INTRODUCTION

Although the direct relationship of social work and psychiatry began in psychiatric hospitals (see GAP Report No. 2, January 1948), the concept of the social worker as a member of the clinic team developed in the child guidance clinic. For the past twenty odd years the use in the adult psychiatric clinic of clinic teams including the social worker has gradually increased. Recently, as a result of the experience of Army mental hygiene units in World War II, and of the mental hygiene clinics of the Veterans Administration since the War, the structure and objectives of the clinic team have been further clarified.

As the problems of patients in community psychiatric clinics were studied, it was recognized that all disorders of personality, regardless of the age of the patient, are compounds of disturbed interrelationships in which biological, psychological, and sociological processes are always present and interwoven. Personality disturbances may be precipitated by one or a combination of these processes, whether the impetus stems from physical illness, a personal emotional crisis, or a disruption of family or vocational continuity. Every aspect of the person’s life situation may be engaged or thrown out of balance when one of these processes is disturbed. Recognition that the effect of illness pervades the life situation stimulated the emphasis in medicine currently designated as comprehensive care, and has accelerated the use of the clinic team in every kind of psychiatric clinic.

In modern psychiatry the patient no longer appears as a fragment of psychopathology, but as a human being in a structured social situation, a part of an organic social group, who is involved at all times in a complicated system of interpersonal relationships, and whose inner tensions and conflicts are inseparably bound to his social matrix. In recognition of these interrelationships, the provision of effective psychiatric service in clinics has become a collaborative activity of the several professional disciplines, particularly psychiatry, clinical psychology and psychiatric social work, functioning together in the interests of the patient and of the persons important to him.

A psychiatric clinic is only one of the facilities provided by society for the purpose of conserving human resources by offering emotional support to people in distress and by assisting in the repair of their adaptive failures. The basic structuring of society itself, in the family, in schools, in church activities, and in employment, i.e., in the community life of the person, is the most fundamental and important source of individual security, and the most effective and reliable mechanism for preventing and reducing anxiety in the individual and in the mass.

The social and health agencies in a community are the more deliberate social inventions which provide specific services for the adjustment or prevention of socially damaging breakdown affecting the individual in the group. Although these agencies are on the whole not usually concerned directly with mental illness, the services they provide are of importance to community morale and to the control of the anxiety level in the social group.

The services of a psychiatric clinic represent a more highly specialized method of coping with the relatively narrow range of problems which do not respond either to the resources inherent in the structure of society, or made available through other social and health agencies. The operation of a psychiatric clinic, to be most effective, must be based upon acceptance of a social role, of the concept of comprehensive care, and of sound clinic team practice.

Separate professional disciplines in the same place do not in themselves make a clinic team. The idea is rather that of a coordinating administrative principle whereby a number of disciplines may work together toward common professional objectives with enhancement of their own special professional status, distinction, or contribution. This idea requires the minimizing of hierarchy and of strivings for power and prestige. It means the protection of human dignity of staff members as well as patients, the participation of all staff members in decisions affecting policy, practice, standards and working conditions, and the provision of opportunities for the continuous development of the professional understanding and skill of the staff in the interest of patients.

In psychiatric social work, the concepts of the psychological and social sources of emotional illness, and of the team relationship, have been transmitted by curricular provisions in professional training for social work. The graduate of a properly accredited school, who has completed the psychiatric specialty course, comes into a psychiatric clinic prepared to adapt his professional training to the requirements of the particular setting, be it a child guidance or adult psychiatric clinic, or a psychiatric hospital. Whatever the setting, the psychiatric social worker employs the method of social casework in making his contribution toward the achievement of the therapeutic purposes of the clinic. He is also prepared to assist the other members of the team in understanding the therapeutic resources which may be discovered and utilized within the community for the welfare of the patient. In this report, we shall discuss the application of the principles of social casework to practice in a psychiatric clinic. The clinic may be under public or private auspices, accepting as patients children, adults, or both, with either special or unselected problems, provided it is a medical unit estab-
lished to provide psychiatric services. We shall follow here the definition of psychiatric social work formulated by the American Association of Psychiatric Social Workers, i.e., that it is "social casework practiced in direct and responsible working relationship with psychiatry." This we understand to mean practice in a psychiatric clinic or hospital. The principles determining the practice of social work in psychiatric clinics as commonly accepted throughout most of the country will be discussed, and in addition some recent trends and developments will be indicated.

The Committee on Psychiatric Social Work was assisted in the writing of this report by the contributions of a great many psychiatrists and social workers who responded generously with their interest and time to an interim report which they were invited to consider. On the basis of their many thoughtful and constructive comments, it was possible to revise the report extensively to bring it into line with the practice of a representative cross-section of the field which it considers.

In this report, the functions of the psychiatric social worker in a clinic are somewhat arbitrarily delineated for the sake of establishing useful principles of practice. The Committee is well aware that treatment of patients cannot be compartmentalized, and that a dynamically oriented program must consider treatment as a process originating in a patient's interest in receiving help and continuing beyond his supervision by the clinic.

A. Principles of Interpretation in the Psychiatric Clinic

Psychiatric clinics differ according to their auspices, their organization, the nature of the problems for which their services are offered, and the technical methods they use. They are also influenced by the personality, interests and training of the clinic director and his staff. The character of a specific community and its demands also affect the nature and quality of the service offered. Because of the training of the psychiatric social worker in community organization, as well as in casework, he understands these environmental variations and is skillful in adapting his professional efforts to different conditions within and outside the clinic. He is the member of the clinic team who works most frequently with sources of referral and inquiry and is therefore the proper representative to interpret the clinic's services and procedures to a potential patient, his family, and referring health or welfare agencies at the point of intake. In fact, even before actual referral, he may interpret the clinic's function and help an individual or agency to determine whether its services are appropriate to the problem, or he may point out more suitable resources in the community. Since the interpretation of community services in relation to one another is an integral part of social work practice, the handling of referrals is usually assigned to the psychiatric social worker in a clinic.

On a broader basis, he also participates in interpretation through work in councils of social agencies and other civic and professional organizations involved in community planning. In such groups he helps coordinate the clinic services with other community resources, points up the need for new clinical and related services, and assists in developing them, as community requirements are better understood. These activities of the psychiatric social worker give the clinic a working relation with the community and aid the team to become established as an available resource for certain types of problems. All members of the team, of course, make their specialized contribution to interpretation through relations with individuals, representation on committees, and public appearances. More systematic educational work with allied professions, such as teaching and nursing, and mental hygiene study groups for parents, form a large part of the interpretive job in some clinics. The traditional skill of the social caseworker in dealing with families and with other individuals who influence the patient, has proved especially adaptable to mental health education of this type.

B. Principles Related to the Process at Intake

Intake is a major function of the psychiatric clinic. It is the concern of the entire clinic team, all of whose members participate in it directly or indirectly. During intake the representative of the clinic and the applicant first become acquainted with each other. What happens during this period of initial acquaintance may significantly influence the therapeutic outcome. This is true whether the patient comes of his own volition, or, like a child or psychiatric patient, is brought by another person. It is at intake that the applicant (or a responsible member of his family) is helped to decide whether to use the clinic further, to utilize a more appropriate resource, or to deal with his problem in some other way. The clinic representative at intake must then be able to present to the other team members at the intake conference an accurate, dynamic description of the patient and his problems. For this he should possess not only a dynamic understanding of personality and of the problems involved in accepting psychiatric help but also a knowledge of social factors, community resources, and the clinic's role in the community. He must understand that the applicant is a troubled person trying to function within his own circumstances. He must grasp whether the clinic policy is compatible with the patient's needs, and he must be able to explain his understanding to the applicant and to the referral source clearly and with full awareness of the therapeutic requirements of the situation.

To this complex task, different clinics assign different team members. In diagnostic and in teaching clinics, the psychiatrist is sometimes delegated. Usually, however, the psychiatric social worker represents the clinic at intake. The Committee agrees with this practice because the training and experience of the psychiatric social worker place him in a particularly advantageous position for the principles of intake outlined above. It is further supported by a recent study of a group of adult psychiatric clinics in New York City,* according to which, in clinics using psy-

chiastic social workers for intake, patients were selected with greater discrimination, and there were fewer broken appointments. The average duration of treatment per patient increased and there was a higher percentage of successful treatment results.

C. Principles Related to Study and Exploration

Formerly in psychiatric clinic practice, study and treatment were somewhat arbitrarily separated in order to emphasize, for persons in training, the value of independent study by all the disciplines comprising the team, the correlation of the findings at staff conference, and the formulation of a therapeutic plan on a sound diagnostic basis. Realistically, treatment begins with the applicant's approach, and diagnosis is constantly refined and plans reformulated throughout treatment. The division into intake, study, and treatment in this report is therefore primarily for convenience of presentation.

It is assumed that, as a result of the intake process, a decision has been reached that the patient's problems lie within the area of service offered by a psychiatric clinic. In the continuing clinic process, it is necessary to move from the patient's difficulties, as he and/or the referring person presents them, to a deeper understanding of his emotional conflicts and their relation to circumstances. It is essential to have pertinent information on such matters as the patient's physical health, intellectual capacity, vocational adjustment, family life, and social, ethnic and religious background. Knowledge of earlier or current attempts of the patient to solve his problem by recourse to other professional help, or in some other way, is also essential. It is taken for granted that preparation of a social history is not an interrogative procedure. It evolves from a skillful, therapeutically oriented relation with the patient, which maintains a continuous awareness of his immediate reality situation, of his readiness to participate in treatment and of the nuances of his use of the service. The psychiatric social worker brings to this process certain specific skills taught in schools of social work and refined under a type of supervision in which social workers have pioneered. Among these skills are a disciplined use of interviewing techniques, involving an ability to develop and maintain positive relationships, and a conscious and professional therapeutic approach to an understanding of the patient's problems. The skilled caseworker also is accustomed to resourceful and selective use of environmental aids and to extending his activities in the interest of the patient outside the clinic walls, if desirable. No part of these procedures is stereotyped. All activity grows out of a sensitive awareness of its significance for the patient's progress. Social caseworkers follow the principle of respect for the privacy, dignity and independence of the individual. The content of interviews and their feeling tone are determined by the interaction of the two persons involved. It is, of course, the responsibility of the worker to focus these early interviews on material that will contribute to an understanding of the patient.

In many clinics, the psychiatric social worker also coordinates, for the patient and his family, the medical and other services set in motion within and outside the psychiatric clinic. He may secure the patient's or relative's permission for some measures, interpret administrative procedures, and in general provide a sense of continuity and interest for the patient in the midst of diverse experiences. In some clinics, the patient's therapist performs this coordinating function.

This Committee recommends continuing the use of the psychiatric social worker in his traditional function of securing pertinent material for dynamic understanding of the family, of appraising the social data, of enlisting the help of persons important to the patient, and of preparing them for his treatment and its implications. This function now may include the performance of any or all of these services directly with the patient, if his needs are such that casework service is considered the most effective method of assistance.

D. Principles in the Formulation of Treatment Plan and Responsibility

As the psychodynamic study of the patient and his environment progresses, the clinic team arrives at a tentative working diagnosis, a treatment plan and treatment objectives. From intake through treatment planning, the psychiatric social worker contributes to the understanding of the patient's emotional problems and his life situation. In addition, he suggests areas in which psychiatric social work skills can be utilized in attaining the treatment goals. Through the medium of formal and informal conference, new information is evaluated in the light of what is already known, hypotheses and conclusions are revised, and responsibilities reallocated.

The interviewing skill of the psychiatric social worker is based upon a cultivated sensitivity to human reactions extended by attention to psychotherapeutic principles derived from dynamic concepts. Over the years, as these principles have been subjected to the test of practice, they have been continuously modified and readapted until, at the present time, they provide social work with a flexible method of interviewing, consistently taught in schools of social work, which serves as an invaluable means of relieving the emotional stresses of people with a wide variety of social and personal problems. In presenting the contribution of social work to the treatment program in a psychiatric clinic, we wish to emphasize that the worker utilizes this dynamic interviewing approach in all of the services which it is his responsibility to carry out.

The nature of the responsibility for treatment which is allocated to the psychiatric social worker in psychiatric clinics is determined by many factors, among which, as we have stated, are the clinic auspices, the organization and administration of the clinic, its intake policies, its training or research emphases, and the philosophy and skill of the staff. In the child guidance clinic, a traditional approach, and one which is still widely accepted, is the assignment of the child to the psychiatrist for therapy, and of the parent, usually the mother, to the psychiatric social worker for casework treatment. This assignment is based upon the conviction that the training and experience of the social worker especially qualifies
him for the delicate task of treating the parent, usually the mother, in her relation to the child. This is a casework method of improving the relationship of parent and child, a method which has proved to be of high therapeutic value. It is not a responsibility which the social worker assumes because of the shortage of psychiatric personnel. Rather it is a particular contribution of the social worker to team practice, a specific application of casework method to the problem of the parent's concerns, conflicts, and defensive reactions, all of which is one part of the treatment process for the child. If the parent asks for treatment of his own problems, not closely related to the problems of his child, in the majority of clinics he is referred to a psychiatrist. There is increasing interest too in having the father play a more active role in the treatment of the child’s problems.

Experimentation with other patterns of allocation of function has been carried out in many child guidance clinics. For example, the child may be assigned to the social worker and the mother to the psychiatrist, or two workers or two psychiatrists may be assigned to treat mother and child. In all these modifications of the original pattern of child guidance treatment, we believe that it is essential to maintain the principle of differentiation of professional function, recognizing that psychiatric diagnosis and psychotherapy are a primary responsibility of the psychiatrist, just as the dynamic practice of casework is the major contribution of the social worker. If a social worker in a clinic, with or without specialized training as a psychotherapist, is regarded primarily as a psychotherapist, and carries activities said to be psychotherapy, then the contribution which he makes, though it may be valuable, is no longer casework, and the clinic team can avoid a functional loss only by the employment of a social worker who does casework.

In the adult psychiatric clinic, the problem of the optimum use of the dynamic skills of the social worker in the team relationship has proved to be more difficult to work out satisfactorily and still is in the explorative stage. There is not the same opportunity for the sharing of treatment responsibility in the same case as in parent-child treatment. While there are many patients who respond more readily to casework treatment than to psychotherapy, it is not always possible to identify them when they first appear in the clinic. On the other hand, there is a growing body of evidence from the adult clinics that a surprisingly large number of patients with psychiatric problems can be helped by casework. This seems to be particularly true of patients whose difficulties are directly related, without much defensive interposition, to current life problems. Furthermore, the severity of illness is not in itself a contra-indication to casework treatment, since, for example, an ambulatory schizophrenic patient with situational anxiety may often respond to it very well. It should be clear that such a differential approach can only be based on sound psychiatric evaluation.

Treatment of course is not only concerned with the worker-patient or the doctor-patient relationship, but often includes planning in relation to many aspects of the patient's life situation. Treatment plans may include certain members of the patient's family, or involve the use of resources in the community. In such activities the social worker usually plays the leading role. Since the scope of treatment and its emphasis depend upon the needs of the individual patient, a flexible, alert and imaginative clinic program will make use of every possible treatment aid, whether in direct psychotherapy or in relation to the therapeutic management of environmental factors through a highly individualized and psychologically sound mode of procedure. Whatever the procedure, however, the psychiatrist assumes the psychiatric and medical responsibility for each patient whether he or any other member of the clinic team is working directly in treatment of the patient. This concept of treatment responsibility is consistent with the status of a psychiatric clinic as a medical agency.

The psychiatric social worker may, when indicated, through social casework interviews with the patient before, after, or at strategic times during the psychiatric treatment of the patient, be of direct assistance in such practical matters as finances, jobs, living arrangements, school or camp placement, or arrangements for medical examinations. He may help to prepare patients for psychiatric examination and treatment. His knowledge of psychopathology equips him to be alert to signs suggesting an acute psychiatric disturbance, and to refer the patient promptly for psychiatric consideration.

In some clinics, not all cases treated by the psychiatrist involve direct participation by the social worker. This is especially true of current practice in many adult clinics. With certain adults and adolescents, the participation of the psychiatric social worker may be unnecessary, impractical, or incompatible with psychiatric treatment. Work with relatives may at times be contra-indicated in adult clinics. In any case, it should not be considered without respecting the wishes of the patient as well as his motives in requesting, for example, that his wife be seen in treatment.

On the other hand, casework treatment may be undertaken independently of any psychiatric treatment of the patient and this with either the patient, a member of his family, or both, when the worker has the opportunity for regular, planned consultation with the psychiatrist. For example, an adolescent or an adult is considered by the psychiatrist to be unable, at the time, to accept a psychiatric approach, and casework treatment is selected as the method of choice. Or, in exceptional circumstances, work with the parents alone may be indicated as a means of modifying the emotional climate to which the child is exposed. In any case, the principle of psychiatric direction is maintained as basic to the practice of a psychiatric clinic.

Because social casework procedures make fewer psychological demands upon the patient than psychotherapy, their range of application is actually much wider. This scope and variety in the application of casework to the emotional disturbance arising out of current life situations offer many natural opportunities for an effective contribution by the social
worker in the extensive treatment planning of a skilled clinic team.

E. Principles to be Observed in the Evaluation of Progress of the Treatment Plan

A plan which requires the participation of more than one professional worker in treating a patient and the persons closely related to him, becomes a complex undertaking. It requires continual interchange of information among team members, and may require continual re-evaluation. Since treatment is a flexibly adaptive process, the psychiatric social worker like other members of the team contributes through the conference to the revision of treatment formulations and the planning of termination of treatment.

F. Principles in Regard to Planning for Disposition or Termination of Relationship with the Service

Ending of treatment is part of clinic team planning. It requires a sense of timing, alertness to the patient’s readiness for termination of his clinic relationships, encouragement and support of the patient, and preparation of the family or community to tolerate and sustain his strivings for readaptation. The psychiatric social worker brings to this process awareness of shifts in the feeling of persons on whom the patient must depend, and of their responses to changes in the patient. He is also aware of factors in the environment which may affect the patient's adaptation and which must be evaluated in the light of his current status.

The decision to end the formal treatment relation-

ship should be planned with the patient. He is given the understanding that there is continued interest in his progress. There may be a planned follow-up visit, often decided upon at the end of treatment, or the patient may be encouraged to return for additional help if new problems occur.

G. Principles in Relation to Research in Psychiatric Social Work

Research activity in psychiatric social work has been largely confined to two areas: 1) administrative studies for statistical and budget purposes, and 2) descriptive studies of casework processes and problems, and the practice of supervision. Important contributions have been made in both areas not only to social work but also to psychiatry. The growth and development of psychiatric social work in a clinic require that research in casework content, methods, problems, and results be a planned activity. Psychiatric social work must not only be concerned with research in its own field, but also has a significant opportunity to participate in general clinical research projects. Social workers in the schools of social work and in agencies are moving steadily toward the recognition of the importance of a research attitude in the teaching and practice of their profession. A start has been made in budgeting research time in teaching and practice programs, and making research personnel available. As social work attains a more conscious recognition of its professional status and responsibilities, it may be expected to make increasingly valuable contributions to our understanding of the problems of people in the infinite variety of human experience.

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