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Pediatric Psychology in Emergency Services: a Clinical Practice to Follow in Hospital Context

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Abstract

Since the beginning of 2016, the team of the Emergency Service (SU) of the Pediatric Department of the Hospital de Santa Maria, Centro Hospitalar Universitário Lisboa Norte (HSM-CHULN), counts with another valence in its intervention plan. Traditionally specialized in an approach of organic pathology, the service is now composed of a specialized intervention of Pediatric Psychology. This paper has the purpose of review, deepen and disclose (i) the psychological intervention model that is used in the SU, focused on babies, children and adolescents, as well as on direct/indirect support to families, at a Physical and Mental Health levels, (ii) the developed work in stress management of the emergency team and (iii) the performance of psychologists in the emergency context, as a way to update the intervention protocols within this practice according to international guidelines. The intervention carried in this SU, in situations of emergency, urgency or crisis, resort from strategies that mitigate and treat the intense cognitive, behavioral and emotional malaise of the pediatric patient and families/caregivers, in a interprofessional perspective and always as a *first line resource*. Given the increase and clinical relevance of the psychological variables, the inclusion of this specialized area presents itself as a sustainable and important intervention for a practice that we wish to be implemented transversally, contributing to the reduction of outpatient visits, therapeutic prescriptions, number of consultations and frequency of hospitalizations. A pre- and postgraduate training that privilege this type of knowledge and enables the implementation of these intervention models in a larger number of institutions presents itself as a sustained practice of health services.

Keywords: Pediatric psychology, Health psychology, Emergency service, Crisis intervention.

Introduction

The Emergency Service (SU) of the Pediatric Department of the HSM-CHULN counts, since 2016, with the specialized intervention of pediatric psychology as a formally implanted valence; this formal status recognizes the fact that psychology has been present in this department for the last three decades and in the SU, although with an indefinite representation of its status that emerges as a gap in the provision of healthcare and good practices.

Its implementation relates with a growing recognition of the clinical relevance of psychological factors in pediatric emergencies. This is an increasing reality in medical practice, in alternative to the exclusive approach of the organic pathology (American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, American College of Emergency Physicians & Pediatric Emergency Medicine Committee, 2006). Nevertheless, the inclusion of psychology in the SU is not yet transversally implemented (Kwok, Tori & Rainer, 2013), although it reveals a contribution to the

reduction of outpatient visits in the SU, therapeutic prescriptions, number of consultations and frequency of hospitalizations (Carlson & Bultz, 2003; Sobel, 2000).

Pediatric psychology has been progressively occupying a place in several health services, given the real necessities of the pediatric intervention concerning interpersonal and emotional aspects of health/illness in children, adolescents and with families in hospital contexts (Rozensky & Janicke, 2012; Roberts, Canter & Odar, 2012; cited by Roberts & Steele, 2017). And, as Barros referred, the specificity and working methods of this area is required at a national level (Barros, 2003; Menezes, Moré & Barros, 2008).

At emergency services, the provision of care through pediatric psychology assessment, diagnosis and intervention benefits from the use of specific strategies that mitigate and treat the intense cognitive, behavioral and emotional malaise, such as (i) intervening in situations of emergency, urgency and crisis, identifying the problems that benefit from a psychological intervention (American Academy of Pediatrics et al., 2006) and following fixed protocols in specific conditions, such as anxiety disorders with or without panic episodes and/or psychosomatic disorders (Minen, Tanev & Friedman, 2014), and (ii) in the observation service, intervening in short-term hospitalization, in situations of psychological adaptation to physical illness condition and in the preparation for hospitalization.

An updated research literature supports the perspective that the integration of pediatric psychology in the SU (Buckloh & Greco, 2009; Chow, Lieshout, Schmidt, Dobson, & Bucley, 2016; Dias-Ferreira, 2016) is an innovative practice, taking action with (i) children/adolescents with behavior and emotional disorders (e.g., anxiety disorders, psychosomatics disorders, among others), (ii) the assessment and screening of self-injurious behaviors situations, (iii) psychological care to traumatic events victims and witnesses, (iv) inpatient preparation for complex clinical cases, (v) study/comprehension of the emergency service constant utilisation related factors and (vi) intervention with the health professional team, ensuring their psychological well-being, promoting group cohesion, and maximising the efficiency and efficacy of the healthcare provided.

Over the years, some hospital centers, at a national or international level, have made a very significant contribution in establishing good practices and integrating psychologists in emergency contexts, in emergency teams, and in crisis situations.

At a national level, there is already a reference for these specialized practices at hospitals from Guarda, Torres Vedras, Algarve and Cascais (Serviço Nacional de Saúde, s.d.; Hospital de Sousa Martins, Unidade Local de Saúde da Guarda, 2016; Centro Hospitalar Oeste, 2018). Worldwide, this practice is better established and presents itself as a robust practice, having been cultivated already for decades in countries such as Madrid (Tabuenca, 2010), Chile, Belgium (Bervoets, Goderis, Demunter & Fruyt, 2017), California, Brazil, Israel (Kwok et al., 2013; Baládron, 2015; Almondes, Sales & Meira, 2016; Bervoets et al., 2017; Lubetzky, 2017) or Russia (Shoygu, 2014). Nonetheless, it is still a practice that lacks established guidelines and regulation.

Psychology Intervention and Practice Model in Hospital Emergency Services

At a national (Portuguese) level, due to the lack of a consensual practice and guidelines for psychological intervention models at hospital emergency services, the following model is proposed, anchored in empirical and theoretical evidence (see *Figure 1*).

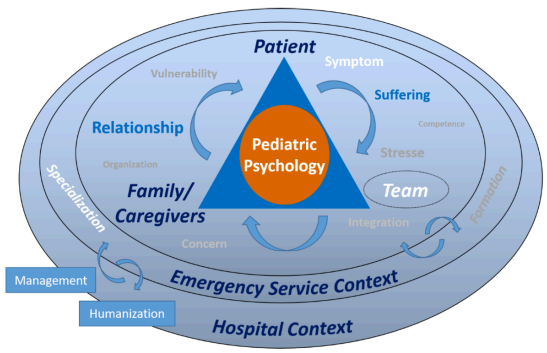

Figure 1. Psychology Intervention and Practice Model in the Emergency Service (adapted from Dias-Ferreira, 2016)

This model of intervention aims for an integrated care, provided by interprofessional teams, facing the patient in its multiple dimensions of existence. It is imperative to treat not only the disease but, *above all* and more than anything else, to treat *the baby, the child, and the adolescent who is ill*, in other words, considering the treatment of the patient as he presents himself: as a *whole*, cohesive and coherent.

The psychological intervention in the SU develops its own work at two levels of action: at a micro and individual level, with the patient, the family and with the team (Vieira, 2010); at a macro level, interacting with the emergency department itself, preserving the institutional regulations of the Hospital Center and merging with the community (McGrady & Hommel, 2015).

The *Patient-Family-Team* triad strives for the integration of all of the involved, from the process of acceptance/confrontation of the illness and its amelioration, as well as to the stress management, bounded in a coherent and integrated treatment.

The Patient: the baby, the child and the adolescent in the SU

Emergency situations are associated with particular situations of vulnerability, namely because the patient is abruptly withdrawn from his/her daily routine by an unusual malaise or unexpected accident, experiencing a situation of psycho-emotional helplessness, often disruptive and evocative of distress of several natures (constitutive or acquired) (Barbosa, 2007).

The patient needs to be contemplated as a *whole*; the team acts not only targeting the treatment of physical damage, but also in the repair of latent or adjacent emotional damages (Sterian, 2001), becoming relevant in this emergency context a careful psychological assessment of the patients, for signaling and referral of cases of marked or latent psychopathology, or of cases requiring further psychological follow-up (Kwok et al., 2013).

It is at this moment of anxiety and anguish that the psychologist intervenes, by containing and understanding the affective experience of suffering, aiming to its transformation. Resorting of a clinical listening of the patient's history and by the specific intervention aiming at his/her present suffering, the psychologist discriminates the physical emergency from the subjective experience and seeks to rescue the *subject* (Silva, 2014) from the symptom (Hatala, 2012).

The Family of the patient in the SU

Upon the arrival at the SU, the pediatric patient is, usually, not alone; does not come alone. Behind the baby, child or adolescent exists a family that also gets ill. The family is also implied by the emergency and suffers from the trauma; they can demonstrate, in severity situations, a variety of emotional responses such as concern, vulnerability, generalized anxiety, hopelessness, traumatic anguish, and all these require and benefit from psychological assistance.

In these cases, given the family (dis)organization and dysfunction, the psychological intervention endorses all of the involved, fomenting an adequate communication and a relationship that propitiates the treatment itself as well as the rebalance of the family structure (Kwok et al., 2013), involving a contention of their anxieties with a solid, real and affective presence.

Therefore, with an adequate intervention, the family can contribute to the enhancement of the therapeutic resources and to the healing context, and must be understood as an integrated and important part of the hospitalization process. Accordingly, if traditionally the family stood at the SU "entry" (i.e., waiting room), we now have an opening and inviting space, due to the pretension of having a treatment that is global and integrative.

The Team of the SU

The psychologist must be alert to this vertex of the *Patient-Family-Team* triad, i.e., to the psychological health of the team, given their exposure to high levels

of anxiety and acute stress situations. All personnel, technicians, and professionals are inevitably *affected* by important affective discharges (many times without space or time to be elaborated).

A main role of the psychologist is the translation of the psychological meaning of patient´s experiences; to promote the individual's comprehension of emotionally complex situations; and, in certain cases, the mediation between professionals and patient/family. This last intermediation aims to ensure the share of a mutual language, necessary for a constructive joint interaction, with a purpose of minimize the mismatches and safeguard the expression of the desires and needs of the patient (American Academy of Pediatrics et al., 2006).

Thereby, the integration of psychology as a *first line resource* at hospital emergency services contexts contributes to health professionals' team cohesion, to the maximization of the management and to cost-effectiveness and, simultaneously, to humanization of healthcare (The Centre for Economics Performance's Mental Health Policy Group, 2006).

The empirical and theoretical proof of this model is based mostly on the real necessity of having pediatric psychology as a formal specialization, detaining both competence in emergency and unforeseeable circumstances attended in crisis context (Lorente, 2005).

Such competence can be affirmed as a specific post-graduate formation area, with awareness/practice secure from health educational institutions, in order to pro-actively identify and intervene in potential problems of development and behavior, and taking its action at hospitalization, outpatient, emergency and rehabilitation services levels (Fonseca, 1998; cited by Roberts & Steele, 2009); all this keeping in mind a complementarity approach to the health service.

The work at SU requires important adjustment and flexibility competencies, as well as integration skills of interprofessional teams, coordination with the follow-up contacts, at ambulatory consultations.

Conclusions

Current guidelines for the intervention in health services establish the development of a psychological act, as well as the evaluation and monitoring of the intervention itself, in order to meet an (i) increasing profitability and refinement of human resources, and (ii) unification of the employed proceedings.

As mentioned, psychological interventions reveal their effectiveness not only due to the improvement of the outcomes regarding health care (e.g., the reduction of outpatient visits, therapeutic prescriptions, number of consultations, frequency of hospitalizations and prevention in relapses and re-incidents situations), but also by expressing a potential cost reduction of healthcare services (Canadian Psychological Association, 2002; cited by Ordem dos Psicólogos Portugueses, 2011).

The state-of-the-art of psychological science expresses its presence in the elaboration process of guidelines and published procedures to several backgrounds and fields (namely in the Pediatric Department of the HSM-CHULN), from promotion of health behaviors to interventions and treatment of illnesses targeting improvement of physical and psychological well-being. This role of psychologists can happen in different areas, such as (among other): (i) action in acute and/or chronic pain, (ii) organ transplantation, (iii) chronic illness, (vi) long-term/palliatives care, (v) nursing practices, (vi) cardiology acts, (vii) neurosurgery, (viii) surgical preparation, (ix) eating behaviors, (x) elimination disorder, (xi) pediatric obesity, (xii) pediatric neurology (e.g., epilepsy), (xiii) mental illness (e.g., schizophrenia), (xiv) anxiety disorder, (xv) suicide, (xvi) attention deficit hyperactivity disorder (ADHD), (xvii) neurodevelopment, (xviii) sleep disorders, (xix) forensic practices, and (xx) work/connection with families/caregivers.

The intervention/practice model in the SU, here proposed, is perceived as a decisive milestone of global healthcare in the development of *the baby, the child*

and the adolescent who attend to emergency services, as well as respective families/caregivers, and to the sustainability of emergency health services; efficacy and efficiency in the provided cares and the setting of guidelines within this practice need to be continuously evaluated.

This intervention underlies a large commitment from the psychology workforce, enhancing the necessity of creating a formal speciality of psychological intervention; indeed, Ricou, Cordeiro, Franco and Lobo (2018) recognised that the development of psychology demands the establishment of guidelines and outlines.
According to what has been envisioned by Ungar and Denbrug (2018), it becomes crucial the assessment of interventions and resources used in health services pointing towards a working structure incorporated on economic, cost-effectiveness, safety, legal, environmental, social and ethical levels; the pediatric psychologist is an essential element in the healthcare decision-making and acting processes, specifically in the emergency service.

Due to the nature of the pediatric psychologists' intervention, this assumes itself as one of the humanization guarantees of healthcare provided at the SU, where the patient is approached in the multiple dimensions of *his/her existence* and in the whole process of their treatment: in the repair of their physical, emotional and relation injuries. Therefore, it becomes fundamental that every patient who enters the pediatric emergency service by the *front door* is received and treated as *the whole* that he or she is.

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