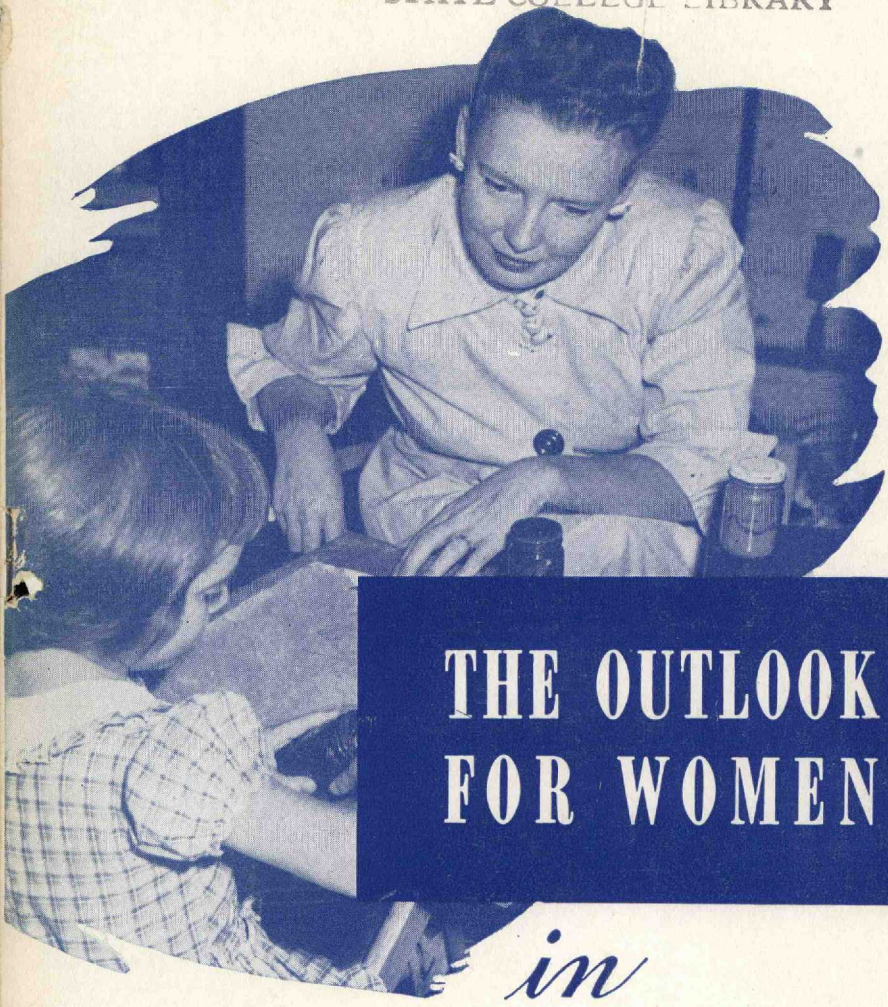

THE OUTLOOK FOR WOMEN

in

SOCIAL CASE WORK IN A PSYCHIATRIC SETTING

Social Work Series
Bulletin No. 235–2
U. S. DEPARTMENT OF LABOR
WOMEN'S BUREAU

UNITED STATES DEPARTMENT OF LABOR
MAURICE J. TOBIN, SECRETARY

WOMEN'S BUREAU
FRIEDA S. MILLER, DIRECTOR

The Outlook for Women in Social Case Work in a Psychiatric Setting

Bulletin of the Women's Bureau No. 235–2

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No. 235–1 *The Outlook for Women in Social Case Work in a Medical Setting.*

No. 235–2 *The Outlook for Women in Social Case Work in a Psychiatric Setting.*

LETTER OF TRANSMITTAL

UNITED STATES DEPARTMENT OF LABOR,
WOMEN'S BUREAU,
Washington, May 31, 1950.

SIR: I have the honor of transmitting this report on the outlook for women in psychiatric social work. It is the second of a series resulting from our study of the need for women in the social services.

The study was planned, directed, and written by Marguerite W. Zapoleon.

Grateful acknowledgment is made to the many individuals and agencies who cooperated so generously in supplying information and helpful criticism.

Respectfully submitted.

FRIEDA S. MILLER, *Director.*

Hon. MAURICE J. TOBIN,
Secretary of Labor.

Figure 1.—A social case worker (second from the left) in a mental hospital participating in a clinical team conference with a psychiatrist, a psychologist, an occupational therapist, and a nurse.

FOREWORD

The social well-being of our people, like their health, has received growing attention over the years. Of the increasing numbers in our economy engaged in rendering professional social service, two-thirds or more are women. The story of their progress and the current and future needs for their services have been the subject of a Women's Bureau study which will be reported in a series of bulletins of which this is the second.

Those which follow, like the first report on social case work in a medical setting and this report on social case work in a psychiatric setting, will describe the employment outlook for women in areas of specialization within the field of social work. The final bulletin in the series will describe the outlook for women in the entire field of social work, showing its relation to other professions of women and comparing the specializations within the field. Unlike the usual monograph which describes an occupation in detail at a particular point in time, this study, like the earlier Women's Bureau series on occupations in the medical and health services and in the sciences, is concerned primarily with changes and trends.

Although more than 2,200 books, articles, or pamphlets have been culled for information, the principal information for this series has been obtained from professional organizations, public and private social agencies, schools of social work, and individual social workers. The following sources have contributed to the study thus far:

37 National professional organizations. For help on this particular report, the Bureau is indebted especially to the American Association of Psychiatric Social Workers.

49 Schools of social work and other colleges and universities.

87 Agencies employing social workers, including 23 community chests and councils of social agencies, the American National Red Cross, and 15 non-Federal hospitals.

37 Government agencies concerned with social service programs or employment in this field, including international, State, and local agencies, and such Federal agencies as the Bureau of Labor Statistics and the United States Employment Service in the United States Department of Labor; the Bureau of Public Assistance, the Children's Bureau, the Office of Education, and the Office of Vocational Rehabilitation in the Federal Security Agency; the United States Civil Service Commission; and the United States Veterans' Administration. The National Institute of Mental Health of the Public Health Service in the Federal Security Agency was especially helpful in supplying statistics for this report.

To these contributors the Bureau is indebted for the raw material which made this report possible.

The Bureau is also grateful to the following for the illustrations

used in the bulletin: Alexandria (Va.) Mental Hygiene Clinic, The Evening Star, and the board member of the clinic whose child was substituted in the cover picture for a clinic patient; the American National Red Cross (fig. 19); the Atlantic City Press and Central Studios (fig. 16); the Brockton (Mass.) Public Schools (fig. 18); Children's Hospital of the District of Columbia (fig. 7); Massachusetts Department of Mental Health, Division of Mental Hygiene (figs. 10, 12); National Defense Agency (fig. 9—an employee of the hospital is posed as a patient); St. Elizabeths Hospital, Washington, D. C. (figs. 2, 3, 5, 6, 11, 13, 17, 20—persons shown are authentic, except patients and relatives of patients, who are posed); Veterans' Administration (figs. 1, 4, 8, 14, 15—persons shown are authentic, except patients and relatives of patients, who are posed).

The reader will recognize gaps in our statistical knowledge of employment in psychiatric settings and the unsurmounted difficulty of distinguishing always individuals who are fully qualified for the profession from those who are not. But it is hoped that she will find here a useful synthesis of existing knowledge on an important field of work in which more women are needed.

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Illustrations:

Psychiatric Social Worker, as Defined in the Dictionary of Occupational Titles (65)

A Case Worker who "Performs duties in organizations, such as hospitals and clinics, concerned with assisting persons suffering from nervous or mental diseases or serious emotional maladjustments: Investigates case situations and gives Psychiatrist supplementary information on patients' environment, behavior, and personal history. Interprets psychiatric treatment to patients' families and suggests means of expediting recovery of patients. Assists patients and their families in developing mental and emotional adjustments to illness. Attempts to eliminate fear, prejudice, and other attitudes that are obstacles to acceptance of psychiatric care and continuation of treatments. Assists patients to regulate their lives so that treatments will be most effective. Arranges for institutionalization of patients if recommended by proper authorities. Assists patients in making adjustments to community life during treatment or on discharge from institution."

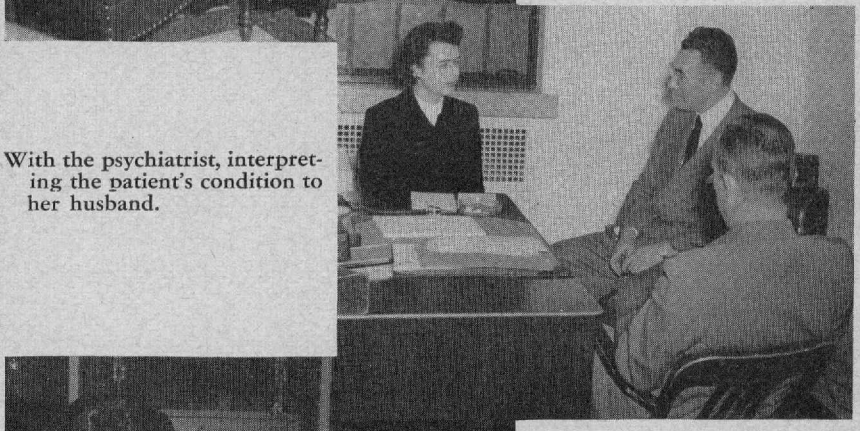
Case Worker (Professional and Kindred) 0–27.20, as Defined in the Dictionary of Occupational Titles (65)

"Performs any one or a combination of the following social service duties, usually requiring a college degree and applying techniques acquired through postgraduate training in social service work, in pursuance of a welfare program organized by a public or private agency or organization: Studies physical and social environment of a family, person, or persons in order to determine and execute practical plans for alleviating existing undesirable conditions. Visits persons in need of assistance or receives clients at intake desk of agency. Interviews clients to ascertain nature of their problem. Diagnoses problems, considering factors involved, and plans treatment. Makes necessary contacts to ascertain background and needs of clients and their eligibility for financial, medical, and material assistance. Helps clients understand their situations more clearly and assists them to reach satisfactory solutions for their problems. Refers clients to community resources, such as hospitals, clinics, recreational facilities, and schools, which may assist in rectifying the maladjustments. Endeavors to foster self-development of individuals in order that they may successfully meet social exigencies. Follows progress of cases beyond solution of immediate problems. Keeps case histories and other records."

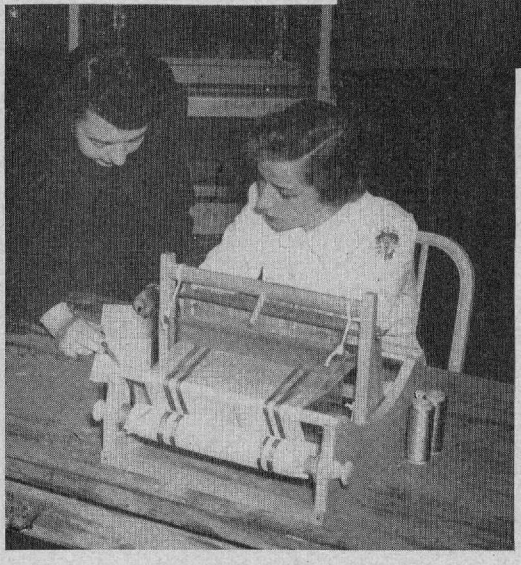
Psychiatric Social Work, as Defined by the American Association of Psychiatric Social Workers (5)

"Psychiatric social work, for the purpose of Association usage in determining eligibility for membership, shall be defined as social work undertaken in direct and responsible working relation with psychiatry. Psychiatric social work is practiced in hospitals, clinics or under other psychiatric auspices, the essential purpose of which is to serve people with mental or emotional disturbances."

Having the first of several case work interviews with a newly admitted patient.



With the psychiatrist, interpreting the patient's condition to her husband.



Consulting with occupational therapist about patient.

Figure 2.—A social case worker in a mental hospital.

THE OUTLOOK FOR WOMEN IN SOCIAL CASE WORK IN A PSYCHIATRIC SETTING

Section I

THE PSYCHIATRIC SETTING

More than 1,500, possibly 2,000, social workers were assisting psychiatrists in the prevention and treatment of mental illness in 1949. More than 85 percent of them were women. Like all other social case workers, they were trained to deal with individuals in need to help them to understand what they need and to obtain the help indicated. Like all social workers, they were also skilled in seeing the individual in relation to his family and all the circumstances of his environment and in using community resources to help him work out his problems (*54*). But, unlike the family case worker and the child welfare worker, the case worker in a psychiatric setting worked constantly with those whose mental or emotional disturbances had reached the stage where the help of a psychiatrist was called for.

The usual psychiatric setting is the psychiatric hospital or clinic where mental and nervous illnesses are diagnosed and treated. But psychiatric social workers may find employment wherever a psychiatrist does, for example, in a general or children's hospital, in a court or correctional institution, in an industrial plant, in a school or college, or in private practice. In a psychiatric hospital, the woman who works as a social worker obtains, records, and interprets facts about the patient's background and his environment that reveal the social problems involved in the illness and will aid the psychiatrist in diagnosis and treatment. She helps the patient's family to understand the nature of the illness, to deal with the problems it creates for them, and to cooperate in the patient's recovery. She helps patients to adjust to the hospital environment and encourages them to follow the recommendations of the psychiatrist. She assists those who are ready to leave the hospital for convalescence at home and helps them to reestablish themselves in the community; she visits later to see that progress is being made or to arrange for further treatment. She also sees that such necessary services as transportation and medical atten-

tion are made available to patients. In carrying on her work, she makes wise use of her skill in interviewing and of the confidence the patient and his relatives may have in her. She works with the psychologist, the nurse, the dietitian, the therapist, the teacher, the vocational counselor, and all others who are assisting the patient to recover. In this work she uses her case work skills as a member of a hospital team which is directed by the psychiatrist.

In a mental hygiene or child guidance clinic, patients vary markedly in the degree of their mental disturbances. A young child may be referred by his parents because of unexplained lying or temper tantrums; an adult may seek help in finding an emotional cause for an illness for which no physical basis has been found; an adolescent may be referred by a probation officer to find the reason for his repeated violation of the law. The minimum clinic team for solving the problems presented usually includes a psychiatrist, a clinical psychologist, and two psychiatric social workers. A physician for medical consultation and a nurse are sometimes on the staff, and, in a few clinics, a social group worker is employed.

In 1948 more than three-fourths of 327 agencies participating in a study conducted by the American Orthopsychiatric Association, Inc., reported that they had the traditional clinical team of psychiatrist, psychologist, and social worker. The relations and functions of the members of the team varied. In some the traditional pattern was followed, in which the psychologist tested the patient, the social worker studied the home and environment, and the psychiatrist treated the patient, after the team had arrived at a diagnosis based on the reports of the psychologist and social worker together with interviews of the psychiatrist with the patient. The social worker carried out those phases of the treatment which involved changes in the environment of the patient or case work with his family. In other clinics, the services were so organized that each member of the staff participated according to the need of the patient and called in other staff members only when necessary. In only two-fifths of the 192 agencies reporting on this item were more than half of all patients seen by all three members of the team—the psychiatrist, psychologist, and social worker. One-fifth reported that none of the patients was seen by all three (*46*). However, in most clinics it is customary for the social worker to handle problems involving community relations, while the psychologist tends to specialize in diagnostic and evaluative testing and research, and the psychiatrist in therapy (*25*).

In general hospitals, the psychiatric social worker works closely with the medical social worker, but usually specializes in work with patients in the psychiatric ward or clinics. (See Bulletin No. 235–1 in this series for further information on the social worker in a medical setting.)

Talking with psychiatrist about patient leaving the hospital.

Seeing the patient off as she leaves to live at home with her husband.

Visiting the patient in her home.

Figure 3.—A social case worker in a mental hospital.

Some family and child welfare agencies have psychiatrists on the staff, usually in a consulting capacity; some employ persons with training and experience in a psychiatric setting to serve as case workers on their regular staffs. More than one-fifth of the members of the American Association of Psychiatric Social Workers were employed by such agencies or in case work with veterans not using clinics or hospitals in 1948. (See table 1, p. 12.) This type of work, however, when a psychiatrist is not employed to direct it, is no longer purely "psychiatric." Although these social workers are no less competent, their setting is not psychiatric, despite the fact that consultation with a psychiatrist may be periodically provided (*25*).

This bulletin is concerned primarily with those case workers who work directly with psychiatrists in a psychiatric setting. It excludes a growing number of socal group workers who work with patients in mental hospitals and other psychiatric settings. The relation of the group worker to the case worker in a mental hospital has been described in detail in a recent thesis based on the program at the Crile Hospital in Cleveland, Ohio (*50*). The group worker and the case worker have been cooperating in group therapy in a child guidance clinic in Pittsburgh for some years (*14*). Group therapy will be described in a later bulletin in this series on social group work.

THE OUTLOOK

Employers of psychiatric social workers, educators who train them, and groups concerned with mental health needs were unanimous in 1949 in their reports that the demand for psychiatric social workers was growing rapidly and would continue to outstrip the supply for some years to come. Other evidence confirmed these reports: unfilled positions; the postponement of the opening and expansion of clinics and other psychiatric services because of lack of personnel; the employment of part-time personnel because of the inability to obtain full-time persons; and the high turn-over among psychiatric social workers induced by multiple job choices.

The public interest in helping servicemen to recover from mental illness contracted during World War II has resulted in a continuing demand for more and better mental health services. The popular demand is reflected at the national level by the development of a psychiatric social work program in the Army, the expansion of neuropsychiatric hospital and clinic facilities in the Veterans' Administration, the inauguration in 1946 of a National Mental Health Program under the direction of the Mental Hygiene Division of the United States Public Health Service with funds for assistance to State and local agencies and for training mental health personnel, and the exten-

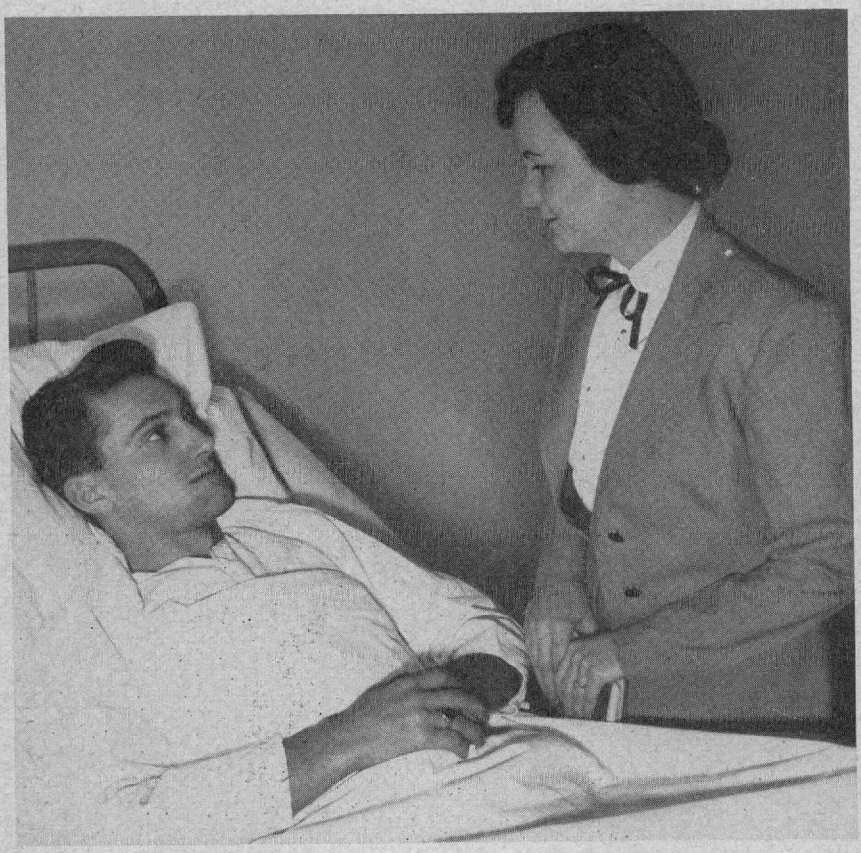


Figure 4.—A social case worker sees patient in veterans' neuropsychiatric hospital, at his request.

sion of the Vocational Rehabilitation Act to cover persons with mental as well as physical disabilities. States also increased appropriations for mental health programs. Mississippi and Montana in 1948 made their first appropriations for noninstitutional mental health services (*63*). New York State was expected to spend nearly 103 million dollars for its Department of Mental Hygiene and its mental institutions in 1949–50, an increase of nearly 62 million dollars over its comparable expenditures for 1942–43. Programs in schools and colleges and the increase in the number of individuals who seek psychiatric help in handling their emotional problems indicate a growing public understanding of and support for increased expenditures for psychiatric services.

The need for additional services is unquestioned (*45*). Physicians report that 40 percent to 70 percent of their medical patients are in need of psychotherapy in relation to physical medical problems (*34*).

Figure 5.—A social case worker in a mental hospital greets a social worker from a community agency who has come to confer regarding the care of a patient's children.

A spokesman for the Public Health Service has said that by conservative estimate more than 8 million persons in the United States are suffering from some form of mental or nervous illness (*21*). The executive secretary of the American Psychiatric Association estimated in 1947 that at least 12 million need help to enable them to adjust to life situations.

The Public Health Service has figured that, for an adequate mental hygiene program, the long-range goal should be 1 psychiatric social

worker for 10,000 people (*62*). This would mean 16,000 psychiatric social workers for the population in 1960 which the Bureau of the Census estimates will be 160 million. The achievement of a more immediate goal of 1 psychiatric social worker for 20,000 persons by 1950 would reduce the number needed to 7,500. This lower figure is far greater than the estimated 1,500 to 2,000 available in 1949. In 1947 only one State, New York, and the District of Columbia had a member of the American Association of Psychiatric Social Workers for every 50,000 of its people; and only California, Colorado, Connecticut, Massachusetts, and Rhode Island had 1 for each 100,000, according to the Public Health Service.

The need for additional mental hospital facilities has been emphasized by reports of the badly overcrowded conditions existing in most of these hospitals. A normal growth in population and the increasing number of the aged among us create additional needs. The admissions of senile patients by mental hospitals in one State were estimated to have increased sevenfold in a decade. In 1948 the Group for the Advancement of Psychiatry stated that the American Psychiatric Association's estimate that there should be 1 psychiatric social worker for every 100 new admissions to mental hospitals each year was too low. It suggested 1 to every 80, in addition to at least 1 psychiatric social worker for every 60 patients in convalescent or family care status (*26*). This would mean, on the basis of 305,000 new admissions in 1948, that the minimum required would be 3,800 psychiatric social workers, plus those needed for the growing number of convalescent and home care patients. At least 3,050 would be needed if the 1 to 100 ratio were used. This lower figure is about 5 times the number of social workers employed in mental hospitals in 1947.

The need for additional clinical facilities was also great. The Mental Hygiene Division of the Public Health Service in 1948 estimated that there should be 1 psychiatric clinic for every group of 100,000 people. In this year there were fewer than 850 clinics in the United States, many of which were only partially staffed and offered only limited service. On the basis of the Public Health Service estimate, the need is for 1,500 full-time, completely staffed clinics. The minimum staff for a clinic includes 2 social workers in addition to a psychiatrist and a psychologist (*62*). The load in the existing psychiatric clinics, excluding the 140 or so in mental hospitals, indicates that the estimate of the Public Health Service is conservative. They report a demand that already doubles and triples the number they actually can serve.

As the needs for additional clinical facilities are met, more clinics designed to meet special problems rather than to serve a general population group or community will also be created. Increasingly,

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the need for psychiatric service for those who are brought into court is being recognized (*13*) (*12*). A clinic responsible for the diagnosis and treatment of the psychiatric, medical, and dental needs of residents was declared by the United States Office of Education to be an essential service in training schools for delinquent youth (*60*). The requirement of a psychiatric examination before probation or parole is arranged has been frequently urged not only for the well-being of the offender but for the protection of the public. Undoubtedly there will be a growth in psychiatric social service in correctional work, both with young people and adults, although relatively few psychiatrists have been employed in criminology in the past (*33*). Along with education, industry, and the military services, it is one of the fields in which there is likely to be a steady future growth in the demand for psychiatric service.

Preventive work with young children is one of the areas of psychiatric work in which expansion may also be expected. Although the experiences in the early years of a child's life are generally considered to determine in a large measure the ease with which he makes later adjustments, few children below school age have had psychiatric attention. Psychiatric service in a few nursery schools and children's hospitals has demonstrated its value and indicated a latent demand among parents for such services to their children. The work of child-guidance clinics, which for the most part have dealt with school-age children, has convinced parents and others of the need for early attention to disturbances of children. The need for psychiatric services for children placed in foster homes and for those who do not attain normal mental development has also been for the most part unmet, except in isolated communities. Resident child-treatment centers, in existence in some 20 communities in 1949, have demonstrated their usefulness and will grow in number.

Teachers of psychiatric social work will be needed to prepare the increasing numbers required for social work in a psychiatric setting. Added to this, a growing number of teachers will be instructing social work students in the basic principles of psychiatric social work. The extensive belief that all case workers should be oriented to social psychiatry and the tendency for personnel workers, school teachers, and others working with individuals to take courses in mental hygiene and psychiatric social work will tend to augment the teaching load in schools of social work and other university departments and the need for psychiatric social workers who can teach.

The demand for more psychiatrists and for more training in psychiatry for all physicians also will require additional related training in the social aspects of psychiatry for which the social service department in the teaching hospital is responsible in part. A similar

trend is likely in the teaching programs for nurses, dietitians, and other hospital personnel. This load, combined with the field supervision of students of social work, already a full-time position in some hospitals, is likely to increase the need for full-time psychiatric social work personnel to assist the head of the social service department in the teaching program. Obviously, for such positions teaching skills as well as case work skills are required.

Research into the causes and care of mental illness and emotional disturbances will also offer opportunity to a small but growing num-

Figure 6.—A scene in a teaching hospital in which students are being taught by a skilled case worker how to interview the upset parents of a patient, whose roles are assumed by two assistants.

ber of social workers. They will usually work with a psychiatric team on a group project in a hospital, clinic, or research agency, or organize student research in a school of social work. The other area of research to which more psychiatric social workers will probably give time in the future is that of analysis of the methods and processes by which they can improve their skills in helping patients.

The extent to which social workers are used in psychotherapy in the future will also affect the demand for the case workers trained to work in the psychiatric field. In 1949 there was some difference

of opinion as to the exact meaning of psychotherapy, which in turn affected opinion as to whether it should be included among the functions of the psychiatric social worker. The Committee on Psychiatric Social Work of the Group for the Advancement of Psychiatry recommends that the practice of psychotherapy be limited to the medically trained psychiatrists. It has defined psychotherapy as—

> * * * any considered and competent medical endeavor, directed toward the improvement of the emotional health of the individual, based upon the understanding of the psychodynamics involved and of the needs of the individual under treatment. Psychotherapeutic endeavor may include adjunctive professional services under the supervision of the psychiatrist. An essential of psychotherapy is found in the interpersonal relationship existing between two people, one asking for help, and the other assuming the authority and having the competence to give help in an area involving a personal problem which is handled through a psychological process (*26*).

According to this interpretation the social worker in a psychiatric clinic would continue to be primarily responsible for the social and community relationships involved in the treatment of the patient and for assisting him in adjusting to his environment, but not for that part of the treatment which involved basic emotional changes within himself. On the other hand, psychiatric case workers sometimes engage in therapy (*3*), and one authority on social work describes psychotherapy as "a specialization * * *, within the larger field of social work" (*29*). There are also those who recommend further graduate specialization for psychiatric social workers who wish to become therapists. The extent to which social workers aided in psychotherapy during the war in work with servicemen and the continuing shortage of psychiatrists have suggested the need for preparing psychotherapists with less training than that of the psychiatrist. Trained psychotherapists have also been suggested as a means of meeting the needs of individuals who do not have access to psychiatrists and would not seek that sort of help because they do not realize their need for it (*29*). But it is likely that the psychiatric social worker will continue to specialize in the field in which she is making a unique contribution to social adjustment, and that psychotherapy will be closely directed by psychiatrists, who will place limits on the extent to which others participate. One well-known psychiatrist has said, "* * * in all cases the social worker becomes not only an investigator but invariably a therapist. His therapy is primarily directed toward helping the individual accept the situation, modifying the external factors insofar as this is possible." The psychiatrist, on the other hand, attempts to change the structure of the personality (*39*).

Fortunately, the interest in psychiatric social work developed during the war resulted in increased enrollments and applications for

training in psychiatric social work and offered some hope that ultimately those trained would be adequate for the demand. In 1949 nearly 500 students who specialized in psychiatric work were graduated from schools of social work. Although this was more than double the 1944 number, it was only half of the number that will be needed annually during the early fifties to staff psychiatric programs already planned in the United States (*35*).

Unless these new graduates work in psychiatric settings, however, they will help to increase the total supply of social workers without

Figure 7.—The psychiatrist, the psychiatric social worker, and the psychologist discuss the finger painting of a psychiatric clinic patient at a children's hospital.

reducing the shortage of psychiatric social workers. Follow-up studies of the graduates of schools of social work do not offer much promise for the future in this respect, unless there is a marked change from the past. In one school where half the graduates in the period from 1936 to 1945 specialized in psychiatric social work, only one-fourth of these specialists reported that their first jobs were in mental hospitals, clinics, or other psychiatric units.

The fact that there is an increasing variety of psychiatric settings and that salaries in many agencies have increased in recent years may

induce more graduates to remain in the field. Only 60 percent of all psychiatrists were employed in State mental hospitals in 1948, as compared with 80 percent 20 years before (*39*). Mental hospitals ranked third in size as an employer of members of the American Association of Psychiatric Social Workers in 1948. (See table 1.) Of 21 graduates from one school of social work in 1948 who entered psychiatric settings, only 7 were in psychiatric hospitals or the psychiatric departments of general hospitals, while 8 were in child guidance clinics, 4 in other psychiatric clinics, and 2 in diagnostic homes. Although almost three-fourths of all the alumnae of that school who in 1948 reported employment in psychiatric work were in hospitals or clinics, others reported that they were engaged in private practice, teaching in a school of social work, court work, mental hygiene work, or administrative and counseling work. Of 14 jobs listed with Social Workers' Placement Service of the California Department of Employment in a 3-month period in 1947–48, for which psychiatric social worker training was required, only 5 were in hospitals or clinics. The remainder were in schools, children's or other case work agencies, membership organizations, or in a court or a church.

The demand for social workers trained for psychiatric specialization is likely to continue in nonpsychiatric agencies as well as in psychiatric settings. But the predictable demand in psychiatric settings is so great that those who take training in this field are urged to utilize it to the fullest in service to the mentally ill.

Table 1.—*Type of Employment of 874 Members of the American Association of Psychiatric Social Workers, 1948*

Type of employment	Number	Percent
Total	[1] 874	100.0
Clinics	243	27.8
Social case work agencies [2]	179	20.5
Hospitals	177	20.3
Teaching in social work school, undergraduate college, or nursing school	75	8.6
Mental hygiene associations or bureaus	30	3.4
Schools, working with pupils	27	3.1
Consultant	23	2.6
Institutions, except hospitals	21	2.4
Medical social work	20	2.3
Public welfare agencies	14	1.6
Private practice	6	.7
Vocational rehabilitation	4	.5
Courts	1	.1
Group work agencies	3	.3
Miscellaneous related work	39	4.5
Occupation other than social work or work in a social agency	10	1.1
Unclassified	2	.2

[1] An additional 182 members did not state employment, and 27 were employed outside the United States.
[2] Nonclinical work with the Veterans' Administration is included here, whereas work in Veterans' Administration clinics or hospitals are reported under clinics and hospitals respectively.

Source: Tabulation made from August 1948 membership list of the A. A. P. S. W.

DEMAND AND SUPPLY IN 1949

Psychiatric Clinics

The largest demand for psychiatric social workers in 1949 was in psychiatric hospitals and clinics. Some 800 were employed in clinics alone in 1948, according to the United States Public Health Service, 538 in full-time clinics and 302 in part-time clinics. About 300 other social workers without psychiatric specialization were also employed in these clinics. Some 200 psychiatric social workers were working in 1949 in the 59 mental hygiene clinics of the Veterans' Administration. A rather high percentage, possibly one-fourth, of these were men. Another large group were in some of the 510 mental hygiene clinics operated by hospitals of all types in 1949, according to the American Hospital Association (*9*). Some of these clinics in general hospitals served out-patients, but even these were limited directly to the intake of the hospital and seldom gave community-wide service (*25*). Some of the 143 clinics in mental and allied hospitals included in the hospital clinic group served entire communities, but usually their major load consisted of residents and out-patients still under hospital treatment.

Some of these 800 psychiatric social workers were employed in the 300 or more child guidance clinics, most of which operated part time (*64*). A few worked in the growing number of specialized clinics for those suffering from alcoholism or venereal disease. In San Francisco, for example, psychiatric social workers were helping promiscuous and potentially promiscuous young men and women at a venereal disease clinic (*17*). And in many large cities, as well as in some State clinics, they were employed in clinics for alcoholics (*52*). The demand for clinics open to all persons in the community was stimulated by the Nation-wide clinical services opened to veterans and by the National Mental Health Act of 1946 which provided funds to States for programs of mental hygiene including services to communities. In 1948 more than 100 clinics were organized or expanded in 34 States under this program. In 1949 the demand for additional service was great. One city clinic, for example, which served 700 patients in 1 year reported more than 900 potential patients whom it could not accept because of lack of staff. As clinics go, it was well-staffed with 9 full-time professional persons (including 5 psychiatric social workers) and 6 part-time psychiatrists.

The largest number of openings, in psychiatric social work, reported to the American Association of Psychiatric Social Workers in a 6-month period in 1948–49 was in the clinical field. The 70 positions ranged from junior psychiatric social workers and members of traveling clinics to directors of clinics; from openings in child guidance

clinics to those in clinics for alcoholic patients and others in community clinics.

Under the mental hygiene program authorized by the National Mental Health Act, increasing emphasis is being placed on prevention. In the newest demonstration clinic, for example, 30 percent of the work is treatment of emotionally disturbed persons, but 70 percent is preventive work with such agencies as prenatal and other clinics and the public schools.

Psychiatric Hospitals

About 600 additional social workers were employed in psychiatric hospitals in 1949. In 1947 the Bureau of the Census reported 613 social and field workers in State mental hospitals, which house 87 percent of all hospitalized mental patients in the United States. Some of these may not have been fully trained social workers, and some may have been working primarily in clinics and so may be included among the 800 persons reported as working in full-time or part-time clinics. However, probably at least 300 of them were psychiatric social workers not otherwise reported. In addition, in 1949, there were 215 psychiatric social workers employed in 33 veterans' neuropsychiatric hospitals and 56 psychiatric social workers employed by the American Red Cross for work in military hospitals. In other Federal hospitals such as St. Elizabeths Hospital and the marine and narcotics hospitals operated by the United States Public Health Service, there were 17 positions for psychiatric social workers.

The need for additional social workers in mental hospitals was enormous. In all State mental hospitals, there was an average of only 1.4 social workers per 1,000 resident patients in 1947. Although this was an improvement over the 1.1 ratio in 1946, it was far below the number required for adequate social service. Nine States had no social workers in State mental hospitals. Less than half of the 504 mental and allied hospitals listed in the 1949 directory of the American Hospital Association reported having a social service department (*9*). In 1947 only 1 State, New Jersey, met the standard recommended by the American Psychiatric Association of 1 trained social worker for each 100 admissions. The average for the United States as a whole was 0.47 social workers for 100 admissions.

Wide variation existed not only in the ratio of patients to social workers but in the type of services rendered. Service to convalescent patients who report to clinics, follow-up services to those who have gone home from the hospital, and family-care programs for patients placed during convalescence with families other than their own were in some cases added to the usual treatment of newly admitted and resident patients. Such services require a higher proportion of social

workers. The Group for the Advancement of Psychiatry, for example, which recommends 1 social worker to 80 newly admitted patients, adds that 1 social worker for 60 convalescent and home care patients is needed (*26*).

Twenty-eight psychiatric social work positions in mental hospitals listed with the American Association of Psychiatric Social Workers in a 6-month period in 1948–49 indicated the extent of the demand for trained social workers in mental hospitals. These positions varied from those of case workers with in-patients or out-patients and rela-

Figure 8.—A social case worker preparing for her first interview with a patient in a mental hospital.

tives of patients, to those of directors of social service departments. Directors were expected to integrate the department with the total hospital program, to administer in-patient, clinic, and family care programs, and to supervise and train social workers. Some directors' positions also involved the teaching of medical students.

Other Institutions and Organizations

Some large school systems, like those in New York and San Francisco, operate psychiatric clinics, and others employ psychiatrists on a consulting basis. For example, one city has a psychiatrist who

serves as a consultant to school administrators, to teachers, and to a considerable number of school social workers. (The school social worker will be discussed more fully in the bulletin on social case work with children.) Most school systems, however, refer children needing psychiatric service to clinics under other auspices in the community. Study homes where very disturbed children live while receiving psychiatric help are growing in number (*27*) (*47*). In New Jersey, for example, there is a State-supported resident child-treatment center to which such children may be referred. Connecticut and New Hampshire have authorized such programs, and probably 20 communities in 1949 had facilities of this sort employing possibly 50 psychiatric social workers.

In 1947 one authority estimated that only 10 or 15 colleges and universities employed full-time psychiatrists but that at least an equal number were seeking psychiatrists for mental health counseling in the student health service.

More than half of 300 colleges replying to a 1947 questionnaire reported that mental hygiene counseling was available to students, and almost half reported psychiatric consultation available through the student health service (*38*). That psychiatric social workers are used as mental hygiene counselors in colleges is indicated by a request to the American Association of Psychiatric Social Workers in 1948–49 for a man with a master's degree in psychiatric social work and clinic experience to counsel students on personal problems, in association with a psychiatrist working on a half-time basis. In Wisconsin a psychiatric social worker was employed in 1948 at a State teachers' college under the State mental health program (*63*).

In the Army, too, there is a definite program of psychiatric social work, initiated during World War II. A lieutenant colonel in the Army in 1949 headed the Psychiatric Social Work Branch of the Psychiatry and Neurology Consultants Division in the Surgeon General's Office, which was responsible for developing psychiatric social services for servicemen and their dependents for whom assistance was being made available through Army general hospitals, training centers, and the psychiatry and sociology divisions of disciplinary barracks. Eight Regular Army officers were taking graduate social work training in civilian schools for this program in 1948–49, and selected officers and enlisted men were being trained in the Army at the subprofessional case aide level to assist in the program, because of the shortage of trained social workers (*15*).

Psychiatric services are also being utilized in criminal and juvenile courts. In 1947 about 10 adult criminal courts and a large number of juvenile courts employed psychiatrists full or part time, and some actually operated a full-time psychiatric clinic. Another group of 40 full-time and 43 part-time psychiatrists were employed in 1945,

according to the Bureau of the Census, in Federal or State prisons and reformatories (*38*). All Federal penitentiaries and detention homes are authorized to have a full-time psychiatrist, but the jobs are not always filled (*39*). There is no report available on the number of psychiatric social workers employed to work with these psychiatrists. They are probably few in relation to the probation and parole officers employed in correctional work, whose work will be discussed in another bulletin in this series.

The need for psychiatric service in all penal and corrective institutions and the need for psychiatric study of children awaiting court

Figure 9.—A psychiatric social work officer at an Army general hospital interviewing a patient in an out-patient clinic.

disposition has been demonstrated, but only a few centers have developed adequate services. Wisconsin was one of the States which in 1949 was recruiting psychiatric social workers to assist in the treatment of delinquent girls in limited security institutions and of defective children in training schools.

Psychiatric service in most business, industrial, and Government personnel departments is limited. Usually employees needing psychiatric help are referred to outside services. In 1947 there were, according to a prominent psychiatrist, probably six or eight psychiatrists employed full time by a business or industrial organization to

serve employees (*39*) and an additional number served as consultants to the personnel or medical staff of the organization. A trained psychiatric social worker is employed at the diagnostic clinic of the Medical Health Center of the United Auto Workers of Detroit, which serves members of the union. Social workers are also employed by the United States Public Health Service in a mental hygiene clinic included as part of its medical service for Federal employees in Washington; no information was available on psychiatric services offered by other Government units.

Consultation and Mental Hygiene Education

With the development of mental health programs and the emphasis on psychiatric problems in other programs, the demand for psychiatric consultants has increased. In 1949 the National Institute of Mental Health of the United States Public Health Service employed three women psychiatric social workers as regional consultants in addition to the division head and an assistant, who were men. Besides several assigned to hospitals or clinics, as noted earlier, there were three additional openings for consulting and demonstration work under the National Mental Health Act, which authorized grants-in-aid and consultation services to the States and demonstration clinics. The Children's Bureau and the Office of Vocational Rehabilitation each employed one consultant in psychiatric social work in connection with their respective programs. Four of the Veterans' Administration headquarters staff in social service were also psychiatric social workers by training and experience, as were many of those employed in the regional and area offices of the Administration to offer consultation to case workers.

The largest group of consultants were employed in State agencies, where mental health programs were growing rapidly. All but 2 of the 53 States and territories of the United States had such programs in 1949, as compared with only 15 in the preceding year. According to the Public Health Service, 209 psychiatric social workers were employed in these State mental health programs, which is twice the number employed in 1948. Not all of these were consultants, because many were engaged in direct case work in institutions or clinics in the State. However, some were engaged in such work as consultants in community mental health education and in the development and supervision of homes for out-patient treatment, or as liaison workers between child guidance clinics and teachers in rural and urban schools, where they served as consultants in mental hygiene programs with children.

That there is a real need for such programs, which encourage and promote mental health, is evident from hospital and clinical experience and from records of soldiers who served in two wars (*51*).

Leadership in this field has been taken by the National Committee for Mental Hygiene and State and local mental hygiene societies. About 36 State and local mental hygiene societies were in existence in 1949. Of this number, about 16 had paid executives, about half of whom had training and experience in psychiatric social work. Also, two other psychiatric social workers were known to have non-executive positions on the staffs of these mental hygiene societies. An opening for an educational director of a local mental hygiene association reported to the American Association of Psychiatric Social Workers in 1948 specified experience in speaking and in organizing

Figure 10.—A social case worker connected with a State mental hygiene division conferring with a troubled mother.

and developing programs. Only one or two States in 1948 had any sort of program for the prevention of mental illness, because the psychiatric program in most States was still limited to the supervision of State mental hospitals (*39*). However, an opening for an assistant director of a State division of mental hygiene in 1948, for which a psychiatric social worker with 5 to 6 years of clinical and hospital experience was sought, stressed ability to educate professional groups and serve as a consultant to community organizations. Public relations and community organization experience and training are as important as knowledge of psychiatric social work in positions of this kind, where so much work with lay and professional groups is involved.

Private Practice

Only six members of the American Association of Psychiatric Social Workers in 1948 reported themselves in private practice work. One of these did psychiatric social work for a private psychiatrist in New York. Another was employed as a consultant in psychiatric social work several hours a week at various agencies in California. Over the years, more than 30 members have been engaged in private practice for brief intervals, although the number at any one time did not exceed half a dozen. The need for standards and licensing provision for social workers engaging in private practice was emphasized in 1948, after an exploratory inquiry into private practice by members of the American Association of Psychiatric Social Workers (*48*).

Teaching

Most of the full-time teachers in the field of psychiatric social work are on the faculties of graduate schools of social work, especially those offering specialization in psychiatric social work as approved by the American Association of Psychiatric Social Workers. In 1948–49 20 women were teaching psychiatric social work full time in graduate schools of social work, and an additional 35 women and 11 men were teaching psychiatric social work part time in these schools. Of the latter, 13 women and 5 men were full-time faculty members but gave only part time to the psychiatric specialization. More than 100 physicians also gave part-time instruction in psychiatric information and problems. At least 6 full-time psychiatric social work teaching positions in schools of social work were open in 1948–49, varying from that of supervisor of psychiatric social work students and instructor to that of an assistant professor. For 1949–50 the American Association of Psychiatric Social Workers announced 3 faculty openings for the teaching of psychiatric social work and 3 additional openings for teaching case work for which psychiatric case workers were required.

A larger group of psychiatric social workers were also supervising students of social work part time in the psychiatric setting in which they themselves were employed in the practice or supervision of psychiatric social work. Members of the staff of the social service department in teaching hospitals also were engaged part time in the teaching of medical students. Although in most medical schools psychiatry was not given more than 2 percent of the teaching hours and never more than 4 or 5 percent, the trend was toward an increased number of hours devoted to this teaching (*39*). The National Mental Health Act has encouraged the expansion of psychiatric departments by supplying funds for expansion. It has also provided funds for and stimulated the training of additional psychiatrists in postgraduate courses at

medical schools. The increase in this type of training, and the corresponding increase in psychiatric emphasis in the training of nurses and occupational and physical therapists has steadily added to the teaching load of psychiatric social workers employed in hospitals. More and more, other professions are seeking instruction in the relationships of psychiatric and social problems. Many theological schools now arrange internships in psychiatric hospitals for their students (*39*). The desire for background in mental hygiene has extended to the

Figure 11.—Using psychodrama in a teaching hospital, a case worker directs a student in interviewing a depressed patient, whose role is assumed by an assistant.

undergraduate college level, too. Ninety colleges out of three hundred replying to a 1947 questionnaire offered courses in mental hygiene for college credit (*39*).

Research

Very few persons were engaged in full-time research in psychiatric social work in 1949, although a few were participating part time in research related to their regular work in a psychiatric setting. More research was encouraged when the National Mental Health Act of 1946 authorized the creation of the National Institute of Mental Health

in the United States Public Health Service as a research and training center with full-time staff. In addition, it authorized the United States Public Health Service to foster research in the causes, diagnosis, and methods of treatment and prevention of mental and nervous disorders through grants in aid to universities, hospitals, laboratories, and other public and private institutions, and to individuals. By 1948 38 research projects had been approved and 19 fellowships had been granted for the fiscal year 1948 (*20*). Although most of the research involved medical and psychiatric personnel, psychiatric social workers

Figure 12.—A social case worker with the Massachusetts Department of Mental Health, Division of Mental Hygiene, receiving a request for service from a social agency.

participated in some of these projects. At one hospital, for example, a member of the psychiatric social service staff was borrowed for 1 year to work full time on a research project directed by a psychiatrist on the hospital staff.

Geographic Variations in Employment

All available information indicates an uneven distribution of psychiatric social workers in relation to need. Agencies which employ on a Nation-wide scale, such as the Veterans' Administration and the American Red Cross, report that a relatively larger supply of trained psychiatric social workers is available in such centers as New York

City, Washington, D. C., San Francisco, and Los Angeles; while in the States west of the Great Lakes and in the Southeastern States, it is difficult to find qualified people to fill vacant positions.

Almost half the members of the American Association of Psychiatric Social Workers in 1949 were in the Northeastern States, more than one-fourth in New York State alone.[1] (See table 2.) This is understandable in view of the heavy concentration of psychiatrists there. Half the psychiatrists listed in the 1944 directory of the American Psychiatric Association were in those States. In relation to population, the Public Health Service in 1949 reported that California, Colorado, Connecticut, the District of Columbia, Kansas, Maryland, Massachusetts, New Jersey, New York, and Rhode Island were best

Table 2.—*Geographic Distribution of Psychiatric Social Workers Compared With That of Psychiatrists and the General Population*

Region	Members of the A.A.P.S.W., 1949 [1]		Social workers and field workers in State mental hospitals, 1947 [1]		Psychiatric social workers in psychiatric clinics, 1948 [1]		Psychiatric social workers in State mental health programs, 1949 [1]		Members of the American Psychiatric Association, 1943–44 [2]		Estimated population of the United States, 1948 [3]
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Percent
United States	1,181	100.0	613	100.0	840	100.0	209	100.0	2,196	100.0	100.0
Northeastern States	587	49.7	293	47.8	386	46.0	79	37.8	1,091	49.7	26.8
North Central States	261	22.1	180	29.3	231	27.5	60	28.7	504	22.9	30.0
South	173	14.6	69	11.3	97	11.5	55	26.3	419	19.1	30.4
West	160	13.6	71	11.6	126	15.0	15	7.2	182	8.3	12.8

[1] National Institute of Mental Health, U. S. Public Health Service.
[2] Directory of the American Psychiatric Association.
[3] U. S. Bureau of the Census (*55*).

supplied with psychiatric social workers, each having 1 or more members of the American Association of Psychiatric Social Workers per 100,000 population, as estimated in 1948. Alabama, Idaho, Maine, Mississippi, Montana, Nevada, North and South Dakota, Oklahoma, West Virginia, and Wyoming were poorest in this respect.

In all the principal types of mental health agencies except State mental health units, where the distribution was less askew, unevenness in relation to population is repeated, according to information assembled by the United States Public Health Service. (See table 2.)

[1] Regions as designated in U. S. Census reports are used throughout—

Northeastern States—Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont;

North Central States—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin;

South—Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia;

West—Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming (*58*).

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Nearly half of the psychiatric social workers in clinics as well as in mental hospitals were concentrated in the Northeastern States. New Jersey, Illinois, New York, Michigan, Maryland, Delaware, and New Hampshire, in 1947, had the highest number of social workers in State mental hospitals in relation to patients residing in them; Alabama, Florida, Kansas, Nevada, New Mexico, North and South Dakota, Tennessee, and Wyoming had no social workers in State mental hospitals. Some of this maldistribution may have stemmed from an early concentration in the Northeastern States of training centers offering specialization in psychiatric social work. However, in 1949–50 the schools were more evenly distributed than the workers. Only 9 of the 22 schools of social work offering an approved curriculum in psychiatric social work were in the Northeastern States; 5 were in the North Central States; 5 in the South; and 3 in the West.

Supply

The supply of social workers qualified to work in psychiatric settings can only be estimated. Unlike doctors and nurses, social workers, even those who work in medical settings, are not required to have licenses. Only one State, California, provides for the voluntary registration of social workers. However, the desirability of licensing psychiatric social workers has been recognized by psychiatrists as well as by social workers (*26*). Until such time as the several States provide for licensing, the standards set up by the American Association of Psychiatric Social Workers for membership are the chief controlling influence on supply in this field. (See appendix, p. 49, for membership requirements.) According to these standards, the source of supply tends to be limited to graduates from an accredited school of social work with specialization in the approved curriculum in psychiatric social work or in another curriculum with offsetting subsequent supervised experience in psychiatric social work. In 1948, there were about 900 members of the American Association of Psychiatric Social Workers who were employed either in this country or abroad and an additional 182 members, including 116 married women, who did not report employment. Possibly there were 500 to 1,000 additional nonmembers of equivalent training and experience.

That this supply was insufficient was evident from continued reports of shortages. However, the increasing number of students specializing in this field offered some hope of narrowing the gap between demand and supply.

Nearly 500 students were prepared to complete their specialized training in this field in 1949, according to the American Association of Psychiatric Social Workers, as compared with 200 in 1944. In 1950, 22 universities and colleges, as compared with 8 before World War II, offered curricula approved by the American Association

of Psychiatric Social Workers. But more were needed. Most schools reported that they usually had more applicants of high caliber than the number for which they could provide adequate supervised field training. At least 1,000 trainees in psychiatric social work would be needed each year for the next few years to produce the 13,000 to 15,000 psychiatric social workers that estimates indicate are needed in the 1950's to staff programs already planned for in the United States (*35*).

The National Mental Health Program of the United States Public Health Service and the Veterans' Administration supervised field work program, like the Commonwealth Fund scholarships in earlier years, have done much to stimulate interest in this field and to encourage training for it. The use of male psychiatric social workers in the Army and the Veterans' Administration, higher salaries, and the public interest in the treatment of mental illness have also awakened many to the possibilities in this field of work. Most schools of social work report an increased interest on the part of students in psychiatric social work specialization.

TRAINING

The continued acute demand for social workers in psychiatric settings resulted in lowering the amount of experience required for some positions. But the training required for positions in this field usually conforms to educational requirements set by the American Association of Psychiatric Social Workers and endorsed by the National Advisory Mental Health Council: Completion of a 2-year graduate course in an accredited school of social work, including specialization in psychiatric social work as approved by the American Association of Psychiatric Social Workers. (See appendix, p. 50, for essential elements in this specialization.) Those hired in the past who had not completed an approved course in an accredited school of social work were usually urged to complete their training following employment.

So great has the emphasis on initial training become that the Group for the Advancement of Psychiatry has recommended that when personnel without graduate professional training in a school of social work with major emphasis in psychiatric social work must be employed, they should be designated by a completely different title. Work experience in a social service department even in a psychiatric setting is not likely to be accepted as a substitute for graduate training in social case work in the future. On the other hand, such experience in addition to adequate training is often required for particular positions (*26*).

Schools of social work in the United States offering the 2-year graduate training approved by the American Association of Psychiatric Social Workers almost tripled in number from 8 in 1940 to 22 in

1949. (For a list of accredited schools, see appendix, p. 51.) Six of these schools offer a third-year graduate program. In order to develop more advanced training facilities, the National Mental Health Institute of the Public Health Service is encouraging other schools of social work to arrange a third-year program for outstanding graduates of the 2-year program who have had at least 3 years of successful experience in a psychiatric setting. Fellowships of $2,400 are available to qualified candidates for this type of training.

Figure 13.—A psychiatric social work supervisor in a mental hospital conferring with a social work student who is obtaining her field experience at the hospital.

In the second year of the graduate program it is customary for schools of social work to arrange for a considerable amount of field work experience in the type of agency in which the student wishes to work following graduation. For work in a psychiatric hospital, at least 9 months or 3 quarters spent in field work in a psychiatric hospital are recommended by the Group for the Advancement of Psychiatry (*26*). Some experience in a psychiatric hospital with its extensive and varied problems and facilities is recommended for all, including those who intend to work in a child guidance clinic or other nonhospital setting.

Further training of those already employed is commonly encouraged and often provided by the employing agency in this rapidly developing field where it is difficult to keep abreast of new techniques and methods. Thirty-six States and Territories in 1948 were using Federal funds for training their psychiatric personnel, including psychiatric social workers, for better service in their mental health programs (*20*). Recent emphasis in training has been on the use of group techniques with psychiatric patients. Schools of social work of the University of Pittsburgh, Western Reserve University, and the University of Minnesota train social group workers for work in psychiatric settings. Case workers in psychiatric hospitals and clinics also have been increasingly drawn into group therapy work with patients under the supervision of a psychiatrist. The Jewish Board of Guardians in New York City has had a continuous seminar for its workers in activity group therapy for 10 years, as well as a seminar in interview group treatment. Because in its clinics, contrary to the usual clinical practice, case workers are expected to engage in psychotherapy, seminars are also given in clinical orientation, diagnostic categories, and treatment (*31*). It is generally recognized by authorities in this field that if social workers are to engage in psychiatric treatment, customarily handled by the psychiatrist, they need intensive training in psychotherapy following the 2-year approved program for psychiatric social work and several years of experience in a psychiatric setting (*29*) (*1*). The experience of going through a psychoanalysis is also recommended by some authorities for those who attempt treatment of the emotionally disturbed (*1*).

Scholarships, Fellowships, and Other Student Aids

The scholarships available under the National Mental Health Act of 1946 have given financial encouragement to potential students of psychiatric social work (*61*). In 1949, 60 women and 2 men were receiving scholarships under this program, after being chosen from more than 300 individuals applying for such assistance to schools of social work cooperating in the program. Fifty-three, including one of the men, were completing their second year of training in an accredited school of social work in a curriculum approved by the American Association of Psychiatric Social Workers. (See appendix, p. 50.) Each received a stipend of $1,600. Nine others, who had completed their master's degree and had at least 3 years of successful experience in psychiatric social work, were completing a third year of graduate work to train them for administrative, supervisory, research, or teaching positions in the field. Their stipends were $2,400. Grants for predoctorate and postdoctorate research fellowships in mental health are also made by the Division of Research Grants and Fellowships of

the National Institute of Mental Health for work on research projects approved by the United States Public Health Service. Grants vary from $1,200 to $3,600 depending on the academic degree possessed by the researcher and whether or not he has dependents. Scholarships and fellowships for psychiatric social work training are available through some State departments of health and mental hygiene, financed by State and National Mental Health Act funds.

Other scholarships designed specifically for training in psychiatric social work were available through schools of social work. The California Congress of Parents and Teachers offered fellowships for 1949–50 at the University of California and at the University of Southern California for students preparing for psychiatric social work with children who would agree to work subsequently for 2 years in public schools or other public agencies in California. Other scholarships for those who desire to work in the field of mental health for children were also made available at the University of Southern California and at Smith College School for Social Work by the George Davis Bivin Foundation. At the University of Louisville's Raymond A. Kent School of Social Work, several fellowships were offered in 1949–50 by the Kentucky State Board of Health to students who would subsequently work in the psychiatric social work program of the Board. Scholarships for first-year students planning to specialize in psychiatric social work as well as for second-year students, were offered in cooperation with local agencies at a number of schools, for instance, the Pennsylvania School of Social Work, Smith College School of Social Work, and at Western Reserve University's School of Applied Social Sciences. Some schools like the Pennsylvania School of Social Work offered special scholarships for training in psychiatric social work for students who have had at least 3 years of experience in social work. Simmons College School of Social Work was among those which in 1949–50 offered resident scholarships for second-year students specializing in psychiatric social work (*8*).

Resident scholarships in a State hospital were available for 1949–50 for second-year students majoring in psychiatric social work at the Carnegie Institute of Technology, for instance. Internships covering all living expenses were also available at certain mental hospitals and clinics on the list of cooperating field work agencies of Smith College School for Social Work (*8*). The dearth of skilled workers in psychiatric social work, as well as the limited financial remuneration for persons with such training, was given as a reason for failure to find qualified candidates in 1946 for an annual fellowship in child therapy at the Washington Institute of Mental Hygiene.

Provision for supervised field work in social service in the Veterans' Administration hospitals and clinics over the country, either on a part-time paid field work or an unpaid basis, was also of great help in

increasing the total supply of psychiatric social workers as well as in meeting Veterans' Administration needs. Under the paid field work program, begun in 1947, selected students who had completed 1 year in a recognized school of social work and had 1 year of case work experience in a health or welfare agency of acceptable standard, were paid for part-time work performed in the Veterans' Administration. This placement met the second-year field work requirement of the school of social work in which the candidate was enrolled for specialization either in psychiatric or in medical social work. Students

Figure 14.—An experienced case worker in a veterans' neuropsychiatric hospital sees patient in her office to discuss plans for his return home when doctor indicates he is ready for discharge.

worked a minimum of 24 hours a week (*66*) and were paid $1.64 an hour. In December 1948, 232 students from 36 schools were placed in Veterans' Administration hospitals and regional offices, 159 of them in psychiatric settings.

Only male graduate students of social case work enrolled in graduate schools of social work were eligible for selection in 1949 for the Army's new program to secure psychiatric social workers for a career as officers in the Regular Army Medical Service Corps, under which pay and allowances for the second year of graduate training averaged $3,800 per student.

EARNINGS, HOURS, AND ADVANCEMENT

Earnings.—The most recent comprehensive study of salaries of psychiatric social workers was that made in December 1942, when 380 members of the American Association of Psychiatric Social Workers replied to a questionnaire. Almost half, or 46 percent, were in the $2,000 to $2,900 group; one-fifth (21 percent) received from $3,000 to $3,900; the remaining 23 percent were divided almost equally between the extremes, those who earned $1,800 to $1,900 and those who earned $4,000 or more. Nearly three-fourths of those employed in public mental hospitals received from $2,000 to $2,900. Salaries were higher, however, in child guidance clinics where more than half reported salaries of $3,000 or more, and some received $5,000 or more. Salaries were lowest in nonpublic hospitals and clinics for adults where almost one-fourth received less than $2,000. More than nine-tenths of the members engaged in teaching in schools of social work received $3,000 or more, and this group had the greatest proportion (14 percent) in the $5,000 or above group. The report calls attention to the fact that New York City and Pennsylvania salaries may have distorted the picture upward (*11*).

Nation-wide information for 1950 will be available shortly from the Bureau of Labor Statistics' current study of the economic status of social workers. Meanwhile, the following scattered evidence indicates that salaries have increased considerably since the 1942 study.

Salaries offered in 1949 on openings in psychiatric social work were slightly higher than those offered on other case work openings, according to the Social Work Vocational Bureau and reports from scattered employers and schools. Graduates of schools of social work with specialization in psychiatric social work were starting at $2,400 to $3,000, while requests for alumnae for executive positions offered $5,000 to $6,000. In Pittsburgh a local report on salaries in 1946 had recommended that salaries for all case workers range from $2,100 to $3,000, but commented that the higher salaries offered by the Veterans' Administration for psychiatric and medical social workers would handicap local agencies in obtaining experienced workers in these fields. In 1949, a beginning salary of $3,825 was paid in the Veterans' Administration. (For requirements for beginning positions in the Veterans' Administration see appendix, p. 49.)

On hospital jobs listed with the American Association of Psychiatric Social Workers in a 6-month period in 1948–49, the lowest minimum offered psychiatric case workers was $2,400; the highest maximum, that for a director of the social service department, was $4,848. On many jobs salaries were not quoted, the employer usually stating in that case that the salaries were flexible and depended on

the experience of the person hired. One State hospital mentioned that a charge for maintenance was deducted; another offered $2,250 per year with complete maintenance, or $2,490 plus meals and some laundry if the worker lived off the grounds. Six offered complete maintenance if desired, ranging in cost from $360 to $810.

On clinical jobs, the lowest salary quoted was $2,400, with one exception at $2,160; the highest, for directors, was usually $5,000, although one child guidance clinic offered $6,200. The minimum quoted in child guidance clinics was $2,700. Salaries in educational work were in the higher brackets. In mental hygiene educational work, salaries

Figure 15.—A social case worker in a mental hospital interviews patient's wife to learn about social and emotional factors related to his illness.

in two openings ranged from $4,000 to $5,652. For a 9-month year, the lowest salary quoted for a school of social work job was $3,000, the 12-month equivalent of which would be $4,000. Salaries on 1949–50 teaching openings listed with the American Association of Psychiatric Social Workers ranged from $3,600 to $5,000 for a school year of 9 months.

In California in 1949 one agency paid a consultant in psychiatric social work $7.50 an hour for 2½ hours a week. Salaries on six psychiatric case work jobs, listed with the California Department of Employment's Social Workers' Placement Service, in a 3-month period

in the years 1947–48, ranged from $2,580 to $4,260. On supervisory, consultant, and executive jobs the range was from $3,600 to $5,400. The State of Wisconsin in 1949 paid $3,240 and a cost-of-living bonus to its beginning psychiatric social workers, and salaries on psychiatric social consultant positions in Southern States in late 1946 were reported to range from $2,100 to $5,000 (*32*). Beginning case work positions in more than 100 mental hospitals in 1947, according to the Group for the Advancement of Psychiatry, offered from $1,530 plus maintenance to $2,400 without maintenance. Salaries ranged up to $5,000 without maintenance for chief social workers who headed social service departments (*26*).

The median annual salary for social workers providing direct services to individuals in Michigan in 1948 was found by the Bureau of Labor Statistics to be $2,640 for women and $3,320 for men. For social work executives, the median was $3,680 for women, $4,500 for men. No special report was made of those working in psychiatric settings (*18*).

Hours and Working Conditions.—For many years, the hours of work of social workers in hospitals, which, of course, operate 7 days a week and 24 hours a day, were longer, more uncertain, and on a less desirable schedule than those in social agencies. However, in 1949 psychiatric social workers in mental hospitals, like those who worked in clinics not connected with them, generally had regular hours. The workweek seldom exceeded 40–44 hours, and compensatory time off for Saturday, Sunday, evening, or holiday work was customary.

Living in the institution was sometimes required in isolated hospitals or in child study homes, but most psychiatric social workers did not live at their place of employment. Jobs involving work with patients residing outside the hospital but still under its supervision, as well as some regional jobs of the Veterans' Administration and some State consulting jobs, practically required the possession of a car for travel.

More comprehensive and recent information on hours and working conditions will be available in the Bureau of Labor Statistics' report on its 1950 study of the economic status of social workers.

Advancement.—Opportunities for advancement to supervisory or administrative work within a psychiatric agency depend upon the size of its staff. In a small clinic employing only one social worker, advancement for the social worker usually lies only in transfer to a larger organization where advancement to a case supervisor or possibly to a position as director of social service is possible. In only a few clinics has a social worker become director of the entire clinic, a post usually held by a psychiatrist and less often by a psychologist.

In large psychiatric hospitals and organizations such as the Veterans' Administration and the American Red Cross, directors of social serv-

ice or chief social workers have an administrative job of some size. For instance, in large Veterans' Administration hospitals, the chief social worker does not engage in direct case supervision or actual case work. However, a wartime study of members of the American Association of Psychiatric Social Workers indicated that administrative jobs in this field usually involve direct supervision of case work or actual case work. About half of all the jobs reported by 277 members involved administrative responsibility either in a psychiatric or nonpsychiatric agency (*11*). For the position of director of social service in a psychiatric hospital, the Group for the Advancement of Psychiatry has recommended a minimum of 5 years of experience, including at least 3 in a psychiatric setting and 2 in a supervisory capacity (*26*).

Many psychiatric social workers prefer to remain in positions where they are giving service directly to patients. As in other case work fields, salary increases usually recognize the growing skill and experience of those who prefer to remain in case work positions.

ORGANIZATIONS

The American Association of Psychiatric Social Workers is the principal professional organization for case workers who have specialized in work with psychiatrists. It stemmed from a club of psychiatric social workers which was organized in Boston in 1920 and in 1922 became a section of the American Association of Hospital Social Workers. In 1926, as more and more of its members were found in such nonhospital agencies as mental hygiene and child guidance clinics, it formed a separate organization under its present name with 99 members (*24*). In 1949 it had 1,150 members who qualified by training and experience as psychiatric social workers. (See appendix, p. 49, for minimum requirements.) It publishes a journal, a newsletter, and a monthly job information service bulletin for members. It is affiliated with other social work groups through the National Conference of Social Work and holds its annual meeting in that connection. Some of its members who work in hospitals also belong to the American Association of Medical Social Workers. Many also belong to the American Association of Social Workers, whose membership is open to all social workers who meet certain standards of training and experience, regardless of their specializations.

The American Orthopsychiatric Association is a membership organization which provides for the professional affiliation of psychiatric social workers with other members of the psychiatric clinical team—psychiatrists and psychologists. In 1948 members totaled 706, of whom 332 were psychiatrists, 151 were psychologists, 163 were psychiatric social workers, and 60 were in other classifications. In 1949 its president was a woman psychiatric social worker.

The American Psychiatric Association has for many years had a committee on psychiatric social service which concerns itself with liaison between these two professional fields, and which works toward the most effective use of social work in the treatment of emotionally disturbed people.

The Group for the Advancement of Psychiatry, organized in May 1946 and composed of 150 psychiatrists in the United States and Canada, has a committee on psychiatric social work. Psychiatric social workers serve as consultants to this committee. The National Committee for Mental Hygiene, Inc., established in 1909, includes 750 elected members who have rendered distinctive service in the field

Figure 16.—The president of the American Orthopsychiatric Association (center) conferring with speakers at the 27th annual convention of the association.

of mental hygiene, of whom about 10 percent in 1949 were social workers. State societies for mental hygiene are organizations for the promotion of better mental health through work with the public and are not professional membership organizations.

SUGGESTIONS TO THOSE CONSIDERING TRAINING FOR PSYCHIATRIC SOCIAL WORK

Maturity and stability as evidenced by one's own ability to meet life's problems and to savor its joys are considered essential for success in this field. These qualities are considered important in most social work positions but are more important than ever in work

that is continuously with disturbed people. In addition, therefore, to the usual qualifications for social work and interest in social service, which now can be measured to some extent through interest tests, those who wish to become psychiatric social workers must feel a personal warmth toward emotionally disturbed people and a deep concern for their mental health.

Many employers of psychiatric social workers have emphasized the need for training and experience with badly disturbed patients in mental hospitals as background for all types of psychiatric social work including child guidance. Some have also stressed the desirability of

Figure 17.—A psychiatrist in a mental hospital opening conference to discuss a convalescent patient about to leave the hospital. Participating (clockwise) are an occupational therapist, the head of the social service department, a case work supervisor, a case worker, a psychologist, and a nurse.

case work experience with emotionally well-adjusted or "normal" people as essential to a perspective on those whose emotional disturbances are great enough to warrant psychiatric help. The same range of advice is reflected in the suggestion of those who train psychiatric social workers. Some suggest summer jobs as aides in mental hospitals to test one's ability to face constantly the personality deviation in patients; others believe that summer experience as an aide in a family or children's agency is preferable. It is well to obtain both types of experience if possible.

Like the medical social worker, the psychiatric social worker must also acquire skill in working out problems in daily cooperation with

other professional persons, in this case the psychiatrist and psychologist, and often the physical therapist, the occupational therapist, the teacher, the nurse, the physician, the dietitian, and others. She must understand the ethics and practice of these related professions in order to work effectively with those engaged in them for the welfare of the patient.

Adequate initial training and continuing study are important in this field in which new theories and practices are constantly challenging the old. Scholarships are available for well-qualified women to enable them to complete the 2 years of graduate training usually required. No rigid undergraduate requirements for entrance have been set by the member schools of the American Association of Schools of Social Work. However, a sound foundation in general education, a concentration in the social sciences and closely related fields, and some orientation to the field of social work through a course or courses with social work content have been recommended (*7*). Individual schools vary in their requirements, some making no subject specification and others requiring 30 semester hours in the social and biological sciences. Courses in psychology, including abnormal psychology, are useful both as background and try-out experiences. More attention is now being given in many colleges to preprofessional preparation, and counselors and advisors are available on many campuses to work out suitable programs. They can also be useful in helping determine fitness for this field of work.

The first year of training in a graduate school of social work also serves as a further try-out period, during which fitness and liking for social case work in a psychiatric setting may be tested both through courses and practical experience.

The great majority of psychiatric social work jobs are in government agencies, such as State and veterans' hospitals and county and city clinics, where the advantages and disadvantages of government work apply. However, the variety of psychiatric work within and without government agencies, combined with the urgent demand for it, offers many choices (*44*). Women who are well-suited and well-trained for this work will find in the future many opportunities to help in the great task of salvaging for society and for their own happiness those who are threatened by mental illness.

Section II

EMPLOYMENT BEFORE WORLD WAR II

Social services to patients suffering from mental illness were developed along with services to other patients in general hospitals in the early 1900's. The neurological clinic at Massachusetts General Hospital in Boston and at Bellevue Hospital and at the Cornell Clinic in New York City as early as 1905 assigned social workers to assist physicians by supplying information on the patient's home environment and his social problems. A year later, the State Charities Aid Association of New York introduced social workers into the Manhattan State Hospital on Ward's Island. They remained undifferentiated from other social workers in hospitals in name or in training until 1913, when the Boston Psychopathic Hospital developed the specialty of "psychiatric social workers" (*24*). World War I gave a sudden spurt to the growing demand for social workers trained to work with individuals with nervous or emotional disorders. Programs of training were begun at Smith College School of Social Work in 1918 and at the New York School of Social Work in 1919 to meet the need for specially trained workers (*26*). In March 1919 the American Red Cross was asked to organize social service in mental hospitals for servicemen similar to that existing in mental hospitals for civilians. By January 1920, 42 hospitals had social service departments and the Red Cross offered special scholarships and cooperated with schools of social work in training programs (*24*).

In Psychiatric Hospitals

By 1940 there were at least 503 full-time social workers employed in mental institutions in the United States, according to the Bureau of the Census. This number was reported by 209 mental hospitals and 134 State institutions for mental defectives or epileptics and represented the bulk of such institutions as well as of the resident patients in them. Not reported were those employed in county, city, and private hospitals for mental diseases (which were credited with about 8 percent of all mental patients) and those in psychiatric wards of general hospitals and in military hospitals. The largest number, 349, of the social workers were in State hospitals for mental diseases, where the resident patients numbered approximately 400,000. Ninety-five were in State institutions for mental defectives and epileptics where the resident patient population exceeded 100,000. Ninety

percent of the social workers in the State hospitals were women, and it may be assumed that this proportion held for the remaining group for which sex data were not given. Fifty-nine of the 176 State hospitals reporting to the Census employed no social workers, and in 12 States no social workers at all were reported employed in mental hospitals. Half of the States employed no social workers in institutions for the mentally defective or epileptics; the Southern and Mountain States were most lacking in this type of personnel (*56*).

Less than 1,000 patients in State mental hospitals were being given family care outside the institution in a home other than that of a relative, and only six States had provision for this sort of care, which requires intensive case work. Most of the social workers worked with resident patients or with some of the more than 50,000 patients paroled to their homes in 1940 preceding discharge (*56*).

In 1941, a 71 percent shortage of social work personnel in State hospitals for mental disease was reported by the United States Public Health Service (*22*). Some of this may have been due to the steadily growing demand for social workers in mental hospitals and the increase of mental patients, but one writer in 1940 said: "Social work in mental hospitals has been, for the last 10 years, a field not generally regarded * * * as one offering desirable opportunities. Reasons given have been lower salaries, isolation from community contacts, necessity of living within the institution, discouragingly heavy case loads, demands made upon the time of social workers for routine duties within the institution." She concluded, however, that salaries were improving, that the isolation was breaking down, and that mental hospitals would again offer attractive opportunities (*24*).

In Psychiatric Clinics

About 60 percent of all psychiatric clinics in the country were under State auspices in 25 States in 1935, and three-fourths of these 373 clinics under State auspices were clinics of mental hospitals. More than two-thirds had social workers on their staffs, though there were wide variations in set-up and services (*67*). Some of the clinics in mental hospitals in which patients were diagnosed and treated were early extended to give service to out-patients. As early as 1914, the Massachusetts State Department of Education in cooperation with the Department of Mental Health established traveling clinics out of and by State mental hospitals for examination of school children retarded 3 years or more (*2*). But the most spectacular growth in psychiatric clinics took place outside mental hospitals. The recognition that many of the mental breakdowns that occurred among soldiers in World War I were traceable to childhood maladjustments and the need for reducing juvenile delinquency resulted in emphasis

on psychiatric clinics for children and on "child guidance." As early as 1915, a psychiatric social worker had been added to the Juvenile Psychopathic Institute in Chicago which in 1909 became the first child guidance clinic in the United States (later known as the Institute for Juvenile Research of the Illinois Department of Public Welfare) (*16*).

In 1921 the National Committee for Mental Hygiene, assisted by large appropriations from the Commonwealth Fund, embarked on a program of demonstration clinics and advisory services throughout the country to prevent juvenile delinquency. Most of the clinics were set up in urban centers, and there were none in cities under 150,000 population though some had service from traveling staffs (*67*). Some were noninstitutional State clinics operated by the department of health, department of education, or by a State university hospital. The boards of education in at least four cities operated clinics with a full-time psychiatrist, and those in several other cities helped finance community clinics for children (*24*). More often, however, the schools relied on occasional psychiatric help from other agencies. The Educational Policies Commission of the National Education Association and the American Association of School Administrators in 1939 reported that only the largest school systems would ordinarily need a full-time psychiatrist and that use should be made of psychiatric services available in the community or of traveling clinics (*19*). A United States Office of Education bulletin in the same year also said that most school systems find it impossible to employ the services of a full-time psychiatrist but recommended that every attempt be made to locate either within or without the school system a psychiatrist versed in child guidance whose services could be made a part of the total program. Other essentials in a clinical organization were the services of a physician, psychologist, and case worker such as a visiting teacher or social worker (*59*).

Visiting teachers had been assigned as early as 1906 and 1907 in Boston, Hartford, and New York to work intensively with families to better adjustment of pupils in school whose behavior was abnormal. Later, as many visiting teachers took training in psychiatric social work and many psychiatric social workers took jobs in school systems, the distinction between the two in school work, whether in function or in training, was chiefly that the visiting teacher had more extensive teaching and educational experience and the psychiatric social worker in the school had more experience in working with psychiatrists. Both did case work with students and educational work to promote a better understanding of mental hygiene. The psychiatric social workers, fewer in number than the visiting teachers, were more often attached to a clinic and carried a smaller case load. In 1937, however, only

28 members of the American Association of Psychiatric Social Workers were working in educational institutions or colleges, whereas most of the members of the American Association of Visiting Teachers were working in schools (*24*). All types of social workers in schools will be discussed in a later bulletin in this series.

There were only a few colleges in 1940 in which psychiatric social workers were employed as part of a clinical staff to service students. At that time one writer concluded that the use of psychiatry in colleges was not clear cut, and the relations of psychiatric staff to other staff members working with individual students remained to be defined.

Figure 18.—A psychiatric social case worker interviewing a parent at a child guidance center operated in a public school system by the State Division of Mental Hygiene.

At the opposite end of the educational scale only a few nursery schools connected with psychiatric clinics employed psychiatric social workers, although some had services of psychiatric social workers through board of education or combined facilities. A few churches had operated psychiatric clinics and there were a few marriage clinics and life adjustment centers in which psychiatric social workers were employed. But the amount of such employment, like that in private practice, was negligible. Only occasionally and for short periods were psychiatric social workers engaged by psychiatrists in private practice to give social service to their patients (*24*).

In 1940 there were 461 psychiatric clinics serving both children and adults and 38 for adults only. Most of them were attached to general

or mental hospitals, but some were attached to criminal, family, or domestic-relations courts, or to local community agencies (*24*). One authority, in 1940, noted that State hospital clinics, especially in work with the mentally defective, utilized psychologists more than social workers (*67*).

Some traveling clinics were operated by the State. Virginia's Bureau of Mental Hygiene in 1928, for example, with aid from the Commonwealth Fund, employed two psychiatrists, two psychologists, and one psychiatric social worker to travel through the State working with public health and private physicians. Regular services were supplied to all children received at the Department of Public Welfare and to institutions for the mentally ill and mentally defective, and limited clinical services were rendered to juvenile courts in the State and also to schools through local court or welfare services (*30*). Under provisions of the Social Security Act, funds for psychiatric and psychological services were available in connection with the extension of child welfare services to rural areas, and, by 1942, about one-third of the States had psychiatrists or psychologists on their staffs to aid local child welfare workers (*36*). Three States in 1939 had separate departments of mental hygiene, and nine others had mental health divisions in their health or welfare departments. A few psychiatric social workers were known to be employed in State departments in a consulting capacity before the war, in addition to those employed in clinics (*24*).

In Preventive Work

The prevention of mental illness was spread gradually from the mental hospital and the clinic to the court, the school, the public health agency and other settings where young people and others who showed early symptoms of maladjustment might be reached. Prominent in spreading this recognition was the National Committee for Mental Hygiene and State and local mental hygiene societies which published information on mental health and assisted in the permeation of principles of mental hygiene in all agencies dealing with individuals. As early as 1936, 12 out of 400 public health nursing organizations had mental health supervisors, and 11 members of the American Association of Psychiatric Social Workers were so employed at that time, while 9 members were employed by mental hygiene societies. About one-fourth of the members of the American Association of Psychiatric Social Workers were working as consultants or case workers in family or child welfare agencies where emphasis on psychiatric problems was increasing (*24*).

Throughout the history of psychiatric social work, the demand has exceeded the supply, according to publications of the American Association of Psychiatric Social Workers. Even during the depression of

the thirties, all job openings were not filled. Years ago, turn-over figures for the American Association of Psychiatric Social Workers revealed that the average member stayed in one position less than 2 years as an array of job choices was presented (*24*). The only type of psychiatric agency in which the supply ever closely approached the demand before World War II was the child guidance clinic. In State hospitals, mental hygiene organizations, and schools of social work, there were usually budgeted positions vacant. Reasons given by various authorities for this undersupply included prejudice against psychiatric work, low salaries in some centers, and lack of training facilities.

WARTIME CHANGES IN EMPLOYMENT

World War II accentuated the shortage of psychiatric social workers. So critical was the need that the Rockefeller Foundation helped finance a war service office of the American Association of Psychiatric Social Workers, which continued to operate until the close of the war in 1945. By 1944, the Red Cross had expanded its prewar staff of 94 medical and psychiatric social workers in Army and Navy hospitals to 1,083 case workers in domestic hospitals, of whom about 270 were psychiatric social workers. By 1945, it also had in its overseas hospitals 281 social workers, of whom from 70 to 75 were psychiatric social workers. One of these overseas workers described her experiences as unlike anything for which her previous experience had prepared her. The lack of usual facilities and resources and the short association with patients under war pressures called for the utmost in resourcefulness (*53*).

Meanwhile, the Army itself recognized the need for psychiatric social work and in the fall of 1943 provided for a special SSN 263 classification for enlisted men under the title "military psychiatric social worker," which was later used in many installations (*49*). Some were assigned to neuropsychiatric wards and hospitals, supplementing the Red Cross social work staff; others worked in psychiatric clinics, called mental hygiene units, or "consultation services" set up in training and other centers to assist service men with emotional ills. Generally, they prepared case histories on the patients for use by the psychiatrist, made referrals to resources of aid in treating the patient, and assisted in the solution of his social problems. Sometimes, they participated in treatment involving groups, called "group therapy," used increasingly because of the tremendous need for psychiatric treatment and the lack of available personnel. Minimum qualifications for the SSN 263 classification were graduation from a recognized school of social work or 2 years of supervised social work activities in a public or private agency. Many without these qualifications

were later assigned from related fields such as teaching, public welfare, and employment interviewing.

Extraordinary efforts were made by the War Service Office of the American Association of Psychiatric Social Workers to inform its membership and, through the Wartime Committee on Personnel of the American Association of Social Workers, other social workers concerning the Army's program and to supply the Army periodically with lists of persons qualified for and interested in the classification. It reported more than 300 social case workers in the Army who wanted to use their skills in psychiatric work (*40*). It issued a bibliography

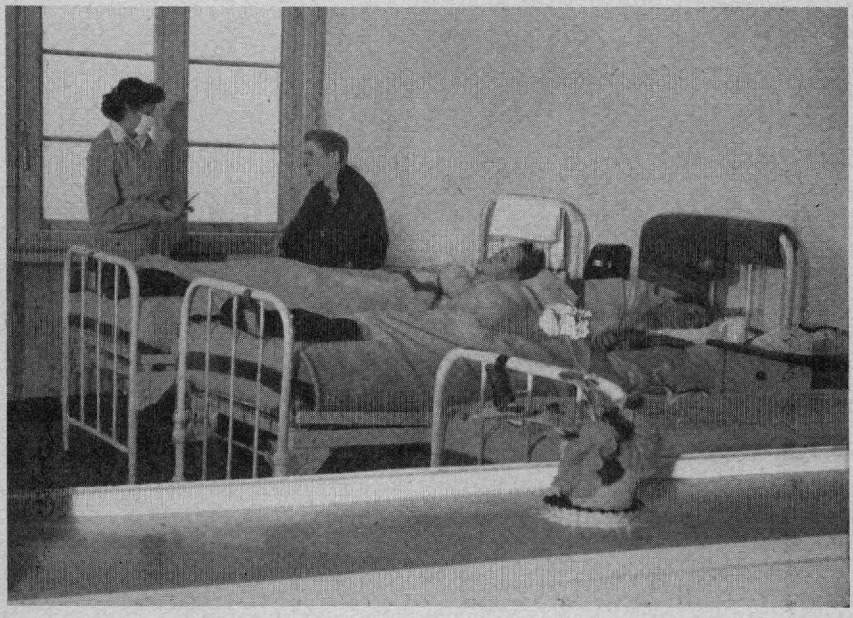

Figure 19.—A Red Cross psychiatric case worker visits patients in isolation ward of an Army station hospital in Bayreuth, Germany.

on military psychiatric social work which also included references on the use of social work skill in such military assignments as personnel consultant and personal service worker (*23*). Recruitment for the SSN 263, which came late, was hampered by the lack of officer status in the social work specialization and the availability of commissions in the field of psychology, for which a number of social workers also qualified. Further, many psychiatric social workers on duty in the Army were already officers in nonclinical assignments, including combat units. Although the Neuropsychiatry Consultants Division of the Surgeon General's Office established a Psychiatric Social Work Branch in June 1945 under an officer who was a psychiatric social worker, it was not until after the close of hostilities in

September 1945 that the Army set up a corresponding classification for commissioned officers, MOS 3605 (*35*).

No records are available as to how many of the more than 700 persons classified as military psychiatric social workers in the armed forces shortly after VJ-day were fully qualified. Due to the lack of trained persons available and the adjustment of standards to meet immediate Army needs, probably only 150 to 200 were fully trained social workers, according to an estimate by the social worker in charge of the program (*43*). A considerable number of WAC's were given in-service training and assigned to consultation and mental hygiene units, especially toward the end of the war, and the Women's Army Corps actively recruited civilian social workers for this program (*68*).

Although some psychiatric social workers may have been among the 93 WAVE officers with social work training or experience assigned to personnel or welfare jobs in which their social work background was utilized, no records are available as to their number. At least 2 were known to be members of the American Association of Psychiatric Social Workers.

Meanwhile, the pressures of war were felt in civilian programs (*69*). A large number of men were rejected for military service and classified as "psychoneurotic" because their mental or emotional disturbances made them poor risks. Later the number of men discharged after service for the same reason amounted to nearly one-half of all medical discharges. These facts aroused public interest in psychiatric treatment. Some selective service boards employed psychiatric social workers to assist psychiatrists in screening men ready for induction. Much of this work, however, as well as the discussion of their problems with rejected men, was done by social workers who volunteered their services as a wartime contribution (*37*) (*42*). As a number of psychiatrists and psychiatric social workers left civilian hospitals and clinics for military service, their places were often left vacant because trained personnel were not available (*41*). By 1945 more than one-fourth of the 550 positions for social workers in State mental hospitals were vacant (*57*). The 30 graduates in psychiatric social work in 1941–42 at one school included 16 men and 1 woman who were in the armed forces in the following spring. Of the remaining 13 graduates, only 4 went into hospital work. Some civilian clinics closed down, although the need for psychiatric services increased under the strains and stresses of war, and later the need for community clinics for service and rejected men arose. A number of communities provided funds for such clinics but were unable to secure qualified personnel. In some clinics already established, psychiatric social workers were left to carry on service without a psychiatrist.

A new demand for women with psychiatric social work training came from large industrial plants and government agencies which inaugurated employee counseling programs to hasten the adjustment to war work of large numbers of inexperienced and often poorly qualified employees (*40*). In some of these psychiatrists were on the staff, permitting close consultation, but in most the worker was on her own. The extension in 1943 of the Federal Vocational Rehabilitation Act to include mental as well as physical rehabilitation also

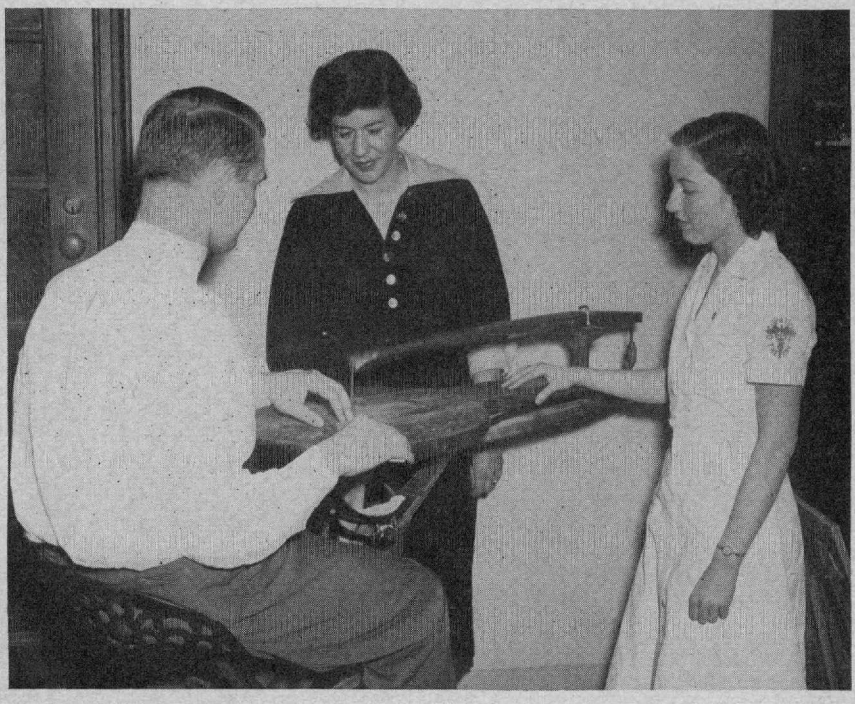

Figure 20.—A social case worker and an occupational therapist in a mental hospital observing a patient working on a jig saw.

created a new demand for psychiatric social workers as consultants in vocational rehabilitation programs.

With only 600 members at the outbreak of World War II, the American Association of Psychiatric Social Workers early recognized the need for utilizing their skills only in positions where less well-trained persons could not be substituted. A statement prepared in 1943 by the War Service Office reported that, on the basis of information from more than two-thirds of its 600 members, only one-third were using their specialized training and experience in a direct working relation to psychiatry in hospitals or clinics. (See table 3.) An additional 18 percent were engaged in teaching, administrative, or

consulting positions in psychiatric social work or mental hygiene, also considered essential wartime positions. Of the remaining half of the membership, 8 percent were not working, 1 percent were in private practice, and the others were in positions where their services could not be considered as essential psychiatric social service (*11*).

In December 1942, the War Service Office reported 251 openings requiring psychiatric social work training and involving a direct working relation to psychiatry, excluding the blanket call from the American Red Cross for 700 social workers. The information presented suggested that members who voluntarily moved from a nonessential job to an essential job in mental health service, as agreed upon by the American Association of Psychiatric Social Work membership, would be conserving their much-needed skills and performing a useful service (*4*).

Table 3.—*Type of Employment of 418 Members of the American Association of Psychiatric Social Workers, December 1942*

Type of employment	Percent	
Total		100
Psychiatric settings		33
Child guidance clinics	13	
Public mental hospitals	9	
Other mental hospitals and clinics	9	
Veterans' Administration and Army Mental Hygiene Units	2	
Other war essential positions in psychiatric social work		18
American Red Cross	9	
Teaching in schools of social work	5	
Mental hygiene programs	4	
Private practice		1
Other employment		40
Family agency	11	
Children's agency	10	
Public welfare	7	
Medical social service	4	
School social work (except in child guidance clinic)	3	
Miscellaneous, including college teaching, work in nursing organization, etc	5	
Not working		8

Source: American Association of Psychiatric Social Workers Membership Personnel Inquiry (*11*).

The American Red Cross in 1942, in an attempt to obtain qualified staff for military hospitals, announced a scholarship aid program for students eligible for the second-year course in a school of social work offering approved curricula in psychiatric or medical social work. (See appendix, p. 50, for approved curriculum in psychiatric social work.) Later, grants were made to beginners for graduate social service study, and only 1 year of service with the Red Cross following training was required. From December 1, 1942, to August 1947, 525 scholarships or grants were given to prepare staff for case work service in military hospitals. Of these, 119 were granted to second-year students specializing in psychiatric social work; 163 to other second-year students; and 243 to first-year students whose specialty was undetermined.

In the final year of the war, postwar requirements for psychiatric social workers were estimated at 12,000 by the National Committee for Mental Hygiene (*6*). More men in the field and better distribution through more widespread location of schools were stressed as needs by one authority. The War Office of the American Association of Psychiatric Social Workers and the National Committee for Mental Hygiene urged men and women in the armed forces to consider training for psychiatric social work, noting that the number of positions open to men was "large and expanding daily." This in no way interfered with the continuing demand for women in the field.

VOLUNTEERS AND PAID AIDES

Volunteers to assist social workers by performing some of their nonprofessional duties were recruited by the American Red Cross for wartime service, and some have continued to serve since the war (*10*). In 1949 some were used as social welfare aides in military wards for mental patients, following completion of the required Red Cross training course and subsequent orientation in the hospital selected for service. Most mental hospitals, as compared with general and other hospitals, however, have had relatively little experience with volunteers. A majority of the 100 psychiatric hospitals represented by a group of leading psychiatrists in 1948 reported no employment of lay volunteers (*26*). Where volunteers were used, their work has been mainly that of transportation, entertainment, recreation, or general visiting, rather than assistance in case work.

Encouraged by the Friends Service Committee, and under a program worked out by the National Committee for Mental Hygiene, a number of conscientious objectors gave service in institutions for mental patients during the war. These psychiatric aides more often served as attendants to badly disturbed patients than as case work aides, but some assisted the social workers with routine case work problems, depending on their own background and interest and on the extent to which the psychiatric social worker could supply the necessary training. Their observations and reports gave rise to the formation of the National Mental Health Foundation in 1946, the aim of which is to work toward the improvement of conditions in mental institutions and to promote mental health.

The continued use of paid "subprofessional" personnel as a temporary expedient to relieve the shortage of psychiatric social workers in hospitals has been deemed feasible if proper training is given (*26*) (*28*). In 1948 the Army was training selected officers with college degrees and enlisted men for subprofessional work as "case aides." A 26-week course for officers and a 20-week course for enlisted men were given for this purpose at Fort Sam Houston, Tex. (*15*).

APPENDIX

Minimum Requirements for Beginning Position as Psychiatric Social Worker at St. Elizabeths Hospital in the U. S. Public Health Service and in the District of Columbia Government [1]

(As taken from Civil Service Announcement No. 99 (Assembled), issued May 4, 1948, amended September 21, 1948, closed October 5, 1948.)[2]

Age: Eighteen years of age or over but under 62 (waived for veterans).

Education and Experience:

1. (*a*) Completion of the following work in a college, university, or school of social work of recognized standing—2 courses in social case work theory and principles, 1 course in medical or psychiatric information, 500 hours of supervised field work in social case work, and 6 additional courses in one or more of the following fields: Child welfare, juvenile delinquency, probation and parole, social legislation, labor problems, social group work, community organization, public welfare administration, or social research. (A year of study in an accredited school of social work, including supervised field work, will be accepted as meeting this requirement.) PLUS

(*b*) One year of experience in psychiatric social work;

OR

2. Completion of 2 years of study in an accredited school of social work.

Physical Requirements:

A physical examination is required before appointment. Amputation of arm, hand, leg, or foot will not disqualify an applicant for appointment, but loss of foot or leg must be compensated by use of satisfactory prosthesis. Vision with or without glasses must be sufficiently acute, and near vision, glasses permitted, must be acute enough for the reading of printed material the size of typewritten characters without strain. Applicants must be able to hear the conversational voice, with or without a hearing aid. Applicants must be free from

[1] In November 1949, the beginning salary on this position was $3,825. A lower grade position at $3,100 per year did not carry the psychiatric social worker title; it required only 1 full year of study in an accredited school of social work or a year of experience in social case work following college graduation or 5 years of experience in social case work or equivalent combinations of training and experience.

[2] For more recent and complete information consult latest announcements of the Civil Service Commission in first- and second-class post offices.

emotional instability and have no history or presence of serious mental diseases. Any physical condition which would cause the applicant to be a hazard to himself or others, or which would prevent efficient performance of the duties of the position, will disqualify for appointment.

Minimum Requirements for Beginning Position as Psychiatric Social Worker for Duty in the U. S. Veterans' Administration [3]

(As taken from Civil Service Announcement No. 60 (Unassembled), issued July 15, 1947. closed August 12, 1947)[4]

Age: Eighteen years of age or over but under 62 (waived for veterans).

Education and Experience:

One year of training in an accredited school of social work, including supervised field work and courses in psychiatric or medical information.

One year of experience in social case work in a health or welfare agency or in the armed forces. One year of training completed in an accredited school of social work, beyond the training used to meet the above educational requirement, may be substituted for this experience.

Physical Requirements:

A physical examination is required before appointment. Duties require moderate physical exertion involving prolonged walking. Arms, hands, legs, and feet must be sufficiently intact and functioning, and vision sufficiently acute, with or without glasses, to perform the duties. Applicants must be able to hear ordinary conversation, with or without a hearing aid. Emotional and mental stability is essential. Any physical defect which would cause the applicant to be a hazard to himself or to others, or which would prevent efficient performance of the duties of the position, will disqualify the applicant for appointment.

Minimum Requirements for Membership in the American Association of Psychiatric Social Workers

For active membership:

A bachelor's degree or its equivalent, plus—

1. Graduation from a curriculum in psychiatric social work approved by the American Association of Psychiatric Social Workers at a school of social work accredited by the American Association of Schools of Social Work.

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[3] In November 1949 the beginning salary on this position was $3,825.

[4] For more recent and complete information consult latest announcements of the Civil Service Commission in first- and second-class post offices.

2. One year of subsequent paid continuous employment in psychiatric social work in positions lasting not less than 6 months each.

Or,

1. Graduation from a curriculum in social case work in a school accredited by the American Association of Schools of Social Work.
2. Two years of subsequent paid continuous employment in psychiatric social work 6 months of which must have been under the supervision of a psychiatric social worker, and at least 1 year of which must have been in a single position.

For associate membership (which includes all privileges except the right to vote, hold office, and serve as an endorser):

A bachelor's degree or its equivalent, plus—

1. Graduation from a curriculum in psychiatric social work approved by the American Association of Psychiatric Social Work at a school of social work accredited by the American Association of Schools of Social Work.

Or,

1. Graduation from a curriculum in social case work in a school accredited by the American Association of Schools of Social Work, and
2. Six months' paid experience in psychiatric social work under the supervision of a psychiatric social worker.

Essential Elements in a Training Program Approved by the American Association of Psychiatric Social Workers, 1949

A 2-year graduate program leading to a master's degree in a school of social work approved by the American Association of Schools of Social Work, including—

1. Completion of the basic social work curriculum as defined by the American Association of Schools of Social Work, covering—
   (a) Instruction in case work, group work, community organization, public welfare, medical information, psychiatric information, research, and administration.
   (b) 400 hours of field work (in the first-year basic curriculum).
2. A sequence of courses having to do with psychiatric understanding of individuals and its application and the practice of social case work in the various possible psychiatric settings, including at least the following: Dynamics of personality, psychopathology, health and disease, mental testing, seminar in psychiatric social case work.

3. Field work of at least 3 days a week for 2 semesters or 3 quarters in all are required. This should include not less than 600 clock hours in a psychiatric hospital, a psychiatric department of a hospital, or a psychiatric clinic, under the direction of a qualified psychiatric social worker. At least 6 months of consecutive field work in any given agency is necessary to count toward the amount needed.
4. Completion of a research project or thesis, preferably relating to the field of psychiatric social work.

Schools of Social Work in the United States Offering Curricula in Psychiatric Social Work Approved by the American Association of Psychiatric Social Workers, January 1950 [5]

Boston College,
School of Social Work,
Boston, Mass.

Boston University,
School of Social Work,
Boston, Mass.

Catholic University of America,
The National Catholic School of Social Service,
Washington, D. C.

College of William and Mary,
School of Social Work,
Richmond, Va.

Fordham University,
Graduate School of Social Work,
New York, N. Y.

The New York School of Social Work of Columbia University,[6]
New York, N. Y.

Pennsylvania School of Social Work,[6]
Philadelphia, Pa.

Simmons College,
School of Social Work,
Boston 16, Mass.

Smith College,[6]
School of Social Work,
Northampton, Mass.

Tulane University,
School of Social Work,
New Orleans, La.

University of Buffalo,
School of Social Work,
Buffalo, N. Y.

University of California,
Graduate School of Social Welfare,
Berkeley, Calif.

University of Chicago,[6]
School of Social Service Administration,
Chicago, Ill.

University of Denver,
School of Social Work,
Denver, Colo.

University of Louisville,
Raymond A. Kent School of Social Work,
Louisville, Ky.

University of Minnesota,[6]
School of Social Work,
Minneapolis, Minn.

[5] All the member schools of the American Association of Schools of Social Work offer the first year of the accredited program. A current list of these schools, showing those offering the second year of the approved specialization in psychiatric social work, is published semiannually by the American Association of Schools of Social Work, 1 Park Avenue, New York 16, N. Y.

[6] Also offer advanced training beyond the second year.

University of North Carolina,
Division of Public Welfare and Social Work,
Chapel Hill, N. C.

University of Pittsburgh,[6]
School of Social Work,
Pittsburgh, Pa.

University of Southern California,
Graduate School of Social Work,
Los Angeles, Calif.

Washington University,
George Warren Brown School of Social Work,
St. Louis, Mo.

Wayne University,
Detroit, Mich.

Western Reserve University,
School of Applied Social Sciences,
Cleveland, Ohio.

[6] Also offer advanced training beyond the second year.

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Social Work Series. Bull. 235. The Outlook for Women in:

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