Inpatient Child & Adolescent Psychiatry: Dr. Bender's Journey Through Curiosity and Connection

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There are no conflicts of interest for this episode.

Introduction

In the realm of Child and Adolescent Psychiatry, especially within an inpatient psychiatric setting, a narrative-driven and curiosity-based approach has proven invaluable. Each child who is admitted is navigating a crisis, making it imperative to deeply understand their unique situation to chart an effective treatment plan. This goes beyond clinical observations; it's about immersive engagement with patients and their families, diving into their lived experiences to piece together a holistic patient narrative. The practice, while time-intensive, lays the foundation for a more personalized and empathetic care strategy. While there's a systematic structure, like maintaining a manageable patient cap, the real focus is on equipping the care team—residents and medical students—with the skills to truly listen, discern, and articulate each patient's story. Strong mentorship, reminiscent of what many seasoned professionals received in their early days, amplifies this approach. The capacity to deeply connect with and understand every patient and their families is enhanced through collective efforts.

Harnessing Curiosity: The Role of Psychodynamic Theory in Inpatient Units

Curiosity serves as a potent tool in engaging pediatric patients within inpatient settings. A sincere interest in their experiences can pave the way for establishing rapport, especially when a longer-term relationship might be elusive. While these young patients may outwardly engage in typical activities, like playing or watching movies, it belies the deep-seated crises that led them to the facility. Penetrating the mental barriers these children erect for self-preservation can be challenging. However, guiding them to recount their journey in a story-like manner offers insights into the events precipitating their admission. Equally crucial is juxtaposing the child's account with the parent's version, spotlighting any discrepancies and potential conflicts. Caregivers can frame a more comprehensive understanding of the patient's circumstances by delving into the patient's support systems, relationships, and daily experiences. The psychodynamic theory, especially when viewed through the prism of Object Relation Theory, allows for a more profound empathy and understanding, drawing caregivers closer to the patient's authentic narrative and possibly illuminating the underpinnings of their symptoms.

The Foundations of Early Relationships: Insights from Klein's Object Relations and Bowlby's Attachment Theory

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Melanie Klein is generally recognized as one of the pioneering figures in object relations theory. This theory emphasizes the child's internal world, where internalized figures or 'objects' play a role in shaping their emotions, thoughts, and later relationships. Klein believed that an infant's

relationships with these objects, often the primary caregivers, form the foundation for future relationships and the development of personality. While Klein laid the groundwork, John Bowlby later expanded on these ideas with his attachment theory, suggesting that the quality of early-life interactions with primary caregivers directly influenced an individual's attachment style and subsequent relationships. The children in an inpatient unit are surrounded by and reliant on family and other support figures. Closely examining these relationships from both the child and family perspectives, using the lens of Klein's object relations and Bowlby's attachment theories, can often help uncover why a patient is in crisis and allow one to understand the deep-seated pain inherent in their situation. Understanding their pain can be invaluable when addressing a patient and family in crisis. To have a clearer conceptualization of the pain or conflict feeding into a behavior that led to admission can foster empathy in parents and providers. Inpatient frequently acts as a gateway into the mental health system for those who wouldn’t typically pursue treatment. Allowing a patient and their family the opportunity to feel truly seen and understood within a moment of crisis can establish a positive perception of treatment moving forward.

Considering the Potential Value and Threat in a Diagnosis

Although the medical model centers on diagnosing illness, it is worth considering the value and impact of diagnosis from a broader lens. A diagnosis is typically utilized as a tool to help patients understand their emotions, manage them more effectively, and access appropriate treatments. There is significant power in diagnosing a child or adolescent; it can help a patient and their family better understand the patient’s experience. The counter perspective is that a diagnosis can potentially be anti-therapeutic if it separates the patient from their family or perpetuates a dysfunctional family narrative.

Borderline Personality Disorder (BPD), for example, is a personality disorder characterized by instability in personal relationships, emotions, self-image, and behavior, and it is a highly stigmatized condition. There are potential positives and negatives to labeling a teenager with a diagnosis of BPD. A positive outcome occurs when the diagnosis leads to effective treatment. Dialectical Behavioral Therapy (DBT) is an effective first-line treatment for BPD, and by providing a diagnosis, patients are more likely to receive the appropriate treatment. DBT is effective in reducing suicidal behaviors, increasing adherence to treatment, and reducing the number of hospitalizations. Patients can also find the diagnosis therapeutic in understanding the intensity and lability of their emotions and use it as motivation to engage in treatment. However, the diagnosis has potential risks as well. Attachment style has long been considered a piece in the potential development of borderline personality disorder. Secure attachment and parental attunement are important factors in developing effective regulation in a child. Insecure

or disorganized attachment styles have been correlated with affective dysregulation and the potential development of borderline personality disorder. Considering this, when dealing with an adolescent patient who is exhibiting affective dysregulation, interpersonal instability, self-harm,

or other symptoms of borderline personality disorder, a diagnosis may contain and alleviate anxious distress within a parent; this, in turn, could allow the parent to be more attuned with their child's experience. If a parent can manage their own distress about their child's difficulties, they may be able to provide a more predictable and secure environment, thereby shifting a dysfunctional and insecure pattern that may have developed.

Conversely, if an adolescent patient is demonstrating these symptoms and the parent or patient is pursuing a diagnosis as a means of resolution, it is unlikely to be protective and can inadvertently reinforce a dysfunctional narrative or insecure attachment style within the family. The diagnosis could then paint a clinical picture that the patient is the only member of the family who requires treatment or is expected to change. In a situation where there is unaddressed conflict within the family or an unaddressed insecure relationship, diagnosis without appropriate psychoeducation can serve as a barrier to change and divert from addressing conflicts within the patient's family or social environment. Without addressing these potential contributors to a patient's presentation, there is a risk that a diagnosis can work against the clinical management of familial patterns that may be core components of the patient's symptom development.

Embracing the Power of the Clinical Moment to Address Burnout in Psychiatric Training

Burnout is a syndrome consisting of emotional exhaustion, depersonalization, and decreased personal accomplishment, thought to develop from chronically adverse working conditions. Literature shows that approximately 34% of psychiatric residents experience burnout. Research has shown that rates of burnout are also associated with training factors such as junior residency years, long working hours, and learner characteristics such as greater anxiety or depressive symptoms and diminished empathic capacity.

Addressing burnout in psychiatric residency requires a multifaceted approach and frequently includes steps such as ensuring adequate supervision, keeping with duty hour rules, and having a supportive learning environment. A more difficult component to address in psychiatric trainee burnout is a perceived diminished empathic capacity. This relates to a component of care where, in the context of working long hours and not receiving adequate supervision, residents can feel less capable of empathizing with or feeling connected with their patients. To feel overburdened while also feeling less effective or connected with your patients and work can contribute to a vicious cycle of perceived inadequacy.

In addition, the majority of clinical experience in the first two years of training is in inpatient or acute settings. This means residents are generally not exposed to longitudinal patient progress and, therefore, miss out on the potential clinical gratification of witnessing human progress over time in their patients. Residents can see psychosis, mania, catatonia, and other crises resolve in

acute settings, but a large proportion of their patient experience can be with chronic, complicated cases of depressed, anxious, or personality-disordered patients. These clinical experiences can be frustrating, and one is frequently left to gauge their effectiveness on whether a patient is subjectively reporting improvement in their mood or presenting symptoms. Training residents to focus on building a human understanding of their patient's pain or why specifically they are presenting in a crisis can potentially increase their sense of empathic capacity. While this is most likely to be achieved through good supervision and broad exposure to the wealth of variable theoretical models to allow residents to find the approach that fits their perspective, a general focus on clinical, humanistic curiosity about patients seems essential in residency training. While an early year resident can meet a chronically suicidal patient and quickly form an assessment and differential, it can come with a sense that they serve no purpose in that patient's life or situation. Leston Havens would say that the first goal of any clinician is to "find the patient." To "find the patient" is to witness their pain in the most basic human sense, and to witness a patient's pain can foster a sense of purpose in trainees. Singular moments of empathic connection can occur regardless of the treatment setting or length of clinical involvement in a case. Building a sense of gratification in these singular moments of empathic connection and shared humanistic understanding of a patient's pain can address feelings of diminished personal accomplishment in trainees. When a patient senses their pain is truly being witnessed, seen, or heard, a more human connection can be experienced in the clinical space by them and the provider. There can be an understanding that a patient may continue to struggle, but the narrative shifts from something clinical and disconnected to something more realistic and in line with the patient's experience. It could be argued that understanding a patient's pain in a basic, human way is simply a starting point. To residents in the cycle of inpatient and emergency room work and for patients in a cycle of feeling missed or unheard in the mental health field, that understanding can be uniquely powerful.

Further Reading:

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