THE UNIQUE ROLE OF THE CHILD PSYCHIATRY TRAINEE ON AN INPATIENT OR DAY CARE UNIT

Irving N. Berlin, M.D. and Adolph E. Christ, M.D.

The trainee in child psychiatry who is involved in an inpatient or day care setting is beset by many problems, perhaps the most ubiquitous of which is that of finding a unique role for himself. He discovers that nurses, teachers, occupational therapists, etc., who spend most of their day with the child, have more information and in some instances a more intimate relationship with the patient than he is likely to have. Each worker feels that his interaction with the child is the most vital to his recovery. The child psychiatry trainee, having lived through similar feelings early in his adult inpatient work, is again beset by uncertainties about how much his few therapeutic hours with the child are worth in contrast to the time and effort of his collaborators. When he finds that other child care personnel are also involved on a daily basis in helping parents learn to interact more effectively with their child, he often wonders what he does have to contribute that is his and only his (Christ et al., 1965; Christ and Griffiths, 1965; Christ and Wagner, 1966). In addition to the psychotherapeutic role, we have come to believe that

Dr. Berlin is Professor of Psychiatry and Pediatrics and Head, Division of Child Psychiatry, University of Washington School of Medicine, Seattle, Washington. Dr. Christ was, at the time of preparation of this paper, Assistant Professor of Psychiatry and Director, Psychiatric Day Care Service for Children, University of Washington School of Medicine, Seattle, Washington. He is presently Assistant Professor of Psychiatry and Director of Child Psychiatry Inpatient Services, Department of Psychiatry, Albert Einstein School of Medicine, Bronx, New York.

the synthesizing or integrating role is a potentially unique one for the trainee. We shall describe our efforts at delineating that role somewhat later.

The concepts to be discussed have concerned teachers of child psychiatry and directors of child psychiatric inpatient settings for many years (Berlin, 1960, 1964; Greenwood, 1955; Ittelson, 1960; Pavenstludp, 1966; Redl, 1959; Robinson, 1951; Szurek and Berlin, 1964, 1966). We have tried to analyze our experiences, consider many of the issues raised by our trainees, and synthesize our formulations for our own learning and to stimulate discussion with others.

The specific tasks which the trainee should master can be roughly classified as follows: (1) assessment of psychopathology in the child and parents; (2) evaluation of emotional level of development of the child, especially in terms of degree of ego development needed to plan a therapeutic milieu program; (3) assessment of cognitive development of the child, in Piaget's terms (Flavell, 1963; Wolff, 1960), to help plan the steps in educational experiences to promote mastery and cognitive growth; and (4) psychotherapeutic work with child and parents.

The assessment of parental pathology, defenses, and ego strengths, which help decide how to assist parents to provide a facilitating milieu for their child, is a collaborative task for the trainee and ward staff. In addition to the trainee's role as collaborator and team member, he is expected to provide leadership. One of the recurring miracles is that many trainees do manage to master these tasks and find their unique role in the process. It also reassures the teachers and helps them expect more of the impossible from their students.

**Psychotherapy with the Child**

Psychotherapeutic work with the child and family enables the therapist gradually to identify and isolate the areas of nuclear psychopathology and to define those in which the child and family are most ready to engage therapeutically. As the therapist can share the psychotic experience or empathically understand the child's feeling, he may become aware of the child's ambivalent fear of involvement with and investment in another person. Such fears result from serious deprivation of nurturance and may be expressed in psychotic behavior. Similarly, the therapist may understand the child's terror
about communicating feelings, especially expression of angry, sexual, sensual, and tender feelings experienced from and toward another person. Guilt, rage, hate, love, fear, strong desires for nurturance, and fear of retaliation from adults for direct or symbolic expression of negative feelings are all present. The resulting admixture makes understanding the meaning of behavior as well as the therapeutic work difficult.

With even the most primitive child, the therapist must learn as his first task to follow the child carefully in play therapy. Later he may need to focus actively and sometimes forcefully on the emerging nuclear conflicts. This may be done by clarifying one aspect of the emotional interaction between them. The therapist tries in various ways to describe both verbally and nonverbally his state of feeling and his perceptions of the interactions so that the child, from repeated experiences, finds a dependable base for his interactions. Diagnostic understanding of nuclear conflicts comes not only from direct observations of child and parents, but also from data gathered in a careful evaluation of the family events which preceded the illness. There is no need to stress the importance of the data which slowly take shape from the past history of each family member and reveal their resultant integrative and conflictful capacities for living. The interactions of family members in response to specific stresses presented by the child's emerging pathology and his response to therapeutic efforts give further clues which help clarify nuclear conflict areas. As the family members are involved in a search for ways to meet each other's needs, clarification and beginning resolution of these core conflicts result in gradually increasing sensitivity to mutual needs and a greater repertoire of satisfying interactions. In the child this results in a greater readiness to move beyond the areas of fixated or regressed emotional and cognitive development.

The Therapist's Role as a Team Member

In his role vis-à-vis the other team members, the trainee has a twofold task. The first is to share his growing insight about child and family with the other team members, thus alerting them to the possible meaning of the child's behavior as it is continually observed in the milieu. It helps them focus on using each experience with the
child to contribute to the clarification and refinement of the meaning of the child’s behavior. Increased understanding and awareness begin to provide a different, more integrative and responsive milieu experience for the child.

The trainee’s second function is to facilitate a collaborative interchange with the ward staff so that their interactive behavior with the child, parents, or child and parents together, leads to a better understanding of the family. It is no easy task to integrate and synthesize data so that the behavior of the child or parents as observed on the ward and in psychotherapeutic work can be understood as an expression of their circular psychopathological conflicts rather than as oppositional or malicious.

Senior child psychiatrists must first provide examples of such integration of data and help the trainee and ward staff experience its usefulness. This is particularly true in the interpretation of anxiety-producing behavior of the parents in their interaction with ward personnel. As such behavior becomes understandable to the staff, therapeutic handling of interactions with child and parents also becomes important in altering the behavior and attitudes of each. The material which results from all such therapeutic interaction is considered available to the psychotherapist in fostering insight and conflict reduction in his patients. As part of the therapeutic contract parents and child are helped from the beginning to understand and agree to the exchange of observations of the ward team with the psychotherapist. The trainee’s transition from having a theoretical understanding to providing practical examples of how the staff might use these interactions therapeutically around specific activities is usually not achieved until some time in the second year of child psychiatry fellowship. Hence, the responsibility for development of strategies on the basis of such complex understanding rests with the more experienced psychiatric social workers, psychologists, chief nurse, and senior child psychiatrists, until the trainee can assume this function with his own cases.

**Facilitating Emotional Development**

The therapist’s role in facilitating the emotional development of the child is twofold. First, he needs to enlist the collaboration of all
the ward staff in elucidating elements of the child's present stage of development. He then encourages the staff to utilize their knowledge and insight to help the child achieve the very next developmental steps. Thus, when a child being cared for by a new staff member indicates a need to be fed or cuddled, the experienced staff members and trainees can describe from their experiences the sequences that might be expected to occur as the child works through this particular stage and is ready to move on. Nurses can be particularly helpful by describing in case vignettes how their own involvement for a time precluded recognition of the child's readiness to move on because they were enjoying the feeding or cuddling so much themselves. The trainee needs to develop skills which facilitate other staff members' contributions to the learning of all the staff. How a particular child may be helped to take the next step requires close and free collaboration, sharing of information, and freedom to alter the plan as new data are gathered and assessed in the team effort. The capacity of the trainee and other staff members to predict sequences of behavior and direction of growth makes it easier for inexperienced staff to recognize readiness for change and thus to be helpful to the child.

Close collaboration between staff and psychotherapist is essential, as a child may sometimes function on different levels with milieu staff and therapist. Thus, in psychotherapy the more primitive core of his nuclear conflicts may still be worked on after he has progressed through several successive stages of psychosexual development, especially in terms of ego function with the ward staff.

How are these sequences learned by the fellow? We have found that most trainees are deficient in applicable knowledge of the emotional developmental stages of the child. In lectures, seminars, and journal seminars they learn the theoretical framework of emotional maturational stages (Bridges, 1932; Bruner, 1960, 1966; Bruner et al., 1966; Erikson, 1950; Flavell, 1963; Freud, 1905; Gesell and Ilg, 1948; Spitz, 1959). They are, however, still a long way from using this theoretical framework to understand the observed behavior of the normal, neurotic, or psychotic child.

Furthermore, we find it is very difficult for the trainees to separate out in a behavioral sequence those aspects that represent regressive pathological distortions from those due to fixation. Essen-
tial as this differentiation is for the therapist in play therapy, it may become crucial at times for the ward staff. Understanding the conflictful components of behavior which have resulted in the symptoms permits corrective interaction. However, in developmental arrest an environment must be created which is suitable for emotional growth and development at the emotional level of the child and which facilitates the next steps beyond it. For example, destructive behavior may be symptomatic of unconscious conflict and may engage the adults in a characteristic way for that child and family. However, the child's striving for autonomy and independence indicates not only conflict but the need to be helped toward greater self-direction. He needs to be given choices or he gets drawn into severe power struggles (White, 1960).

Thus, when Sandy, a four-year-old psychotic boy, initially hit himself and others at every opportunity, this could be understood historically in terms of conflicts from experiences with his harsh, punitive father and helpless, nonnurturant mother. The ward staff were alerted to interrupt his assaultiveness by restraining him until his experiences with the staff and playing out his terror and anger with the therapist made it possible for him to relate to others with verbal demands and abusiveness which slowly merged into permitting physical closeness.

Jenny, at age five, however, began to lash out at everyone as she emerged from autistic isolation and frozen immobility. She slowly reacted to the warmth, nurturance, and cuddling of the nurses and to the patient engagement of her therapist who used her inert hands in his to mold clay. The violent striking out was seen as a developmental phase combining assertiveness and testing of her world as she slowly lost her fear. Jenny was helped to channel her anger into more effective use of large and small muscles. Thus, with each outburst she was given a choice of clay to pound, paint to splash, or wet sand and flour to mash. These were her first vehicles for discharge of feelings and later opportunities to select areas for mastery in clay modeling and building. Each outburst was viewed as an opportunity to provide Jenny with alternative ways of asserting herself and of selecting the vehicles for learning and mastery. With the development of large and small muscle skills and greater
independence and initiative, she was then able to take her place in the ward kindergarten group.

When the staff understands the child's behavior in terms of efforts to master developmental tasks, they are quickly able to recognize any new signs of increasing maturation and to foster independence and autonomy with rapid reduction of the destructive behavior. They are also less disturbed by the sometimes necessary brief periods of regressive behavior. The child psychiatry fellow can achieve such learning through repeatedly observing someone else attempting this differentiation. Thus, he slowly acquires competence in classifying levels of the child's emotional development, in translating the theory and applying it to concrete behavioral examples given by the ward staff, and involving them in planning ways to help the child develop.

When sequential development is not specifically fostered, the child's conflicts may be reduced, but he often fails to mature. The milieu may in this way iatrogenically produce a new conflict area. Thus, Frank, a six-year-old autistic boy, very gradually was able to move out of his shell and to communicate in clearly heard words rather than frightened, barely audible whispers. The self-rocking stopped and echolalic singsong TV commercials were more audible as he responded to the nurturance and encouragement of ward staff and engaged in the playroom in alternately feeding the baby doll and then, with gradually increased vigor, smashing it to the ground. For several months the repetitive verbalizations were clear and strong. He moved with confidence and could be persuaded to join in group activities, though on the periphery. Parents reported greater vigor in speech and movement with occasional single word commands for food or a toy. Then he began to fade into his old soft, hardly audible speech, moved about less, appeared awkward, and became isolated. Close analysis of this phenomenon brought into focus staff contentment with the first behavioral changes without any clear plan to assess where he was in terms of ego development and to work toward the next step to help him move toward more age-appropriate behavior. Our second and planned efforts had to overcome the massive withdrawal and then utilize his readiness at each developmental stage to provide opportunities for relation-
ships, learning, and mastery appropriate for the next stage via nurses, nursery school, occupational therapy, dance therapy, etc. This time the milieu facilitated continued progress rather than being content with the prolonged plateau which usually ends in regression.

EFFORTS AT COGNITIVE ASSESSMENT

We now come to the area of cognitive development of the child. Using Piaget's model (Flavell, 1963), we observed that most of the severely disturbed psychotic children who require hospitalization operate in the sensorimotor or preoperational stages of development. The task of the therapist is to involve a collaborative team of teacher, occupational therapist, nurse, and psychologist in an attempt to clarify the thinking level of the child. Does he have an inkling of causality? Does he recognize the permanence of the object? How much and when can he structure his environment? Is he capable of using any make-believe or imagination? Are there any areas where he can distinguish between self and others? Can he find the thread that relates several behavioral sequences? These are but some of the questions to which therapist and staff must address themselves if they are to make teaching of the child possible. The major task of teaching while the child is on an inpatient or day care unit is to help him acquire those precursors to academic skills which will enhance his satisfaction in learning and eventuate in his being able to learn and participate in the school situation after discharge.

The therapist's role in this area is to stimulate the recurrent analysis of the child's cognitive level. Thus, the psychologist's evaluations and the teacher's observations must be correlated with other staff observations and data from the psychotherapeutic work. Often such an assessment takes many weeks of close observation and careful testing and retesting of the parameters of the child's cognitive functioning. Sometimes a child's disruptive behavior will not be an expression of psychopathology as much as an expression of utter frustration because the environment is making intellectual demands on him for which he is not ready.

Another task of the therapist is to serve as a stimulus to the other members to collaborate with him in the exciting discovery of methods and techniques which will teach the child such things as the dif-
ference between self and others, what is pretend play, fantasy and reality, and to help him understand that hitting a child and getting hit back by that child are related. They must also find ways to help the child begin to experience object constancy.

Still another task is to encourage and help the teacher and nurse to relay their experiences to the parents. His intimate knowledge of the parents' psychopathology, resistances, and defenses allows the therapist to clarify with the teacher and nurse the best possible methods by which this can be done. Should parents be observers and participate in some activities with other children, or are they ready, with help, to be engaged with their own child in ward activities? How is all this learned? Usually the fellow is totally unprepared for this task.

The greatest problem in the trainee's learning about cognition is in structuring the day care program in such a way that he is not left out of this process. Usually the teacher, occupational therapist, and nurse bring these areas up with the ward director or the psychologist when the trainees are not present. In part it is out of his province, hence it does not require his involvement. Since this material is not taught elsewhere in a general or child psychiatry program, he must learn it in this setting. Since it does not deal with psychopathology or psychotherapy, he may prefer not to be involved in an area for which he is so ill-prepared. Besides, until he learns about cognitive development, he feels anxious and vulnerable and requires support from senior staff members.

This is an area of particular importance to the child psychiatry trainee. It adds a dimension for understanding and discussing the child which enhances his contacts with educators, either as a therapist of the schoolchild or as a school consultant. A major collaborative effort, particularly on the part of teachers, psychologist, chief resident, and ward director, is required to discuss the cognitive aspects of the child's problems in meetings where the trainees participate in order to clarify these concepts and to become familiar with them. The senior child psychiatrists must then repetitively help the fellows carry out observations and engage in discussion until these concepts are useful and familiar to the trainee.

One final unique area in the role of the child psychiatric trainee is responsibility for planning termination of the day care experience
for child and family, with transition to outpatient treatment and involvement in other community resources such as school. The intense involvement of the ward staff with a severely disturbed child, so necessary for the child's improvement, demands that the trainee maintain sufficient objectivity to help the ward staff make the termination a therapeutic experience.

**The Synthesizing Role**

The trainee uses his psychotherapeutic work with the child and parents to provide additional data for understanding the degree of psychopathology and emotional and cognitive levels of the child, as well as to facilitate overall planning for the next steps toward which the team should work. As the trainee learns to assume the synthesizing role, he is faced with examining data from all sources and trying to integrate them for himself and for the team. He must similarly learn to explore gently and uncover the data available in the observations of team members and himself to explain a crisis and to help resolve it. This learning process occurs with some difficulty and discomfort. As has been indicated, it requires the model of a senior child psychiatrist who demonstrates the process to the trainee and whose involvement in this process decreases as the trainee gains experience and competence.

Another aspect of the child psychiatry fellow's work with the child differentiates him from his collaborators. He begins to use his growing understanding of psychopathology and psychotherapeutic methods not only to contribute to the child's general gains, but also to consolidate each step of the growth occurring from all aspects of the therapeutic milieu efforts with the child and parents. Thus, interpretive behavior, comments, and play therapy activities timed in terms of the overall movement may serve to focus sharply and resolve conflicts at a moment when symbolic mastery is possible. With the very sick child he may be the only one who can permit himself to share the child's psychosis as a way of understanding the conflicts and slowly begin to find methods of conflict resolution. This is another aspect of the synthesizing role.

Thus, Phil, a seven-year-old child whose oral-sadistic behaviors were gradually reduced in ward activities and in school, with in-
creased mastery through a variety of living and learning tasks, did not make full use of his energies. He could not move on to the next step in conflict resolution until, in the light of this progress, an old theme in play was reintroduced by his therapist to permit symbolic playing out of a conflict. The therapist brought out alligator and frog puppets which had been abandoned months before. In the ensuing five play therapy sessions, biting, chewing, and swallowing of the frog were increasingly free and voracious as the therapist first made the appropriate sounds and verbalizations for both puppets. Finally, the child joined in and then took over with increasing freedom. This was quite different from the violent, anxious, and desperate play of some months back. In the last of these hours he, as the alligator puppet, restored the frog he had just killed to life with a grand gesture. Subsequently the child's capacity to learn, to pay attention, and to experience pleasure noticeably increased on the ward as his teasing and aggressive behavior decreased at home.

A similar consolidative function occurs in work with parents. The variety of therapeutic efforts by all team members and the parents' experiences, both successes and problems in dealing with the child and their efforts in psychotherapy, are synthesized in terms of their past history and their intra- and interpersonal conflicts. Well-timed interpretive comments often permit the parents to move to the next step in their work.

**Summary**

The specific tasks of the child psychiatry trainee are to learn to use his growing knowledge and competence to synthesize all the data provided by every team member, to define the psychopathology of the child and parents, the emotional and cognitive levels, and to help evolve a collaborative therapeutic program step by step for his patients. He synthesizes all of the data from the setting and his psychotherapeutic work in order to evaluate and promote the next steps in emotional and cognitive growth for the child and conflict resolution for the child and parents. Most important, his psychotherapeutic engagement with child and parents provides the base for all his learning.
REFERENCES


