Public health perspective of the psychosocial dimensions of paediatric asthma care during crises

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Dear Editor,

I never imagined that treating a child with asthma during crises would challenge us more emotionally than medically. One night in the paediatric emergency department, an 8-year-old boy arrived with severe respiratory distress, pale lips, laboured breathing, and 88% oxygen saturation. Nebulised salbutamol, supplemental oxygen and intravenous corticosteroids were administered immediately.

Despite gradual physiologic improvement, the emotional atmosphere – driven by his mother's anxious attention to war news on her phone – continued to constrict his breathing. I gently asked her to set the phone down and hold his hand. We dimmed the lights in the room, silenced unnecessary alarms and a nurse gently massaged his shoulders. In calming words, I reassured him that the medication would soon help him breathe more easily. Within minutes, his oxygen saturation increased to 94%, his breathing eased and calm returned to his gaze.

This was not an isolated incident. During conflicts, earthquakes and other disasters, children's respiratory distress is often made worse by emotional burdens, not just airway inflammation. Crises transform emergency departments into spaces where fear becomes a comorbidity; children express inner turmoil through restlessness, silence or aggravated asthma attacks (*1,2*).

From these experiences, we advocate 5 feasible, low-resource interventions for children in such situation:

1. Create a calming environment by minimising noise, softening lighting and limiting movement.
2. Ensure a trusted presence. A caregiver's physical reassurance can be more therapeutic than medication.
3. Reduce distressing stimuli. Silence noisy media or alarms and shield the child from additional stressors.
4. Combine medical care with human connection. Gentle touch, focused eye contact or a reassuring smile can enhance patient cooperation.
5. Deliver empathetic explanations. Clear, age-appropriate communication transforms fear into cooperation.

These measures do not require advanced tools, they require only humanity and attentiveness, reiterating that paediatric care must heal physiology and preserve the child's sense of safety. Such moments remind us that effective asthma management during crises relies on cohesive teamwork among physicians, nurses, respiratory therapists, and technicians, each contributing to restoring the child's breath and calm.

Conclusion

Asthma management during crises must go beyond bronchodilators and corticosteroids. Children bring their fears to the hospital with them and if those fears remain unaddressed, recovery cannot be complete. Integrating psychosocial support into paediatric emergency care is not an optional luxury; it is a humanitarian imperative and a professional obligation (*3,4*).

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