1) safety; (2) trustworthiness and transparency; (3) peer support; (4) collaboration and mutuality; (5) empowerment and choice; and (6) cultural, historical, and gender issues.[1,12] These 6 principles offer some pragmatic considerations when integrating trauma-informed care.

Safety is the first principle of trauma-informed care for children in the pediatric intensive care unit.

Safety is the first principle of trauma-informed care for the child in the PICU. National initiatives drive physical safety and therefore it receives heightened attention. Emotional and psychological safety do not automatically garner the same level of awareness and attention. The provision of emotional security through compassion and nurturing is crucial.

The second principle is trustworthiness and transparency. If false promises are made to gain trust (eg, "this will not hurt much"), the child can feel repeatedly traumatized. Encouraging parents to be present during procedures and actively involved in the child's care supports transparency while providing familiar support for the child; this approach aims to prevent secondary trauma.[10]

The third principle, peer support, is invaluable, as is active listening. Children often make statements that indicate the need to initiate interdisciplinary services (eg, behavioral health) for precise diagnosis. Comments by the family lend insight into resources and connections previously shown to be helpful to the child (eg, support

Table 1 Glossary of terms specific to trauma-informed care

Term	Definition
Adverse childhood events (ACEs)	Potentially traumatic events during childhood, often leading to mental and physical health issues and possibly resulting in early death[2]
Acute stress disorder (ASD), posttraumatic stress disorder (PTSD)	Symptoms in response to a perceived trauma. The term used depends on timing of symptom occurrence. Acute stress disorder symptoms appear within 1 month of trauma exposure. Posttraumatic stress disorder symptoms appear more than 1 month after trauma exposure. In school-aged children and adolescents, diagnosis depends on the presence of 4 symptom clusters: intrusion (reexperiencing the trauma), avoidance behaviors, hyperarousal, and cognitive function decline/mood dysfunction. In younger children, diagnosis depends on 3 symptom clusters: reexperiencing the trauma, avoidance behaviors/alterations in cognition or mood, and hyperarousal.[12,13]
Resilience	Ability to overcome traumatic events and meet new situations with strength.[14]
Trauma	"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"[1(p7)]
Trauma-informed care	"A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization."[1(p9)]
Triggers	Memories, especially sensory, of what happened just before or during an event that reinitiate symptoms of trauma and may cause a person who has had trauma to react as if they are in danger. Anniversaries of traumatic events may also initiate such reactions.[12,13]

groups or sharing information with a school nurse). Health care providers, especially nurses, are accustomed to fixing problems, and yet actively listening to what is being said can be the most helpful action for children and families experiencing trauma.

The benefits of the fourth principle, collaboration and mutuality, are not unique to trauma-informed care. However, effective interdisciplinary collaboration ensures consistent messaging and care planning to avoid retraumatization of children. It is also important to encourage a shared decision-making model by engaging the child and family as collaborating partners in care decisions when possible. Interdisciplinary collaboration among all team members, while including the child, will support and promote improvements in care.

The fifth principle, empowerment, can be summed up as "voice and choice." When children and families have real choices, they have greater control over their health. As with collaboration, nurses can promote empowerment by providing age-appropriate choices while including the child and family in care decisions. Supporting voice and choice aims to avoid retraumatization of the child.

The final principle, although certainly not the least important, is cultural considerations. Prior trauma experiences can result from cultural or historical events or any gender or racial biases that one may have experienced. Recognition and awareness of the potential for such past experiences is of utmost importance to prevent any additional biases from influencing care and thereby causing retraumatization. Mitigating any potential influence of biases is critical in trauma-informed care.

Strategies for Implementing Trauma-Informed Care

To provide trauma-informed care in the PICU, one must first assume that everyone has had trauma and then approach each child and family accordingly.[11,14] Screening for trauma must begin early in care and remain ongoing. If past trauma is discovered, its context for the child and family should be determined through the child's and/or family's thorough description of the experience, including any sensory components (sights, sounds, smells, tastes, sensations) and known triggers. Having an awareness of the child's coping skills will enable the PICU nurse to tailor care to the child's individual needs.[11]

The ability to recognize the signs of a trauma response is central to care planning for these patients. Identifying the manifestations of intrusive thoughts, avoidance behaviors, hyperarousal, and cognitive function disruptions

Table 2 Resources for providing trauma-informed care

Center for Pediatric Traumatic Stress. Health care toolbox. Accessed March 20, 2022. https://www.healthcaretoolbox.org

Coughlin ME. *Transformative Nursing in the NICU: Trauma-Informed, Age-Appropriate Care.* 2nd ed. Springer Publishing; 2021.

Galindo N, Lewis-Stoner M. Creating a Trauma-Informed System of Care. Relias; 2020. Accessed March 20, 2022. https://www.relias.com/resource/creating-a-trauma-informed-system-of-care

National Child Traumatic Stress Network. Pediatric medical traumatic stress: a comprehensive guide. Accessed March 20, 2022. https://www.nctsn.org/sites/default/files/resources/pediatric_toolkit_for_health_care_providers.pdf

National Child Traumatic Stress Network. Trauma-informed integrated care for children and families in healthcare settings. 2018. Updated March 2021. Accessed August 17, 2022. https://www.nctsn.org/resources/trauma-informed-integrated-care-children-and-families-healthcare-settings

Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* HHS publication (SMA) 14-4884. Substance Abuse and Mental Health Services Administration; 2014.

Trauma. American Psychological Association. Accessed August 17, 2022. https://www.apa.org/topics/trauma

Trauma-informed care. Agency for Healthcare Research and Quality. April 2015. Accessed August 17, 2022. https://www.ahrq.gov/ncepcr/tools/healthier-pregnancy/fact-sheets/trauma.html

and/or mood dysfunction and noting the timing of these manifestations confirms the presence of stress disorders, either within the first month after trauma (acute stress disorder) or greater than 1 month after the traumatic event (posttraumatic stress disorder).[12,14,15]

Responding to trauma with deliberate and evidence-based principles is imperative. As Nightingale noted over 150 years ago,[4] providing a healing, supportive environment is important. Skin-to-skin (kangaroo) care and lateral positioning are particularly beneficial for small infants.[4] The importance of protected sleep and other health promotion activities cannot be overemphasized for all ages.[4,11] Applying best evidence-based practice to interventions such as the distress, emotional support, and family bundle is important.[4,7,11,12,16] Methods of regulating the central nervous system (medications and nonpharmacological measures such as relaxation, massage therapy, and cognitive behavioral therapy) modulate physiological stress, including pain. Active therapies such as play therapy, animal-assisted therapy, biofeedback, journaling, and creative arts (music therapy and arts/crafts) plus passive techniques such as distraction also reduce a child's stress and reduce retraumatization.[7,12]

In summary, trauma-informed care is based on the acknowledgment that nearly everyone has had at least 1 past trauma experience and therefore universal implementation is warranted. Nurses must be aware that reactions to current hospital experiences may reflect past trauma experiences, so trauma-informed care should be individualized for each child to anticipate known or suspected triggers. For example, a child who has experienced physical abuse by their father may feel more comfortable being cared for by female health care providers. Loud noises and dark clouds may trigger flashbacks about a tornado that hit the family's home. The anniversary of a traumatic event may serve as a trigger. By including the anniversary date of such an event in the child's plan of care, all health care providers and family members can monitor for the occurrence of trauma reactivity or posttraumatic stress disorder symptoms. It is by anticipating known or suspected triggers that critical care nurses can best mitigate or minimize the impact of current hospital experiences for the child. Trauma-informed care must be individualized for each child on the basis of their unique circumstances. Resources to assist the PICU staff in delivering trauma-informed care are provided in Table 2.

Active therapies such as play therapy, animal-assisted therapy, biofeedback, journaling, and creative arts reduce a child's stress and reduce retraumatization.

Case Examples

The following 3 case examples illustrate the use of trauma-informed care in the PICU. The first depicts a school-aged child admitted by the trauma service following an accident on his bicycle. The second portrays a toddler who sustained injuries in an automobile wreck. The third describes a neonate who sustained a head injury after being dropped by her mother. All case examples use pseudonyms because they are based on actual patients and events.

Case Example 1

Jimmy is a 10-year-old boy who had a dirt bike accident while in the care of his mother and her significant other. Jimmy was transported via ambulance to a pediatric trauma center. He sustained significant abdominal injuries. Jimmy seemed to be quite sensitive and bothered by loud voices and noises, exhibited by putting his hands over his ears and squeezing his eyes shut, first observed in the trauma bay. Triage and resuscitation in the trauma bay typically involve many people surrounding the patient. Despite best efforts at crowd and volume control, at times the noise level became quite high. Jimmy required a trip to the operating room followed by admission to the PICU.

As Jimmy's condition started to improve, he began to act out by refusing to participate in his care (physical therapy, occupational therapy, etc) and staff described him as difficult. His mother asked that staff not push or force him to participate. Jimmy's father was furious with his mother about the accident, increasing tension. Jimmy observed interactions between his parents that were very tense and uncomfortable for him. He was worried that his parents' fighting was his fault because he had the bicycle accident.

Jimmy's Background.

Jimmy and his siblings grew up in a somewhat toxic and unpredictable household in which his parents often verbally fought; it was usually loud and scary. Jimmy also occasionally saw his father physically abuse his mother. During these times, he would try to hide or become very quiet because he was scared. His parents' divorce involved a bitter custody battle. Jimmy and his mother moved to a new house in a new neighborhood. Jimmy had been struggling in his new school and his mother bought him the bicycle to entice Jimmy to work harder in school to get better grades. He was also struggling to make new friends.

Trauma-Informed Care Interventions.

The clinical care team would not have automatically known Jimmy's background, reinforcing the need for a universal approach to trauma-informed care. The trauma-informed interventions implemented with Jimmy were aimed at fostering safety, choice, and trustworthiness.

- Establishing a predictable routine and continuity of care team was important for Jimmy. The consistent nursing care team fostered trust for Jimmy. Providing structure and explanations of what would be happening, such as treatments and his schedule, alleviated some worry for Jimmy.
- Nursing and therapy staff (occupational and physical therapists) supported safety and choice for Jimmy by asking simple questions like "Do you want your door open or closed?" and providing him with a level of control by involving him in his medical decision-making, for example, "Do you want to take the medicine with milk or water? Do you want to assist with cleaning your wound?"
- The nursing team and child life specialists helped Jimmy stay grounded in the present by singing songs with him during interventions and providing him with age-appropriate activities for increased engagement. Child life specialists also taught relaxation skills to decrease distress during medical procedures.
- The social worker established an alternating visitation schedule with the parents to limit Jimmy's exposure to their toxic interactions in his presence. Child life specialists and social workers also encouraged Jimmy to share his fears and worries with family and health care providers. This fostered Jimmy's sense of safety.

Case Example 2

Tommy is a 2-year-old boy who was a passenger in a car driven by his mother. Their car was hit at a high rate of speed by another car and both he and his mother were injured. His mother sustained significant injuries and was transported to an adult trauma center while Tommy was taken to a pediatric trauma center. Tommy had a small epidural hemorrhage that required observation in the PICU; he had no other obvious major injuries. His mother had multiple orthopedic injuries and an abdominal injury that required surgery and long-term recovery. Tommy always seemed to cry when men would approach and enter his room. He could not be comforted. Tommy's grandmother was also a part of Tommy's life, but she too had health issues, so Tommy's mother was her primary caregiver.

Tommy was safely secured in his car seat when the impact happened. He was taken from the car by an all-male emergency medical services crew. The fire crew was also male. There were many sounds and sights that frightened such a young child. Tommy watched his mother be removed from the car, cared for, and assessed

by only men. Surrounded by primarily male rescuers, he cried and was inconsolable. This situation made it difficult to assess Tommy's level of injury and know if he had any further injuries. Tommy was taken from the scene to the pediatric trauma center, but his mother was not there to comfort him.

Tommy's Background. Tommy was never involved with his father, so he only knew the support of his mother and grandmother. He had not been around men and having an all-male crew of rescuers scared him further. Tommy had just watched the male crew take his mother away from him and did not understand that they were helping her. He was scared and alone and unable to have female family support.

Trauma-Informed Care Interventions. The PICU care team did not realize that the configuration of the care team could be traumatic for Tommy, considering the on-scene rescuers and his past experiences. Often, the care team is not aware of social situations when a patient is brought to the trauma bay. Tommy came alone from the scene without anyone who could provide the team with information specific to his background. His mother was intubated at another facility and unable to be reached for information, and his grandmother lived too far away to come to the hospital for initial admission. Once the care team noted Tommy's fear and that his crying continued when mostly men were in the room, the PICU staff was able to prioritize women to examine Tommy. If men had to assess Tommy, then a woman would also accompany Tommy to provide support and comfort.

This case emphasizes the need for trauma-informed care with all patients because those who cannot verbalize concerns may be affected by past traumas. Being aware and practicing trauma-informed care will help alleviate further harm. Experiencing trauma at a young age can affect trust in future care and can lead to treatment avoidance because of an unconscious fear of more trauma. Ensuring that PICU nurses are building trust with their patients and fostering safety while recognizing how trauma can be reduced, even if not eliminated, will be successful.

Case Example 3

Sara is a 12-hour-old newborn who was dropped while her mother was feeding her in the hospital. Sara was born at 36 weeks' gestation to a first-time mother who was having anxiety over motherhood. Sara was found to have a skull fracture and a subdural hematoma. She was then transported to the pediatric trauma center while her mother remained in the labor and delivery hospital after cesarean delivery.

In the trauma center, Sara was placed in a cold examination room and was uncovered for examinations and testing. Sara was crying inconsolably during the examinations. At this time Sara was placed in a hard papoose for cervical spine precautions and was unable to eat. An intravenous catheter was placed in her arm, making it immovable, and an intravenous fluid infusion was started. While receiving spinal precautions, she remained on bed rest for the first night.

Sara's Background. Sara was admitted to the PICU for close observation of her subdural hematoma. She was permitted nothing by mouth, and frequent laboratory tests and neurological examinations were ordered. While Sara was in the PICU, her neonatal developmental needs were a secondary priority to her physiological care requirements (eg, neurological assessment and sodium management). She did not have bonding time with her mother via skin-to-skin contact, her natural need to eat was paused because of her nothing-by-mouth status, and she was irritable because of the lack of enteral nutrition. Her normal neonatal sleep pattern was interrupted by the frequent requirements of trauma care and monitoring.

This case emphasizes the need for trauma-informed care with all patients because those who cannot verbalize concerns may be affected by past traumas.

Trauma-Informed Care Interventions. While Sara was in the trauma unit several nursing measures were taken to prevent her traumatization by future treatments. (These measures can be taken with any pediatric patient, regardless of age.) Once Sara was cleared from bed rest, staff members frequently held her and provided emotional support. Placing a piece of clothing containing her mother's scent in Sara's crib allowed Sara to begin bonding with her mother even before her mother could be with her. As soon as Sara could begin feeding by mouth, the care team supported her mother's choice of breast milk or formula feeding. Once her mother could be at Sara's bedside, she was allowed to feed Sara.

Sara's neurological examinations were coordinated with other care activities to facilitate uninterrupted sleep. While obtaining blood samples to test sodium levels, staff members used a pacifier and oral sucrose to reduce pain associated with needle pricks. The trauma team worked to clear Sara's cervical spine precautions soon to allow for skin-to-skin bonding. The team at the labor and delivery hospital worked with Sara's mother to discharge her as early as possible to encourage her to be present and build an emotional connection with Sara. After observation, the team worked with both of Sara's parents to educate and provide the support needed to ensure the parents' comfort with Sara's care. The team considered the potential of future trauma and the trauma the parents were enduring. Because the parents were traumatized too, they might be hesitant to care for Sara or afraid to be retraumatized by her care, potentially affecting Sara's experiences. The team focused on facilitating bonding and developing a relationship with Sara and her parents to prevent future trauma.

Summary and Implications

Successfully implementing trauma-informed care begins with educating clinical and nonclinical staff on its components and how to employ it with children, families, and staff. "Train-the-trainer" workshops (short-term, multiple-day, or ongoing events) with a standardized focus on knowledge, skills, and attitudes have been employed effectively in some health care settings.[3] Other organizations have relied on staff attitude surveys to determine content for curricula (in-service, formal coursework).[3] Burton and colleagues[17] demonstrated how trauma-informed care fits with the American Association of Colleges of Nursing Essentials for prelicensure nursing curricula. Research into newer therapies (pharmacological and nonpharmacological) to reduce chronic stress responses and bolster resilience in children and families is needed.

Providing trauma-informed care is essential for nurses interacting with diverse populations in a chaotic world. Advocates for universal trauma precautions view trauma-informed care as fundamental to caring for all patients, similar to universal body fluid precautions.[11] Instituting the 4 *R*'s of trauma-informed care—realize, recognize, respond, and resist retraumatization—with every patient supports the patient- and family-centered care that is a hallmark of pediatric nursing.[1,11] CCN

Financial Disclosures
None reported.

See also

To learn more about pediatric care in the critical care setting, read "Improving Collaborative Decision-making in the Pediatric Setting" by Small in *AACN Advanced Critical Care,* 2019;30(2):189-192. https://doi.org/10.4037/aacnacc2019934. Available at **www.aacnacconline.org.**

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