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Reviewing the Evidence and Frameworks of Trauma-Informed Practice in Pediatric Critical Care

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Abstract

PICUs function as lifesaving facilities for children under intensive care but the very stressful atmosphere combined with invasive medical operations and extended hospital stays often creates psychological trauma for patients alongside their families. The emerging healthcare frameworkTrauma-informed care (TIC) focuses on identifying trauma while aiming to prevent it and take actions against it throughout medical settings. This study analyzes TIC practices for pediatric intensive care by evaluating recent research about integration methods along with the barriers and patient results from its utilization. This paper investigates four main concepts in TIC which include psychological safety along with family-centered care and staff training and policy development recommendations. Research has shown that some parts of TIC can be found within PICU clinical practice but full systemwide integration of TIC has not been achieved yet. Additional investigation must focus on creating standardized procedures while evaluating how TIC benefits pediatric recovery together with the wellbeing of families over extended periods.

Keywords: ***The framework includes Pediatric intensive care, trauma-informed care, psychological safety, family-centered care, pediatric critical illness, stress reduction as well as patient-centered care.***

1.Introduction

1.1 Medical Traumatic Stress in Children After Pediatric Critical Care

The emergence of pediatric medical traumatic stress (PMTS) becomes a complex and significant issue between children and their families after spending time in critical hospital care for severe medical conditions or traumatic injuries. The PICUs in hospitals receive 300,000 children annually because of their life-threatening situations such as respiratory failure and neurological crises and cardiac arrest and septic conditions and traumas and other critical medical conditions. PICU admission causes distress to patients because they experience sudden transitions from regular health to life-threatening conditions of critical medical nature. The PICU admission of many children happens without warning which creates an unexpected and emotionally overwhelming situation. Patients experience an intense mood shift upon transitioning to critical care when they encounter unfamiliar spaces alongside invasive treatments alongside mechanical ventilation combined with intensive monitoring and numerous medical procedures which together generate overwhelming vulnerability and complete helplessness and deep fear. Intensive care admission leads children to experience acute psychological distress through stressful reactions as well as confusion and sensory disruptions because of their severe condition alongside necessary survival treatments. Children suffer extra stress alongside their parents who watch their child endure complex medical treatments through an unpredictable survival challenge(1).

Physical hospitalization of children in critical health condition produces psychological distress that continues after PICU care and results in enduring adverse effects for the child and their family caregivers. A rising number of studies demonstrate the occurrence of post-intensive care syndrome (PICS) in children and indicate its physical as well as cognitive emotional and social impairments resulting from critical illness. Patients with PICS develop serious psychological effects because these conditions include persistent post-traumatic stress symptoms (PTSS) in addition to anxiety and depression along with behavioral issues that remain after hospital discharge. The medical crisis along with hospitalization creates PMTS as a PICS subset where children with their families develop trauma-based emotional behavioral and physiological responses. The symptoms of PMTS express through multiple indicators such as distressing hospital flashbacks and intrusive thoughts with nightmares and emotional numbing which leads to medical facility avoidance and physiological response activation triggered by hospital-related events.

Multiple clinical causes affect the development and worsening of PMTS symptoms in children undergoing hospital care. Children face elevated PMTS risk when they need multiple invasive treatments coupled with long mechanical ventilation or need high amounts of benzodiazepines and opioids as sedative and analgesic medications. The susceptibility to PMTS rises when patients experience specific medical conditions including chronic illnesses together with severe physical trauma or neurological disorders. The psychological response to intensive care of children depends significantly on their medical variables but equally depends on their socioeconomic status and demographic characteristics. Children who come from disadvantaged financial groups together with those who had mental health issues before hospitalization and patients under care at rural or critical-access stations display inferior psychological results compared to other admitted patients.

Psychological recovery of children needs assessment for parental distress levels as this determines their healing process. Research shows that when parents develop post-traumatic stress symptoms (PTSS) after their child needs PICU care these symptoms strongly relate to negative mental conditions in children. Parental anxious behavior and depressive states or emotional distresses make it difficult for parents to offer essential emotional support to their child which leads to intensified trauma reactions in the child. The reciprocal effects between child distress and parental distress maintain an unending cycle that intensifies the child's PMTS(2). Parents who go through intense emotional turmoil face barriers when making medical decisions while their improved communication with healthcare staff suffers as well as their involvement in treating their child.

The hospital must adopt trauma-informed care (TIC) approaches in the PICU to reduce possible long-term psychological harm. Trauma-informed care represents a complete method of treatment which both establishes awareness of widespread trauma influences and identifies patient and family traumatic stress indicators to build protective care environments that promote healing. TIC becomes essential for improving the outcomes of critical pediatric care by adopting evidence-based screening and psychological support services along with family-centered approaches and multidisciplinary treatments. The inconsistent and limited implementation of TIC in PICUs shows an immediate requirement for standard trauma-informed practices, policy modifications and healthcare provider training as well as research initiatives into standardized trauma-informed care processes within pediatric intensive care units.

1.2 Pediatric Critical Care and Premorbid Trauma

Research about pediatric critical illness and intensive care hospital experiences among children and families has solid evidence but analyses of pre-existing trauma that influences PICU experiences remain under-studied. A child develops premorbid trauma through experiences of physical, emotional, sexual abuse as well as neglect, domestic violence, parent substance abuse, family mental health disorders and other major stressors before hospital admission occurs. Young patients experience adverse childhood events that strongly impact their ability to handle critical illness treatment and medical care within PICU facilities. Approximately sixty-five percent of children face one major adverse childhood event (ACE) throughout their lives hence the knowledge of pediatric critical care interaction with preexisting trauma needs urgent examination.

The presence of past trauma in PICU patients typically produces elevated medical stress susceptibility along with biochemical and emotional reactions that affect their reaction to care treatment methods and the duration of their recovery period. Research demonstrates that children who experienced adverse childhood events (ACEs) show higher probabilities of displaying impaired stress responses which manifest through increased bodily activation and emotional outbursts as well as withdrawal and dissociative symptoms when they face stressful medical challenges. Previous exposure to distressful events will sensitize the child's nervous system to increase their sensitivity to intense fear and anxiety when they face new traumatic medical experiences such as ventilation, painful procedures and caregiver separation during treatment(3).

Premorbid trauma affects both children and their healthcare providers since it shapes how caregivers support their sick child. Children of parents who survived trauma especially losses or abuse or adverse medical experiences face increased difficulty managing their hospital experience. Parents who go through this experience display two contrasting reactions: they either become excessively anxious and worried with constant monitoring demands or detach themselves emotionally and delay important discussions and display emotional detachment. The responses expressed by parents impact their communication with providers and decision making and participation in child healthcare which create substantial effects on psychological recovery and treatment results.

Children who already have behavioral or emotional disorders including anxiety disorders or ADHD and ASD or a history of psychiatric hospitalization will encounter exclusive challenges when receiving treatment in the PICU. Developmental differences and prior psychiatric conditions in children frequently result in severe emotional

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dysregulation and interruption of comprehension and medical procedure understanding which both intensify their distress level and their treatment resistance and their need for sedation and physical restraint. The fear reaction of children suffering past negative hospital experiences may include both anxiety about new medical situations and development of panic attacks as well as behaviors intended to avoid the environment.

The possibility of patients suffering more trauma becomes an essential factor that doctors and caregivers need to prioritize in PICU settings. When people encounter scenarios which replicate historical traumatic situations their bodies automatically respond by generating severe emotional and physical distress. Pediatric critical care hospital experiences including restraint procedures alongsides exposures to loud alarms and sudden awakenings together with caregiver separation serve as triggers which make children experience repeated distressing events from their past. The hospital experience induces severe agitation and fear in children who suffered domestic violence because they hear loud noises and raised voices or alarms. Patients who survived medical trauma in the past could experience severe panic attacks or distress reactions towards invasive healthcare treatments including intubation and intravenous therapy.

The identification and management of premorbid trauma requires immediate attention from PICU teams because this presents critical risks for patient safety. The TIC model understands typical hospital patients arrive with specific vulnerabilities so it establishes environments which support and provide predictability with emotional safety for promoting better distress management and better outcomes. The delivery of genuinely holistic patient-centered care demands organizations to establish standard trauma screening mechanisms and teach provider trauma response detection skills while adding psychological support services to critical care environments.

The most efficient approach to manage premorbid trauma symptoms involves prior interventions that focus on individualized care as well as emotional safety. Providing children with opportunities to maintain control through medical decision participation as well as age-appropriate procedure explanations and choice selections effectively decreases their helplessness and anxiety. Children undergoing trauma receive better stress regulation through sustained caregiver oversight combined with comfort remedies such as blankets and friendly toys and non-drug pain treatment approaches involving visualization techniques and musical healing and calming practices(4).

1.3 Pediatric Intensive Care Units: Trauma-Informed Care

Trauma-Informed Care (TIC) maintains its significance in the intensive care unit environment for pediatric patients.

Trauma-informed care represents a complete healthcare method which uses patient-directed strategies to handle widespread trauma symptoms especially in medical environments characterized by intense pressure like pediatric intensive care units (PICUs). TIC's primary assumption establishes that medical facilities receive patients who carry existing trauma histories and patients might develop new trauma or recover from trauma based on the methods of care delivery. The purpose of TIC involves two main components since it helps prevent additional trauma while simultaneously creating emotionally secure conditions which support patients' empowerment processes together with standard medical practice integration of psychological help. The use of TIC is widespread in behavioral health and social services but its implementation in pediatric critical care units shows minimal progress and development. Intensive care institutions must adopt trauma-informed principles because medical trauma together with adverse childhood experiences combine with the extreme PICU distress factors to create essential requirements for enhanced short- and long-term health successes for critically ill children.

The main focus of pediatric critical care through history concentrated on treating physiological instability to ensure patient survival while ignoring emotional needs of children and family members. Current studies show intensive care hospital stays produce substantial mental health outcomes that lead to pediatric medical traumatic stress (PMTS) as well as post-traumatic stress symptoms (PTSS) and both anxiety and depression among patients(5). Surgically demanding practices within the PICU combined with invasive treatments and extended sleep medications along with sensory overload (alarms, lights, rapid staff actions) and variable disease outcomes consistently raise critical pediatric patients' danger of stress-related disorders. PICU patients commonly present with existing psychological sensitivities which stem from medical trauma history or neurodevelopmental conditions or abuse/neglect events thus escalating their distress reactions. Children without proper trauma-informed interventions are likely to show deteriorating mental outcomes and decreased treatment cooperation and enduring cognitive and emotional problems.

The foundations of trauma-informed care in healthcare.settings developed during the 1970s through 1980s when psychiatry and behavioral health defined initial models of this practice. TIC principles underwent expansion

throughout multiple medical disciplines starting from the 1970s and 1980s with primary care and emergency medicine and neonatal intensive care units (NICUs) being among the adapted fields. The awareness of trauma-sensitive practices continues to grow but most pediatric critical care units remain without established standard TIC frameworks. The American Academy of Pediatrics (AAP) and National Child Traumatic Stress Network (NCTSN) and Substance Abuse and Mental Health Services Administration (SAMHSA) advocate for TIC adoption throughout pediatric healthcare to help patients and strengthen provider-patient relationships while reducing medical trauma effects.

The American Academy of Pediatrics (AAP) along with other healthcare organizations specify the key domains of TIC as they consist of awareness, readiness, detection and assessment, management and integration. The structured framework within trauma-informed domains creates a system for pediatric intensive care staff to carry out trauma-informed approaches(6).

2. Methods

2.1 Research Design and Approach

This research uses narrative review as an appropriate methodology to examine existing literature since the studied field lacks available randomized controlled trials (RCTs) or systematic reviews. The structured inclusion approach of systematic reviews exists but narrative reviews create more flexible space during research synthesis to include findings from multiple fields. The narrative review method serves this research to evaluate current trauma-informed care practices in pediatric intensive care units and generate recommendations toward sensitive clinical care improvement. A narrative review remains an appropriate methodology for exploring trauma-related distress effects on pediatric patients and their families through critical assessments of psychological and medical and sociocultural impact on TIC implementation in critical care units.

This approach usesedics and mental health practitioners together because trauma-informed care derives from the collaborative work of pediatric medicine with psychology and psychiatry and nursing alongside social work. The developing nature of TIC in PICUs requires analyzing research through a medical as well as behavioral health framework because both disciplines contribute essential knowledge. This study reviews both empirical research and clinical guidelines and expert consensus statements to create a complete assessment of current TIC strategies found in pediatric intensive care environments(7). This review focuses on analyzing hospital implementation challenges for TIC and develops research-backed approaches that can strengthen patient treatment and workforce guidance and organizational guidelines.

The research process required the development of the following questions to determine literature selection:

- Do trauma-informed care practices exist widely in PICUs at present?
- The application of TIC strategies produces effects on both pediatric post-intensive care syndrome (PICS) and pediatric medical traumatic stress (PMTS).
- What prevents the implementation of TIC systems within pediatric critical care facilities?
- Hospitals need to implement what strategies to increase provider readiness for implementing TIC.

What combination of screening methods and intervention techniques demonstrate the best results in treating traumatic distress symptoms among critically ill pediatric patients together with their family members?

2.2 Literature Search Strategy

The research employed systematic methods to obtain a complete set of relevant studies by searching through multiple academic databases containing PubMed and Google Scholar and WorldCat and Scopus and PsycINFO and Web of Science. The author selected these databases for their medical and psychological research focus to review extensive peer-reviewed publications about trauma-informed care for children in healthcare environments.

The research evaluation used particular keyword series to find appropriate papers which comprised of:

"trauma-informed care" AND "pediatric intensive care unit"

"medical trauma" AND "pediatric critical care"

"post-intensive care syndrome" AND "children"

"pediatric medical traumatic stress" AND "ICU hospitalization"

"secondary traumatic stress" AND "PICU healthcare providers"

Further studies were identified by a “snowballing” technique which examined the reference sections of critical articles. The "cited by" function in Google Scholar was used to discover recent research that connected to fundamental pediatric

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healthcare works about TIC. A repeated searching approach found seminal publications about the field that did not emerge from the initial keyword search methods.

Selection criteria guided the process of choosing articles that would be included in the review.

2.3 Ethical Considerations

According to the narrative literature review format that used no human subjects there was no need to submit information to an institutional review board (IRB). The research maintained ethical standards using correct scientific findings presentation coupled with the prevention of plagiarism along with clear explanations of research boundary restrictions. The process of source citation integrated academic integrity into the entire review stage to maintain proper academic practice.

The research outcomes from this review will direct hospital protocols as well as training programs for staff members and future study projects seeking to enhance mental health outcomes for critically ill children and their families(8).

3. Results

3.1 Awareness of Trauma-Informed Care in PICUs

Research shows that awareness about TIC principles remains minimal among PICU providers even though there is increasing recognition of medical trauma effects. Several research reports demonstrate that pediatric critical care education fails to include standard TIC training programs. Family medicine residency programs taught TIC during their curriculum at only thirty-three percent based on 2017 Council of Academy Family Medicine Educational Research Alliance (CERA) survey results thus demonstrating substandard training readiness. Several healthcare professionals including pediatric specialists and critical care nurses and hospital administrators show inadequate understanding regarding pediatric patient trauma manifestation.

Medical staff frequently mistake typical child reactions derived from trauma scenarios. Medical professionals often misunderstand a child's hyperarousal or dissociative reactions together with behavioral agitation as non-compliance and difficulty rather than traumatic behavior in medical settings. Parents showing symptoms of post-traumatic stress from their child's hospitalization often get emotionally misinterpreted as being overly controlling or negligent instead of being recognized for their psychological state(9). Wrong interpretations betweenproviders and families result in damaged healthcare relationships together with communication breakdowns along with reduced quality of care.

The majority of hospitals lack formal data regarding their staff members' consciousness regarding TIC. Research analyzing PICU patient records revealed that staff members used the term “trauma” solely when referring to physical harm while neglecting to diagnose psychological distress which indicates pediatric critical care personnel inconsistently recognize trauma-related mental health problems. Adult ICU providers discussed trauma-informed care primarily regarding post-traumatic stress disorder symptoms related to physical trauma according to another survey but they did not mention premorbid psychological trauma as a contributing factor for patient distress.

The majority of healthcare settings do not exhibit proper recognition of TIC practices. The research showed hospital administrators from Australian tertiary children’s hospitals demonstrated the poorest understanding of TIC principles alongside limited confidence in its implementation thus revealing leadership engagement as necessary for systematic transformation. Ineffective organizational support together with inadequate policy backing and institutional dedication will continue to create inconsistent and fragmented integration efforts of TIC in PICUs.

3.2 Readiness for Trauma-Informed Care in PICUs

Challenges and Barriers to Readiness

TIC demands institutional readiness from healthcare organizations through establishing both technological and support systems as well as active engagement from staff members to execute trauma-sensitive practices in pediatric intensive care units (PICUs). Most pediatric intensive care units currently do not possess the needed TIC protocols together with appropriate staff training or essential resources for standardized trauma-specific distress care for patients and their families even though some hospitals have started their TIC integration process. The main obstacles which prevent readiness involve time shortages and inadequate education for staff and physician doubts and weak organizational backing(10).

Patients dealing with PICU environments encounter significant obstacles because healthcare providers have limited time to care for emotional and psychological patient needs because they must manage critical decisions and multiple

patients with limited staff support. Professional pediatric emergency physicians and intensive care providers showed positive attitudes toward trauma-informed practice implementation yet admitted they were burdened down by their workload responsibilities. Almost all critical care medical staff considered TIC an excellent theoretical approach yet struggled to implement it due to the fast-paced critical care work environment that limits their ability to perform extended psychosocial evaluations.

Frontline providers struggle to implement trauma-informed practices because they lack proper training and experience in identifying as well as treating trauma-related patient distress. Clinicians from trauma, emergency, and pediatric critical care departments showed knowledge about TIC concepts yet few had learned practical TIC application skills for clinical practice. Survey participants showed unclear understanding of TIC standards because they believed this concept resembled basic patient-centered approaches instead of trauma-specific practices for treating distress symptoms.

Organizational readiness plays an equal vital role alongside individual provider readiness. Hospital leaders and administrators remain fundamental in deciding the outcome of TIC program implementation. The results show that hospital administrators together with policymakers stand as the most untrained group regarding trauma-informed practices. The absence of institutional dedication leads TIC initiatives to split into separate islands because only single providers or departments create trauma-sensitive programs(11). Healthcare facilities which successfully connect TIC to pediatric services achieve this outcome by making leadership involvement central while investing funds and integrating TIC strategies throughout their organization-wide procedures.

Steps Toward Enhancing Readiness

The enhancement of readiness requires hospitals to develop training programs alongside workflow modifications and between-discipline cooperation. The inclusion of TIC content into medical education programs presents an effective solution by teaching clinical providers trauma science knowledge as well as recognition and evidence-based intervention methods of psychological distress. Medical education includes basic trauma-informed education through new school modules yet these modules do not exist in a majority of training facilities.

Medical organizations embedding behavioral health professionals into PICU teams enhances real-time staff and provider consultation as well as training and psychological assistance for medical patients and healthcare workers. Hospitals employing this model show their staff becomes more confident regarding trauma symptoms while reducing provider work stress and achieving better patient results. TIC protocols with standard components that include pre-procedure mental preparation and patient screening and person-centered communication techniques can smooth TIC integration while avoiding major increases in provider responsibilities.

Important to sustain any initiative is the constant active support from institutions. Medical facilities must create TIC leadership boards while funding personnel education and launching quality enhancement projects for monitoring progress. The implementation of TIC as a standard practice in pediatric intensive care requires PICU providers to develop psychological safety culture that supports them in helping patients deal with trauma-related distress while ensuring staffing remains manageable.

3.3 Detection and Assessment of Trauma-Related Distress in PICUs

The Importance of Early Screening for Trauma-Related Symptoms

Trauma-informed care depends on trauma-related distress detection and assessment because rapid identification enables timely treatments to prevent chronic psychological effects. PTSS and PMTS symptoms affect many critically ill children yet most PICUs do not implement routine screening for psychological distress. Healthcare professionals fail to detect psychological symptoms which only receive attention after they escalate into critical states thus minimizing potentials for prompt intervention(12).

Research indicates that between 30–50% of PICU survivors experience post-traumatic stress symptoms after hospitalization along with depression and anxiety and signs of post-intensive care syndrome. Psychological symptoms create barriers for patients' recovery and diminish both their capacity to follow medical instructions and decline their future life quality. Caregivers who take care of PICU patients face extensive distress leading to the development of post-traumatic stress disorder (PTSD), depression and anxiety symptoms. Only 20% of U.S. Level 1 Trauma Centers admit to operating patient and family trauma symptom screening and intervention services at their facilities.

4. Discussion

4.1 Interpretation of Findings

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- Evidence from this review demonstrates strong evidence of missing trauma-informed care elements in pediatric intensive care units despite strong evidence of critical illness's psychological consequences for children and their families. Healthcare provider awareness about TIC continues to grow but actual readiness for execution along with system-wide implementation remains restricted because of health system obstacles and lack of formal education and practical challenges. PICU care needs standardized trauma screening protocols and better training support and critical medical staff must overcome challenging working conditions to achieve routine TIC implementation. The findings highlight an immediate necessity to establish standardized policies along with interprofessional cooperation while obtaining institutional backing to improve PICU implementation of TIC.
- Many health providers working in PICUs lack the formal education needed to deliver trauma-sensitive care while critical ill children exhibit high rates of both post-traumatic stress symptoms (PTSS) and pediatric medical traumatic stress (PMTS). Healthcare providers who lack trauma training often mistake distress symptoms caused by trauma for noncompliance or emotional behavior issues which results in inferior patient-provider relationships. The problem arises from inaccurate interpretations because solid evidence demonstrates the effectiveness of prompt psychological treatments for better recovery results. The provision of trauma-informed support in the PICU period leads children to demonstrate lower incidence of PTSS and anxiety and depression symptoms. The improvement of healthcare quality depends heavily on provider education about traumatic event detection alongside training for emotional management methods and techniques of patient-centered communication(13).
- This review shows evidence that parental support helps reduce medical trauma impacts. When children need PICU care their parents face secondary traumatic stress and this condition prevents them from delivering proper emotional support to their children. Hospitals generally ignore both emotional assessment of parents undergoing care alongside provision of mental healthcare resources and this is resulting in families who lack sufficient assistance before and after hospitalization. Future TIC initiatives must establish three core components: caregiver educational programs along with family treatment methods and mental health resources for parents.
- Several pediatric intensive care units have managed to implement trauma-sensitive approaches successfully thus proving that healthcare frameworks alongside workplace cultures can promote TIC standards. PICU teams receive benefit from behavioral health professionals along with structured training programs and standardized trauma screening tools which leads to lower distress levels as well as higher provider confidence and superior patient outcomes. TIC implementation succeeds when medical staff work alongside professionals providing psychological care and social assistance.

4.2 Barriers to Implementation

- Documents show extensive advantages from TIC implementation yet multiple obstacles block its extensive use in PICUs. Affriadels of Critical Care Medicine experience a rapid workflow that creates problems for staff who need to perform both vital interventions swiftly and deliver sensitive communication to patients. Hospital staff frequently report work overload from different duties which limits their ability to provide psychological assessments or support therapies. Insufficient dedicated financial resources for TIC training programs creates obstacles for hospitals in delivering full-staff educational programs which reduces their ability to maintain readiness levels.
- The implementation of TIC practices faces an obstacle because there are no established hospital policies which require their use. TIC differs from pain management protocols and sedation guidelines because hospitals have an option to use it inconsistently. Initiatives without established institutional standards and workflow modification and leadership backing mainly depend on provider initiatives to maintain their existence.
- Hospitals need to establish TIC as a vital part of pediatric intensive care services that they should implement with top priority versus treating it as an additional feature. Organizations need executive commitment together with policy interconnection as well as monetary funding for TIC education programs and staffing and programs creation.

5.Conclusion and Future work

The research study demonstrates that pediatric intensive care units strongly require trauma-informed care because critically ill children along with their families face psychological risks. The increased recognition of TIC principles has failed to match consistent readiness and implementation because healthcare institutions face multiple barriers and time constraints and providers lack proper training. Research data reveals PICU children are prone to developing post-traumatic stress symptoms and pediatric medical traumatic stress while experiencing prolonged psychological effects which demand trauma-sensitive structured care to enhance patient recovery.

Hospital PICUs exhibit mixed levels of TIC practice implementation because standard protocols for trauma screening and provider education and interdisciplinary teamwork are missing in numerous PICU facilities. The lack of institutional policies combined with financial backing and leadership commitment stands as major obstacles that halt the wide implementation of TIC strategies in pediatric critical care units.

The available evidence demonstrates that trauma-informed care brings effective changes which reduce distress whereas it increases family-focused treatment while leading to improved recovery rates. Organizations that station specialists in behavioral health within PICU units combined with structured TIC educational initiatives and specified trauma evaluation tools demonstrate a positive impact on patient satisfaction rates as well as improved practitioner capabilities and better psychological health for children and their loved ones.

Future Research Directions

- The examination of TIC in PICUs delivers extensive assessment but requires additional research to understand its extended impact on trauma-focused interventions. Future studies should:
- Researchers need to evaluate individual approaches for implementing trauma-informed care as a method to decrease post-intensive care syndrome (PICS) in children.
- Medical professionals who complete TIC training need assessment regarding burnout rates as well as their effect on both practice effectiveness and treatment results among patients.
- Examine potential barriers that exist for integrating TIC within limited-resource facilities.
- The healthcare community needs to concentrate on both long-term research and educational programs which will help establish TIC as a core intensive care practice for children to enhance their medical and psychological health at each stage.

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Conflicts of interest

The authors have no conflicts of interest to declare

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