What I Saw on Krise 6

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 For my internship I worked at Virginia Baptist Hospital in Lynchburg. Centra offers several different mental health services one of which called the Child and Adolescent Psychiatric Unit, also known as Krise 6. The unit is an in-patient facility specializing in helping children and adolescents through times of crisis. The patients stay anywhere from three days to multiple weeks depending on their state upon arrival and how serious they take their treatment program. Every day I was at the hospital I saw new children and different diagnosis. I saw depression, anxiety, mood disorders and the effects of abuse, all on a daily basis. Two courses I have taken that were related to my experiences at the hospital are psychopathology of childhood and psychology of sex and gender. Each of these reminded me of what I had learned in class and how applicable it is to real life situations, such as the ones I encountered within the hospital.

Throughout the duration of my internship I found what I learned in the psychology of sex and gender course to be helpful in understanding the dynamics of the children. Many of the children on the unit came from broken homes. The course prepared me for how the environment within a home can affect the development of a child. For instance, the bonds that are formed at an early age affect their self-esteem later in life (Smith, 268). Many of the children in the hospital suffered from depression and anxiety, likely formed from low self-esteem and poor self-worth. Also within the sex and gender course we reviewed the experiences a child encounters with their own appearance. It has been stated that girls have more problems with their body image than boys (Smith, 284). I found this to be true when reading through many female patients charts. Upon physical examination with doctors, multiple young women reported being bullied about their size, too skinny or too big, which in turn led to eating disorders. For boys, I noticed it was important for them to wear their own clothes. It was rare to find an adolescent boy older than thirteen or fourteen years wearing hospital scrubs. I associated this with what we learned in class about the importance of young boys wanting to belong (Smith, 287). A large portion of the adolescent aged children in the unit are overcoming various transitions within the home. That being said, many of the older patients were admitted for attempted suicide, homicidal ideation, or severe depression and anxiety. This made sense to me because in the sex and gender course there were various materials regarding the transitional periods in a teenagers life.

 A task I did every day at the hospital was to retrieve visitors from the lobby downstairs. Krise 6 is a locked floor within the hospital and all guests of patients must be approved by the parent/legal guardian. Interacting with the family gave me real life examples of how these relationships affect a child. In the sex and gender course we covered family relationships and learned that boys gain an increase in assertiveness in adolescence that causes some conflict especially within female headed households and girls and their mothers make up the largest part parent-adolescent arguments (Smith, 304). I saw this plenty with phone calls between female patients and their mothers, whether it was biological or not. Also, patients who disclosed the reasons as to why they came to the hospital, a trend I heard plenty of was because of parents or step-parents. Most of the patient’s relationships with their parents are faulted in some form. When a patient had a long visitor list, it usually indicated a strong support system to me. Multiple patients had few if any visitors or phone calls their entire stay. My internship related many topics of family relations and youth development of both boys and girls that was of the same in the sex and gender course.

 Another course I related my experiences to was psychopathology of childhood. This course prepared me when I was reading charts, to understand terms and diagnosis used in medical documents. With access to the patient’s charts I could read which medications were being prescribed for which disorders. This I related well with the treatment plans we learned about from the Diagnostic Statistical Manual-Fifth Edition (DSM-5). When the associate mental health professionals (AMHP) had an admission they wrote the treatment plan directly from the DSM-5 on the patient’s chart. While in the hospital, the doctors used behavioral observations as well as interviews, with the child and guardian, to assess the patient and the best form of treatment. I noticed the observational form of assessment from fifteen minute checks the AMHP’s had to have on each patient’s location.

 In psychopathology of childhood I also read about the frequent use of “not otherwise specified” when treating children. This is used when a patient does not meet all criteria of a disorder (Weis, 73). The children in Krise 6 are always diagnosed with disorders ‘not otherwise specified’ because most of their symptoms are not consistent.

 In class we learned about different forms of therapy, specifically family therapy. Family sessions within the unit are primarily structured. Patients must have at least two family sessions with a parent/guardian or DSS worker, to be released from the unit. Reading material from class indicated that family therapy is important for children because there needs to be emotional bonds created between parents and children, as well as respect between a parent and child (Weis, 77). When bonds are not formed it could be from the effects of abuse. A large majority of the patients in the hospital had been through several forms of abuse. Children who have suffered these forms of abuse often lead to conduct disorders later in psychological growth (Weis, 454). Many patients in the hospital were previously diagnosed with conduct disorders before even arriving to the hospital. Along with conduct problems, abused children also are prone to develop anxiety and mood disorders (Weis, 455). Mood disorder NOS and anxiety disorder NOS are among the few doctors on Krise 6 diagnose their patients with.

 Among the patients at Krise 6 there were multiple that had been diagnose with Reactive Attachment Disorder in prior years. I learned about this exact diagnosis within the course, Psychopathology of childhood and adolescents. Reading material suggests that this disorder is definitely an effect of neglect and poorly formed parental bonds (Weis, 437).

 In closing, the unit gave me a very unique experience that I would not dare trade. I took in anything and everything I saw there and asked so many questions I feared of tiring employees. This experience not only gave me complete reassurance that I want to be working with children, but also allowed me to become curious about other age groups as well. My internship gave me a connection with the hospital which will hopefully turn into a job after graduation. The mental health professionals working on the unit had much experience with graduate school and gave me insight I could not get anywhere else. Each and every day working with the children was rewarding in some way; whether it be building rapport with a child and his/her family or watching a child’s mental disorder unfold right in front of me. Being at Virginia Baptist was a glorious conformation as to how much I truly enjoy the mental health field.

References

Smith, Barbara. (2007). Psychology of sex and gender. Baltimore, MA: Pearson Education, Inc.

Weis, R. (2014). Introduction to abnormal child and adolescent psychology (2nd ed.). Granville,

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