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SOCIAL WORK IN PSYCHIATRIC SETTINGS

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Probably at no time has it been more difficult to define and describe the helping process called "psychiatric social work." Since the 1950s it has been, (along with all other "mental-health professions") subject to upheavals in social thought and structures, to shifts in values, and to questions and challenges about causes and cures and instruments and methods of help. Thus psychiatric social work has been pushed and pulled by swift and often radical social and professional movements. The only certainty one can presume to set down in describing what is or what may be, with respect to this field—is that nothing is certain. What follows is an effort to catch and for a brief time hold steady a complex of purposes, forms, and processes that moves even as one tries to pin the subject down. The first step in this chapter is to define the subject's boundaries and nature; the second, to describe its development; and the third, to describe its present operations and directions —which are all in flux.

Social Work in Psychiatric Settings

"Psychiatric social work" is social work within a psychiatric hospital, department, or clinic. It embraces a range of services that stem from the idea that the patient, like all other persons, is affected by (and in turn affects) current and potent transactions between himself, the "significant others," and

significant circumstances in his social environment. Those services include: (1) direct problem-solving guidance, counseling, and psychotherapy for the patients themselves (usually in outpatient clinics); (2) the gathering and transmission to the treatment team of information about the patient's dynamic social milieu (formerly in terms of "background history," currently in transactional terms); (3) direct efforts to influence those persons and situations assumed to be vital to the patient's ill- or well-being; and (4) direct efforts to find and arrange those material aids or services needed by the patient and/or his family to facilitate their adequate social functioning (whether within the hospital or on the outside). Which of these services are most characteristically or frequently in use is determined by a number of factors: the treatment beliefs and bents of the leader psychiatrists in any given setting; and, of course, the beliefs, bents, and skills of the psychiatric social worker herself. (The feminine pronoun is used here not out of female chauvinism but because clinical social workers in psychiatric settings are predominantly women.)

The professionally prepared psychiatric social worker today is more appropriately called a "clinical social worker," "clinical" being used here in its etymological sense of being *with* the patient as observer and helper. This is in contrast with the social worker whose unit of attention is a community or a "catchment area," or one whose activities are focused not on the individual patient or client but on supervising, teaching, consulting with direct service

personnel, administering or organizing services, working with community members towards the development of good mental health conditions on a wider scale, and so forth. These kinds of social work activities have proliferated with the community mental-health movement. Sometimes they are carried along with clinical functions, but often they require the social worker's full time and energies. No identifying title has been given to the combination of these varied functions. Certainly the older term "psychiatric social work" does not convey their nature, even though they are performed under the aegis of a psychiatric setting.

Thus, for the purposes of this account the direct-service functions of social workers in psychiatric settings will be the focus of discussion. Clinical social work was once all but synonymous with casework. Today it often combines case- and groupwork. "The case" is seen not only as the patient/client himself but as a unit of transaction involving family members or "significant others," as well as significant social circumstances. Such "others" may be dealt with as a group (as a family), and sometimes patients themselves may be drawn into group rather than individual interview sessions, in order to increase their socialization capacities or because the patient has problems in common with others, such as preparing for discharge from the hospital, rejoining families, and so forth. The choice of treatment mode, whether by social worker, psychiatrist or others is often a matter of expedience or personal style. Criteria for such choice have yet to be

developed.

The clinical social worker is called a "psychiatric social worker" when she is employed in a psychiatric setting. She may previously have worked in a family counseling agency, where she would have been a "family caseworker." Tomorrow she may elect to work in a child welfare agency, where she would become a "child therapist" or "adoption worker" or, more generally, a "child welfare caseworker." In brief, the major function of the employing agency determines the major area of the clinical social worker's specialization. As will be discussed in detail later, the basic training in schools of social work for direct work with clients/patients is generic, essentially the same for all. Specialization and expertise in any one of the many problem fields in which social workers practice are learned, it is assumed, from various postgraduate sources and from the actual experience that psychiatric (or other) settings offer.

Theoretically—and increasingly in actuality —the special arena for professional clinical social work, whether in the psychiatric setting or elsewhere, is the field of transactions involving the patient/client and his tasks or other persons. It is generally agreed that casework-groupwork processes have as their goal the restoration or enhancement of the individual's social functioning in its twofold aspect of personal gratification and social effectiveness (Bartlett, 1971).The part of the person's global "social

functioning" selected out and concentrated upon at one time, the decisions made about the "treatment of choice," the emphasis given to direct client/patient therapeutic interviewing (rather than, say, the attempt to influence the attitude and behavior of teachers or spouse or to making arrangements for job training, boarding care, relief grants, and so forth)— the determination of all these variables is (or should be) the consequence of diagnostic assessments and treatment planning by the psychiatric team.

The special stance which differentiates the social worker from her clinical teammates (psychologist, psychiatrist, nurse, etc.) is her consistent focus upon the interchange between the psycho- and socio-dynamics in the patient/client's problem. The range of the social worker's treatment targets, then, extends from the disturbed individual himself to those persons and conditions in his proximal environment with which he is in vital transaction. Thus when external relationships or conditions tend to lead to stress and strain, their modification or amelioration becomes the focus of work. In social work this has been called "environmental modification" or "manipulation." When the feelings, thought processes, or actions of the client/patient are the sources of malfunctioning, they become the focus of treatment attention. But even then they are dealt with chiefly as they play themselves out in the person's social situation, bringing him rewards or (more frequently) forms of social punishment or hurt. In varying degree, most cases call for efforts both to increase the patient's coping capacities and to diminish the external

obstacles to this end.

Some problems are inherent in the social worker's special focus. Often —and this is more true in psychiatric hospitals than in clinics—the psychiatric staff views the social-work staff simply as "arrangers" of socially necessary circumstances or as "linkers" between patient and the outside (Barker, 1968). While these are no mean services, and while they may require considerable skill, they are often "handed down from above" by psychiatric authority, with the result that environmental modification services have frequently been denigrated by social workers themselves.

This denigration of the importance of the special skills involved in influencing the patient's social situation has until recently been due to the lack of clear understanding among social workers themselves of just how potent social experience is as it shapes and colors psychological dysfunction. Even today in community health centers and other psychiatric settings, "environmental modification" tends to be assigned to the untrained personnel, on the tacit assumption that it requires more footwork than headwork. But a number of emerging notions and practices have begun to highlight the necessity for professional knowledge and skill in dealing with the persons and happenings in the current life of the psychiatric patient. Among these are: (1) the rise of family treatment as a therapeutic mode, based on recognition of the powerful dynamics in family roles and

interrelationships; (2) concepts from systems theory and concepts of social roles that link the personality to social expectations and inputs; (3) the heightened awareness of the effects of economic-sociocultural forces upon personal development and behavior; and (4) the fresh recognition of the complexities in urban and bureaucratized life that make it difficult for even the fully capable person to find and connect with problem-solving resources. These and other enlightened views of the second half of that long-used hyphenated term "psychosocial" are bringing fresh impetus to the social worker's interest in the current living environment of the client/patient.

When, as is frequent, the psychiatric social worker carries responsibility for direct treatment of the patient's mental-emotional-behavioral disorder, it may be all but impossible— and perhaps not even useful—to differentiate her psychotherapeutic process from that of the psychiatrist. The reasons for this are not hard to see. Many principles of treatment skill and direction are "common property" of all helping professions (Henry, 1971); many psychiatrists, like social workers, are breaking out from old molds and experimenting with new treatment methods; increasingly psychiatrists are sensitive to economic-sociocultural factors in their patient's life (though they may not directly deal with them in treatment); when they operate well team members teach and learn from one another; and so on. Especially for inexperienced social workers "psychotherapy" has both an allure, for its implications of status and helping power, and also a forbidding aspect

because of its ambiguity of definition and its frequent misuse as a synonym for psychoanalysis. The adequately schooled and experienced psychiatric social worker tends to be steady in her recognition of the common knowledge and skills she shares with her collaborators along with the area of special expertise of each.

Whether in the psychiatric setting of clinic or hospital, or in schools, medical centers, family and children's agencies, clinical social work represents a continuum of services. At one extreme is the work of finding and providing resources necessary to physical subsistence and adequate social functioning. At the other is the work of psychological influence upon a person's feelings, thought, and behavior so that he can carry his social relationships and tasks with (for him) minimal cost and maximal satisfaction and effectiveness. In-between lies that broad range of personal social interchanges which requires continuous attention to the interface between people's inner and outer realities. The patient/client may need a job and be unable to find one—and have no means of subsistence. He may want a job and be unable to find one—and feels he is slipping back into his apathy again. He has a job but is unable to bear it. He likes his job, but cannot seem to please his boss. He does alright on his job—but things at home are so bad he cannot keep his mind on it. The psycho-social variations on just this one theme suggest the range of social and psychological services that may be involved in the activities of a psychiatric social worker among many cases

and, often, within a single case.

Within the broad margins of agreement on their functions and purposes, today's clinical social workers use a diversity of treatment methods. Once they adhered to outlines of treatment derived from the psychoanalytic model. Today's modes of treatment are varied, however, reflecting many new perspectives on and notions about the cause and course of mental illness. For reasons to be discussed later, all clinical personnel and not only social workers are trying out a number of new methods in the push to be more effective and to help more people. Short-term, crisis-oriented, task-centered forms of individualized treatment; group therapies such as sensitivity, encounter, and transactional family therapy— all these and others are to be found as the preferred or dominant treatment mode at different places and times. It is not always possible to establish whether the "treatment of choice" derives from the personal style of the helper, from some leap out of frustration onto the bandwagon of a fad, or from some persuasive theory that has been carefully translated into action principles.

The treatment mode that seems currently to be gaining most interest and adherents in psychiatric settings, among all staff members, is operant conditioning. Its specificity, its controls, the measurability of its outcomes— these among other factors offer the attraction of security and limits in settings that are characteristically stressful because of the overload of patients and

the complexities of the problems encountered. But many psychiatric social workers are uneasy about this treatment mode, fearing that the humanism that underlies more traditional treatment methods may wither under actual or pseudo-scientism.

For the most part, however, a few long-practiced modes of clinical social work still seem to be predominant (Hollis, 1972; National Association of Social Workers, 1971; Perlman, 1957; Roberts, 1970). Currently they are the most widely taught in schools of social work. While there are differences of emphasis among them, certain convictions and principles governing skill are basic to them all.

Underlying all of clinical social work is a belief in the worth of the individual man, and therefore a commitment to provide the necessary means, social and psychological, by which he can realize his worth. There is the belief that the person is more than his illness or failure, and that, therefore, his motivation, capacities and opportunities to realize that "more" must be ascertained and developed. The belief in the interpenetration between man's psychological and social experience, already explicated, suggests focus and goal (Perlman, 1969).

Among the skills learned and practiced by most clinical social workers are: the development and management of relationship with the client for the

many powers of nurture and safety that this human bond proffers; the lowering of excess stress through environmental changes as well as empathic sharing of emotion and ventilation of conflict; the identification, clarification, and selection or division of the problem to be placed in the center of attention at any given time; the exploration of conflict and ambivalences; the consideration of the connections between the person's feelings, thought, actions, and between these and their effects upon others; consideration of action choices and decisions, in the light of their probable consequences; the facilitation of connections between the primary client and such persons and/or things as he may need. In capsule, the skills of the competent clinical social worker, used differentially in line with her ongoing assessments, are fashioned by present-day understanding of the means by which ego capacities are strengthened and exercised in coping.

Professional Education for Clinical Social Work

The professionally prepared social worker has earned a master's degree from an accredited school of social work in a university. Until the mid-1950s many such schools had a carefully prescribed curriculum of courses for the preparation of "psychiatric social workers," just as there was a specialized curriculum in other fields such as child welfare, medical social work, family casework, and so forth. Since that time however, such specializations have been abandoned.

Several major factors supported the movement towards "generic" casework and, later, group work. One was the fact that social workers were highly mobile, moving often from one setting to another and apparently able to adapt their basic knowledge and skills to the particular requirements of the new field. More important was the growing conviction (and actual evidence) that whatever the problem area that differentiated one setting from another, all work with individuals and small groups required a basic understanding of normal and deviant behavior, of personality development, of psychosocial forces in people's daily lives, and of the means by which people could be influenced to cope with their recognized problems. Indeed, in family and children's agencies, in school social work, in general hospitals, and elsewhere, social caseworkers were dealing with as many problems of psychological disturbance and social malfunctioning as were to be found in psychiatric clinics. Therefore schools of social work moved to infuse all courses concerning direct work with people with the theoretical perspectives and the ensuing treatment principles that had previously been the special content of the psychiatric sequence.

The social work student who wants to do "social treatment," as differentiated from the student interested in "social development,"[1] now undertakes approximately the following course of study:

1. Courses in personality development and socialization, combining psychodynamic theory with theories and findings on ethnic,

class, and cultural dynamics; courses in deviant development and behavior, as found both in adults and children.

2. Courses in social welfare policies, programs, and problems (in order to attain a basic orientation toward income maintenance and social insurance programs, health care provisions, and so forth).

3. Courses in "methods", that is, instruction in the processes by which people's emotions, attitudes, thought, and behavior may be influenced towards more satisfying and adequate social functioning. Such courses may concentrate on casework or on group work; increasingly, there are combinations of both. The problems such methods deal with are identified and studied both in their objective forms (marital conflicts, child neglect, school dropout, and so forth) and in their subjective and individualized forms with consequent implications for treatment.

4. Increasingly, as research studies and experiments have yielded knowledge not only of the nature of psychological and social problems but of outcomes of social and psychological interventions such studies have been incorporated into relevant courses and/or studied as research. Research courses at the master's-degree level attempt chiefly to teach the rudiments of statistical and measurement concepts, so that clinical (and other) social workers may be intelligent and critical readers of published studies and cogent participants in agency research projects.

5. A practicum, or "field work"—the counterpart of classroom theory on treatment. Concurrent with class work, cases in psychiatric, medical, or social agencies are carried under the tutelage of experienced, professionally qualified supervisors or field teachers. This is done two to three days a week or in block placements of several months at a time, following and preceding class sessions. The student whose interest lies in working with emotionally disturbed adults or children may opt for a field placement in a psychiatric clinic or hospital. In that sense she may establish her specialization. The fact is, however, that many family and children's agencies also offer experience in dealing with people suffering emotional disturbances and have close collaborative or consultative relationships with psychiatrists.

Doctoral study in schools of social work has been developing rapidly over the past decade. Most doctoral programs have concentrated on preparing experienced social workers to become teachers, researchers, or social development planners. Few as yet offer clinical doctorates, but the need for ongoing, higher-level clinical knowledge, skill, and critical analysis is increasingly recognized. A number of other urgent pressures in the 1960s—among them, the pressure to use money and brain-power resources for dealing with massive social problems—forced attention away from individualized treatment. In the meantime, many clinical social workers take advanced courses in problems or processes in treatment where they can find them—in extension courses, in psychotherapy institutes, in private group

seminars with psychiatrists, and so on.

At the other end of educational preparation for social work, there has been a recent burgeoning of undergraduate "social welfare" courses in bachelor's programs and in junior colleges. Casework and/or group work, often accompanied by field experience, take a prominent place in these undergraduate programs. Widespread manpower needs within mental health programs have brought many young and only partially prepared persons into positions as aides, sub-professionals, and paraprofessionals; as a result, there has been a frequent blurring of the boundaries of skill and responsibilities between such persons and the professional clinical worker.

Background and Development of Psychiatric Social Work

"Social treatment" in conjunction with psychiatry was instituted by several outstanding psychiatrists who, early in the 20th century, had come to understand the relationship between people's mental and emotional health or sickness and their social circumstances. In 1904, Adolph Meyer of the Manhattan State Hospital encouraged his wife to visit the families of his patients for the purposes of helping to broaden the clinical understanding of social forces affecting the patients' lives and "reaching out to the sources of sickness . . ." Not long thereafter, social services began to be part of the treatment in a number of neurological and psychiatric hospitals in Boston and

New York. Best known was the development at Boston Psychopathic Hospital under E. E. Southard, because its social worker director, Mary Jarrett, gave impetus and direction to the growth of psychiatric social work. The purposes and operations of the psychiatric social worker—a title coined by Jarrett—in collaborative work with the psychiatrist were first clearly set forth there. Treatment was "construed in its broadest sense to mean restoration of capacity for normal living or provision of the greatest possible comfort" (Southard, 1922, p. 521). To this end the social worker, in addition to taking a social history, dealt with the patient's family in relation to his needs and acted as a linker between the patient and such community resources and agencies as were necessary to his social and emotional adaptations.

In 1914 Southard, Jarrett, and others began apprentice training for social workers at the hospital, and courses were given at the Simmons College School of Social Work. Adolph Meyer, having become director of the Phipps Clinic of Johns Hopkins Hospital, hired a social worker who, along with her clinical responsibilities, took part in the training of students of social work in the School of Economics at Johns Hopkins. By 1918 social workers had been drawn into leading psychiatric clinics and hospitals not only in the large eastern cities but as far west as Chicago. Schools preparing social workers in New York, Boston, Philadelphia, and Chicago all offered courses in aspects of psychopathology. In 1918 Smith College put forward the first curriculum for the preparation of psychiatric social workers. World War I, with its aftermath

of mentally and emotionally disturbed veterans, had given impetus to the public recognition of mental disturbance and the need for social as well as psychiatric treatment.

Concurrent with the growth of psychiatric social work were several other developments that required the services and the special training of psychiatrically oriented caseworkers. One was the "visiting teacher" movement (later called "school social work"), which came into being as behavior problems of children began to concern school personnel and as the concept of prevention became widespread. Another was the study (particularly by William Healy at Chicago's Juvenile Psychopathic Institute) of the "feeble-minded" and the "psychopaths" and the noxious social conditions of which these cases were held to be both cause and effect. A third development was the "mental hygiene movement," with its intent to disseminate conceptions of mental health that would contribute toward goals both of reform and of prevention. Psychiatric social workers were drawn into each of these developments. Beyond their direct service to individual cases, they were extensively involved as interpreters and educators in mental health concepts, as consultants to social agencies dealing with families and children, and as co-planners and administrators of programs aimed at increasing community understanding and support of mental health efforts.

Because of the psychiatric social worker's identification with dynamic

psychiatry, because her training (based on the medical model) was probably the most disciplined in form and content, and because she was visible within the "social psychiatry" movement as a leader outside clinical and hospital walls, the psychiatric social worker came to be regarded by her fellow social workers as one of an "elite" group. When in 1926 the American Association of Psychiatric Social Workers was formed, its purpose was twofold: to develop the specialization of social work in relation to psychiatry, and to contribute to other fields of social-work practice the "mental hygiene" knowledge and insights essential to working with people. This dual commitment—to people needing psychiatric help and to the dissemination of psychodynamic knowledge for use by all social workers—was articulated in 1919 by Jarrett. It was a position broadened and strengthened in 1929 by two outstanding leaders of social psychiatry, Porter Lee, a social worker, and Marion Kenworthy (1926), a psychiatrist.

As far as expertise in social work treatment was involved, the psychiatric social worker remained a leader for the next decade, especially the worker in child guidance clinics. Established and founded in the early 1920s by the Commonwealth Fund, eight outstanding "demonstration" child guidance clinics flourished into the 1930s. In a number of planned (and also unforeseen) ways, the clinics heavily influenced the direction and quality of all social casework. They were innovative by design and attracted clearly superior personnel from the several collaborating professions. The

psychiatric social worker in these clinics was able to develop her clinical skills in diagnosis and treatment most fully (French, 1940). Typically, she probed the social-environment factors with which the problem child was in transaction. But more than this: while the psychiatrist took the child as his patient, the caseworker took the mother as client, in treatment collaboration. Not infrequently the mother was more disturbed than the child, and often she was the more difficult client. Under the tutelage of such talented psychiatrists as David Levy, Lawson Lowrey, and Marion Kenworthy, the psychiatric social worker learned and then articulated and taught the principles governing treatment that emerged from a growing grasp of psychodynamics. The therapeutic powers of relationship, long experienced by social workers, now began to be understood and put to conscious use. The effect of scarcely conscious attitudes and motivations upon behavior turned social workers to eliciting feelings and ambivalences. By these and many other insights applied to treatment, and by her observations and assessments of the active social components involved in cause and cure, the child guidance caseworker found herself a valued and vital member of the clinical team. Whether because of the "halo effect" of demonstration clinics or because of the happy combinations of secure and competent personnel, the team relationships in these clinics seem to have achieved a high level of collaborative respect and effectiveness. For the psychiatric social worker, it was an experience that secured her professional identity and proficiency.

The dissemination of the insights and skills of psychiatric social work came largely as a result of the depression in the 1930s. Child guidance clinics and demonstration projects in school social work were all but choked off by the constriction of supporting funds and by the sudden shift of attention from preventive mental hygiene to the harsh realities of the economic collapse and its resultant crises. Many psychiatrically knowledgeable and skillful caseworkers moved into the newly established public welfare agencies, concerned to build a system that not only provided "relief" but also considered the "common human needs" of relief clients. Many others, pushed by the contraction of psychiatric services and pulled by their interest in the problems of families and children being dealt with under social work's own auspices, joined the staffs of family and children's agencies. Often they served as consultants and teachers of psychodynamic theories to staff members who had not as yet been educated in this area. Often they taught, full or part-time, in schools of social work.

Small though their number was, their influence was powerful in the development of treatment of psychosocial problems, partly because of the implicit promise and hope that psychiatric knowledge might unlock the mysteries of human motivation and influence, and partly because the psychiatrically trained social worker of the 1930s was probably the most systematically trained and clinically sophisticated of caseworkers. From the social agency the psychiatric social worker in turn drew sustenance and

added knowledge and stature. Beyond the immediate patient or client and his family, she came to see more broadly the environmental factors that affect emotional well-being as well as the psychological import inherent in such humdrum things as money, housing, and jobs.[2] Added to this was the psychiatric social worker's new experience within the social agency of both the responsibilities and rewards of autonomy. Though she frequently used psychiatrists as guides and consultants on her cases, her accountability was to a social rather than to a medical agency, and her sense of identification with social work (rather than with psychiatry) was enhanced. Under these conditions, psychiatric casework and generic casework began to fuse.

In 1955 the American Association of Psychiatric Social Workers, along with several other specialist organizations of social workers, merged with social work's over-all membership organization, the National Association of Social Workers. The assumption was that all good direct service to clients and patients should be psychodynamically informed. "Psychiatric social work" came specifically to mean social work under psychiatric auspices.

Trends and Problems

The years since World War II have brought social upheavals of many sorts. Expectably, the mental health professions—social work among them—have undergone shifts and upheavals of perspectives, beliefs, and modes of

work. Along with other professions, clinical social work has made many adaptations of its practices to cope with new problems or with old ones freshly perceived and more fully understood. Two (among other) salient forces have affected social work in psychiatric settings: one, the rapprochement between psychodynamic and social science theories and research; and the other, the reorganization and expansion of hospital and clinical services resulting from the community mental health movement. These are intertwined factors, scarcely separable in reality; but each will be given separate comment.

Rapprochement of Theories

Hospitable to and informed in recent years by psychodynamic theories and perspectives, the research and constructs of several of the social sciences have been shaped by and have become more relevant to mental health concerns. Simultaneously, both dynamic psychiatry and social work began in the 1950s to look out from their long concentration upon intrapsychic and narrow interpersonal dynamics to identify the factors in the patient's or client's wider social experience that seemed to be potent determinants of his attitudes and behaviors. The social group to which the person was attached, the family as a transactional system, the "milieu" or environmental systems with which the person was in interaction—these social determinants, among others, came increasingly to be recognized and taken account of in the

diagnosis and treatment of mental disturbance.

Among the earliest essays that affected social-work thought and practice was *Men Under Stress* (Grinker, 1945), a study of soldiers whose breakdown under combat and subsequent course of recovery seemed signally related to current group morale and leadership. The author of a later work, *Social Science and Psychotherapy for Children* (Pollak, 1952), was hired by the Jewish Board of Guardians, a psychoanalytically oriented social agency for the treatment of children, to identify social factors operating in emotional and behavioral disturbance. Today's clinical thinking— certainly that in schools of social work preparing case and group workers—is literally awash with concepts and notions from social science: systems theory as it bears on the therapeutic milieu, concepts of role, status, class, and ethnicity as they bear upon internalized and externally expressed attitudes and behavior; ideas from communications theory related to interpersonal and family group transactions; learning-theory propositions and their implications for conditioning of behavior; and so on.

Along with the spillover into social work of these newly formulated ways of viewing social forces in the lives of people, there has been the heightened concern of the total society over the persistence of poverty, the existence of racism, and the increase of crime—in short, over the prevalence and visibility of social "evils" and problems that both create and are created

by mental/emotional disturbances. This concern has been experienced with particular intensity within social work.

The effects of these intensified concerns and new (or revived) perspectives upon the training and practice of social work have been manifold, unsettling, and as yet difficult to assess. In barest outline: in addition to explanations of psychodynamics social work students are increasingly exposed to considerations of socio-dynamic factors in the lives of their clients and to the behavior-shaping forces inherent in social systems, whether in the dyad of a marital pair or in the staff groupings within an institution. Practice has shifted from exclusive use of the individual interview as the desired and status-giving mode of treatment to include family interviewing and often family treatment; group interviews (of persons with common concerns); "reaching out" by home visits and persistent efforts to engage the "hard-to-reach" or unmotivated patient or client; attempts to modify traditional "middleclass" treatment approaches in line with the differences of expectation and perception created by the client/patient's educational-sociocultural background; and efforts, as yet more trial-and-error than systematized, to deal with the "significant others" and the significant circumstances that constitute the individual's psychosocial life-space. Perhaps "ecosystem," a less static and more up-to-date term now given to "environment," will further social work's willing involvement in "social diagnosis" and in dealing with environmental forces (Germain, 1973; Grinnell,

1973).

Reorganization of Services

The community mental-health movement, responsive to the vision of a group of "social psychiatrists" (Joint Commission on Mental Illness and Health, 1961), has been a second major force in the reshaping of psychiatric hospitals and clinics and of social work practice within them. Interchanges between the intent to provide accessible, swift, and comprehensive mental-health services to total communities and the impact of burgeoning knowledge about both social deficits and desiderata have resulted not only in a tremendous expansion and variation in services but also in changed methods of direct service.

The combination of chemotherapy with convictions about the undesirability of prolonged hospitalization and the psychological values of the patient's remaining in his natural community has led to recurring waves of discharged patients from (and of repeated readmissions to) hospitals. Yet the resumption of social functioning outside the hospital (whether with family, job or job training, a boarding home, or with sources of recreation) and the carrying of essential social tasks and roles is often a staggering prospect for the discharged patient. The necessity that he have an "enabler"—a linker between his needs and resources, a supporter, an advocate, a supplier

of information and material aids—is obvious.

Social workers offer these services, which require many psychological skills of intervention with and influence upon the people who make up the patient's environment, in addition to those needed for dealing with the ex-patient himself. But the need for such services has far outstripped supply. Thus large numbers of untrained or partially trained personnel have been added to hospital and clinical staffs. Variously called "caseworkers," "social workers," "paraprofessionals," "social work aides," and so forth, they are often oriented, supervised, and taught by professional social workers whose own direct clinical work with patients and their families has diminished as their teaching-supervisory and administrative functions have increased. A recent study shows that on "casework therapy" for after-care patients, nonprofessional social workers gave far more time than did the professionals, as they did also in providing concrete services to patients and their families. They spent more than twice as much of their time "interviewing patients" as did the trained social workers (Barker, 1968, p. 108).

In part as a counteraction to the blurring of the social worker's professional identity and standards by this influx into clinical practice of large numbers of untrained personnel, a National Federation of Societies for Clinical Social Workers has been formed. While concerned with such problems as "third party payments" and licensing, another objective seems to

be the protection and solidification of the values, knowledge and competences considered to be the benchmarks of professional clinical social work.

Necessity, sometimes happily and sometimes uneasily combined with theory, has forced many other changes in the direct diagnostic and treatment services at the community health center outpatient clinics. Staff shortages, increased patient applications, and some evidence of success in experiments with forms of short-term treatment have combined to make limited, brief help the typical treatment mode in the community clinic. Crisis treatment focused on a current crucial need or event, task-centered treatment focused on one selected aspect of a problem, operant conditioning focused on the elimination of an identified symptom, group interviews wherein several persons with like problems are engaged in problem-solving—these are among the common methods in use today by clinical social workers, trained and untrained. It is evident that many treatment values are to be found in these new modes. It is quite possible, too, that they are a healthy antidote to former slavish adherence to interminable psychotherapy. Yet among social workers (as among their colleagues in psychiatry, psychology, and psychiatric nursing) there is some emerging and uneasy awareness that the "treatment of choice" seems to be determined more by expedience and the lure of the new than by diagnostic considerations. But the press of service demands has thus far not allowed for critical examination of this possibility (Cooper, 1968).

Upon the fully trained social worker has been placed many of the essential tasks of disseminating mental health ideas to lay persons and also to other professionals in the community, of consulting with other human welfare institutions, and of collaborating with others to develop social resources to fill the deficit needs of ex-patients. These duties, along with supervising sub-professional workers, teaching and learning in staff/team sessions, and carrying some or most administrative responsibilities, have considerably enlarged the scope but often fragmented the work of the present day psychiatric social worker.

One further and differently directioned trend in clinical social work must be noted: the widespread growth of private practice by professionally trained and clinically experienced social workers. The service provided is usually psychotherapy. Its responsible practitioners attempt to maintain their social-work identification, calling themselves "social psychotherapists," "psychiatric social workers," or the like. Their required qualifications (set in 1964 by the National Association of Social Workers) are a master's degree in social work, followed by five years of fulltime practice under the supervision of a professionally qualified supervisor. Beyond these basic requirements, many private social-work practitioners have had personal psychotherapy and have taken postgraduate courses in psychopathology, psychotherapeutic treatment, and so forth. Furthermore, 95 percent of all private practitioners maintain some practice connection with a social or psychiatric agency as a

source of both professional stimulation and anchorage (National Association of Social Workers, 1971).

That rapid social changes and new notions and institutional rearrangements should bring new problems in their wake is axiomatic. The problems faced today in clinical social work cluster mainly about considerations of its functions in psychiatric settings and about the educational preparation of its practitioners.

The growth and proliferation of community mental-health centers occurred on a high wave of both responsible concern for the mental health of the population and of optimism about the available means by which it could be secured and reinforced. Along with other psychiatric personnel, social workers were literally scooped up into what took on the aspect of a "movement." Their ranks were supplemented by numbers of paraprofessionals (often also called "social workers"). As is inevitable, the visibility of resources raises the awareness of need. Applications for help grew geometrically, not only for problems of psychological dysfunction but for their social accompaniments, namely, need for boarding arrangements, recreational or affiliative possibilities, rearrangements in family responsibilities and understandings, income provision, and so on.

Psychiatric social workers were thrust, thus, into carrying a number of

highly varied functions: (1) direct work with patient/clients and their "significant others"; (2) efforts to locate and connect the isolated patient with significant others; (3) efforts to influence community leaders and agencies to develop and support provisions for adequate housing, boarding and half-way houses, and financial aid; and (4) the supervision and direction of nonprofessional staff. In brief, in the burgeoning "mental-health business" the psychiatric social worker has been thrust into being all things to all men. As a result many of them have felt a fragmentation and diffusion of their work activity. Furthermore, it has taken an energy toll, and has operated against the development of mastery and skill that depends in part, at least, on concentration and specialization.

As the study by Berg et al. (1972) has shown, the sense of role diffusion and role stress is high among social workers in community-health centers. In part this is due to carrying too many diverse roles, in part due to the fact that the social worker has often not been prepared by professional training for many of the activities into which she has been thrust. Most social workers who have chosen to be clinicians have "majored" in one-to-one or one-to-small-group processes aimed at psychotherapy. Then they find themselves in community organization or development work, or teaching and training others, sometimes before they themselves have had time to digest their learning, and usually more ready to give directions than to educate. As in the other clinical professions there are among these social workers, of course, the

"naturals"—those whose talents make them adaptable to shifting roles and responsibilities. But schools of social work are facing the need to reassess the nature of the preparation of social work clinicians.

The role problem experienced by psychiatric social workers in any hospital or clinic setting, namely that of her likeness to and difference from other psychiatric personnel, has already been alluded to. But now, with the widespread use, not only in community mental-health clinics but in hospital settings too, of "aides," "social-work associates," para-professionals—most of whom come to be grouped loosely under "social work," there is another boundary that blurs out the psychiatric social worker's identity and area of specialization. In 1968 (Barker) most of the direct work with patients and their families in psychiatric hospitals was performed by the untrained workers. In short, who does what, and why, are frequent unspoken but present questions in psychiatric settings.

All mental-health professions face the problem of how collaboration may be maximized and competition and communication gaps minimized among often equally competent team members. Few of them in their formal professional education have had the instruction or guidance that would help them to tackle and solve these on-going issues. Social workers are perhaps best schooled in the desirability of "collaboration" and "cooperation." But the principles governing teamwork have yet to be articulated if they are to be

operationalized beyond "good human relations."

Graduate schools of social work characteristically stand with one foot in a university and one in the field of practice, with one eye upon what has intellectual, theoretical, empirical validity and integrity, and the other upon what the field of practice seems to need. The 1970s have for many reasons brought a number of upheavals and imbalances into social work education, many of which have been problematic to the development of clinical social work and to the preparation of psychiatric social workers. Specifically to the latter is the development of undergraduate social-work curricula and courses, in bachelor degree programs and in community colleges that have spread across the country in great numbers. At least until the economic recession of the mid-1970s graduates of these programs have found jobs in mental hospitals and community mental-health clinics as well as in other tax-supported health and welfare agencies.

Questions are facing graduate schools on the necessary changes they must make in the preparation of their students. What, for instance, is the nature of an advanced degree? Does it fie in a higher degree of clinical sophistication towards direct work with clients who have psychological problems? And is this what psychiatric settings want and need? Does it lie in a more variegated, generalized kind of educational experience, where, say, all students are required to take courses and get some actual experience in

community work, administration, supervision, and teaching? Is this what psychiatric settings need and want? Can mastery be achieved without specialization? And if specialization in consultation, administration or community organization is chosen, for instance, is it possible to consult or administer processes in which one's experience has been minimal? Of course, similar questions plague almost all professional schools today.

The literature of social-work education and of clinical social work is rife with self-questioning and self-criticism. Not only are the above-noted issues in scrutiny, but there is widespread concern to predict the future of the several helping professions, predictions of some hoped for steady state from a position of disequilibrium. There is, furthermore, serious concern over what most research has revealed about outcomes of clinical efforts, the apparent ineffectiveness of one-to-one or one-to-group services in a "sick society" (Briar, 1971). These have roused considerable malaise among psychiatric social workers as among others. At the same time they have served to firm up considerations of accountability, of reasonable goals, of valid research hypotheses and methods, of treatment choice.

Meantime, back at the hospitals and clinics, psychiatric patients still seem to need the help toward "restoration of capacity for normal living or provision of the greatest possible comfort" (Southard, 1922, p. 521). Still proffered by psychiatric social workers and their colleagues, it is that same

modest but irreducible goal articulated by a social psychiatrist and his social worker collaborator fifty years ago.

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Notes

1 The terms, "social treatment" and "social development," are taken from curriculum statements of the University of Chicago's School of Social Service Administration. Other schools may use these or synonymous terms. "Social treatment" embraces helping services and processes used in direct work with individuals and/or small groups. "Social development" encompasses community organization and planning, administration, research and other processes aimed at macro-system influence.

2 For perspectives of one outstanding psychiatric social worker and teacher see Charlotte Towle's comments in articles published in 1936 and 1939 (Perlman, 1969, pp. 54, 61-65, 220-226, 228-234). See also her 1945 work (Towle, 1945). Still read as a small classic it is an interpretation to new public assistance workers of the psychodynamics of everyday functioning of everyday people.