All these changes within the family due to hospitalization of their emotionally disturbed child are meaningful for the treatment rationale. As our cases illustrate, the changes occurring within these families upon separation from their sick child give us clues to the meaning of the child's illness to the family. The child's choice of symptoms, with all its etiological and adaptational implications, can be further investigated along these paths. We are now studying this very interesting matter of the symptom choice and our findings will be reported.

From our proposition, it follows that an accurate understanding of the meaning to the family of the child's illness will help our therapeutic intervention. We conclude that, as children cannot be observed in isolation, neither can they be treated in isolation.

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SOME ASPECTS OF GROUPING IN A CHILDREN'S PSYCHIATRIC HOSPITAL*

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PLANNING for treatment of a child on an inpatient psychiatric service presents problems arising not only from consideration of the child's individual psychopathology and of the difficulties in his home environment, but also those inherent in creating and maintaining a therapeutic milieu. A vital aspect of this milieu is the composition of the groups in which the patient will be placed. The importance of grouping is underscored when one considers that almost without exception children accepted for residential treatment have failed to integrate themselves successfully into a group of any sort in their home environment.

From the standpoint of the child alone, the number of variables to be considered in grouping are manifold—age, sex, size, other physical characteristics, intelligence, social and cultural background, symptomatology, behavior and diagnosis. Academic achievement and a variety of other skills assume more importance in some activities than others. These factors must be weighed in relation to the realities of the institution's physical plant; the composition, attitudes, and capabilities of the staff;

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the number of available groups; and the philosophy underlying treatment at the particular center.

We have neither attempted to present a complete list of variables nor discussed the relative merits of utilizing these factors to achieve homogeneity or heterogeneity in the different groups. Nevertheless, it is patently evident that the resultant number of groups would be burdensomely extravagent were each of the variables to be utilized as a determinant in grouping. Clearly a compromise must be effected. The precise nature of that compromise will vary from center to center. Nevertheless, we thought there might be some merit in describing and discussing the methods that we have evolved empirically. In doing so we make no pretense of having the final answer for ourselves, much less for others.

As a teaching hospital, we maintain control over our limited intake. Thus, the first problem concerning grouping arises when admission for a child is planned and he must be assigned to a ward. As a matter of fact, children are selected from the waiting list on the basis of which ward has space available. (We regret that limited space does not permit even a brief orienting description of our physical plant, admission policies, and therapeutic philosophy.) Our three wards are home base for the children and contain the rooms where they sleep, eat and spend much of their free time. One of the wards cares for the younger children, eight years or younger, so that all children in this age range are automatically assigned to this floor. The question as to which of the two other wards available for older children will be used is determined almost entirely on our speculations as to whether the child needs a closed ward. Children who are extremely impulsive, anxious, or in poor contact with reality and who we feel would be supported by the more structured atmosphere in a closed ward are assigned there. As we have matured as a therapeutic team and rely less on locks, this usually involves no more than six to eight of the older children out of our total census of 50 or so. This means that other beds on the closed ward are filled as the space becomes available, regardless of the child's need for closed ward area. These children may have hospital privileges which gives them free access to the areas where other activities are scheduled and to an outdoor recreational area. The kind of situation resulting in this almost accidental assignment to a closed ward can be illustrated by the example of an inhibited 12-year-old girl seriously ill with ulcerative colitis, who was referred to us when the only available bed for a girl of her age was on the closed ward. She was assigned to that ward although nothing in her behavior indicated a need for a locked ward.

Perhaps a special feature of our program results from its close association with the University Medical Center and our interest in psychophysiological problems. This means that three or four children on each ward are admitted for treatment of psychophysiological disorders with or without other symptomatology. Therefore, some of the children on the floor are seriously physically ill and may require special nursing care, diets and so on. For example, we had one boy in a full body cast requiring stretcher care, and we have admitted several youngsters who had lost over half of their body weight. Our impression has been that the presence of children with physical symptoms has advantages as well as disadvantages. It

has helped convey the message that we function as a hospital and not a substitute home or boarding school. We try to foster the attitude that the children are sick and admitted for treatment. A more evident problem has been created by the reaction of the physically healthy child to those with physical symptoms. Our approach to psychophysiological problems is *not* one of encouraging regression. To the maximum extent of their physical capabilities and perhaps a little beyond, they are expected to participate in all school and recreational activities along with the other children. Most of these children have previously capitalized on the secondary gain aspects of their physical illness in their home environment. After admission they usually have an opportunity to continue to do so initially, as the children without physical problems attempt to cater to their special needs. This infantilization by the other children wears thin after a while, and we then find the physically healthy children apparently denying the presence of physical illness in their peers as they begin to make demands of them.

Another interesting phenomenon has been the effect that children with the gross distortions of reality, the psychotic children, have had on those with poor impulse control and manifest aggressive behavior. This type of agressive child is notorious for his ability omnipotently to avoid awareness of the fact that he has problems and of his own role in them. This defense is sometimes rather abruptly threatened by admission to a hospital ward containing some children that are obviously "crazy." The instinctual material that may be expressed or acted out by the psychotic child poses a threat to the delinquent children who are generally struggling with their impulse control. This rising tide of anxiety is often considered a hard-to-achieve initial therapeutic goal. It has certainly given us abundant opportunity to recognize with the child his problems in impulse control and gives us a realistic framework on which to begin to help him improve his own control efforts.

Probably the most persistent problem troubling our ward staff is a consequence of the sexual stimulation arising in a situation where children live so close together. Except for a few four-bed rooms, most of the children live in single or double rooms. The rooms are arranged along one long corridor with recreational areas and dining rooms at either end. One end is the girls' side, the other, the boys', and along the corridor between are the bathrooms, nurses' station and storage rooms. The children mingle freely together in the hallways, recreational areas and dining room. The staff enforces the rule that patients not enter the bedroom of a member of the opposite sex. It is indeed rare for children well into or beyond latency age, regardless of psychopathology, to live in such close proximity to members of the opposite sex without the support of an incest taboo.

This unsolved dilemma was recently verbalized most directly and constructively by a ten-year-old girl who, as spokesman of a three-girl delegation, requested a separate ward for girls. At the time of her admission to the hospital her principal symptom had been compulsive masturbation. She had grown up in a distorted family situation where mother and father slept apart. She and an older sister had been covertly overstimulated by the father. Her presenting defensive structure struggled against recognition of the sexual aspects of her conflicts. After many months of treatment had succeeded in bringing the nature of her difficulties more into awareness, she

approached the ward administrators with her request. She said that another girl had suggested that the world would be better off without boys, but she disagreed with this, saying that some day she wanted to grow up, get married and have her own family. She said, "I like boys for schoolmates and I don't mind eating with them. It's just living with them that is so hard." Needless to say, most of our patients do not express this in such a constructive fashion. Of greater concern is the relative inarticulateness of our ward staff. We are in the fortunate position of being able to select our staff from a large number of highly motivated, intelligent, energetic, adaptable university students. The disadvantages of this source of child-care workers are that they do not make a career of it and that they tend to share a special vulnerability in the realm of sexuality.

In other portions of the hospital, the nature of the activity is often the determinant of permissable limits for composition of groups. For instance, in the occupational therapy shops, assignment to a group is based primarily on age. Secondary consideration is afforded the skills appropriate to the area. Little attention is given to diagnosis or type of behavior. An exception is that extremely disturbed children are generally seen individually. This is one area where we separate boys and girls. (We have room for more flexibility here than we do with our three wards.) We have tried having both sexes in the same shop, but found this unsuccessful. Boys and girls do not share interests in the same kind of shop activity. Additionally, the freedom of movement and the stimulation presented by the shop atmosphere makes it an area easily disrupted. One of our shops is a home economics room, which is routinely part of the program for the girls. The boys have an option of spending part of their time each week taking their turn at cooking. Most of them do so, although participation in this activity proves to be a problem for some boys.

A similar situation prevails in recreational activities where differing interests have led us to segregate the sexes. Once again, assignment to a group is based primarily on a combination of the youngster's age and his ability in organized athletic events such as swimming and baseball. However, in some of the evening and weekend organized recreational programs centered on the ward, we have found that the ward group as it is constituted is satisfactory for quieter activities such as bingo, talent shows and the like. All recreational programs in our hospital struggle with the disability our patients have in their capacity to sublimate sufficiently to enjoy conventional recreational outlets. We have a great need for individualized programs. Many of the activities that involve conformity to rules, competition and teamwork prove to be particularly threatening to some of our children. Other children are threatened with exposure of defensive patterns highlighting their inadequacies. For this reason, a child is frequently removed from the group or not put in it until he is better able to tolerate these stresses.

Our school program is different in that we are able to offer a large number of different kinds of groups. For about 50 children, we have 12 groups available. Almost all are co-educational. The composition of the group is based primarily on the child's level of academic functioning. Age is a secondary consideration. Usually we have a few children who are functioning at their appropriate grade level and they are grouped according to age. Several different groups, also based on age, are com-

posed of children who are significantly retarded academically. A special problem is presented by those with an extremely negative attitude toward school and who are extraordinarily disruptive in the classroom situation. As one might anticipate, most of these children are retarded academically and through this selective process generally end up together.

The composition of our groups is altered most often in accord with the prevalent activity. One might question the relative infrequency of assignment to groups based on diagnosis, personality characteristics or behavior. We certainly do not have symptomatically homogeneous groups. Our staff is usually unanimous in the feeling that symptomatically homogeneous groups are not necessary or even desirable as long as we are able to individualize each child's program sufficiently within the small groups with which we are fortunate to work.

The matter of staff morale and attitude deserves special comment. Some of our staff objected to the idea of working on an all-girls' ward when this was considered. The problems inherent in their attitude toward girls are somewhat diluted and can be dealt with more constructively with our present arrangement. On the ward for small children, for example, we have noticed a rising sense of futility and discouragement among the staff if too many of the youngsters are markedly regressed, autistic children. Certain types of patients seriously drain the resources of our staff. To attempt to handle *all* such problems as manifestations of personality conflicts and countertransference attitudes on the part of the staff is to be idealistic and unrealistic. Working with different kinds of children within a single group requires a flexibility difficult to achieve; nevertheless, once this is done, both the patient and staff seem to operate with greater satisfaction.

We must limit our discussion to those groups created by the staff, postponing exploration of the children's spontaneous group formations for the future. Finally, a word about the problems arising from the fact that the individual child is not always part of the same peer group or with the same adults in different activities. For the older children, the slightly different composition of the activity groups has not seemed much of a problem. The exposure to several different adults in the course of a day, and to more than one adult at a time, requires a high degree of staff communication, to maintain some consistency in approach. Yet we appreciate that each member of the staff will have his own style, which works best for him within the roles he plays with the child in a particular activity. However, with the younger children, particularly the psychotic, we try to keep the number of new faces at a minimum. These children are generally with the same groups throughout the day and are exposed to the same staff people as much as possible. However, as soon as we feel the child can handle it, he has the opportunity to enter some new situations with new faces. For example, one of our groups in the play school was enlarged to include a few children who are in our day care program. In the midst of the familiar surroundings of the same room, same adults and same children, a few new young faces were added, altering the group's composition. This sort of change must be timed carefully for the optimal therapeutic benefit.