bers of the seminar. Here it is especially important that the psychiatrist assert his objective role, that he try to give equal weight to the opinion of workers on different levels wherever possible, and to take from their mutual criticism any personal coloring while he encourages sound divergence of opinion geared towards helping the patient.

The following is an example how divergences of opinion can be handled to the benefit of the group, the individual worker and the patient. A seriously neurotic mother had been transferred from a male to a young woman worker, who presented her case to the group. The patient had continuously expressed the fear of becoming insane. She eventually faced the worker with a demand for a definite answer to her question whether she was neurotic, implying fear about being psychotic. The worker did not answer directly, but tried to go behind the patient's need for labelling her emotional state. At this point a vehement discussion by the group followed, some feeling that the worker's technique was correct, others thinking that the patient needed the reassurance that she was not psychotic. The psychiatrist and the supervisor agreed that the worker's technique was usually the correct one and that we do not give a diagnosis to the patient. However, with this insecure, panicky woman another approach based on her specific needs should be used. The psychiatrist pointed out that this patient needed reassurance that she was not psychotic and could be helped. This group discussion was most helpful to the individual worker, as well as to the other members of the seminar. The psychiatrist did not take sides in the cross discussion. Instead, he pointed out that a general principle of technique is not always appropriate if it is not geared to a specific client. In this situation the psychiatrist functioned as a mediator in group teaching and his objective attitude enhanced the learning process.

In summing up, it must be pointed out that we have dealt here with the psychiatrist as he ideally should function in our clinical set up. However, neither his status nor his own thorough analysis can always prevent his personal involvement. There were instances in the past where a psychiatrist had to be helped by the supervisor to check his own countertransference to a worker or his authoritative approach which might have aroused anxiety. There were also situations where the psychiatrist, because of his unawareness of the importance of cooperation within the team, during consultation with a patient made recommendations which had not been discussed with other members. But at the present, with the greater realization of the significance of the team, closer cooperation and a better understanding of each member by the others has been achieved.

PSYCHIATRY IN CHILDREN'S SERVICE*

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THE use of psychiatry by social agencies makes it necessary for both disciplines continuously to define their relative spheres of activity, their goals and specific tools. In practice, we grapple with the problem of how psychiatrist and social worker can best work with each other in the interest of the patient or client who comes for help. In this paper, I shall attempt to show how we have defined the two areas of competency, and the setting in practice resulting from this definition, at the Jewish Community Services of Queens-Nassau. The Jewish Community Services of Queens-Nassau is a multiple service agency with three divisions: Family Service, Services for the Aged, and Children's and Youth Service. Each of these has separate intake procedures and specific services. Our agency aims at meeting as many as possible of those social service needs of the Jewish community as are not met by other specialized agencies, and to serve as a referral source for such services as are available elsewhere in the community. My illustration will be limited to one division, the Children's and Youth Service which, however, represents the basic approach of the entire agency.

Children's and Youth Service sees as its goal helping children grow up in their own homes wherever this is possible, supported by constructive parental attitudes, through a physically, mentally and emotionally healthy adolescence into mature adulthood. The Children's and Youth Service believes it has a preventive task which consists in helping to avoid blockings on the road to this, and a therapeutic one which calls for clearing away such blockings where this is necessary, totally or partially. Our services are offered to parents and children who can roughly be divided into three groups: the completely healthy children whose parents request a concrete service; the group of parents and children whose relationship has become a distorted one to the point where outside help is needed to break a pattern in which they seem to be unhappily caught; finally, parents who come for help with the deeply disturbed child who presents conversion symptoms, is compulsive or cannot live with his reality situation.

In relation to each of the above types of problems, the Children's and Youth Service offers three different types of services, according to the child's need: case work—counseling—and psychiatric treatment. By case work, we mean a process which has a tangible service as its core. It is more difficult to define where we see a dividing line between what we call counseling, and a therapeutic experience such as the psychiatrist can offer, because we are aware of the existence of an overlapping area. As social work-

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ers, we know about relationships of people to each other, about the roles which in our culture have been assigned to each family member and about the distortions of these roles which are sometimes created by the need of one or more family members to project on the other. We can recognize when a client is thus forced into a part which he has not chosen or accepted as his and when he fights this either directly, or by internalization of the conflict.

If it is within our province as social workers to recognize such distortions and to try to re-establish a healthier balance, how are we equipped for this? We learn something, in our schools and in the field, about personality development, about the impact of social, economic, and cultural factors in our environment upon this development. We learn to understand what it means to have to take help; we get to know about the implications of dependency versus independence, about yielding to limitations inherent in human reality, and about give and take within a relationship. In counseling we try to help our client by focussing on any specific, reality-related trouble area. We can help him work on a problem which is expressed in his relationship to another person or in some other concrete area of his life, of which he is aware, in terms of its effect, if not in terms of underlying causes. Such help can be offered within a comparatively limited period of time because it does not aim at total reorganization of the personality. The material which the client brings to the interview is related back to the problem area in which he is seeking help. In the Children's and Youth Service, we offer such a focussed helping process in the form of parent counseling, youth counseling, or parent-child counseling with involvement of both parent and child in a parallel process, according to who needs the help and who can and should take responsibility for the problem and the change needed to solve it.

Sometimes, however, a limiting focus would be unbearable to the more disorganized client and more fundamental help is needed. Like all family agencies we meet with situations which seem to go beyond what we could call a limited and well defined problem in relationship but where we are actually dealing with emotional illness. Admittedly, the demarcation line is a rather fine one, and we have to cope with subtle differentiations. There are two main criteria, however, which are usable, in a general way at least, to approximate the extent of mental health or illness in a client who comes for help. One is relatedness to reality. A client who has hallucinations or delusions, is obviously mentally ill. Such cases are not too frequently met in the social agency. The second criterion is less gross and consists in the general symptomatic picture. The differentiation becomes one of scope, degree and focus. In the children's service, we get the picture of the child initially from the parent. If she describes a child who functions well in many areas, even though he acts out hostility by direct aggression, or a child who reacts by withdrawal from social contacts because of a sense of failure and inferiority, this can be understood in social terms, and we can try to help as social workers in a counseling process. The picture becomes a very different one where we are told about conversion symptoms, where the child for instance is persistently enuretic, has asthmatic attacks, whose actions are obviously compulsive, or whose hostility has been turned into intense, uncontrolled aggression, or self-destruction.

Let us look again at our equipment as

social workers. We have not studied medicine and do not know much about the subtle relationship between body and mind, the intricate cause and effect pattern of disturbances which can start in either area, and shift back and forth mysteriously. We have not learned, further, as the analyst has, to trace subconscious material, to bring it to light, and to interpret it as is obviously necessary where the causes of the disturbance have been suppressed by the patient to the point where he has no longer any awareness of cause and effect. In these situations the client of the social agency becomes a patient, in need of help by a psychiatrist. The most difficult problem is presented by the in-between group where counseling might, or might not suffice. For this doubtful group, as well as for those children whom we consider "ill" as defined above, we need a psychiatric diagnosis as a basis for any further planning and a careful sifting process helps us to designate those children who seem to be in need of treatment through the psychiatrist. To establish this, psychiatrist and social worker cooperate closely.

Before I go into a description of this cooperation in both diagnostic and treatment situations, I should like to say a few words about our panel psychiatrists. In our Children's and Youth Service, we have six doctors at present on our panel, who have special experience in working with children or adolescents. They have been thoroughly acquainted with the agency, its function, its role in the community, and its structure before they and the agency decide to work together. They make available a varying number of hours to our clients in need of psychiatric treatment. The treatment sessions take place in the doctor's office. Payments are made by the agency for each hour used and for each consultation with the social worker. Panel doctors, administrator and social work staff get together at formal meetings for discussion of general principles, or problems concerning specific situations.

Where a psychiatric diagnosis for a child seems indicated, both parents participate in the decision. Sometimes the worker, sometimes the parent takes the initiative in suggesting this step. Preparation of the child is thoroughly discussed with the parent and a developmental history taken for the use of the psychiatrist. This background material is incorporated in the worker's report for the psychiatrist which also contains a fairly clear picture of symptoms, onset of difficulties, family dynamics and personality problems of the parents. At the appointed time, the worker introduces mother and child to the psychiatrist at his office. Occasionally, the mother is interviewed by the psychiatrist, if there seems to be good reason for this, but more often only the child is actually seen by him. It is the social worker who handles the mother's anxiety when the child leaves her to go with the doctor.

Within a 2 week's period, the diagnostic report of the psychiatrist is sent to the social worker who shares it with and interprets it to the parents in the way which seems most helpful to the latter. If the diagnosis suggests that counseling may meet the child's need, this service is offered. Otherwise the examining doctor recommends further diagnostic study, treatment by a psychiatrist, or in rare instances, hospitalization of the child. Our agency offers psychiatric treatment as one of its services. This service is a costly one and available funds are limited. It has therefore become necessary to define the

type of case which seems to be appropriate for a community service agency like ours. It seemed that, particularly since there is always risk involved as far as therapeutic results are concerned, those cases with a good prognosis and consequently a predictable time limit would best fit into our general program and definition of function. Therefore, our psychiatrists indicate, in their diagnostic report, whether or not they believe that there is a good chance for improvement of the specific child within the number of treatment sessions our agency can make available. Our present maximum is approximately 75 sessions which may be spaced as the psychiatrist sees fit. If the diagnosis indicates a need for long-term treatment or intensive analysis, our agency cannot take on this responsibility. We then try to find other community resources and work with the client towards referral. I should like to mention here that, as for all our services, the client is charged a fee according to his ability to pay and related to our own cost.

Once psychiatrist and social worker on the one hand, and social worker and parents on the other, agree on psychiatric treatment for the child, and money for this is still available in the budget, or the client can pay full fee, a trial month of treatment is initiated. This means that the psychiatrist sees the child for four weeks, in most instances on the basis of one weekly session, while the social worker has weekly interviews with the mother, and sees the father at least once so that he is included in his child's beginning experience. Before starting this, a conference between worker, sometimes worker's supervisor, and psychiatrist takes place. Significant material is exchanged between worker and psychiatrist. At no point is the psychiatrist's function a supervisory one. This responsibility rests with the worker's own supervisor. The psychiatrist learns from the worker how the child reacts to treatment outside of the therapeutic hour. The worker in turn needs to know from the psychiatrist what goes on in treatment so that she can help the parents to understand and bear the child's reactions and behavior.

After the trial month, the psychiatrist sends a report which particularly points out whether or not the child has been able to use the treatment sessions constructively. During the same period, the social worker and the mother test out the latter's willingness to let the child use therapy, i.e. to let him establish a relationship in which she has no direct part. Also, both parents are helped to look at their own attitudes towards the child and faced with the need for change and for understanding the child who during the initial treatment period may become even more difficult to live with. After the trial period, psychiatrist and social worker confer and if continuation of treatment seems warranted, the parents can make their own decision, with the worker's help, with regard to going ahead. In the continued case, psychiatrist and worker keep sharing and exchanging all pertinent information, sometimes through telephone contacts, sometimes through conferences. In the middle of the treatment period as approximately established at the point of diagnosis, the psychiatrist gives a progress report. His final report, shortly before the ending, outlines the areas of improvement and describes the extent to which problem persists and of which parent and child have to be made aware. Ending is carefully planned by psychiatrist and worker together and the readiness of both parents and child is evaluated.

In order to bring this type of psy-

chiatric service to life, I should like to give a brief case illustration. I have chosen the Moss case because of the extensive use of the psychiatrist made in this situation. Mrs. Moss came to us for help with her 14½ year old daughter Faith, whom, because of a variety of difficulties manifested in school and at home, she had taken to a private psychologist. The latter had recommended psychiatric treatment, but Mrs. Moss was unable to follow up on this recommendation on a private basis because of Mr. Moss' limited income. The Mosses were both rigid people. Mr. Moss has been only moderately successful in life, but had built up a picture of himself as the strong fighter who recognized the world's evils, but was ready and able to master them. He admired Mrs. Moss and had developed a strong dependency on her. Mrs. Moss' father had died when she was a young child. Her mother had favored another sister. Mrs. Moss had become an ambitious career woman before her marriage, was strong willed, wanted to be admired rather than loved, and called herself in retrospect "the born spinster." She was 30 years old when she married Mr. Moss against her family's wishes. They were in love with each other and Mrs. Moss decided to make this marriage a success at all costs. She made a conscious decision only to live for Mr. Moss and his happiness, while at the same time she subconsciously resented giving up so much of herself and thus retained a good deal of control. She did not wish to have children, but in this too she submitted to Mr. Moss. She was unready for Faith, and feared that she might be mentally abnormal. This fear stemmed from her suspicion that her own father had died in a mental hospital, even though Mrs. Moss had never been able to ascertain the circumstances of his death. In spite of a precarious financial situation, Faith and her two younger brothers were brought up by a nurse during their early years. When Mrs. Moss asked for our help, she had already gained some insight through her contact with the private psychologist. She recognized her conflict about her maternal role and her part in the difficulties all three children presented. At home, there were violent scenes between Mrs. Moss and Faith. The latter had no friends, did not apply herself in school in spite of high intelligence, was extremely careless about her room, and inconsiderate of the other family members. The youngest child had sudden attacks of extreme fear, the middle child was blocked in his learning. It was difficult to decide, with so much disturbance in the family, where to start and on whom to focus the helping process.

Mrs. Moss had such strong guilt feelings and at the same time seemed so blocked that there was question whether she was emotionally balanced enough to enter into a counseling relationship which could not be geared to helping her with her own personality difficulties, but only to helping her sustain treatment of the most disturbed of her children. A somewhat unusual step was therefore taken: we started with a diagnostic examination of Mrs. Moss, who herself was eager for this. The doctor saw Mrs. Moss as a severely neurotic personality whose difficulties could be tackled only in a long term intensive treatment process, but whose defenses were strong and who could be involved in a counseling relationship around treatment of Faith without much probability of a breakdown.

The parents, after considerable discussion with the worker, decided to seek treatment for Faith, by far the most dis-

turbed of the children. Our psychiatrist confirmed what had already been suggested by the psychological report, namely an incipient schizophrenic process. At the same time the child related sufficiently to the examining doctor to warrant a fairly favorable prognosis. Up to now, Faith has had 41 psychiatric sessions over a period of one year, Mrs. Moss was seen 32 times for counseling, Mr. Moss five times. There were about four conferences between psychiatrist and case worker, at least monthly telephone contacts and three written reports from the psychiatrist. The case is still active and we do not yet have the ending report. Already, however, the psychiatrist considers Faith as considerably improved. She is better organized, more related to reality, less hostile towards her mother, and has made a number of friends. Mrs. Moss was able to involve herself deeply in counseling, even though she at first resisted the threatening dependency and suffered acutely whenever she shared her emotions. She has lessened her need to impress people and to be perfect. She thus allows herself to be more human, shows more warmth and has developed a budding sense of humor. Even though Faith will continue to present problems, Mr. and Mrs. Moss understand them as the symptoms of a deep emotional struggle which even at this point no longer overwhelm them. Mrs. Moss was able to keep the main focus on her difficulties with Faith and to allow the latter to use her psychiatrist for a deep, all-inclusive helping relationship. Through her and Mr. Moss' movement in counseling, Faith's treatment was strongly supported.

In conclusion, I should like to say that I do not think that our agency's answer to the problem of how the two disciplines of social work and psychiatry can use each other is the only one, but I believe it is a workable one. This is so in spite of the considerable difference in basic approach between psychiatrists, most of whom are Freudian and a functionally oriented agency. Social workers and psychiatrists can accept this difference as they find their working together effective, and indispensable to their clients' and patients' interest.

Both psychotherapy and case work have a short past. I believe that, as they develop further, they will ever more clearly define their respective goals, skills and areas of competence. In the meantime, they can continue to learn from each other, to use each other and to unite in a humble but strong wish to heal and to help where the burden of living has become too heavy for a human being to carry it alone.

THE PSYCHIATRIST IN A CHILD PLACEMENT AGENCY*

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THE purpose of this paper is to present the ways in which the psychiatrist is used in one child placement agency, in this instance, the Jewish Child Care Association of New York.

The JCCA serves children up to 18 years of age for whom care away from their families is necessary. The Intake Department, on the basis of thorough study and case work process, is responsible for making the decision for placement and allocation to an under-care department. The Foster Home Department serves the largest number of children, 763 at present. Pleasantville Cottage School has 160 children under care. Edenwald School which serves the retarded child, who invariably is also emotionally disturbed, has a population currently of 51 boys. Finally, there are two small group living units situated within New York City proper. Fellowship House serves 16 boys over 15½ years of age for the limited period of approximately one year. Similarly, Friendly Home has 10 girls of about the same age also for the limited period of about one year.

Out of the approximately 1000 children under care, there is a large proportion needing psychiatric attention in terms of diagnosis, consultation and direct treatment. This is seen by the fact that during 1950, approximately 30% of this population were seen by the psychiatrist in a diagnostic interview, and that 8% of the total population were in direct psychiatric treatment. In recent years, there has also been a trend towards a greater percentage of disturbed children coming into placement. For example, the year 1950 showed an 8% increase over the preceding year. Moreover, there were twice as many referrals from state hospitals and psychiatric clinics in 1950 as against 1949. There has also been a marked qualitative difference in the depth and degree of pathology as seen at the point of intake and there are fewer and fewer areas in which the children have achieved a feeling of success and comfort in their previous life situations. In order to meet this need for psychiatric service, the agency has eight staff psychiatrists who give a total of 85 hours per week. In addition, there are 22 panel psychiatrists who provide 25 to 30 hours per week of service. Each of the departments has at least one staff psychiatrist assigned to it. While the staff psychiatrists function for diagnostic, consultation and treatment purposes, the panel psychiatrists are used only for treatment. In the latter connection, the panel psychiatrists are used only by the Foster Home Department, Fellowship

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