ity of treating behavior problems of children or parent-child problems without making certain that at every stage in the treatment psychiatric and psychological knowledge can be fully incorporated.

This brings me to another question which is not clear to me from the presentation. Mr. Aptekar gives as an example of a "counseling" problem: "my child does poorly in school." He describes this as "an externalized behavior problem . . . with a distinct social center of emphasis." If by "externalized behavior problem" he means it is a *symptom* of something deviant, that is true. If by a social center of emphasis he means it shows itself in school, and that it is a matter of concern to the mother and may be a part of a deviant mother-child relationship, that is true. But doing poorly in school may be due to retarded intelligence, a beginning schizophrenic process, a defiance of parental pressures, a preoccupation with fantasy material, possibly neurotic in nature. If intake is not centralized to which unit is such a problem referred? If this occurs in an essentially normal child but is a problem to, let us say for example, an aggressive, intellectually driven mother, who is trying to find some type of neurotic satisfaction in her child, this may very well be treated through the mother alone; it is her problem. How and when is the real meaning of the child's problem determined? A child guidance service has to be child-centered but with equal attention to the *unit* of parent and child.

It is an axiom of almost all child guidance problems that they arise out of deviant familial relationships and should be treated as a parent-child unit. This is true no matter what the degree of internalization of the problem. Of course there are exceptions. But this does not alter the basic concept. There are situations where a cooperative relationship between two agencies or between an outside psychiatrist and an agency can be worked out so that the treatment is essentially a unit. Perhaps in the afternoon discussion Mr. Aptekar can give us a fuller picture of the management of child guidance cases under psychiatric treatment.

The problem of who treats what is not as important in my opinion as the proper identification of problems and their management after identification. Intrinsic to this is that whoever treats must be trained and oriented to the total demands of child guidance problems.

DISCUSSION OF MR. APTEKAR'S PAPER

By SAMUEL RICHARD ROSEN, M.D.
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IN discussing Mr. Aptekar's excellent and significant paper, it is necessary for me to insist that I shall limit myself to those areas in which I feel qualified to offer my opinions. It is obvious therefore that I shall be forced to leave many of its interesting controversial points to those whose greater experience in social work allows them more ground for discussion. Accordingly I will not deal with what constitutes the boundaries of case work, counseling on psychiatry in an agency, but shall confine my comments to what I feel the private psychiatrist can do in such an agency as the Jewish Community Services of Queens-Nassau, with which I am happy to be associated. Perhaps my reluctance to discuss such administrative questions may be understood better when I tell you that my wife is a former social worker, and still seems to think along those lines.

First I would like to discuss the attitudes which the private psychiatrist must develop if he is to work successfully with an agency. He has to accept the fact that he is a member of a much larger team, and that he is not necessarily the star of the group although he usually likes to be. This means that he also must subscribe to the essentials of agency routine such as reports, conferences and the financial and temporal limitations of the agency's program. This immediately raises a problem about which there is a great deal of difference of opinion among psychiatrists. I am referring to the use of brief psychotherapy. Outside of its use in an agency program brief psychotherapy, especially along psychoanalytically oriented lines, has been under considerable fire by the more orthodox psychiatrists. It poses the question, is it possible to reduce from what is often a matter of years of therapy to a matter of six to nine months, and still obtain the same result? The answer of course is "No." However we can also ask the question, what are we after in our therapy? If we are seeking for a type of treatment result that we can select for a special group of cases which means the attainment of enough functional improvement so that the individual can get along with his problem, then I believe that brief therapy can supply this result in the average type of case that this agency refers for psychiatric treatment. It must be borne in mind that a certain amount of case selection occurs automatically. The frank psychoses for example are rarely seen. Even the very severe neurotic that comes for agency help has by the very use of the agency indicated a desire to cooperate, which already makes the case an easier one to handle. The point I wish to make is that the great majority of cases that I have seen for the agency have seemed to me more accessible to such therapy than the unselected cases I see in my office practice. At this time one can properly inquire how much credit is due the case worker who has already spent some time with the pros-

pective patient, so that he usually comes to the office eager for treatment.

Aside from the above there are some special theoretical considerations that pertain to the advisability of attempting to apply psychoanalytical principles and partial techniques to such brief therapy. It can be argued that when one tries to set an arbitrary treatment time, one can't wait for the patient to associate spontaneously as often as the psychoanalytic rule demands. In fact the "brief psychotherapist" attempts to formulate a frame of reference for his case as soon as possible. By this I mean he tries to get a diagnosis and a formulation of some of the psychodynamics of the case. I believe it is possible to do this in most instances in a careful initial or second interview. If the psychiatrist feels that the patient will be responsive to a brief therapy program, he has to direct the patient's efforts to open up the problem rapidly. He has to be intuitive and allow himself certain risks by attempting to do some of the associating for the patient. Even more than this is a facility for affecting rapid patient transference. It has been my experience, especially in work done under military conditions where brevity of time was imperative, that patients suffering from many conditions previously regarded as requiring long therapy made very good functional recoveries. By this I mean that, while the individual was infrequently cured, the usual picture was that of a return to duty with a sufficient degree of resolution of the acute problem so that we didn't lose the war. I have had the opportunity to follow about fifteen such cases over a three year period that has included the transition to civilian life, in which there have been no regression from the ability to make a sufficiently good socio-economic adjustment so that further treatment has not been necessary. I believe that these soldiers did not have problems essentially different from what we see in civilian life. The so-called combat situation in the rear echelon was often much less hectic than the morning rush at Grand Central. A great deal more can be said to justify the empirical use of a forcing therapy of this type. The fact remains that I believe it works and an ever-increasing group of psychiatrists feels likewise.

There is a small point I would like to add here on the use of the private psychiatrist. The patients in general seem to like it better. They have a feeling that they are getting better treatment than they would in a clinic set-up or hospital. I found this to be the case also in work with veterans, who were being given private treatment under authorization of the Veterans Administration. It has been my experience that a fairly large number of veterans who had been privately treated were unable to resume and maintain treatment in the clinic after the private treatment program was discontinued.

I would like to go on now to a discussion of the facilities offered to the psychiatrist by the agency in the area of involvement of the patient's family. The psychiatrist working alone constantly suffers from his inability to establish contact with the members of the patient's family. Very often he does not have the time or the family cannot afford the additional fees for such conferences, or there just is not a set-up available in which the family learns to feel they have a role to play along with the treatment of the patient. This is a service that this agency offers in a way which does not transcend the privacy of the family's relationship to the psychiatrist. By the use of the conference between social worker and psychiatrist, it is easy to take care of the personal differences in interpretation which pertain to the patient that may arise. Most important of all the social worker may frequently take on a surrogate role in her contacts with patient or members of the family. Since the patient and the family know that the treatment comes through the agency and that it is only because of the agency's financial program that the psychiatrist has been made available at all, the social worker as the agency's representative may acquire a position which can often be used in a therapeutic way by the psychiatrist. Sometimes he may not avail himself of this at all, such as we heard in the case of Mr. M in which the important matter of the significance of the fee had to be handled entirely by the social worker. Actually she had already served an important therapeutic function in focussing the patient's attention on this matter. It is possible the remainder of the therapy might have been even more brief had the psychiatrist recognized what was going on in that phase of the therapeutic situation.

An interesting instance of a similar role of the social worker appears in the subsequent history of the case of Mrs. G. It seems that the patient had developed a considerable antipathy to the social worker in one of the follow-up interviews. In the analysis of this reaction which the patient brought to her treatment session the patient was helped to gain considerable insight into her antagonism to any woman who occupies an authoritative position with respect to the patient. I am prepared to state that as a result of this agency situation involving the patient she was enabled to see a number of very important relationships to her mother and to a school teacher both of whom she resented and to whom she would lie or cheat. It developed that she had always carried on in this fashion without any compunctions whatsoever. The relationship with the social worker focussed the patient's attention upon these attitudes with subsequent improvement. I regret to say that, as is often the case in such instances, the social worker tends to remain the surrogate object of the patient's resentment. A third instance of the agency's surrogate role concerned a patient who had been previously treated by the agency through the same social worker who was later seeing the patient's wife. This patient had been previously given brief therapy for an extremely severe compulsive-obsessive neurosis of long duration in which some paranoid features were quite prominent. It was felt that the wife's therapy by another psychiatrist on the panel should be coordinated with a program of weekly visits to enable the patient to facilitate his wife's progress. It was important for me to determine to what degree this patient was possibly psychotically paranoid before I could go ahead with any coordinated therapy. Conferences were held with the other psychiatrist and the social worker. It developed that the patient showed a marked feeling that the social worker was favoring his wife against him, and that there was some malicious intention on her part toward him. This was checked with the social worker who also noted this change in the patient's attitude toward her. It was decided to utilize what was already a suggestion of positive transference of the patient toward the therapist. It was realized that the patient was practically psychotic at this time. However, it was possible to get the patient to see

that he had been showing definite paranoid traits in his relationship to the social worker. She absorbed what might have been a similar mechanism that the patient might have used against the psychiatrist. A considerable amount of insight was established and it is expected that in this instance it will not remain at the expense of the patient's feelings toward the social worker. I think that these cases illustrate a somewhat new emphasis on the role of the social worker as a lever in the therapeutic situation.

Finally I would like to discuss the embattled subject of the overlapping of functions between social worker and psychiatrist. I intend to be very careful because in bringing up such a subject it is very easy to step on all kinds of toes, even my own. If one looks at the matter from the viewpoint of the psychiatrist who feels that his special province includes the cause, description and treatment of all abnormalities of human behavior, then there isn't much room for any argument and our all-inclusive friend will find comfort only in the echo of the words of his colleagues provided they are of the same school of thought. It is obvious that the ivory-tower-ism of this type of psychiatrist certainly is not going to contribute much to the treatment of the large number of people needing therapy, especially if he keeps his isolationist caseload to eight patients a year. I believe that the recent upheavals in psychiatric thinking of the last three or four decades have had a lot to do with opening the psychiatrist's eyes to all kinds of new horizons. This increase in his psycho-visual field has apraised him of the utter incapacity of the small and sometimes not overly select psychiatric fellowship to cope with the sheer weight and number of cases that require treatment. To his surprise he discovered that there was already a very active body of individuals with considerable training and experience in individual and social problems who were very busy trying to solve them. In addition it seems that these social workers were quite willing to discuss the matter. Of course they had to be reassured that they weren't going to be snubbed too often. However, it turned out eventually that there were lots of nice people in both camps. So when they finally got to work together this business of the overlapping of function did not disturb the teamwork which resulted in the most good for the patient.

I wish to say that the concern for the patient should be at all times the main consideration that determines who does what for him. I know that there are some very definite qualifying standards which psychiatrists have to meet, before they can accept the medical responsibility for the patient's welfare. It is my belief that there are similar standardized qualifying procedures that the social worker must pass before an agency of good standing will accept him. I submit that qualified individuals know their limitations. If there should be any areas where some doubt about these limitations exist, the agency that utilizes the social worker-psychiatrist conference system should in most instances iron these out.

In closing I wish to express my gratitude to Mr. Aptekar for this paper which has given me the opportunity to elaborate on those aspects of psychiatry which the agency he represents has stimulated to make further investigations and, we hope, further advances. I feel that the program that has been discussed offers the private psychiatrist a great opportunity to be a little less private and certainly more useful.

DISCUSSION OF MR. APTEKAR'S PAPER

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WHATEVER the differences in theory may be, I can state from my experiences as a panel psychiatrist with the Jewish Community Services of Queens-Nassau, that the system described by Mr. Aptekar shows definite and encouraging practical results. Mr. Aptekar's remark that we are often involved in questions of semantics is very true. However, while a desk might occasionally be useful as a table or a table as a desk, I do not think that desks should ever try to be actually tables or vice versa. The collaboration of social worker, psychiatrist and psychologist does not have to be on a competitive basis—i.e., real teamwork means that we can work together on a level of complete equality as Dr. William Menninger has emphasized repeatedly during the war when he was Chief Psychiatrist of the U. S. Army.

I think that those of us who do child psychiatry in private practice are aware of the need for the social worker because direct contact with the family frequently disturbs the transference relationship between child and therapist. Our therapeutic efforts are too often frustrated when the child's behavior is not interpreted to the parents by a professional worker. Private practice in child psychotherapy—and possibly also in adult psychotherapy—may have to be reoriented in this direction in the future. In diagnostic procedure, the psychiatrically oriented social worker is an equally indispensable member of a psychiatric team. In dynamic psychiatry and analytically oriented child psychotherapy, we are very often involved in the dynamic mechanism of a family constellation where the singling-out of our patient as an individual does not permit us a satisfactory diagnosis. The psychiatric diagnosis of the future will necessitate more knowledge of the pathology of the family as a functional unit. In such a procedure that integrates the dynamic psychiatric diagnostic formula of each individual family member into a dynamic diagnosis of the family pathology, the social worker will play an increasingly important part.