

Helping Children Recover from Traumatic Medical Experiences

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Illness, injury, and medical procedures can be distressing and overwhelming. They pose a particular challenge for children who are too young to understand what is happening, who have limited ability to express their concerns, and who are not capable of participating in decision-making about their care. Medical experiences can be traumatizing and may interfere with a child's normal social, emotional, and cognitive development. Clinicians who recognize the signs and symptoms associated with medical trauma can help children recover from its potentially debilitating effects.

What is trauma?

“Trauma” refers to overwhelming experiences that undermine a person's sense of safety and wellbeing and leave the victim with distorted, negative beliefs about self and the world. Trauma can result from exposure to clearly tragic events, such as violent crimes or natural disasters. Trauma may also arise from more minor events, such as criticism by a teacher, bullying by peers, or the birth of a sibling. Both catastrophic and minor trauma can result in a feelings of helplessness or powerlessness, distorted beliefs about self, and loss of trust.

Some children and adults who experience potentially traumatizing events do not develop posttraumatic stress disorder. The risk of developing posttraumatic symptoms following exposure to a traumatic experience varies, generally depending on characteristics of the child, characteristics of the event, and characteristics of the family and social system. (Webb, 2007)

What is medical trauma?

In this chapter, the term “medical trauma” refers to any overwhelming experience that is related to illness, injury, or medical treatment. Medical experiences inherently have the potential for being traumatic. The experiences of illness, pain, loss of control, violation of integrity through intrusive medical procedures, separation from parents and other family members, and parental distress are difficult for children. In combination, these experiences can overwhelm a child and result in feelings of helplessness and loss of trust in self and others.

Trauma sometimes cannot be prevented. Even lifesaving medical interventions, provided competently and tenderly by excellent professionals, can be traumatizing.

For children, traumatic medical memories may forge behavioral and personality problems that interfere with normal development and with the formation of healthy relationships. Distressing memories of medical experiences

may prevent an individual from seeking or receiving necessary medical care as an adult.

This chapter discusses factors that can make a medical experience traumatic for a child, posttraumatic symptoms that can arise from medical trauma, how the symptoms can interfere with normal child development, what the clinician needs to know in order to help the traumatized child, and the role of a behavioral pediatrician in the treatment of medical trauma. The chapter includes a case example of a boy who became fearful of going to the hospital after a medical procedure.

Similarities of medical trauma to other trauma

Medical trauma has many similarities to other kinds of trauma. Typically, children who have been traumatized tend to have distorted, negative beliefs about themselves like, “I’m bad,” “Whatever happened is my fault,” “I’m not loveable,” “I’m not important,” “I don’t deserve good things,” “I can’t tolerate it if things don’t go the way I want,” “I can’t tolerate anything going wrong,” or “I am in danger if I’m not in control.” Children may develop behaviors of protest and avoidance that indicate their belief that anything that reminds them of the traumatic event, even medical care, is dangerous. Negative and distorted thoughts can circulate repeatedly, distracting children from their important tasks of learning, playing, and relating to others.

Posttraumatic symptoms may occur immediately after medical trauma or may be delayed for a year or more. Sometimes symptoms do not arise until the child encounters a subsequent illness, injury, or medical encounter. Delayed symptoms can be confusing, especially if symptoms like separation anxiety, school refusal, or anxiety about sleep do not immediately suggest medical trauma. Sometimes it is not obvious that trauma is involved. A history of previous medical intervention or injury should raise suspicions of medical trauma.

Factors that can make a medical experience traumatic for a child:

Helplessness and vulnerability

A child undergoing any type of medical procedure has very little, if any, say about what is being done to him or her. In addition, physical restraint by adults or a restraining “papoose” are often used to hold a child still during a medical procedure, rendering the child physically powerless. This sense of helplessness contributes to the development of medical trauma. A perceived threat to physical well-being, caused by illness, injury, or medical intervention can be traumatic.

Having experienced a loss of control and actual helplessness in a previous medical situation, a traumatized child may regard himself or herself as ineffectual or incapable in other areas of his or her life. Children who develop a

sense of helplessness and vulnerability following trauma may be fearful and reluctant to engage in developmentally appropriate activities. Presuming ineffectiveness, they may adopt a “why try?” attitude that makes them reluctant to experiment or learn. They may shun independent activities and need help with routine self-care activities that they had previously mastered. They may develop fears and separation anxiety that interfere with normal sleep, school activities, or relationships with peers.

Discomfort and pain

Physical discomfort and pain that accompany illness or injury, as well as under-medication for medical procedures, may be traumatizing. Occasionally anesthesia wears off during surgery, and the resulting posttraumatic symptoms may include nightmares or fear of lights.

Hospitalized infants and children are subjected to many painful procedures. They are routinely poked with a needle for drawing blood and for insertion of intravenous lines for delivering fluids or medication. Because young patients' veins are so tiny, it can take several pokes to successfully insert a needle. Critically ill infants may be subjected to repeated heel sticks, nasogastric tube insertion, central line insertion, suctioning, enemas, and endotracheal intubation, and other invasive procedures. Some infants in neonatal intensive

care units are subjected to more than 50 procedures per day. (McClain & Kain, 2005)

Medical procedures children experience are often more painful than those performed on their adult counterparts. Until recently, even surgery on neonates was performed with paralytics, but with minimal or no analgesia. It was believed that infants did not really feel pain, and even if they did feel pain, they would not remember it. We now know that this is not so. (McClain&Kain, 2005;AAP,2006)

Today we know that the neurotransmitters and structures required for pain sensation as well as structures needed for long-term memory are developed adequately in the neonate and have the potential to affect long-term outcomes. Studies indicate that poorly controlled acute pain may lead to heightened pain sensitivity or hyperalgesia, altered pain perception, and possibly a predilection to chronic pain states. Surgical procedures without pain relief are certainly traumatic – and the memory of pain is stored in the body long after the healing of physical wounds is complete. (McClain & Kain, 2005)

Doctors now realize that lifesaving care in the NICU (neonatal intensive care unit) is intrusive and painful and from the infant's perspective, the pain of lifesaving care is indistinguishable from the pain of abuse. (Gardener, Barland,Merenstein, & Lubchenco,1993.)

Confusion

Another factor central to medical trauma is the confusion related to experiences of medical intervention. In part, this confusion arises from children's developmental limitations. Young children are developmentally unable to comprehend that a painful or frightening medical procedure can be helpful. Children may not be able to articulate their distress and confusion, but we can imagine that they might wonder: "Why would someone hurt me when I am already in pain?" "How can something help if it hurts?" "Who is doing this to me and why?" "What did I do to cause this?" Also, illness or injury that are sudden, unexpected, and hard to understand are inherently confusing.

Another source of confusion is the effect of narcotic pain medications and pre-medication for surgery. Children sometimes experience confusion as well as nausea or dizziness as they emerge from general anesthetic following surgery. It is useful for children to be told that the medicine is making them feel weird and/or nauseated, that this is expected, and that they will feel normal again soon.

According to a study conducted at Great Ormand Street Children's Hospital in London, about one third of children who have been treated in the Pediatric Intensive Care Unit (PICU) have delusional memories or hallucinations. The timing of the hallucinations appeared to coincide with the period during which they were being weaned off the sedatives commonly prescribed on PICU (benzodiazepines and opiates) and children were five times as likely to report having had delusions or hallucinations if they had been prescribed opiates and benzodiazepines for more than two days. These children who reported delusions and hallucinations had a significantly higher score on the post-traumatic stress

screening test than others. (American Thoracic Society, 2008)

Confusion, like pain, becomes a visceral memory. The common practice of under-medicating pediatric pain contributes to the confusion and trauma of medical interventions.

Confusion can interfere with attachment and trust. When parents are absent during medical procedures, the child is more likely to be frightened and may feel abandoned. Parents are encouraged to be with their children and hold them and comfort them during painful medical procedures. While this practice is usually reassuring to the child, it can also be confusing for children because their parents acquiesce to painful procedures.

Special Considerations

Parental distress

Parents' reaction to a child's illness, injury, or medical condition is always important. Parents whose child is ill or injured are sometimes in a state of shock and may themselves develop posttraumatic symptoms. Parents usually believe that they are responsible for protecting their child and keeping him or her safe. When their child is born with a congenital defect or becomes seriously ill or injured, it is not unusual for parents feel guilty or inadequate in caring for their

child. These feelings may interfere with a parent's ability to bond to their child. Some parents of ill, injured, or disabled children may become resentful or depressed when the child's problems interfere with family functioning, deplete finances, or interrupt work schedules. The parents may not be able to provide the care and support their child needs.

Parents whose child has been ill, injured, or has experienced medical trauma may be reluctant to trust that their compromised child will ever be healthy and resilient. This lack of confidence in the child's potential for recovery can be transmitted to the child, further diminishing his or her self-confidence.

Children turn to their parents or caregivers for reassurance and emotional connection. However, it can be difficult for distressed parents to provide effective reassurance. Children often internalize their parents' distress. Seeing parents act frightened, extremely sad, or concerned can cause the child to assume he or she caused the upset and that he or she is in danger. Furthermore, when parents' reassurances don't match with their distressed demeanor, children don't know how to gauge their own emotional response.

The clinician must decide whether the child's recovery will help resolve the parent's trauma or whether the parents need therapy first so that they can be emotionally available and supportive to their child. A referral for support of parents may be more effective than direct services to the child. This referral should be made tactfully so as not to increase the parent's sense of inadequacy or guilt.

Parents' individual therapy can help them gain skills or develop useful beliefs such as "I can cope with my child's medical problems, be his advocate and give him love and emotional support," "I am a good parent, even though my child has these problems." "I can trust my child can heal from this," "I can talk with doctors to advocate for my child."

Complicating Factors

Many factors can complicate the healing process. Multiple events, illness, injury or death of other family members, ongoing uncertainty or disability, unavailability of parents, and family financial problems are all major stresses. The medical social worker or childlife practitioner may need to work with a team of professionals and may need to reassure the child that other caring adults are taking care of their parents. It should not be the responsibility of an injured or ill child to take care of his parents or their feelings. As described in Chapter 1, the clinician may work together with other professionals to serve and support the child and family to strengthen their personal resources for coping with ongoing stress.

Uncertainty of outcome

Sometimes a child's diagnosis and prognosis are unknown or the diagnosed condition will require undetermined or distressing interventions. Medical trauma

may become complex and multifaceted. It is valuable for the child and family to learn stress-reduction strategies and to have on-going support as they face upcoming challenges.

Literal interpretation of language

Traumatized children tend to interpret language very literally. In cases of medical trauma, the words “bad” and “hurt” may be particularly significant.

Traumatized children can confuse feeling “bad” (from physical pain or emotional distress) with being bad (in the sense of being a bad person). They may even believe that illness and painful procedures are punishments for something they have done wrong.

The word “hurt” in the English language can be problematic. “Hurt” can be used as a noun, an adjective, an active verb or a passive verb. “I hurt myself” has a different meaning from “I got hurt.” “I hurt myself” implies purposeful self-injury, whereas “I got hurt” implies accidental harm. A traumatized child may feel confused and uncertain about whether he is responsible for his situation, whether it is accidental, or whether someone else is to blame. Often, at the time of an accident or injury, someone may say, “Oh, you hurt yourself.” In a posttraumatic state, a person may interpret this statement as meaning that he literally actively did something to injure himself.

How can posttraumatic symptoms from medical trauma interfere with normal child development?

Anxiety

Anxiety may manifest as avoidance of medical visits, doctors, medical treatment, or any other experience reminding the child of the traumatic medical experiences. Fear may also appear in the form of separation anxiety, insomnia and nightmares, The hypervigilance resulting from anxiety can interfere with concentration and the ability to stay on task, making it difficult for a child to do well in school. Sometimes even relaxation can trigger anxiety, if the relaxation reminds the child of being anesthetized or if the child perceives relaxation as a precursor to pain.

Confusion may be a trigger for anxiety. Since confusion is a necessary part of learning, the child who has been traumatized may have trouble performing in school or trying new and unfamiliar activities. Academic subjects, like math, are intrinsically confusing, until they have been practiced and understood. Adding anxiety to the confusion may hinder the process of learning.

Unexpected, sudden, or new experiences may trigger anxiety in a child who has experienced sudden illness or injury or who has had frightening medical procedures without preparation. This fear of new experiences can prevent a child from trying new things.

Children who have experienced pain may be afraid of touch, even if it is gentle and loving. This avoidance of touch is called “sensory aversion”. Children who have had oral surgery or procedures like intubation or nasogastric tube insertion may be diagnosed with “oral sensory aversion”. These symptoms may be regarded as developmental or neurological or a sign of a sensory processing disorder, although the symptoms are actually posttraumatic responses. Some children who have experienced severe oral trauma may even refuse to eat and require a gastrostomy tube for years.

Children who have experienced medical trauma may have anxiety triggered by bright lights, mechanical noises, having clothes pulled over their head, medicinal smells or flavors or anything else that reminds them of their traumatic experience. Once aware of the effects of trauma, it is usually not difficult to trace the root of the symptom to the medical experience that provoked it.

Sleep disturbances and nightmares

Children who have been traumatized may have difficulty falling asleep, staying asleep, and sleeping soundly. They often have nightmares or night terrors. The children and their families may become sleep-deprived, further compromising their ability to function during the day

Dissociation

Children who have been severely traumatized may dissociate when they feel physically or emotionally unsafe. Dissociation during a painful medical procedure is adaptive and helpful. Dissociation is a type of psychic hiding, in which being conscious and aware is too painful to bear. The child may appear dazed or blank or display inappropriate affect. A child who continues to experience dissociation long after painful medical experiences is unavailable for relationships, play, or learning.

Attachment/trust issues

A secure base of attachment is the foundation of a child's emotional well-being. Medical trauma can interfere with a child's relationship with parents, and other family members, as well as with medical personnel. Disturbed attachment can undermine the sense of physical and emotional confidence that is so important in meeting new developmental milestones.

Developmental considerations

Developmental regression can be a sign of trauma. Children who may have mastered falling asleep independently may be unable to sleep without a parent present. Children who have been toilet trained may begin bedwetting or daytime wetting. Those who have become somewhat independent and able to

dress and feed themselves may begin to feel unable to do these tasks. A child who normally speaks fluently may revert to baby-talk. These symptoms may occur transiently with any stress, but are cause for attention if the symptoms persist and interfere with normal development.

Extreme behavior

Children tend to respond to stress by increasing the frequency and intensity of their coping strategies. A young child who has tantrums to express anger when he doesn't get what he wants or when he perceives something as unfair may develop more frequent and more intense tantrums, even if the triggering event is minor. When parents ask friends or their doctor about the symptoms, they may get reassurance that the child's behavior is developmentally appropriate. Young children may have temper tantrums, difficulty sleeping, or toileting inconsistency. An individual child's intensity and frequency of response to minor provocation helps distinguish a normal behavior from a posttraumatic stress response.

Children who have been traumatized can become rigid about schedules and become extremely upset when something unexpected happens. They may not be able to tolerate a change of plans or something not going their way. They can be reluctant to try anything new. Traumatized children can be obsessed with fairness and become very upset when they lose a game or perceive injustice of any kind. They can become excessively controlling. They can have emotional

outbursts over minor incidents. These extreme behaviors can interfere with family and peer relationships and other social interactions.

Changes in play

Traumatized children often re-enact their trauma through play. Posttraumatic play is repetitive, without resolution. (Terr,1983) Children who lose their ability for creative play do not have full access to their problem-solving capability. This loss of flexibility can make it difficult for the child to get along in social situations.

Somatic symptoms

Children who have experienced medical trauma may later develop headaches, stomachaches, and anxiety, sometimes with a racing heart, a lump in the throat, or difficulty breathing. These somatic symptoms may lead the child to the doctor's office – necessitating more diagnostic procedures.

A careful history, physical exam and lab work may be needed to evaluate somatic symptoms. A stomachache can be an indication of stress, constipation, a reaction to a medication, or something more serious. Somatic symptoms that are ongoing, such as stomachaches associated with irritable bowel syndrome or acid reflux may require both medical and psychological intervention. It is important to plan an intervention that will address both medical

and psychological conditions, as they can create an undesirable feedback loop. For example, abdominal pain can cause anxiety in a traumatized child, which then further exacerbates the abdominal pain.

What does the clinician need to know in order to help a traumatized child?

1. Details of the traumatic event

A clinician who works to help children overcome traumatic memories of medical problems must be prepared to offer developmentally appropriate explanations for medical experiences. Familiarity with issues pertaining to medical trauma helps the clinician provide effective therapy for children. This knowledge allows the clinician to teach the child how the interventions are meant to help.

Early childhood trauma is stored “frame by frame”, or as a series of events. Knowing the sequence of upsetting events in detail allows the clinician to address the many fragments of the child’s memories, whenever the child is ready to revisit these.

2. Information about the child’s medical situation

The clinician must know about the child's medical diagnoses, past and anticipated medical course, effects and side-effects of medications, procedures, and prognosis.

3. Posttraumatic symptoms

The clinician must be familiar with the child's behaviors, his or her somatic or physical symptoms, and medical history in order to understand the cause of the trauma and to outline treatment goals.

4. Developmental considerations

The clinician needs to be aware of the behavior range that is normal for a child of this age, the child's cognitive level and understanding of the situation, the developmental milestones the child has already achieved, and any regressive behaviors exhibited by the child.

5. Parental and family functioning

The clinician must evaluate the family situation, determine if anyone else in the family needs help, and organize appropriate support, while helping the child recover from medical trauma.

The Role of a Behavioral Pediatrician

When a child has persistent anxieties or puzzling behaviors that interfere with normal social development and family functioning, it is appropriate to consider an evaluation by a professional who has experience helping stressed, anxious, or traumatized children. The title of that professional may vary and can include behavioral pediatricians, psychiatrists, psychologists, clinical social workers, and therapists who offer a variety of approaches for managing traumatic symptoms. Even within these categories, there is no single standard of evaluation or treatment.

Psychiatrists, behavioral and developmental pediatricians, and pediatricians are the only practitioners qualified to prescribe medication for children. They are also qualified to evaluate children to determine whether symptoms like irritability, fatigue, change in eating habits, or bed-wetting are due to organic problems or whether they have emotional roots.

As a behavioral pediatrician, I begin my evaluation by meeting with parents alone to take a careful medical and developmental history. I listen to their concerns and ask what they would like to have go easier or better for their child and their family. We outline treatment goals. At the next visit, I meet the parents with their child, I observe the child's way of relating to his or her parents, me, and the toys in my room. I begin to develop a relationship with the child and help him or her feel safe, comfortable, and appreciated in my office.

During the next visit, I meet the child alone or with one parent. I continue to assess the child's behavior and pay close attention to the child's themes of play, and work with the parent and child to identify a goal – such as being able to play at other children's houses or being able to have pleasant dreams – that the child may want.

I use a variety of modalities to address medical trauma. Depending on the situation, I may use Eye Movement Desensitization and Reprocessing (EMDR), play, artwork, games, puppetry, narrative, role-playing, as well as therapy involving parents.

Eye Movement Desensitization and Reprocessing (EMDR) is a method for treating trauma, stress, and anxiety. Desensitization refers to the process of taking the emotional charge off of a memory. Reprocessing refers to the process of changing a distorted, negative belief to a belief that is true and useful. For example, a child who has been hospitalized may feel very upset remembering being held down for a medical procedure. EMDR can help to turn the upsetting memory into a neutral one. The child may have come away from the medical experience believing that he/she is powerless, helpless, unable to tolerate not being the one in charge, and unable to trust doctors and nurses. EMDR can be helpful in restoring the child's sense of confidence and trust in professional help.

CASE EXAMPLE

Children's understanding of a medical situation changes with age and their level of maturity. The following case underscores the value of identifying the developmental concerns of the child at the time of a medically traumatic event. Seven-year-old Daniel was born with a congenital eye condition which required several eye examinations under general anesthesia . Daniel was four-years old when he had his last hospitalization, and he was very fearful of going to the hospital again. This case is presented here with the parents' written permission.

In this case, EMDR offered the unique opportunity to address the physical sensations associated with the uncomfortable and traumatic medical experience, as well as reducing or eliminating the distress triggered by reminders of the medical events. Play therapy allowed the possibility of working metaphorically with particularly sensitive and complex issues. EMDR integrated into play and story-telling facilitated the progression from negative, distorted self-assessments, to positive, dynamic beliefs that are essential for a child's growth and development. Artwork and imaginative interweaves facilitated trauma resolution. EMDR, along with a reframing of the trauma by adults important to the child, contributed to a coherent, cohesive story that helped the child integrate his experience into his life story.

Therapeutic decisions

I viewed the memory of Daniel's hospitalization at age 4 as a "critical incident trauma". It was complicated by the fact that both Daniel and his parents

were apprehensive about what the ophthalmologist might find when he examined Daniel's eye.

Initially, it was not clear exactly what was most upsetting about the event – the separation from his parents when he was wheeled into the operating room, the smell of the anesthesia, nausea from anesthesia or something else. In working with Daniel, I wanted to be sure to empower him with information and choices. Traumatic memories feel as if they are current and present. One goal of our work was to help Daniel regard the past experience as over.

I involved Daniel's parents in helping him regain his sense of confidence. Parents who are present during therapy with their child usually feel that they, too, have benefited. I asked one of Daniel's parents to sit beside him and the other to read Daniel's story of what happened when he went to the hospital. I began EMDR to take the upsetting charge off of the memory and to provide the information Daniel needed to develop a positive view of himself and his hospital experience.

While Daniel was recalling the memory of seeing the operating room, I asked him about that experience, "Now you know it was just an eye appointment, but what did you think when you were 4 years old?" Daniel responded, "***I thought I was going somewhere. Like to a haunted house or something.***" Now I knew one source of confusion and anxiety for Daniel. It makes sense that a four-year-old would think that a hospital is a haunted house. The hospital is a strange place with lots of lights where the people are "covered in white and wear masks" and where medicine tastes bad and makes you feel "sad and confused".

Next, I asked Daniel to remember how the medicine tasted. He agreed to draw a picture of the medicine. Daniel's picture was a glass with green scribbling in it. "Yuck", Daniel exclaimed as he remembered the taste. I asked, "If you could use your imagination to make it taste really yummy what kind of taste would cover up the yucky taste?" Daniel replied, "Candy canes." I asked, "OK - can you imagine taking that medicine and turning it into candy canes? ...You have such a good imagination... Is it peppermint flavor? Would you draw a picture to show me?"

Daniel smiled as he drew a picture of a candy cane.

Follow-up

Daniel came back with his parents for a final visit after having the eye exam under general anesthesia. He had handled the hospital visit and medical procedure well. His father asked him, "How did the medicine taste this time?" Daniel calmly replied "Bitter". After EMDR, Daniel was able to be matter-of-fact about his experience.

Comments

Daniel was seven-years-old when he came for treatment of anxiety stemming from a medical experience, and four-years-old when he had the traumatic experience at the hospital. The memory of his traumatic experience as a four-

year-old was “stuck’ in his body as confusion from the anesthesia and from lack of understanding. His four-year-old self thought that the hospital was a haunted house. By understanding the confusing aspects of his experience in a new way and reframing the meaning, and by processing the stuck physical sensations, he was able to resolve the trauma.

The therapy included storytelling, EMDR with cognitive interweaves or educational interweaves, imaginative interweaves, artwork, and parental involvement. All therapy was focused on helping the child believe the positive cognitions, “I’m safe now.” These changes from fear to calm and from passive voice to active indicate that Daniel overcame his trauma.

Summary

Children who have experienced medical trauma may present with fear of anticipated medical procedures, like Daniel. They may present with unusual symptoms following a hospitalization. They may have generalized anxiety. The reason for a child’s posttraumatic symptoms may be obscure, but a history of medical problems is notable.

Medical trauma is complex, and always consists of a series of events. Medical interventions usually involve physical pain or discomfort (from the illness, injury, and/or intervention), as well as feelings of helplessness, fear, uncertainty, confusion, shame, and guilt. Medical trauma affects parents and other family

members. It is important for the therapist to recognize and consider the needs of the whole family system.

Treatment of medical trauma may include the standard EMDR protocol for an older child or teen, but young children do not form a single consolidated memory of medical trauma. Children who experienced preverbal trauma usually do not have conscious memory of the traumatic events. The clinician can work by installing positive cognitions and desensitizing layers of trauma as they emerge.

The clinician who works with children must be versatile! A hallmark symptom of Posttraumatic Stress Disorder is avoidance of traumatic reminders, and children may be unable or unwilling to focus on memories of their traumatic experiences. In order to meet the special needs of children who suffer from medical trauma, the clinician must be familiar with the details of the child's illness or injury, the sequence of events, the medical procedures the child has experienced and anticipates, the prognosis, as well as the effects and side-effects of medications. The therapist must be able to integrate EMDR with play, sandtray and/or storytelling to highlight strengths, to offer educational interweaves, and to desensitize and reprocess distressing memories.

Narrative - storytelling - is a useful way to help a child understand the series of events that happened to him. A story can be constructed following the principles of EMDR: begin with a safe place, detail the upsetting targets to desensitize and reprocess, provide trauma re-framing and resolution, and end the story with positive cognitions. I find that engaging a parent in the child's treatment, calling on the parent to assist the therapist in writing a healing

narrative for their child, and teaching the parents skills for helping their child cope and be comforted in times of distress may all obviate the need for parental psychotherapy.

Resolution of trauma will help the child be more flexible in a variety of situations, more able to comfort himself or herself and be more emotionally stable even in stressful situations. The child will become more compassionate toward himself and others. He will become appropriately trusting. He will be free to develop and explore and learn and play and love.

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