

Early psychological intervention for war-related trauma in a hospitalized child from Gaza: a case report

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Summary. This paper describes the psychological and clinical course of a nine-year-old girl from Gaza admitted to a Pediatric Department. A family-centered psychological intervention was implemented during hospitalization. The clinical presentation was consistent with post-traumatic stress disorder. The case highlights the importance of early psychological intervention in supporting trauma processing, limiting the effects of prolonged hospitalization, and fostering a shared multidisciplinary narrative of the traumatic experience.

Key words. Children, Gaza, hospitalization, psychological intervention, war-related trauma.

Intervento psicologico precoce per traumi legati alla guerra in una bambina proveniente da Gaza ricoverata in ospedale: un caso clinico.

Riassunto. Questo lavoro descrive il percorso psicologico e clinico di una bambina di nove anni proveniente da Gaza, ricoverata presso un reparto di Pediatria. Durante la degenza è stato attuato un intervento psicologico con il coinvolgimento del nucleo familiare, in presenza di un quadro compatibile con disturbo da stress post-traumatico. Il caso evidenzia l'importanza dell'intervento precoce nel favorire l'elaborazione del trauma, ridurre l'impatto della degenza e promuovere una narrazione multidisciplinare condivisa.

Parole chiave. Bambino, disturbo da stress post-traumatico, Gaza, intervento psicologico, ospedalizzazione.

Introduction

Armed conflicts increasingly expose children to complex and prolonged traumatic experiences, often resulting in profound and long-lasting psychological consequences. According to UNICEF¹, over one billion children under the age of 18 live in countries affected by war. Contexts characterized by bombings, loss of family members, and forced displacement create conditions of extreme vulnerability, significantly disrupting emotional, cognitive, and relational development²⁻⁴.

A robust body of literature has documented a strong association between exposure to war-related trauma and an increased risk of psychiatric disorders in childhood, including Post-Traumatic Stress Disorder (PTSD) and other clinically significant presentations⁵⁻⁹. A consistent dose-response relationship has been described, whereby the severity and chronicity of traumatic exposure correlate with poorer mental health outcomes. Direct exposure to violence, loss of caregivers, and separation from primary attachment figures appear to be particularly detrimental¹⁰⁻¹².

In pediatric populations, trauma may manifest through developmental regression (e.g., secondary enuresis or encopresis), disorganized or repetitive play, impaired symbolic functioning, sleep disturbances, somatization, and hyperarousal¹³⁻¹⁸. Emotional withdrawal, avoidance, and affect dysregulation are also frequently observed. When these symptoms remain unrecognized or untreated, they may evolve into persistent psychopathological patterns, negatively affecting identity development and the child's sense of safety, competence, and self-worth¹⁹.

At the time of writing, the civilian population in the Gaza Strip is facing an acute humanitarian crisis due to ongoing armed conflict, with children disproportionately affected. Available reports indicate extremely high rates of civilian casualties, including a substantial number of women and children, alongside widespread injury and displacement²⁰.

This paper presents the case of a nine-year-old girl who recently arrived in Italy from Gaza and was evaluated during hospitalization for medical treatment. The report provides a detailed account of the emergence and evolution of acute post-traumatic symptoms within a protected, integrative clinical setting. Through direct clinical observation, structured and

play-based assessments, and the involvement of a substitute caregiver, the case highlights early psychological responses to war-related trauma and underscores the relevance of culturally sensitive interventions within a pediatric hospital context.

Description of the setting and methodology

The hospital environment represents a privileged setting for the identification and management of psychological vulnerability, particularly among children and families exposed to war, forced migration, or severe trauma²¹. Pediatric hospitalization offers a unique opportunity for continuous observation, interdisciplinary collaboration, and early psychological intervention.

This case took place in the Pediatric Department of Policlinico Umberto I Hospital in Rome and involved a family unit originally from the Gaza Strip. The child – here referred to as *Ameera*, reflecting the princess motif recurrent in her symbolic play – was admitted for the treatment of a brain abscess secondary to a penetrating head injury caused by shrapnel during a bombing. After initial surgical management and antibiotic and anticonvulsant therapy in her home country, she was transferred to a multidisciplinary team in Rome. Neuroimaging confirmed retained foreign bodies and an intracranial abscess, requiring further neurosurgical intervention. The postoperative course was uneventful, and the overall hospitalization lasted approximately two months. Ameera arrived in Italy accompanied by her sister, aunt, and cousin. Her mother had died in the explosion, while her father – abroad at the time of the event – is currently awaiting family reunification.

The psychological intervention began within the first week of hospitalization and continued throughout the entire inpatient stay, with sessions conducted every week and adjusted according to the child's medical condition and emotional availability. Overall, the intervention spanned approximately two months, coinciding with the duration of hospitalization. It was integrated into routine medical care and included play-based sessions, clinical interviews, and cognitive assessment using the Leiter-R. Due to logistical constraints, sessions with the children were conducted jointly by two clinicians within a shared hospital room, allowing close observation of relational dynamics. Individual interviews with the aunt were conducted separately by a third clinician. This organizational framework enabled a comprehensive psychosocial assessment of the family system within the hospital setting.

Written informed consent was obtained from the child's legal representative in Italy.

Case report

From the earliest interviews, a picture of emotional and relational distress involving the entire family emerged. Ameera presented with clear symptoms consistent with PTSD, including behavioral regression, secondary enuresis and encopresis, marked hyperarousal, frequent nightmares, sleep-wake disturbances, and food refusal. She avoided mirrors and persistently refused to speak about her mother's death, showing significant emotional inhibition. These difficulties were initially masked by a compliant, over-adapted attitude toward healthcare staff. Over time, the hospital setting became a legitimate and contained space in which Ameera could begin to express distress.

The hospital environment allowed clinicians to observe multiple facets of her traumatic experience. During cognitive testing, attentional difficulties and hyperarousal were evident: even mild environmental noises elicited acute distress, interrupting tasks with a suddenness reminiscent of the original traumatic events. Despite this heightened arousal, Ameera completed the assessment with notable determination, showing cognitive functioning within the average range (Short Intelligence Quotient= 109).

Psychological work also addressed somatic manifestations. During hospitalization, Ameera developed non-scarring alopecia areata in the absence of identifiable organic causes, occurring in the context of immunosuppressive treatment. This symptom was interpreted as a possible somatic expression of traumatic overload in a child with limited verbal access to internal emotional states. Ongoing dialogue within the multidisciplinary team supported an integrated clinical formulation, facilitating coherent communication between somatic and psychological dimensions.

Play therapy proved central in assessing the affective dimension of the trauma. Initially, Ameera's play appeared aimless and repetitive, and her drawings were concrete and poorly symbolized. As the therapeutic alliance gradually consolidated, she began to shift toward more symbolic representations of separation and loss, particularly in relation to her mother. Play and drawing thus became privileged tools through which Ameera could narrate her experience and render the trauma mentally representable. The presence of multiple professionals within the hospital context further supported the co-construction of a shared trauma narrative.

The therapeutic relationship played a pivotal role in Ameera's clinical course. The clinician assumed the function of a stable and reliable figure – a transitional presence between Ameera's internal world and external reality – capable of tolerating expressions of

anger, withdrawal, and fear without judgment or urgency. This relational continuity served a transformative function, gradually allowing Ameera to rebuild a sense of trust.

Hospitalization itself represented a potential risk for re-traumatization. Invasive procedures and surgical interventions could reactivate experiences of helplessness and loss of control reminiscent of the original trauma. A substantial component of the psychological intervention therefore, focused on the co-construction of clear, predictable, and reassuring narratives regarding medical procedures, in close collaboration with the pediatric team.

The hospital setting also enabled exploration of the broader family trauma narrative. Individual interviews with the aunt helped contextualize Ameera's symptoms within a shared history of loss, displacement, and forced migration. Ameera's trauma appeared inseparable from the collective familial experience. The aunt described her own grief for the loss of her brother, feelings of guilt toward relatives who remained in Gaza, and the emotional burden associated with assuming full caregiving responsibilities for her nieces, whom she now described as her "daughters". She explicitly expressed vulnerability and requested psychological support.

In the final days before discharge, psychological sessions involved all family members –Ameera, her younger sister, their cousin, and the aunt. Alongside persistent trauma-related themes, elements of hope and future orientation began to emerge. Ameera expressed the wish to dress as a princess – *Ameera* (أميرة) – while her cousin spoke about the desire to attend school, signaling the tentative reactivation of positive identity representations and developmental perspectives.

Conclusions

Ameera's story reflects the intertwined personal, familial, and collective suffering associated with the war in Gaza. While the psychological impact of armed conflict on children is well documented, the present case illustrates how such trauma may emerge and evolve within a pediatric hospital setting.

The psychological intervention carried out at the Policlinico Umberto I Pediatric Unit involved both the family and the multidisciplinary healthcare team. The hospital room became a space in which medical care and emotional expression could coexist, allowing post-traumatic symptoms, anxiety, and affective fragmentation to be acknowledged and contained. The clinician's stable presence played a central role in supporting emotional regulation and continuity²².

The involvement of the entire family system proved essential in restoring meaning to the child's symptoms

and reconstructing the trajectory of forced displacement. The hospital setting broadened the field of clinical observation and facilitated an ongoing dialogue between somatic and psychological dimensions, enabling tailored, developmentally appropriate interventions. As a single-case report, the findings cannot be generalized and should be interpreted with caution. However, this case offers clinically relevant insights into early psychological responses to war-related trauma and highlights the potential role of pediatric hospitalization as a window for timely, family-centered, integrated mental health intervention.

Conflict of interests: the authors have no conflict of interests to declare.

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