Expanding the Role of Supervision in Child Psychiatric Education

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ABSTRACT: Despite the burgeoning of available therapeutic interventions, the sparse literature devoted to child psychiatric supervision concentrates on individual psychotherapy. The non-cognitive aspects of the expanding supervisory challenge continues to converge on the clinician's personality, which is a focus of educational attention only in sequestered or haphazard parts of programs. The unidimensional supervisory literature addresses this issue by questioning the extent to which supervision should resemble traditional pedagogy or personal psychotherapy. In contrast to this emphasis on elusive unconscious influences on clinical work, scant attention has been devoted to other influences stemming from the clinician's current experiences, affiliations, identifications, aspirations and similar more easily modifiable factors that exert considerable leverage and tend to be more accessible to rational scrutiny in supervision. The latter half of this paper discusses these factors.

Despite widespread popular acclaim as the most valued educational experience in psychiatric residency, clinical supervision has received only "sparse" [1] attention in the psychiatric literature and has been "almost completely ignored" [2] in child psychiatric publications. Although rarely noted explicitly, another limitation within this restricted literature is its pervasive unidimensionality. It tends to focus on psychotherapy supervision. Even in the relatively infrequent instances when the discussion of supervision ventures beyond the teaching and learning of psychotherapy to address the totality of the education of the child psychiatrist, there is a rapid almost imperceptible drift in the discussion quickly converging on psychotherapy supervision [3]. Review of the literature suggests that of the three sources identified a quarter of a century ago [4] as contributing to the sys-

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tem of planned hours of individual supervision in psychiatric residency education—(a) the preceptor techniques of medical education, (b) the individual supervision that was then often called control hours in psychoanalytic institutes, (c) the productive supervision system in the training of social case workers—the psychoanalytic root has been both the most influential and enduring.

This pattern is thoroughly consistent with child psychiatric clinical efforts during the time when much of this supervision literature was published in the 1950s and 1960s. Two decades ago, child psychiatric clinical activity was limited by and large to two types of therapeutic intervention. The choice tended to be between either some variant of psychodynamically oriented psychotherapy or environmental manipulation. Clinical evaluations, therefore, focused primarily on assessing the suitability of the child and his or her environmental supports for "acceptance" into psychotherapy. Consequently, evaluation was not emphasized as a clinical skill and consultation tended to be dismissed educationally as requiring no more than "common sense."

Since then there has been a substantial expansion in the numbers of available child psychiatric treatment modalities with a corresponding increase in the importance of meticulous diagnostic assessment designed to match the child and/or family with the most appropriate therapeutic strategy [5]. Simultaneously, there has been a fruitful refinement of the subtleties of the consultative process. Logic would suggest a comparable widening of supervisory horizons, which shall constitute the thesis of this paper.

In pursuing this theme, there is no intention to minimize the seminal role of psychotherapy supervision in the education of child psychiatrists. Indeed, its value extends far beyond its merit in "training" the child psychiatrist to do psychotherapy. Far more significantly, it is a rich educational technique through which the resident can derive a unique appreciation of another's internal functioning, facilitating an *in vivo* study of developmental processes, and simultaneously sharpening the clinician's use of self. On the other hand, it should be noted that this valid rationale is sometimes used—or more accurately, abused—to justify features of the residency program that are better explained otherwise. Among these are many programs' traditional clinical and conceptual unidimensionality, reinforced by the usual systematic resistance to change. A pragmatic accompaniment of this circumstance may be the program's excessive reliance on extramural supervisors, i.e., those who are not an integral part of the institution and who thereby tend to be particularly suitable for supervising the resident's psychotherapeutic efforts. Similarly, a heavy dependence on clinical

supervisors who are not physicians and whose primary expertise is psychoanalytic psychotherapy often contributes to psychotherapy being assigned a primacy that can assume precedence over the clinical needs of patients and the educational needs of residents.

It has been the author's experience that when a program director asserts the aforementioned justification for emphasizing psychotherapy supervision as an educational device, there is a risk that residents will perceive his words as sounding like a guilty parent who wants his children to "do as I say, not as I do." Obviously, it is likely that the resident will identify with, if not imitate, the role model as he experiences it rather than as it is verbalized to him. In addition, an admired supervisor's direct declarations, in the course of helping the resident, that "I don't supervise anything except psychotherapy" and "my own practice is limited to psychoanalysis" will prove far more influential than the program director's involved explanations why the program's educational emphasis on psychotherapy does not represent what child psychiatry is or ought to be. Further, in the face of the growing complexity of child psychiatry and the burden of its inevitable ambiguity, the process of learning tends to stimulate students to cope with distressing uncertainty by jumping aboard a "band wagon" therapy [6]. In pursuit of a secure identity as a child psychiatrist, this adherence can reaily assume the aura of a "garden of Eden" therapy [7]. For the student, there is now only one truth. Such an allegiance decreases the resident's discomfort, which is self-reinforcing, and as noted before it often enjoys institutional support, as well.

Unfortunately, this search for an illusory certainty can interfere with the resident's development of empathic clinical sensitivity. Adams [8] noted that it can result in forms of egocentrism on the part of both the child psychiatrist and the young patient which are remarkable for their similarity. This analogy is based on Piaget's [9] observation that as a consequence of the nature of the relationship between child and adult, the child's thinking tends to be isolated. This places the child apart; while he or she believes he is sharing the point of view of the world at large, he actually remains shut off and isolated in his viewpoint.

This cloistering potential may be reinforced inadvertently by the very process of supervision itself. The literature comments frequently about the rarity of specific preparation for the clinical supervisory role beyond the past experience of having been supervised. For instance, in the context of decrying the insufficiency of a scientific emphasis in child psychiatric education, Anthony [10] observed that "child psychiatry training is carried out through a system of super-

vised apprenticeship, and the trainee picks up procedures in the way that children assimilate the practice of parenthood from their parents, first by acting as children, then by becoming surrogate parents, and finally by becoming parents." This description of a sequential intergenerational transmission of what Anthony designates as "gut knowledge" which he notes "dies with the gut" should underscore that supervision, even if it is popularly considered to be the most valued of all educational experiences (an assessment that does not require the support of multiple citations because of its inherent ring of truth) nevertheless should be but one of several teaching efforts. Although it is an effective means of enhancing skill in the art of child psychiatry it is not the only one and there are still other educational devices that are better suited for enhancing the scientific end of the child psychiatric spectrum.

The supervisory challenge posed by the burgeoning numbers of available therapeutic interventions is a most delicate one. Clearly, residency programs can no longer aim to begin to create expertise in every one of the currently available therapeutic modalities. The all-purpose child psychiatric "renaissance" therapist who is the most qualified to administer every conceivable treatment is a creature of the past [5]. Thus, educational priorities must be established carefully while fostering an informed awareness of the availability of alternate intervention strategies and their clinical indications. The goal is to accomplish this without diluting the educational offering in keeping with Ornstein's [11] caution and without engendering the feeling that the therapeutic grass may be greener on the other side of the fence.

The aim is to prepare the resident to be a psychosocially oriented human biologist who will increasingly become an effective problem solver in complex clinical situations. The problems to be addressed are usually multidimensional, of mixed etiology, with the unique idiosyncratic features of the individual and/or the families always present. Diagnostic assessment therefore usually will result in a pluralistic formulation of the problem with selective discriminative prescription of optimally specific therapeutic interventions. It is neither essential nor likely that any single child psychiatrist could be expert in the actual administration of all of the possible therapies. Such versatility is unlikely in today's climate of an exponential burgeoning of therapeutic modalities. Consequently, the child psychiatrist will require the collaboration of other professionals and/or technicians for specific therapeutic interventions.

For the purposes of comprehensive diagnostic assessment, how-

ever, the child psychiatrist has to be ready and able to consider the broad range of possible effective treatments comparable to the physician's familiarity with insulin for diabetic coma and craniotomy for intracranial pathology in order to deal with the comatose patient even as the same physician is not personally capable of administering all these forms of treatment. This panoramic perspective that is a prerequisite for diagnostic assessment would be disadvantageous if it were extended into the actual administration of the therapy. Indeed, in treating patients, it is often advantageous to tune out selectively those techniques judged to be inappropriate for the particular patient and/or family. In addition to many techniques being contraindicated in the specific situation, endeavoring to keep extraneous ideas in mind could contribute to confused therapeutic fuzziness resembling a polyglot Tower of Babel therapy. As noted earlier, however, the same multipolicity of ideas fosters diagnostic enrichment. Thus, the initial diagnostic assessment and the on-going reassessments during the course of treatment require the broadest gauged competence but the actual administration of therapy does not. Indeed, a limited focus may enhance the quality of the treatment.

Despite the cumbersomeness of the foregoing sentences, this orientation is easier to articular than it is to truly integrate. This is because it threatens those child psychiatrists who only yesteryear were the most expert at everything and who draped themselves in an aura of clinical omnipotence. Today's clinical challenges require the child psychiatrist to comfortably accept that a paraprofessional from the same neighborhood may be more gifted than a psychiatrist at talking down a drug overdosed acutely psychotic adolescent in the emergency room and that in the residential or day treatment therapeutic milieu, nurses and child care workers are more expert in life space interviewing than the child psychiatrist. The foregoing examples may be relatively easy to accept but would the same be true for those sophisticated therapeutic intervention techniques that have traditionally been the most esteemed, have been heavily employed educationally as the focus of supervision, and quite frankly have assumed an elitist cast, i.e., intensive individual psychodynamically oriented therapy? The same question could be asked regarding pharmacotherapy.

The foregoing concerns may have deep unconscious determinants, nevertheless there are also highly significant influences stemming from the residents' current experiences, affiliations, identifications, aspirations, and similar easily modifiable factors. The literature on supervision devotes much thought to the thorny issue of the extent to which the supervisory process should resemble a traditional pedagogical ex-

ercise and the extent to which it should resemble personal psychotherapy [1, 12]. Despite all the advances in psychopharmacology and in therapeutic utilization of the behavioral, social, milieu, and other external agents and instruments, the child psychiatrist's personality remains a most potent vital diagnostic and therapeutic instrument. Many psychiatric treatments are enhanced by a quality of spontaneiity on the part of the therapist. Indeed, except in the biological and some of the behavioral therapies, the child psychiatrist has limited opportunity to calculate the dosage of each therapeutic intervention. Consequently, once they have made some assessment of the situation and determined their approach, experienced therapists generally behave relatively spontaneously. These quasi "spontaneous" interventions are subsequently subjected to post hoc scrutiny. Therefore, child psychiatric work encompasses highly individualistic styles of practice requiring a considerable degree of self understanding, self realization and self actualization. These capacities in turn encourage the refinement of sensitivity, intuition and empathy. Such traits are central to the participant observation combination of evocative listening and intervention that characterize most of the diagnostic assessments and so many of the therapeutic interventions of the child psychiatrist. Enhancing these noncognitive problem solving and relationship capacities has tended to be relegated either to sequestered or haphazard parts of child psychiatric educational programs. A notable exception is the program described by Szurek and Berlin [13] which has not been widely emulated.

The bulk of the attention to noncognitive factors has been devoted quite appropriately to the child psychiatrist's psychological functioning. This evolved from origins in psychoanalysis and psychobiology to the still unresolved pedagogy-therapy controversy that is so prominent in the literature about supervision. It is manifested also by faculty fuzziness in distinguishing between the teacher (or administrator) role and a therapeutic role. This often becomes evident in faculty discussions of problem students where it is infrequently a question of passing or failing; typically, the issue of the resident's interfering personality factors becomes the focus for faculty exploration. In consequence, it may be difficult to distinguish a faculty discussion about a student from a clinical discussion about a patient; indeed, parapraxes often occur in which faculty refer to a resident with the label "patient."

The origin of clinical supervision of psychiatric work is generally credited to Adolph Meyer [14]. He was instrumental before the turn of the century in arranging for the junior assistants at an Illinois East-

ern Hospital for the Insane to be directly supervised by their seniors instead of working independently as had previously been the case. Meyer also developed the personality study and life chart which in certain training centers, were subsequently completed by the trainee about himself to serve as a basis for interviews with one of the teaching staff as a means of learning psychotherapy [15]. Clearly, this method of clinical supervision explicitly resembled the process being taught and learned. It is the author's impression that with the passage of time, this formal practice has become less common, if not extinct.

The beginning of psychoanalytic training was dated by Freud [16] to shortly after the turn of the century. This entailed discussions at Freud's home, which have been described as including the interpretation of one another's dreams [17]. Eventually, it became increasingly common for the prospective analyst to undergo personal psychoanalytic therapy. Originally the aim was to demonstrate to the candidate the existence of unconscious mental functioning. This has evolved over the years to encompass the aim of freeing the candidate from emotional conditioned attitudes which could interfere with psychoanalytic therapeutic work. Simultaneously, it has become a required and sequestered part of the psychoanalytic curriculum. The resulting impression that psychoanalytic education has resolved the dilemma regarding the interrelationship of pedagogy and psychotherapy is more apparent than real. Despite the separation of reading, lectures, seminars, and supervision from personal therapy in psychoanalytic education, controversy nevertheless persists about how to proceed when it is evident in clinical supervision that personal emotional problems adversely affect the supervisee's therapeutic work. There is no disagreement about the injunction "know thyself" but the means of accomplishing it are sometimes subject for debate even in this highly refined system.

Probably the most widely cited psychiatric model is Ekstein and Wallerstein's [12] tightly reasoned detailed discussion of psychotherapy supervision. Explicitly, they designate it as "neither personal therapy nor just a conveying of didactic information on theory and technique." Their delineation of personal therapy as a prerequisite for psychoanalytic training but not necessarily required for psychotherapeutic training, is an accurate description of the prevailing current situation. But, phrasing it that way risks conveying a mystique about psychoanalytic education that can serve inadvertently to deemphasize the essential supervisory issue. The basic supervisory question is not whether personal therapy is a prerequisite. Even questioning whether it is needed by a particular supervisee can serve as a glob-

al distraction from carefully defining and delineating the individual supervisee's strengths, weaknesses, vulnerabilities, potential, progress, etc. An ongoing assessment of the supervisee focused on these factors can naturally include in an informed and potentially more sensitive way the question of the potential benefit of personal therapy. In many respects, this should be more of a personal and perhaps private question for the supervisee rather than necessarily being a supervisory one. Obviously, the question can be avoided by making personal psychotherapy a prerequisite for the program as is done in psychoanalytic education; however, it should be emphasized that this does not answer the essential supervisory questions regarding the clinician's strengths, weaknesses, vulnerabilities, potential, etc.

In contrast to the emphasis on elusive unconscious influences on clinical work, scant attention is generally devoted to a myriad of other factors that may exert considerable leverage and are also more accessible to rational scrutiny in the supervisory situation. This is not to say that the illustrative issues about to be noted do not have less accessible unconscious determinants; it is to assert, however, that they may be amenable also to more superficial influences and that merits explicit supervisory attention. Mention of them will proceed from the general to the specific—beginning with global examples applicable to all clinical residents to be followed by selected issues of particular importance in child psychiatry.

Exemplifying global universally applicable issues are the resident's ethnic, racial, and social background factors. More immediate ongoing influences may be derived from stresses that are often byproducts of the educational process, e.g., moving to a new area, the transition in role from physician to student, difficulty in defining the psychiatrist's professional identity, uncertainty about child psychiatry's therapeutic value and its future.

Of a different order are the stresses stemming from what may be a different life style and value system. The frequency of marital separation and divorce appears to be markedly increasing among both psychiatric faculty and residents. If this impression is not an idiosyncratic one (it does seem to be supported by Taintor's et al. [18] questionnaire data in which 12% of the respondents [with 50% return rate] became separated or divorced during residency and many reported that their maturation during training contributed to or caused problems in their personal lives) and if it represents more than a reflection of societal change, what might this mean in terms of the value child psychiatry has traditionally assigned to a stable home and family? If these are no longer as predictable within the profession itself, if the

search for an elusive private personal happiness may be assuming greater importance than family stability, should these issues be opened up to scrutiny in something resembling the supervisory situation? Should the resident's family be included in this exploration [19]?

There is a wide array of features inherent in the content and structure of the educational experience that exert significant influences. The bulk of attention tends to be focused on the ratio (and quality) of supervision, lectures, seminars, critical reading, research, etc., in relation to clinical service. But, almost all child psychiatric residents have been subjected to more subtle influences like those derived from the apparent irrationality of the sequence of the traditional general psychiatric residency that begins with an adult inpatient experience, thereby making the most junior resident responsible for the sickest and most challenging patients. Are comparable ethical messages being conveyed to the child psychiatric resident by the style of organization of the program's clinical services? Are teaching cases designated as "good" and "bad"? Is the trainee responsible only for a small case load or is the resident nominally responsible for a large number of patients from whom a few are picked off an "assembly line" for intensive contact with an educational rationale? What is the fate of the ostensibly less desirable teaching cases and what effect does this have on the resident's professional development? How is this clarified as representing a system variable and not a patient variable?

There is an inexhaustible list of influential factors inherent in the supervisor-supervisee relationship that could be cited. One that has become increasingly significant in recent years stems from the discrepancy between those residents who are not necessarily involved with the counter-culture movement, but nevertheless have far more of a "here and now" action oriented approach than their teacher's focus on the lessons to be learned from reflecting about the developmental "there and then." Another factor that appears to be growing in frequency pertains to whether the resident and supervisor are of the same or different disciplines. Although this issue is less highly charged than it was in the past, nevertheless, it inevitably influences the extent of the role modeling and the nature of the student-teacher competitiveness. Is the supervisor also the supervisee's boss, with direct influence on the supervisee's advancement not only in the educational program but also in the organizational hierarchy? Whether the supervisor has some other intimate involvement with the institution may contribute to a different educational atmosphere than when, for example, the supervisor is an outside consultant who is essentially external to the institution except for his educational contribution.

The question of who is the responsible clinician can contribute to a phenomenal amount of ambiguity in role relationships. Is the supervisee ultimately responsible, with the supervisor's role that of offering advice for the supervisee to use as he sees fit? Or, is the supervisor the person in whom clinical responsibility is really lodged, which he temporarily delegates to the supervisee for educational reasons? Or, is a third party the responsible clinician, e.g., a ward administrator who delegates clinical responsibility to the supervisee and educational responsibility to the supervisor?

Although these role relationships may be unalterably fixed by institutional policy, it is advantageous if there is sufficient flexibility to allow developmental progress. With the supervisee's professional growth, he should assume increasing clinical responsibility so that eventually the supervisor is used primarily as an occasional consultant. The various models of supervision vividly described by Fleming [20] lend themselves to being placed on such a developmental continuum. The "jug-mug model" in which a quantity of information is poured into the resident's mind might constitute an appropriate introductory phase. The next level can be described by the analogy of the "potter" who transforms unformed clay into a shape with utility and beauty. The most advanced supervisory metaphor is that of the "gardener" preparing the soil, planting the seed, nurturing the seedling and encouraging growth to maturity.

To some extent these models point to the distinction between professional *education* on the one hand and *training* to master specific skills on the other. Although professional education usually includes training in specific skills, it should be noted that training in skills by itself does not necessarily constitute professional education. Obviously, certain universal sequential professional developmental considerations pertain but consideration has to be given also to the individual features of the supervisee's growth towards autonomy and also to the individual supervisor's authoritarian tendencies. There is considerable difference between a supervisor asserting what is correct as against assessing with the supervisee the several possible options and mutually establishing priorities. In this context, the supervisor who mentions his own difficulties, mistakes and failures, either with or without soliciting the supervisee's advice, offers far more than the supervisor who invariably offers only excellent, useful, helpful advice. In the extreme, the latter may be designed to train people to behave like automatons as against helping them to exercise their capacity to think and act deductively, constructively, flexibly and creatively. In other words, the rationale underlying the supervisor's advice is more valua-

ble to the supervisee in the long run than the suggestion itself (although the suggestion may be of inestimable value for the patient). But, even that is not sufficient by itself. For example, concern should be engendered if an inexperienced resident passively accepts a supervisor's authoritative statement that two or three additional evaluative contacts with an autistic child will not substantially alter the quality of the youngster's relation with the resident, even if that judgment is supported by a tightly reasoned rationale. In order to learn, the resident needs to experience the fruitlessness of those return visits. This necessitates second and third visits that may be useless from the patient's and the family's point of view but are essential for the resident's education.

While the foregoing example illustrates an instance in which the supervisor could assume too much responsibility, the usual *post hoc* clinical supervision generally poses more of a risk of the opposite. The practice of reacting to clinical material after the fact can easily lull a supervisor into neglecting to initiate anticipatory discussion of issues about which one might not expect an inexperienced supervisee to be prepared. Suggesting how it might have been handled better after the supervisee has muddled through is not as productive as predictively contemplating inevitable clinical issues. Among these are the ubiquity of pain accompanying the frequent avoidance of feelings about separation and the common difficulty that inexperienced clinicians, who wish to be benign good helpers, experience in dealing with negative transference. Anticipatory planning facilitates mastery so much more fruitfully than only correcting errors.

Child psychiatric supervision entails one adult teaching another adult. Because the educational objective is to understand and help children, it is important that both adults consider the extent to which they view their own childhood and adulthood as interrelated aspects of a continuum and the extent to which they consider them to be separate, polarized, discontinuous stages. To truly tune in with children, each of us individually has to address when, how, and why we think of children and adults as distinctly different, when we view children to be miniature adults, and/or adults as larger children. Otherwise, adults who typically look back longingly and nostalgically to their own childhood may have trouble appreciating the impatient child who cannot wait to become an adult.

Is there any reason to think that child psychiatric residents or their supervisors should be endowed with a special immunity against what appears to be a pervasive though unconscious societal prejudice against children [21]? Residents soon find that their intimate involvement

with children may reactivate for them those psychological issues that had presumably been put to rest many years earlier [22]. Supervisors, on the other hand, tend to react more to youths' predilection to criticize their elders while the youngsters are preparing to take their place and send them out to pasture.

The early focus on the stresses imposed by the educational processes and system was not intended to minimize the significance of those psychological vulnerabilities that many believe are overrepresented in people who are attracted to child psychiatry and other mental health work. Indeed, there has been controversy about the relative advantages and disadvantages of such traits for clinical work. Some have asserted that psychological suffering is an inevitable ingredient in psychological mindedness, while Holt and Luborsky's [23] study suggested that competence as residents (and probably as practitioners) was correlated with psychological health and conventional adjustment.

In addition, working with people's mental health differs from medical, surgical, and other helping professional undertakings in a critical way. With the exception of parenthood [22] there are few undertakings where the problems experienced by the provider of the help so closely resemble those of the patient or client. In other words, the range of emotional ractions within the child psychiatrist is likely to include some of the anxieties, depressions, regressions, and hostilities as well as cannibalistic, murderous, and incestuous urges that are so central to the patient's difficulties. Hopefully, the clinician differs from the patient by virtue of being less disturbed and by possessing a basic capacity for self-management and self-awareness. For instance, some colleagues are attracted to working with children in part in an effort to allay anxiety by identifying with the aggressor; in effect they become surrogate parents. There is nothing inherently wrong with this as a motivating force; however, it is vital to be alert to the possibility that it may fuel an overidentification with the child along with a negative attitude toward the child's parents. Lack of awareness of the source of such motivations can cause the child psychiatrist unintentionally to add to the child's discomfort by accepting as literally true what is in fact an expression of hostile fantasies about parents; or he may reinforce the child's pathological distortions by fostering projections onto the family. The clinician's familiarity with his or her own anti-parent, anti-sibling, or whatever prejudices should make it easier to work with the child's hate for the family without losing sight of the child's love for the family. This will play a powerful role in enabling the child to survive with his or her own family.

More than that, however, and of potentially greater significance is the fact that this will be a major support for the future capacity to love.

From still another perspective, the resident's use of self tends to require an alteration in the detached approach model that characterizes traditional medical practice. Many have observed that to accomplish this change may require modifications in their previously adequate coping styles. Again, this is one area in which educational programs typically offer too little help either in a group setting or individually. In addition, the process of learning and applying different clinical approaches tends to require further differentiation in the use of self. This will be illustrated here by contrasting stereotyped characterizations of the use of self required by different therapeutic intervention modes.

Psychodynamically oriented therapy, for instance, requires that the clinician keep personal reactions under control while observing his own internal processes. The goal is to discriminate between objective professional reactions, those that stem from the clinician's own past, and those emotional reactions stimulated by the patient. Simultaneously, the patient is encouraged to look at himself, to explore the past and to study its effect on the present. This is a deep and powerful interaction that demands much of the therapist who experiences the patient through himself.

In contrast, the naturalistic and scientific emphases in the biologic and behavioral therapies make different demands of the therapist. Distance between the clinician and the patient is encouraged in an effort to maximize objectivity. The emphasis is on prediction and control of the problem at the expense of appreciating the patient's subjective experience.

Family therapy (as well as related social intervention modes that are predicated on a systems orientation) postulates change as stemming from the therapist's affiliation with the family (or other social system). He uses his relationship to alter individual roles in the dysfunctional transactional processes of the family and in its total structural organization. In order to successfully affiliate with and experience the pressures of the family, the clinician does not guard against spontaneous personal responses. It is assumed that those responses will be system syntonic; even if they are not, however, they can serve as valuable exploratory probes.

It should be a supervisory responsibility to assess the resident's capacity to use himself flexibly, to help him expand that capacity, and to increase discriminatory dexterity in the clinical use of self. A more

important goal than being able to change from one therapeutic posture to another is for the child psychiatrist to be cognizant of the need and of their individual capabilities and limitations. Central to responsible professionalism is a reliable, trustworthy sense of knowing where one's knowledge and skill begin and end. Those boundaries should be ever expanding with increasing freedom from rigid adherence to any preferred theoretical model of human development and deviance, allowing the clinician to reach beyond the therapeutic intervention stragegies that are integrally related to such a preferred framework. In the absence of such growing autonomy, the child psychiatrist risks confining himself inappropriately to a limited diagnostic and/or therapeutic range which deals with only one aspect of the patient's integrated psycho-bio-social system. This should not be construed as advocating that child psychiatrists should function without a preferred theory. Such a framework is required minimally to organize the inevitably massive data of clinical observation. Accompanying the need for a theoretical framework, however, is a vital need for vigilance that the theory not distort what is observed clinically nor influence which treatment is recommended.

Child psychiatry shares with several other mental health fields a vulnerability to be faithfully devoted to a single framework and technique. This appears to be specially true when a growing momentum of interest is building up around a new therapeutic strategy. Some react to new developments by shutting their eyes to the new approaches and clinging tenaciously to what they have always done. At the same time, other clinicians may be readily persuaded to join the enthusiastic proponents of the new methods who write and speak to the point of overzealousness regarding the merits of exclusive use of the new treatment. That seems to have occurred with psychoanalysis in the 1940s and 1950s whereas in the 1960s and 1970s similar claims are made for behavior therapy and family therapy. It is the responsibility of supervision and of the entire educational program to emphasize that as a bio-psycho-social synthesis, a person suffering disturbance in one aspect of the integrated human system may experience it as being reflected in other parts of the system. Thus, the system manifesting the most disturbance is not necessarily the one in which the basic problem exists.

Hopefully, the continuing education and recertification thrust will serve not only to insure that the professional will endeavor to expand his or her knowledge base, develop new skills, and sharpen old ones but will serve also to reinforce the idea that professional education

has no terminal point and that the formal program is the beginning of an open ended process with a major aim of learning to learn.

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6. NAMES AND COMPLETE ADDRESSES OF PUBLISHER, EDITOR, AND MANAGING EDITOR

PUBLISHER *(Name and Address)*: Human Sciences Press, 72 Fifth Avenue, New York, New York 10011

EDITOR *(Name and Address)*: John C. Duffy, M.D., 7111 44th Street, Chevy Chase, Maryland 20015

MANAGING EDITOR *(Name and Address)*: Daniel Grant, 72 Fifth Avenue, New York, New York 10011

7. OWNER *(If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.)*

NAME	ADDRESS
Human Sciences, Inc.	72 Fifth Avenue, New York, N.Y. 10011

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