

The children's learning (about birth) validates one of the many reasons parents give for wanting their children with them. . . . It is reasonable to speculate that some of the confusion and anger of their own childhood lies behind this parental determination. . . . *Furthermore, it is the parents, in the last analysis, who will be the ones to help their children integrate and recover from whatever traumatic effects may have occurred, whatever emotional price children may pay for the learning* (emphasis supplied).

This indifference to the possibility of physician-assisted traumatogenesis in children is extraordinary and dismaying. Daniels' speculations about her parents' motivations make good psychological sense. They raise the question as to whether we, as professionals, should participate in parents' well-intentioned but misguided efforts to compensate for their own psychic traumata in childhood by subjecting their own children to psychological insult. Would we recommend a child be sutured without anesthesia because a parent thought it would build character or constitute a useful learning experience?

The difficulty with this philosophy is that neither Dr. Feldman nor the references she cites take any account of the internal psychic lives of the children concerned in which fantasy plays an extremely important role.<sup>8</sup> We have known for decades that trauma is not caused by the mere occurrence of an external event, but that the meaning of that event to the person is crucial.<sup>9,10</sup> This is a general phenomenon in children: children frequently blame themselves for the failure of their divorcing parents' marriage or for the death of a parent or sibling despite reassurances and factual evidence to the contrary. Some children have extended nightmares after viewing movies such as the *Wizard of Oz*, despite reassurances from loving, concerned parents.

Piaget<sup>11</sup> has shown that the cognitive and emotional capacities of young children are too immature to appreciate and understand the events they witness, and the younger they are, the more likely fantasy rather than reality testing will dominate the interpretation of an intensely charged emotional event. This is why mere explanation and reassurance given to a child in preparing for a sibling birth will not guarantee protection from trauma. Moreover, recent evidence suggests that childhood trauma can *after only a single exposure* cause functional brain damage<sup>12</sup> in addition to psychological consequences. For those readers who are interested in understanding more about the internal psychic lives of children, I would recommend the Fraiberg<sup>13</sup> book in the reference list below.

Notwithstanding the above, I can do no more than to re-invoke Dr. Feldman's own comments on this subject: "I can draw no definite conclusions about the impact of these experiences on Hanna's psyche or her own future life choices." The point of my letter was to plead for a consideration of the child's psychological vulnerabilities in recommending attendance at sibling birth. We cannot

predict in advance which child will suffer untoward sequelae from such an experience.

Because this is the case, as Dr. Feldman's own words attest, we should follow a longstanding ethical tradition in medicine: *primum non nocere*.

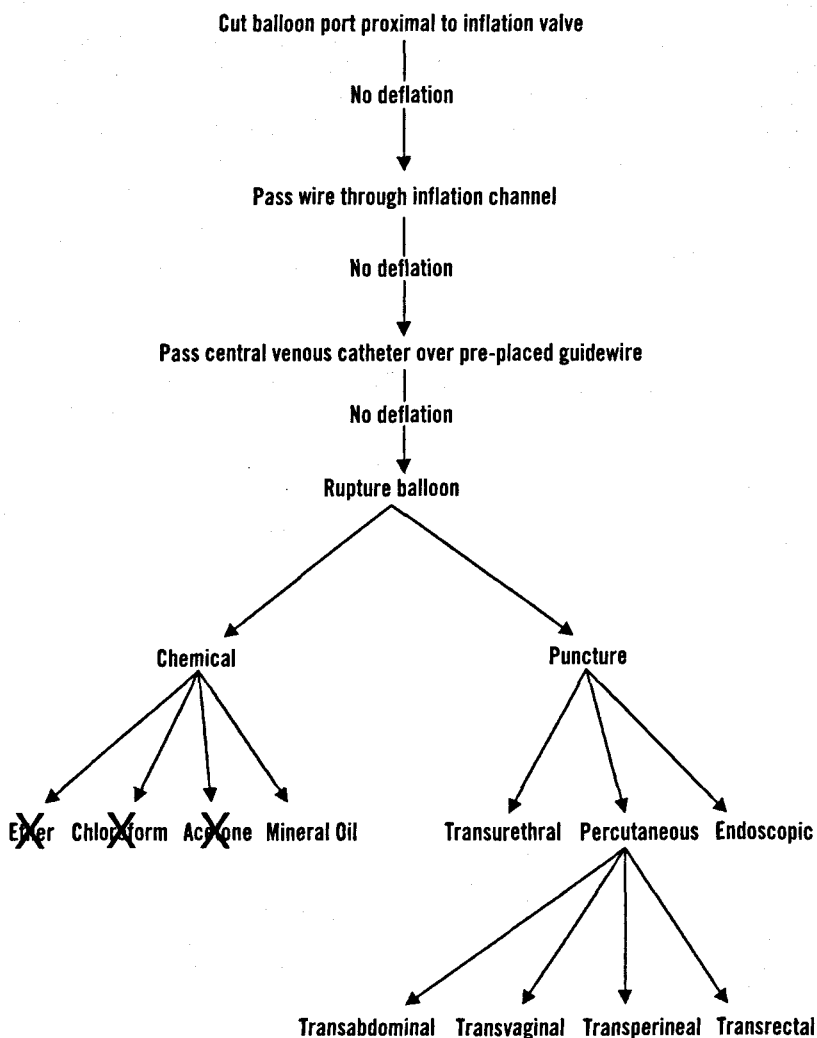
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## References

1. Feldman E. Birth and death through a child's eyes. *J Am Board Fam Pract* 2000;13:87-8.
2. Feldman E. Birth and death: through a child's eyes. *J Am Board Fam Pract* 1999;12:344-4
3. MacLaughlin SM, Johnston KB. The preparation of young children for the birth of a sibling. *J Nurse Midwifery* 1984;29:371-6.
4. Hathaway J, Hathaway M, Hathaway O, et al. *Children at birth*. Sherman Oaks, Calif: Academy Publications, 1978.
5. Nunnally JC, Bernstein IH. *Psychometric theory*. New York: McGraw-Hill, 1994.
6. Daniels MB. The birth experience for the sibling: description and evaluation of a program. *J Nurse Midwifery* 1983; 28:15-22.
7. Lumley J. Preschool siblings at birth: short-term effects. *Birth* 1983;10:11-6.
8. Sarnoff CA. *Latency*. New York: Jason Aronson, 1976.
9. Krystal H, Krystal JH. *Integration and self-healing: affect, trauma and alexithymia*. Hillsdale, NJ: Analytic Press, 1988.
10. Tuch RH. The construction, reconstruction, and deconstruction of memory in the light of social cognition. *J Am Psychoanal Assoc* 1999;47:153-86.
11. Flavell JH. *The developmental psychology of Jean Piaget*. Princeton, NJ: Van Nostrand, 1963.
12. Markowitsch J, Kessler J, Van Der Ven C, Weber-Luxemburger G, Albers M, Heiss WD. Psychic trauma causing grossly reduced brain metabolism and cognitive deterioration. *Neuropsychologia* 1998;36:77-82.
13. Fraiberg SH. *The magic years*. New York: Simon & Schuster Trade, 1996.

## Management of Nondeflating Urethral Catheter

*To the Editor:* Regarding your article in the March-April issue of the *JABFP* on managing the urethral catheter (Shapiro AJ, Soderdahl DW, Stack RS, North JH Jr. Managing the nondeflating urethral catheter. *J Am Board Fam Pract* 2000;13:116-9), when I looked at the algorithm diagram, it all seemed logical until I got to where it shows chemical rupture involving ether, chloroform, acetone, of mineral oil. Reading through the article further, I noted that one paragraph states that "[s]everal chemicals have been used to dissolve the balloon wall and thereby allow its deflation. Ether, chloroform, acetone, and mineral oil are among the agents most commonly used. Unfortunately, exposure of the bladder urothelium to these chemicals can result in chemical cystitis, bladder contractures, hematuria, bladder rupture, and death. In addition, balloon fragments might be retained within the bladder, predisposing the patient to a variety of complications. . . ." I could never imagine instilling ace-



**Figure 1.** Management algorithm for the nondeflating urethral catheter balloon.

tone, chloroform, or ether into a patient's catheter balloon or the catheter itself because of the potential dangers involved as cited by the article. I discussed this article with several other family physicians and several nurses who are well experienced in this sort of problem, and they also would never use these particular chemicals for this purpose.

To me, a more rational approach to deflating the balloon would be to drain the bladder completely through the Foley drainage port, then instill water in the balloon until it ruptures. With the bladder fully emptied, it seems that the chance of bladder rupture is minimal. Even balloon fragments that might remain in the bladder seem to be a lesser risk than that posed by acetone, chloroform, or ether in the bladder. Certainly finding retained balloon fragments could be resolved with cystoscopy if, when the Foley is removed, the entire catheter balloon did not appear to be present.

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The above letter was referred to the corresponding author of the article in question, who offers the following reply.

*To the Editor:* Thank you for the opportunity to reply to Dr. Baker's comments on our article (Shapiro AJ, Soderdahl DW, Stack RS, North JH Jr. Managing the nondeflating urethral catheter. J Am Board Fam Pract 2000;13: 116-9). Dr. Baker's central concern is with the chemical agents used for Foley balloon dissolution listed on the treatment algorithm. We mentioned acetone, chloroform, and ether for historical interest. We do not recommend their use and apologize for the confusion. We do believe, however, that mineral oil instillation is a viable option that can be considered. Perhaps to make the algorithm clearer, we could place a large X through the three chemical agents no longer recommended (as in the revised Figure 1).

Dr. Baker also proposes the technique of balloon rupture by overdistension with water in a fully emptied