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A study of the interprofessional relations of social workers with physicians, psychiatrists, psychologists and clergymen.

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Boston University
A STUDY OF THE INTERPROFESSIONAL RELATIONS
OF SOCIAL WORKERS WITH PHYSICIANS,
PSYCHIATRISTS, PSYCHOLOGISTS AND CLERGYMEN

A Thesis

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Interprofessional cooperation (and conflict) in research, training, and service activities is becoming more common, and there has therefore also been an increasing amount of interest in studying the consequences of interprofessional relationships for the clients, patients, and professional groups involved. This group thesis is one attempt to shed some light upon the area of interprofessional relationships through interviewing social workers about their experiences with clergymen, psychologists, physicians and psychiatrists. It is an exploratory study, and should stimulate further research work, but even so it does make a number of interesting suggestions about social workers' attitudes, relationships and prestige rankings.

I had the privilege of directing this group thesis while I was also doing research work in the field of interprofessional relationships. This made both the direction of the thesis and my own research work more rewarding.

For the past two years I have been a Russell Sage Foundation post-doctoral resident at the Boston Children's Service Association and a research associate and lecturer at the Boston University School of Social Work. As a sociologist, these institutional affiliations should perhaps be explanation enough of my interest in the subject matter of this thesis, and I want at this time to express my thanks to these institutions for the opportunity to learn something about social work and, more generally, about interprofessional relationships.

Hyman Rodman
Research Associate
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CHAPTER I

INTRODUCTION

Purpose of the Study

In recent years there has been an increasing amount of emphasis by the helping professions upon treating "the whole person" and "the whole family". This has naturally led to more contact between members of different professional groups. Social workers, for example, have come to have more contact with physicians, psychiatrists, teachers, psychologists, ministers and members of the legal profession, as the social and emotional factors of illness, crime and delinquency have been increasingly recognized.

Since the welfare of the client or patient frequently depends upon adequate interprofessional communication and cooperation, the purpose of this study was to investigate some aspects of interprofessional relations. Wherever human beings have to coordinate their efforts around one common goal there is always the danger of tensions and frictions. The understanding and recognition of each other's professional differences and contributions, the ability and willingness to communicate with each other in a respectful and accepting way in order to apply one's efforts in regard to the same problem becomes of major importance. As Cockerill stated it:

The major obligation of all the professions in an age of specialization and diversified expertness is that of refining further the ways of working together so that their efforts to help people will always be attuned to the unitary nature of man and his problems. Essential to the achievement of this objective is the commitment to the principle of organic wholeness of human and social problems on the part of
individual members of these professions at all operating levels.¹

This study is an attempt to investigate the interprofessional relationships of social workers with four different disciplines: physicians, psychiatrists, psychologists and ministers. Our interest centered around such questions as the division of functions, ways and means of communicating, the use of authority, and the diversity of problems which can arise from these factors. The main emphasis in the interviews was on eliciting responses that would reflect general attitudes about interprofessional relationships. The interview was divided into two parts. There was a verbal part based on a schedule or questionnaire, and a written part which included four ranking questions on prestige.² It was felt that the amount of prestige accorded to an occupation has an important bearing upon the respect shown to members of that profession, and that it was therefore an important factor in interprofessional relationship.

Kadushin points out that

The prestige of profession, therefore, affects the individual social worker's concept of self, his relationship with representatives of other occupations, his feelings about his job.³

The four professions were chosen for the following reasons. Physicians, psychiatrists and psychologists are part of the clinical team of which the social worker is also a member. Often the chaplain, too, is closely involved with a patient who is receiving or is in need of help from the other professional groups. In addition, social work agencies such as family service


²The questionnaires are included in the Appendix.

agencies, children's agencies and the department of public welfare are making increased use of the specialized services of the clinical team. The function of the clergy, too, is closely related to family casework, marriage counseling and hospital visiting. In recent years ministers have gained more respect for scientific techniques and social workers have lost some of their fear of ministerial amateurishness. It was thought therefore that these professions would give the best picture of the current interprofessional relations of social workers. Also, we hoped that the study might show in what areas there is room for improvement, and that it might suggest some ways in which improved interprofessional relationships could actually be attained.

Methods of research

As we were four students in our group we divided the study according to the four selected professions, each student investigating the social workers' relationships with one particular professional discipline. A common questionnaire was set up and, after a number of pilot interviews, revised independently by each student and adapted somewhat to the different professions. However, certain questions which seemed relevant to all four disciplines were asked in all the interviews. These questions covered such points as, for example, the amount of contact the social workers had had with various related professions, the outstanding experiences they remembered with one particular profession and the general attitude of this profession to social work.

For each of the four professions selected, twelve to eighteen social workers working in different settings were interviewed about their present and previous experiences. The sample was chosen by contacting the social work di-

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rectors of agencies, hospitals and clinics (listed in the Directory of Social Service Resources in Massachusetts, 1955) which were known to employ trained social workers and were situated in the area of greater Boston. Four interviews were carried out in St. Louis, Missouri. The directors of social work were mostly very cooperative. They readily approached their staff to find some volunteers for interviews and in a few cases volunteered themselves to be interviewed. Occasionally the social workers were approached personally by the student or through a friend. Generally the response obtained from the agencies contacted was a favorable one. A few settings refused an interview on the grounds that they had not enough trained social workers or were already overburdened with research projects.

Since we were doing an exploratory and descriptive study of interprofessional relationships, we could afford to be rather flexible in the selection of our sample. Naturally, the social workers who had had considerable contact and experience with one of the four professions were more likely to be interested in the subject and to volunteer for an interview. This introduced some unavoidable bias into our sample. Social workers in a variety of settings were seen in order to get a good picture of the general atmosphere and attitudes in interprofessional relationships and to eliminate any influence which the particular policy of two or three agencies could have on the social workers' responses. Interviews with social workers in twenty-six different agencies were carried out.

Our criterion for interviewing a social worker was that the social worker had to have at least one year of graduate training at a school of social work and two years of experience in the field. The sample was limited to caseworkers only. It was felt that caseworkers probably have more experience with the four professions investigated than group workers might have. Also, to
include group workers would have introduced a slightly different professional orientation, the influence of which would have been difficult to evaluate in a limited sample.

**Limitations**

A study as small as the following one has of necessity many limitations. As pointed out before the sample, for the most part, excludes those social workers who just occasionally have some experience with any one of the four disciplines. Second, it is too small to permit us to draw any certain conclusions from the opinions voiced by the interviewees. Third, although we agreed initially on how to use our questionnaires, our interviewing techniques naturally were influenced by our own personal approach and therefore led to variations in the responses of the social workers. Thus, the study can only give a description of some of the factors which seem of importance in inter-professional relationships. A more thorough investigation of specific problems on this subject has to be left to further research.
CHAPTER II
INTERPROFESSIONAL RELATIONSHIPS OF SOCIAL WORKERS WITH PHYSICIANS

The Social Aspects of Medicine

For years, physicians have concerned themselves with the health of their patients. Formerly, the focus was primarily upon the physical aspect of man and medicine's accomplishments in treating him. More recently, however,

There is a growing realization that problems of physical illness are often inextricably tangled with social and psychological difficulties, and that the best of medical and surgical care alone cannot always be depended on to restore the patient to health; the advance of psychosomatic medicine offers convincing evidence that symptoms cannot effectively be treated in a vacuum.¹

This concept of the whole person must necessarily exist if the physician is to treat his patient as a person rather than as an example of a physical sickness. Therefore, it would seem logical that, early in his professional career, in fact most suitably during the course of his medical education, he be helped to learn that

Patients are people. The student must find out who these people are, get a mental picture of their lives and of the ways they have lived them, discover how they have come to be sick.²

One way of teaching this to physicians would be to introduce courses in the social sciences, such as sociology, in the medical curriculum. However, the merits of such an approach are seemingly not recognized by all medical educators.


For example, Merton states that

Some physicians apparently have another image of sociology, in which it is pictured as a means of equipping medical students with the indispensable professional qualities of sympathy and tact. In more invidious terms, this sometimes appears in the opinion that a sociological orientation toward the patient leads the student to replace a scientific point of view by gross sentimentality. 3

So that while some efforts have been made to include a sociological orientation in the curricula of a large number of the medical schools, the degree to which physicians have been positively influenced in this area is questionable. Thus, the consideration, or lack of it, given the social situation of a patient by the physician as a result of his early training would play a large part in his overall treatment of the patient, as well as his attitude towards the ancillary personnel involved in the social and emotional approach to the treatment process.

On this basis, then, social workers represent those ancillary persons who can contribute to the physician's understanding of the patient's emotional needs and furthermore assume responsibility for those areas of need, regarding the patient, his family, or both, which the physician is perhaps unable to handle. If this division of functions is to be carried out, however, there must presumably be some understanding on the part of the physician of what social work can do. This would necessarily include what services it can offer the patient and how such services can complement or implement the goal of total treatment of the individual. Total treatment would then include (1) consideration of the physical problems as well as the emotional or psychic factors involved in

3 Ibid., p.28.
the illness itself; (2) adjustment to the illness; and (3) the changes or consequences brought about as a result of the illness.

With the aforementioned factors in mind, the writer attempted to assess the attitudes of a group of social workers towards physicians, as related basically to the kinds of experiences they had as well as the social workers' attitudes and experiences with members of other professional groups. From this information, the writer hoped to assess what some of the basic problems or areas of conflict were, as expressed by the respondents; where areas of satisfaction and smooth functioning were present; and how, if at all, this information related to the consideration given earlier to the orientation and application of the sociological and psychological components of illness by physicians.

Information About Workers Interviewed

The study was based on twelve personal interviews with social workers from various agencies. Of the social workers interviewed, one was from a family service agency, nine were medical social workers from hospital settings and two were workers from child placing agencies. These interviews were based entirely on the interview schedule. (See Appendix).

Of the social workers interviewed, all but one had received a master's degree, and the one person who had not was in the process of completing his professional education, having had one year of school prior to employment in the field. Seven persons had worked in other fields prior to their social work training. These work experiences included business, secretarial work, law, and library reference work, while one person had been employed in a public welfare agency doing social work.

The average length of experience in social work of each person interviewed was approximately seven years, with the actual number ranging from two years to
sixteen years of experience. A number of different agencies were represented in the social work experience of those persons interviewed, with nine of the workers having had experience in two or more agencies and three experience in only one agency. The agencies which workers had previously worked in included a Veterans Administration hospital setting, Red Cross, a public assistance agency a family agency and a children's agency.

Contacts with Physicians

The social workers interviewed were questioned about the amount of on-the-job contact they had with ten different professional groups. Six of the twelve workers interviewed said they had most on-the-job contact with medical doctors, five said they had most on-the-job contact with social workers, while one individual said she had more contact with lawyers than any other professional group. The writer found that five of the six persons who said they had most on-the-job contact with physicians also stated that they were the easiest professional group to work with. When asked why they felt this way, two answered that it was due to their frequency of contact, and thus the greater amount of experience they had in working with physicians. Two workers explained their choice on the basis of the success and skill which they had acquired in working with physicians. Still another person explained her choice in the following way:

I put physicians as the easiest professional group to work with because they are content to let the social worker work directly with the patient. They don't feel as threatened by her as the psychiatrist or psychologist, for example, does because of the similarity of the worker's job and their own. The physician is aware of what he can and cannot do and is willing to let the social worker operate in her area (the area of emotions) without the feeling experienced by the psychiatrist.

One worker said that although she had the most on-the-job contact with physicians, social workers were easiest to work with "because they seem to have much more understanding of what we are trying to do and also desire to attain
the same goals in terms of helping people."

Of those persons who had most on-the-job contact with social workers, all rated this professional group as the easiest to work with. When questioned about their choice, the reasons given were as follows:

1. "We have the same goals in mind; we are oriented similarly due to our training."
2. "We talk the same language, our aims are more the same."
3. "Easiest to work with because they are the people I've had the most contact with of these professional groups."
4. "There is a mutual orientation, common language, problems and goals."

All of these reasons seemed to indicate a feeling of professional identification along with the knowledge that they were trying to attain the same goals.

The one worker who claimed most on-the-job contact with lawyers cited psychiatrists as the easiest professional group to work with. When questioned about the reason for her choice, she explained:

"Psychiatrists are easy to work with because there seems to be a better understanding of the kinds of cases we can work with ... what is appropriate as a referral from them and what they can ask workers to do. The line of communication is a more open one between caseworkers and psychiatrists."

It is obvious that there was considerable difference in the attitude toward psychiatrists as expressed by the worker who suggested that psychiatrists might be threatened by social workers and the attitude of the worker quoted above. One possible reason for this difference in attitude might be due to the difference in the type of agency and the consequent difference in functions of the social workers in such an agency.

When asked which professional group was particularly difficult to work with, three persons cited lawyers, two nurses, one, ministers, one, school teachers, one, vocational counselors (who were not listed in the interview schedule) and two stated they found no one professional group particularly difficult to work with.
One respondent was not asked the question due to lack of interviewing time. In only two instances were specific reasons stated for a particular choice. One involved a worker's statement around difficulty in working with nurses which she explained as follows:

Nurses are the most difficult to work with. Here, envy is involved because she wishes to have higher status than the social worker who she sees as working more closely with the physician than she is.

The other instance involved a worker's reference to vocational counselors as being particularly difficult for him to work with. He felt that this group should have been included in the interview schedule because of the frequency of contact and difficulty he had experienced with the group and which he felt other workers may also have experienced. His contact had occurred in a Veterans Administration setting where such a professional group is frequently found. This worker stated:

Other professions take your word most of the time; these are more clearly defined functions. Where the social worker works, however, the vocational counselor works also - that is, their areas overlap such as in finding jobs for a patient. Here, the worker may disagree with counselor as to which kind of job is best for the patient which produces difficulty.

**Noteworthy Experiences**

In relation to interprofessional contact, responses to the question concerning noteworthy experiences of social workers with physicians could perhaps be of greater importance in getting information on the whole area of attitudes and relationships between the two professional groups. It was hoped that this question would elicit both positive and negative responses and provide concrete material which would more vividly illustrate and serve to substantiate some of the more general statements which might be made in response to other questions of the interview schedule.
Of the twelve persons interviewed, only two could not recall any noteworthy experiences. The two workers, employed in hospital settings respectively, referred to their experiences as "generally comfortable;" and as "more of an ongoing satisfactory relationship, not with one doctor, but with a series of them." The experiences described by the remaining respondents fell into three categories:

1. Where the worker recalled only a positive experience
2. Where the worker recalled only a negative experience
3. Where the worker recalled both positive and negative aspects of an experience.

Of the total number of experiences recalled, six were clearly positive, nine were clearly negative, and one a social worker described as "an experience which started out as being negative, but which ended quite positive." Thus, more negative experiences than positive experiences were recalled in response to the question on the noteworthy experiences of the social worker.

Of the six positive experiences, three were from medical social workers in hospital settings, two from workers in child placing agencies and one from a family service worker. Of the nine negative experiences, seven were from medical social workers in hospital settings and two from workers in child placing agencies. The experience which combined both positive and negative elements was cited by a medical social worker in a hospital setting.

In evaluating those noteworthy experiences which fell into the first or positive category, there seemed to be a somewhat basic or underlying theme present in each, which appeared to contribute to the worker's concept of having had a distinctly favorable or satisfying experience - namely, a feeling of cooperation, understanding and responsibility on the part of the physician in collaborating with the worker in a given treatment situation. In such situations, workers felt the understanding and interest of the physician in
what they were doing for the patient as well as in the patient himself. This is clearly illustrated by statements made by respondents in describing their experiences. For example, one worker in a hospital setting stated:

I have had a very good experience of jointly arranging with a physician a conference in which we (physician, social worker and patient) discussed the problem of a patient's discharge. The doctor had told the patient he was ready to leave, and the patient was resistant. Here, the doctor demonstrated his willingness to work with the worker, rather than delegate a job he did not like— that is, the social planning. However, this is not a frequent occurrence.

In most cases, workers spoke of contacting the patients themselves and introducing themselves to the patients without the participation or assistance of the physician either prior to the worker's handling of the case or during the worker's contacts with the patients.

Another worker from a family agency remembered working with a client who was pregnant for the second time through an extra-marital relationship, and in the process the worker was also working closely with the client's obstetrician throughout the pregnancy. She said:

The doctor was sympathetic, supportive and understanding of both the situation and the extreme pathology evidenced by the patient and was seemingly not threatened by the situation. Because of this, I consider the case an unusually positive collaborative experience.

A worker in a child placing agency described one of her cases in which an applicant for adoption had had a relapse of a chronic illness during the waiting period which contra-indicated adoption for her. The worker talked directly to the client's physician about the situation and

Foud him most understanding, as he said it was his responsibility to help the woman understand her physical condition, its encumbent limitations, and help her realize that family responsibility might be too much for her, which he did very successfully.

Another example came from a medical social worker who had worked successfully with a medical resident in establishing social service ward rounds in a
hospital. She stated that:

He himself had a good understanding of social service and was eager to help other residents gain a better understanding. As a result of his interest, we were able to establish ward rounds as well as a good working group of medical students, internes, residents and nurses.

In evaluating those noteworthy experiences which fell into the second or negative category, there appeared to be an obvious lack of those elements underlying the first or positive category. Rather than understanding and cooperation, the workers felt a pronounced lack of both, marked by an indifference to what they were attempting to accomplish in planning for a patient. These feelings were vividly illustrated in a number of experiences cited by workers. One worker, for example, described a T.B. sanatorium where she had worked, in which:

Most of the physicians could not see psychological involvement in the illness. They wanted plans made for the patient that were based purely on medical factors so that discharge planning or even original assignment of a case to a social worker was often seen by them as unnecessary. As a way of showing this feeling, the physician would often not share information regarding the patient with the worker.

Another example of the lack of cooperation was described by a worker in a child placing agency who had attempted to obtain a medical report regarding verification of a couple's inability to have children of their own in relation to an application for adoption by the couple. Such reports are required by the agency as part of their standard procedure in adoption applications. The worker explained:

The physician finally contacted me at the agency and said very angrily that he was aware that I was requesting information regarding his patients, and what right did I have to want such information. I tried to explain the policy of the agency in regard to procuring medical information in order to evaluate the application but he blasted the agency policy on the basis that we had no business requesting such personal information.

Consequently, the information was never obtained, and the couple was never
heard from despite the worker's attempts to help them obtain the necessary data. The worker emphasized her feeling that there is a lack of interpro-
essional appreciation about why a worker needs to know such medical information. She explained that if there is no evidence of physical inability to reproduce, the possibility of psychological components can be considered. She felt that physicians do not realize the worker's responsibility to appraise these emotional components in infertility, which may in time be corrected only if physicians are cooperative in providing such data to begin with.

Another worker in an out-patient clinic of a hospital felt that physicians will often simply ignore the social worker's role:

Sometimes a physician will do something without warning. A doctor referred a patient for evaluation of the social situation in regard to possible casework service and continued medical treat-
ment elsewhere. A day or two afterwards he suddenly discharged the patient without collaborating with me regarding the evaluation he had requested and without informing me of the patient's discharge.

Here, if the worker had not contacted the physician about his progress in the case, he probably would not have known of the patient's unexpected discharge.

In relation to the third or last category, which included both positive and negative elements of an experience, one medical social worker in a hospi-
tal setting described her contact with a physician:

He had just begun his resident training and was a very demanding and authoritative person - he gave orders and expected them to be carried through immediately by the social worker, due very much to his own insecurity and need for recognition in the hospital. I worked closely with him although it was very difficult at times, and interpreted to him what the social worker could do. Through this, he mellowed and became a competent member of the team.

The worker referred to this as being an educational experience - for both the worker and physician, where she had learned to cope with a difficult situation and the physician had learned what functions a medical social worker could perform.
Physician's Understanding of the Worker's Role

In relation to the question involving how many physicians the workers felt understood the role of the social worker, all the respondents encountered difficulty in recalling the exact number of physicians they felt had understood the social worker's role. For the purpose of simplicity the writer therefore encouraged the use of percentages and this seemed to be a more successful way of getting the respondents to estimate the number of physicians they felt had a good understanding of social work.

The predominantly negative experience described by the respondents seemed to correlate with the responses given to the physician involving the physician's understanding of the role of the social worker, which were essentially low, percentage-wise. Here, one person said as few as ten per cent of the physicians they had contact with understood the role of the social worker; three persons said forty per cent understood; while two said as many as ninety per cent understood. One respondent did not answer the question.

Seven workers expanded on their answers by saying that they felt the physician's understanding of the role of the worker was reflected significantly by the type of referral he made. One said, for instance, that:

The physician's understanding is usually quite limited if his referrals are limited only to problems concerning financial assistance or adjustment to a job, rather than request for help with a patient's emotional adjustment either to his illness or family situation which I can be of help with.

So it would appear then that the lack of cooperation and indifference on the part of the physician, as expressed previously by some of the workers, may have been related to his actual lack of understanding of the worker's role. That is, the physician did not have a great deal of knowledge of the actual mechanics of the worker's role - or, more specifically, of what she was actually able to do in working with patients.
Despite the physician's relative lack of understanding of the social worker's role, all but one of the twelve workers (who did not answer the question due to time limitations) stated they were able to develop a good working relationship with eighty to one hundred per cent of those same physicians. This would seem to indicate that even with the limitations involved, workers and physicians could nonetheless work quite comfortably together.

Communication

In evaluating the factors leading to interprofessional communication, the writer found that workers interviewed could recall anywhere from two to fifteen contacts during their last experience with a physician regarding a patient, with the average number of contacts being four. In most cases, the physician had initiated the first contact with the worker (usually the referral contact); the contacts were all face-to-face and had been previously planned by both parties. In four cases, the reason for the contact was discharge planning for a patient which was requested by the physician. In three contacts, a request for social evaluation of the patient by the worker came from the physician. In two contacts, however, the worker contacted the physician in regard to discussion of a patient's physical or emotional condition, and in one contact, a worker contacted the chief physician in a hospital to request funds for social work research purposes.

Generally speaking, requests for social evaluation and discharge planning were considered typical reasons for a physician to contact a worker, while discussion or clarification of a patient's physical condition, and occasionally emotional condition and the sharing of information or progress in a case were considered to be typical reasons for a worker to contact a physician.

In one instance, however, the pattern of contacts differed considerably.
The social worker from a family agency stated that:

The reason I will contact a physician very often is that it is necessary to discuss the possibility of committing a client to a mental institution which would necessitate the family doctor’s signing commitment papers.

In regard to the reasons for a physician contacting the worker in the agency, there was "none - this is the problem our agency is having with the medical profession."

Four-fifths of the persons interviewed felt that in their agencies more attention would be paid to the physician’s recording than to the worker’s recording. One worker in an out-patient clinic setting remarked, "I sometimes wonder if they (physicians) read our recordings or not." This same worker was quoted earlier in the chapter with regard to his experience of preparing a social evaluation for the physician, only to find that the physician had not bothered to wait for it and had discharged the patient. Another worker from a hospital setting commented, "If the records were combined, the physician might not look at the social worker’s recording." In one instance, a worker said the question did not apply because of the agency set-up and, in two cases, workers, both from medical settings, felt the recording of the worker and physician received equal attention.

**Division of Functions**

All of the social workers interviewed agreed in their definitions of the jobs done by the physician and those done by the worker. This clear-cut division was, essentially, that the physician concentrates on the medical aspect of the patient or client while the worker focuses on the social or emotional aspects of the patient or client. While it was indicated by some of the workers that there was some overlapping of these jobs in relation to
the physician's possible concern with the physical problem in the course of treatment, basically there was a clearly defined division in the functions of these professional groups. All of the persons interviewed agreed unanimously that this division of function was a satisfactory one. The overlapping concern of physicians could be thought of as a positive factor in terms of the desirability of the whole person being considered in treatment - and there was some evidence that the physician is concerned with the emotional component and that the worker is concerned with the physical component of an illness. But whether this trend will continue and help to increase the physician's understanding of the social worker's role (and perhaps the social worker's understanding of the physician's role) is a matter for speculation.

Another basis for agreement among the respondents, though in a less positive sense, was their experience with physicians who had made unrealistic plans for their patients. Here, all the workers had personally encountered such a situation and the one who had not knew of someone else's experience. All the persons cited unrealistic or improper discharge planning as an example. One person cited no discharge planning by the physician as unrealistic. In most cases, improper living arrangements or family difficulties were factors in the physician's unrealistic planning. One worker felt that residents on the surgical service of a hospital, who were under more pressure to move patients out of the hospital are:

Not always related to the social aspect; surgeons are less tolerant, on the whole, of dependency of patients and tend to plan on a more precise, less relaxed basis than on other services in the hospital.

**Availability of Physicians**

In the area of communicating with physicians, four-fifths of the workers
found physicians easily available in order to discuss matters with them. Two persons believed that the situations varied according to the specialization of the physician and the schedule of his office hours. Only one person found it difficult to reach physicians, though he thought the situation was realistic in terms of the physician's involvement in his work, such as in the clinic or operating room. All of the workers who found it easy to reach physicians were in hospital settings and attributed their ease to the fact that physicians were usually near to them in clinics and wards and thus were easily contacted. One worker explained that she could usually call the ward nurse and, through her, locate a physician, while another worker mentioned knowing the schedule of the physician so that she could locate him with relative ease. In all but three instances, the worker would usually contact the physician about a case they were both working on. These persons indicated that the physician would usually initiate the contact at the time of referral, while the worker seemed to maintain contacts with the physician about the case they were both working on after referral was made. Three workers felt that contacts made during the course of treatment around a case referred by the physician were made equally by both physician and worker.

**Authority Relationships**

In exploring the collaborative process, the question of final authority in decisions about a treatment plan for a patient or a client evoked several kinds of responses. Six of the workers interviewed felt that the worker would have final authority in a treatment plan related to the social situation while the physician would have authority in a medical treatment plan. Four workers felt the physician, exclusively, would have the final authority in treatment planning. One person felt the authority in decisions varied,
depending upon whether or not the physician actually ever referred the case to social service to begin with (so that there sometimes might not be the need for the physician to do anything but assume the responsibility and authority for planning on his own) or whether the patient, according to the worker's feeling or interpretation, encourages the worker to pursue a plan despite the disapproval of the physician. One-half of the workers interviewed felt that physicians did exercise their authority over social workers in those areas where social workers have the most professional competence. In all but one of the examples given, the physician had discharged the patient over the worker's head on the grounds that the social planning was unnecessary; in one case, the worker over-rode the physician's disapproval and proceeded successfully to execute her plan. In this case, the physician apparently sensed the determination of the worker to go through with her plan and took rather a passive attitude once she had superceded his original disapproval.

Although only four workers deemed the physician entirely responsible for the treatment of patients, several others recalled instances where physicians had actually used their authority in over-riding the treatment plan of the worker. On the basis of these statements, it would seem that the physician could have a more total authority more often than not, but workers were either not aware of it due to their lack of exposure to such circumstances or because of their reluctance to admit such a situation.

Physicians' Attitudes Toward Social Workers

In assessing the broad question of physicians' attitudes toward social workers, slightly less than half of the workers interviewed felt that the attitudes were positive and half felt they were negative. Two persons felt there were both positive and negative elements in physicians' attitudes
towards them. One worker said that the positive side was characterized by the feeling of physicians that the worker "is an important factor in treatment of patients." Another worker stated, "they see our usefulness and see us as a member of the inter-disciplinary team." Of those workers who weighted attitudes on the negative side, one felt that "physicians don't always understand what casework is all about," while another said:

Physicians have diverse feelings about us, as when they will criticize workers in one agency and then afterwards say a patient might be able to use help in another agency; they will judge workers on the basis of how easy they are to work with.

Other comments were that:

Few see us as good for more than planning for discharge.
They see workers as a dumping ground when they don't know what to do.
The way they use workers reflects their questioning of what we can do.
Some are unclear as to what we can offer and often won't bother to ask what we can do.

Another worker said:

They have a very looking-down-the-nose kind of attitude and don't really seem to believe workers know what they are doing; their attitude is that social workers look for problems which don't exist and just make the client more anxious.

This comment which was the most vehement of all given, came from a worker in a family agency where relationships between physicians and workers were very poor.

The responses given above about the physicians' attitudes toward and understanding of the social worker appear to be directly connected with the feelings expressed by the workers in their accounts of noteworthy experiences they have had with physicians. In all of these areas the respondents are primarily concerned with the physician's clarity or lack of clarity about what the social worker can do in treatment and with the physicians' feelings
of how valuable she can be to him in the treatment process. In other words, the function of the worker as perceived by the physician appears to be a persistent theme.

With the problem between the professions being centered chiefly around the lack of understanding of function or role, every worker but one, who would not hazard a suggestion on the basis of too little time left in the interview, felt that the best way to improve interprofessional relationships was through educational approaches. This was thought of in terms of meetings, conferences, on-the-job education and personal contacts rather than telephone contacts with physicians. One worker felt that:

Improvement would come if the professions concerned were more secure in their own individual roles and that a way of communicating and interpreting their ideas to each other be initiated so there would be more understanding.

Another worker felt that constant teaching, starting in the various professional schools (nursing, medical, etc.), would improve interprofessional relations. Finally, one person felt that:

By getting a higher caliber of workers in the various settings, starting with better screening of applicants in the schools of social work, more respect would ultimately be given to workers in their interprofessional relationships.

There was no doubt whatsoever that there was a need felt for better interprofessional relationships by the social workers interviewed.
CHAPTER III

INTERPROFESSIONAL RELATIONSHIPS OF SOCIAL WORKERS WITH PSYCHIATRISTS

Introduction

This part of the study is based on sixteen interviews with social workers working in different agencies, hospitals and clinics, about their experiences with psychiatrists. All of the social workers interviewed had graduated from a school of social work and had been working in the field for more than two years. Five workers had from two to five years of experience, six from six to ten years and four more than ten years of experience.

The sample was not limited to any type of social work or agency setting. Since the purpose of our study was to investigate the experiences social workers had had in general with psychiatrists, such a limitation was not felt to be indicated. Of the sixteen social workers interviewed, four were employed in agencies which used a psychiatrist as a consultant. By consultation we mean the help and advice given to a social worker by a psychiatrist in regard to a client with whom the psychiatrist has no simultaneous and direct contact. Three social workers worked in settings where the psychiatrist was strictly a member of the team and as such involved simultaneously with the social worker in treatment of the patient-client or his family. Nine social workers were employed in hospitals and clinics where the psychiatrist could assume either function; in six of these institutions the emphasis was more on the team while in three consultation was used more commonly. In

1In order to facilitate matters we shall refer throughout this study to the psychiatrist as "he" and the social worker as "she".

24.
this study we shall call the settings which use both psychiatric consultation and the team approach "mixed settings."

Most of the social workers interviewed had had some experience with both approaches. Three workers had been employed at the same institution since their graduation from a school of social work. Three had had no experience with a different approach (either consultation or team) although they had held more than just one social work job. The remaining ten had had a variety of contacts with psychiatrists, depending upon the agency they worked in as can be seen in Table 1.

TABLE 1

<table>
<thead>
<tr>
<th>Type of Approach</th>
<th>Current Settings</th>
<th>Number with Experience in other Settings</th>
<th>Consultation</th>
<th>Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Team</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Mixed settings</td>
<td>9</td>
<td>8</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>11</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

A similar picture of well rounded experience is shown by comparing the present and previous position of the social workers interviewed. Nine of them were presently employed as psychiatric social workers, three as caseworkers, three as medical social workers, and one as a probation officer. Nine held at the same time supervisory, teaching, and administrative functions. Of the nine psychiatric social workers five had had previous experience in non-psychiatric settings, while two of the caseworkers had held previous jobs in child guidance clinics. Obviously the social workers whose experience was or had been in a psychiatric setting had had generally more
contact with psychiatrists, especially insofar as team relationships are concerned.

Although more than half of the social workers interviewed were presently employed in psychiatric settings, Table 2 shows that the work experience previous to the present position has been to a greater extent in non-psychiatric settings.

### TABLE 2

**SETTINGS IN WHICH THE SOCIAL WORKERS HAD SOME WORK EXPERIENCE**

<table>
<thead>
<tr>
<th>Setting</th>
<th>Present work experience</th>
<th>Previous work experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric hospital or clinic</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Medical setting</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Family Service Association</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Children’s agency</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Juvenile Court</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Department of Public Welfare</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

In proceeding with our interviews we soon noticed the differences of experiences the social workers had with psychiatrists depending upon whether they received psychiatric consultation or worked within a team. Evidently these rather fundamental differences in the professional relationship also influence the social worker’s attitude towards and view of the psychiatrist.

In this study we will differentiate between the two approaches of psychiatric consultation and team work and discuss them separately. This differentiation evolved from our investigation and was not planned initially. It has to be left to further research in the field of interprofessional relationships to study each separate approach more thoroughly.
Consultation

Our study showed that all of the social workers interviewed had had some experience with psychiatric consultation at one point or another of their professional career, although for three of them it was limited to their student placement.

Psychiatrists are most commonly employed in a part-time consultatory basis in casework agencies such as family service agencies, children’s agencies and public welfare agencies. In his role as a consultant the psychiatrist offers to the agency his services as a specialist and expert. The caseworker keeps the full responsibility for her client. However, she can ask to discuss a case situation with the psychiatrist whenever she feels the need for it. The psychiatrist thus assumes largely a teaching function by clarifying the dynamics of a case and helping the worker to a better understanding of the client’s reactions, as well as her treatment goals. Through his professional knowledge and his ability to be more objective in a case in which the social worker may be deeply involved, the psychiatrist is felt to be of support to the social worker in her efforts to work with the client. The psychiatrist’s help is also appreciated in the formulation of a prediatory diagnosis and speculation about a client’s future reactions, as it enables the social worker to be better prepared for the handling of the case in the future.

The following two comments by social workers illustrate how psychiatric consultation can be used:

The psychiatrist is most helpful with dynamics. I remember a case where I had the feeling the child did not benefit from casework. I felt there was a problem of negative transference on the child’s part. The consultant was able to be objective in pointing
out the child's history of mistrust and the meaning of the rela-
tionship to the child, although she did not seem to accept me at
the present time. The consultant's objectivity and understand-
ing of the dynamics helped to clarify and simplify the case.

I got a client transferred from another worker. The client
seemed completely stuck. In consultation the psychiatrist iso-
lated the problem as a relationship difficulty. This made sense
to me and I could use the knowledge in the interview. I felt
increasingly more comfortable with the client and the client with
me.

To use consultation to verify one's own diagnosis and clarify
the understanding of a case invariably helps.

The following areas of the psychiatrist's contribution in consulta-
tion were stressed by the social workers in terms of their importance:
clarify dynamics; predict, recommend and clarify treatment goals; teach
the social worker and be capable of greater objectivity in a case.

In those instances where the psychiatrist is acting as a consultant
to the social worker, the social worker retains freedom and decision of
action in regard to her clients and assumes the full final responsibility
for it.

Team approach

Much has been written in recent years on the roles and functions of
psychiatrists and social workers in a team-work setting. Different at-
ttempts have been made to clarify the situation which appears, however,
still far from being clear. The existing confusion in the minds of most

2Alvin Zander et al. Role Relations in the Mental Health professions.
dynamic use of the social work services within the clinical team." Ameri-
can Journal of Orthopsychiatry, 1950, pp. 765-775. Morris Krugman et. al.
"A study of current trends in the use of coordination of Professional
Services of psychiatrists, psychologists, and social workers in Mental
Hygiene Clinics and other psychiatric agencies and institutions." Ameri-
professional people about the respective functions of the psychiatrist and social worker is due partly to the relative newness of the team approach and partly, as a social worker put it, "to the state of flux in regard to their areas of work in which both psychiatrist and social worker still are". This became especially apparent when it was noted that not one of the team-work settings investigated had the same division of functions as any other. Some of the differences were slight but in a few instances the social worker herself was not quite sure whether she was working in a team or on consultation with the psychiatrist. We shall define the team in our study as the collaborative effort of the psychiatrist and social worker directed either towards the same patient or the same family unit. The classical example of a team-work relationship would be found in a child guidance clinic, where the psychiatrist generally does therapy with the child and the social worker casework with the parents. The policy of having the psychiatrist work with the patient and the social worker with the relatives is also followed in many a hospital and outpatient clinic.

Such comments as the following three illustrate the social worker's appreciation of a good team approach:

The mutual sharing of information leads to a rich experience.

In the team you have more of a working relationship than in consultation - one participates in a common goal.

The relationship in a team leads to an unfolding of people's development from week to week through the sharing of information. There is a mutuality of understanding between the team members as well as trust in the abilities of the different professional disciplines.

The following two cases show how a good team approach can operate:

The psychiatrist saw the patient and the social worker the patient's wife. At one point the patient started to resist.
therapy, resistance which seemed partially motivated by his resenting changes in his wife. He told his wife that he would stop treatment. The wife, who received much from the contact with the social worker argued with her husband about his stopping treatment, as she was afraid she would have to leave treatment too. The patient had not discussed the wish to discontinue treatment with the psychiatrist. In consultation between psychiatrist and social worker it was decided that the social worker would offer continuous treatment to the wife, regardless of the husband's decision, although this was against the hospital's normal policy. However, after the social worker made this move, the arguments between the patient and his wife stopped immediately and the patient continued in treatment.

An old patient was hospitalized because after his wife's death he had shown a very acute grief reaction, getting enraged in grief. Previous to his hospitalisation he had been living with a married daughter who felt very guilty about putting him out of her home. In the hospital the patient behaved as if he wanted to settle down there for good and did not respond to therapy with the psychiatrist. The psychiatrist therefore wanted to discharge him. The social worker insisted that the patient be kept a month longer while she was working with the family. The family responded positively and finally with help of community services the patient could be placed in a foster home. The social worker felt that she received a great deal of support from the psychiatrist who appreciated her understanding of the dynamics in the case. The social worker, on the other hand, helped the psychiatrist to see the strength in the family and how it could be used.

**Dual therapy**, where the psychiatrist and the social worker work with the same patient, was generally not recommended by the social workers. Dual therapy was felt to be more often a source of conflict and jealousy for the patient (as well as for the social worker and psychiatrist) than a constructive means of treatment. To be successful this type of therapy asks of both the psychiatrist and the social worker a special awareness of their respective roles, great skill and the ability to work in a smooth relationship with the other discipline. Occasionally, however, dual therapy is suggested by the psychiatrist. The reasons for such a referral are usually the patient's need for help with his interpersonal relationships within the community. The following three cases illustrate the positive aspects as well as the problems of dual therapy:
Both the psychiatrist and the social worker were working with a depressed, physically handicapped woman patient who had started drinking after her husband's death. The patient was seen daily by the psychiatrist while the social worker saw her weekly over a period of two years. The psychiatrist and social worker discussed the case together every two or three weeks. The social worker focused with the patient on her environmental problems in a very supportive way. The psychiatrist was helpful to the social worker by interpreting to her the needs of the patient who was a very demanding person. The social worker helped the patient with the problems she had with her neighbors and was finally able to get her back into community life, using at the same time the services of a group work agency.

In another case dual treatment was set up in a similar way but unfortunately did not work out equally well.

This patient, who was very much alone in the world, was seen by both psychiatrist and social worker. The patient showed negative feelings towards men and had a great need to talk to somebody. It was felt that the more relationships she had the better. The social worker tried to give her a supportive relationship and to help her with her adjustment in the community. However, at one point the patient started to play the doctor and the social worker against each other, by telling the social worker that the doctor was thinking differently and vice versa. This difficulty could not be worked out between the psychiatrist and the social worker and the social worker finally stopped seeing the patient.

In the third instance, however, the social worker could be of help to the psychiatrist in his work with the patient.

An alcoholic patient was seen by both psychiatrist and social worker. The patient liked to talk and it was felt that the social worker should give him support, since the psychiatrist wanted to give him a rough time in therapy. During this period of treatment the patient complained to the social worker about the psychiatrist. The social worker encouraged the patient to talk about his feelings with the psychiatrist, explaining that the psychiatrist wanted him to talk about it. The patient then was able to discuss his negative feelings with the psychiatrist and from then on made marked progress in treatment. The psychiatrist expressed his gratefulness to the social worker for help in this case.

In the team-work setting the psychiatrist generally does therapy with the patient and gets the medical and psychiatric history from the patient's family. The social worker does casework with the family and occasionally some therapy with the patient, is in charge of intake, social history taking, arrangements for discharge, community contacts and some administrative work.
such as keeping appointment schedules and statistics. Another distinction of functions given was that "the psychiatrist works with the patient on his intra-psychic conflicts while the social worker focuses on interpersonal relationships and environmental adjustments".

Social history taking, one of the classical functions of social workers in a psychiatric setting, was only mentioned twice as the social worker's function. Apparently the question about the social worker's function versus the psychiatrist's function in a team relationship centers more around the differences of the psychiatrist's and the social worker's approach to treatment. Numerous papers have been written on this subject in the past ten years. Most of them try to arrive at some clear cut distinction of the psychiatrist's and the social worker's respective functions, a distinction which can rarely be carried out in the practical field. It seems that each mental hygiene setting is trying to reach some solution to this problem within its own four walls.

The existing uncertainty and variety in regard to the role and functions in a team-work approach necessarily leads to more interprofessional friction than in a pure consultatory relationship. Comments such as the following were not infrequent:

How the psychiatrist understands social work varies from simple transportation of patients and fact finding to seeing the worker as a part of the treatment team in working with families and patients.

3 See bibliography.

In some hospitals the social workers are used only to arrange taxi transportation and do not have any treatment cases. The psychiatrist then has only little contact with the family and seems not interested to hear from the social worker about the family situation.

Some psychiatrists feel that all social workers can do is social history taking and work in relation to reality - treatment is for the psychiatrist.

Some psychiatrists get too dependent on the social worker. They get accustomed that the social worker does the bulk of the work and they can concentrate on the patient entirely. However, the psychiatrist should interview the family as well.

The complaints about the psychiatrist using social service in regard to specific practical problems only were voiced in connection with experiences in mental hospitals. It seems that the mental hospital with its often limited and overburdened staff, its great number of patients and pressure to get the patients back into the community, finds it generally harder to achieve a good team relationship. We will come back to this question in the section titled "Major problems between social workers and psychiatrists."

Mixed settings

In many hospitals and clinics the psychiatrist assumes both the function of team member and consultant to the social worker depending on the clients in treatment. His role as a team member stays within the limits described previously. In his capacity of consultant he may either give individual consultation to the social worker or discuss a case presented by one social worker in a group consultation. In both cases he will give the same services to the social worker as described under "consultation".

Nine of the social workers interviewed were employed in "mixed settings". Six of them worked in hospitals and two in medical outpatient clinics. The Juvenile Court takes a separate place in this classification.
We include it under "mixed settings" because the psychiatrist sees the child for diagnosis or treatment but only reports his findings and recommendations to the probation officer. There is relatively little direct contact between the probation officer and the psychiatrist. Two social workers described the psychiatrist's functions as those of consultant but it became apparent in the interview that they were also occasionally carrying a case in a team-work approach with the psychiatrist. In both settings the psychiatrist had suggested to the social worker the joint carrying of a case and the social workers expressed their satisfaction with this experience. Three social workers considered the set up of their hospital to be team work. The interview revealed, however, that they were carrying relatively many clients without the psychiatrist being directly involved in the case. Consultation took place on an individual informal basis, the social worker approaching the psychiatrist whenever she needed advice and help in regard to the treatment of one of her clients. In one hospital the social worker was well aware of the dual role of the psychiatrist as a member of the team and a consultant, since both functions were well defined. This was in contrast to another hospital where both social workers interviewed were not clear about the psychiatrist's functions in relation to their work with the clients. One of the social workers gave the following explanation about the situation:

There is no real team approach at the hospital because it is a training hospital. Many people are involved and therapeutically interested. Many times one does not know who is active on a case. It is easier to function in a non-teaching hospital.

However a "mixed setting" does not necessarily mean confusion about the psychiatrist's role on the social worker's part. It was felt that the flexibility of roles inherent in many a "mixed setting" was in general appreciated by the social workers, since it provided them with the support of
psychiatric consultation as well as with the satisfaction of a good team relationship.

Communication

The frequency of contact between different professional disciplines has considerable bearing upon their understanding of each other's work and the quality of the mutual effort to help the patient-client. Our study showed that the more contact social workers had with psychiatrists the easier they felt it was to work with them. Most of the social workers interviewed had had a good deal of contact with psychiatrists. Therefore, in answer to the question about the amount of on-the-job contact they had had with ten related professional disciplines, three workers put the psychiatrist first, seven second and four third in rank. The correlation between the frequency of contact and the ease of working with another profession can be seen by the fact that of the fourteen social workers who ranked the amount of their contact with psychiatrists first, second or third, nine said that they found it very easy to work together with psychiatrists. In those instances where the social worker had some question about the ease with which she was able to work with the psychiatrist, the difficulties in the working relationship were always described as personality difficulties on the part of the psychiatrist. We shall discuss this further in the section titled "Major problems between social workers and psychiatrists."

Consultation

In those agencies where the psychiatrist functions as a consultant, communication is limited to specific times fixed by the agency's administration. The social worker receives either individual or group consultation, on which occasion she presents and discusses a case with the psychiatrist.
Two of the four social workers employed in agencies who used psychiatric consultation mentioned that they see the psychiatric consultant on a regular basis of one hour a month. The other two social workers explained that they could ask for consultation whenever they felt the need for it, the psychiatric consultant being at the agency one day a week. Three social workers had their consultation in the agency's conference room. This involved at the same time a formal presentation of the case in a written summary form. The time spent in conference was between an hour and an hour and a half. One social worker mentioned that:

The psychiatrist is not kept busy enough because the social workers of the agency do not recognize the opportunity they have for consultation. Consultation is a more formal relationship because the psychiatrist is not a full time member of the staff. The presentations are very formal. We have to write up a full summary of the case which takes a lot of work and time.

However, it was found that all agencies who used this type of formal consultation between the social worker, her supervisor and the psychiatrist, were considering the introduction of more group consultation, in order to give the whole social work staff the opportunity to benefit from the psychiatrist's services.

**Team Approach**

Communication between the psychiatrist and the social worker in a team becomes much more individualized and unstructured and therefore more subject to conflict than in pure consultation. Both psychiatrist and social worker have an equal responsibility to make their team work to the best benefit of their patient-client. The decision about the frequency of contact in a case is left to the individual psychiatrist and social worker and is therefore more liable to bring out individual attitudes and feelings one profession may have towards the other.
Eight of the ten social workers who answered the question about the frequency of contact between the psychiatrist and themselves in a team approach felt that they were contacting each other at an equal rate, while only two spoke of the social worker contacting the psychiatrist more often for information. Zander expressed the opinion that the social worker is more apt to seek communication with the psychiatrist due to her ancillary status to the profession of psychiatry. Our inquiry about the most recent contacts the social workers had had with a psychiatrist about a case revealed the following picture: seven social workers contacted the psychiatrist while only three psychiatrists contacted the social worker. These findings correlate to a certain extent with Zander's findings, although the sample used in this study is too small to draw any conclusions. The three psychiatrists who contacted the social workers all went to the social worker's office for consultation while the social workers went in their turn to the psychiatrist's office except in two instances; in one the social worker met with the psychiatrist in the conference room and in the other on an unplanned, informal way in the lunchroom. In those cases where the psychiatrist contacted the social worker, a very close cooperation already existed between the two; they had shared information on a case over a period of several months for at least once a week and in two cases even more than once a week. This and the fact that all first contacts were made by the social workers leads us to believe that the psychiatrist might be more inclined to contact the social worker

when a very close working relationship between them has already been established, whereas the social worker seems more liable to approach the psychiatrist the first or first few times on a case.

All contacts between psychiatrist and social worker were face to face contacts. The face to face discussion was felt to be the only possible way to achieve good communication, any other contact being subject to misunderstandings and unsuitable for sufficient clarification of the treatment aspects of the case. Time involved in those contacts extended from three minutes to one hour, the most frequent length of time being about fifteen minutes.

The reasons for which the social workers contact the psychiatrist are the following in the sequence of the number of responses obtained from the workers: obtain clearer understanding of the dynamics and treatment goals; share information with psychiatrist; receive specific information and recommendation from psychiatrist; refer client to psychiatrist. The reasons for which the psychiatrist contacts the social worker show a slightly reversed picture, the emphasis being more on the request for practical information than on the discussion of the dynamics of a case. The sharing of information is still in first place; however, the five other reasons given all deal with tangible matters such as: ask for specific information about client’s family; make referrals; ask social worker to do something specific for patient; ask about community resources; check how his recommendations work out.

These findings seem to indicate more frequent requests from the psychiatrist about specific information and action in regard to a patient, while the social worker seems more eager to learn, using the psychiatrist to help her clarify her understanding and treatment of a case.

An important factor for good communication is the availability of the team members. Although the majority of the social workers interviewed were
positive about the frequency of contact they had with the psychiatrist, they were more concerned when questioned about the availability of the latter. Of the ten social workers who responded to the question, five found it easy to get hold of a psychiatrist while the remaining five found it hard. Those latter five social workers were employed in settings which had a great number of psychiatrists in training. Most of these psychiatric residents work in different places and at irregular hours. This was seen as the main difficulty in communication. Other difficulties mentioned were the psychiatrist's personality structure and his way of dealing with time. One social worker explained that because of the psychiatrist's heavy work schedule she has to "catch him on the run." Whether or not in these cases communication may still be successful depends largely on the psychiatrist's readiness to contact the social worker as well. Another social worker pointed out that the lack of a telephone in the psychiatrist's office made it especially hard to reach him. A solution to this problem could be to set up a regular appointment time. However, such an arrangement seems to exist only in those cases where both psychiatrist and social worker are equally involved in the treatment of a patient.

In regard to the question whether the present state of communication and division of functions between psychiatrist and social worker is satisfactory or not we got the following responses: six social workers found it to be satisfactory; four found it satisfactory but mentioned some suggestions for improvements and two found it unsatisfactory. The main criticism by the two social workers who felt that the present working relationship was unsatisfactory was the psychiatrist's use of social service in the purely practical way of rendering tangible services to the clients, which was due to the psychiatrist's limited understanding of what social work was prepared to do
in terms of casework. One social worker defined the problem in the following way:

How the hospital sees the functions of the social service depends on the hospital's administration and the individual psychiatrist. At the hospital there is a tendency to see the social worker as a person who gets information, gets a job for the patient and a place to live.... she only comes into the picture when there is a specific problem in the family. Social service at the hospital could be used to better advantage. The total staff's understanding of social service should be increased. The social worker should have a close contact with the patients' families; this is not yet a usual procedure.

The four social workers who felt that there could be improvements discussed them also in terms of the psychiatrist's understanding of the social worker's role, areas of work, responsibilities and limits. To improve the working relationship between the two professional disciplines, a review and readjustment of the areas mentioned was suggested.

Positive responses were obtained in relation to an excellent team approach, described as flexible and stimulating because it left room to try out various new ideas. It was felt that a homogeneous staff and a good administrator could create a working atmosphere favorable to close and smooth cooperation between the various professional disciplines.

Mixed settings

Since the mixed settings combine team-work and psychiatric consultation their communication process is similar to what has been discussed previously in this section.

Of the five hospitals and clinics included in the mixed settings, three had regular psychiatric consultation for the social work staff. In two of them it was rather the exception for the social worker to work in a team approach. Group consultation on a biweekly basis was their normal way of communicating with the psychiatrist. In the third setting, the team was the main channel of work but the social workers received psychiatric consultation
twice a month in a group situation. In one hospital team conferences and weekly consultation with the psychiatrist were mentioned, but it was not quite clear how steadily this was carried through. In the fifth setting the focus was definitely on the team; in addition to this the social workers were able to approach the psychiatrist about any of their cases in an informal way whenever they felt the need for psychiatric consultation.

Other means of communication between the psychiatrist and the social worker.

In all settings where social workers were interviewed, other means of communication existed besides individual or group consultation and discussion within the team. These additional means of communication were usually felt to be helpful in increasing the mutual understanding of each other's profession.

Nine social workers mentioned staff conferences; there, a case would be discussed within the staff independently of the sharing of information between the psychiatrist and the social worker about their common treatment case. Eight social workers had some responsibility in the training of psychiatric residents, either in the form of lectures or in discussion groups on social work. In three hospitals the whole team (including nurses and medical doctors) meets every morning for a few minutes in order to discuss current matters on a case. Four social workers were involved together with the psychiatrist in ongoing research. Five social workers mentioned the psychiatrist's assistance in planning group meetings with a certain type of clients, e.g. adoptive parents, mothers, etc. and seven social workers felt that the opportunity to meet the psychiatrist at lunch and other informal occasions helped increase the ease of working together.

Authority relationships

Consultation

The agency which employs a psychiatric consultant expects from him
assistance in terms of increased clarification and understanding of a case. The psychiatrist acts in his capacity of specialist, expert and teacher. He is asked for his opinion and his suggestions and recommendations are usually followed. Most psychiatric consultants, however, abstain from giving direct advice to the social worker, keeping more in the area of discussing dynamics, thus helping the social worker to review and readapt her treatment goals. The responsibility for, as well as the decision in regard to treatment of a client remains entirely with the social worker. The social worker is free to follow or not to follow the psychiatric consultant's recommendations. As a social worker put it: "The nice thing about consultation is that the social worker can adapt it to her work as she wishes". Most of the time the social worker will carry out the psychiatrist's recommendation, since such a move is inherent in the philosophy of using psychiatric consultation. There are, however, occasions when the social work staff does not agree entirely with the psychiatrist for one reason or another. In these instances the social worker, after consultation with her supervisor or the agency's administrator, goes ahead with her own planning.

The two following cases will illustrate situations where the social worker did finally not follow through with the psychiatrist's recommendation:

At a family service agency the psychiatrist's recommendation was for a client to be seen by a psychiatrist for treatment. The social worker felt that the client was not ready for a transfer and would not follow through with it. In a conference with the social work supervisor following the psychiatric consultation, the decision was made not to follow through at this time with the referral of the client.

A child was referred from a child guidance clinic to a children's agency for a group or school placement. Since there was at the time no such placement available, the child spent his summer vacation in a foster home of the agency, where he adjusted remarkably well. After summer vacation was over, the agency decided to leave the child in the same foster home.

These examples show that the worker does not lightly disregard the psychia-
trist's recommendation. Sometimes reality factors prevent her from carrying through a recommendation, sometimes her close knowledge of the client makes her hesitate to take a risk. In these cases, which are the exception, a great deal of thought is given by the social worker before she continues with her own plans.

**Team Approach**

The team approach commonly is used in hospitals and clinics. Due to his medical status the psychiatrist is the head of the team and the person with final authority. He not only carries the authority but also the final responsibility for a case. This also applies to the "mixed settings" as well as to those medical settings where the psychiatrist functions as a consultant only. The psychiatrist's authority was generally recognized by the social workers although it was viewed differently depending upon the hospital's and clinic's philosophy and policy. The following comments made by the social workers may illustrate some of these differences:

In essence the psychiatrist has the authority because we work in a medical setting. The social worker, however, still carries the responsibility for her own cases.

There is a tendency for the psychiatrist by nature of his training to use authority and for the social worker to use freedom.

At the clinic there was a feeling that the psychiatrist was generally right. He had administratively most authority.

Whatever the psychiatrist said was done. He did not like anybody to oppose him.

Most of the social workers stressed that decisions in regard to a patient-client's treatment were taken jointly in discussion with the psychiatrist. Only two social workers felt that the psychiatrist made decisions without consulting them. In those cases where the social workers stated that "the psychiatrist has the final authority for the treatment of the patient and the social worker for the treatment of the family", the
statement was explained in terms of the social worker being able to carry on casework with the family even if the patient dropped out of treatment. However, they pointed out that the psychiatrist would have the final authority for the general treatment plan.

Sometimes the psychiatrist uses his authority over the social worker in areas where the social worker has the most professional competence. Ten social workers remembered instances when this had actually happened. Five workers stated that such a thing only happened when they worked on a case with a psychiatric resident, who had not yet acquired a good understanding of social work practice. In seven cases the psychiatrist interfered with the social worker's work with the family. This was explained by referring to the young and unexperienced psychiatrist's lack of confidence in the social worker's handling of a situation and his need to prove himself. In general, the social worker is able to handle the psychiatrist's interference with her work herself or on the supervisory level.

Major problems between social workers and psychiatrists

In the previous sections certain problems of working relationships which can arise between the psychiatrist and the social worker were already mentioned. We would like to discuss them in greater detail in this section. Conflict between the two professional disciplines is usually due to a lack of understanding of each other's functions and/or insufficient communication. The reasons for the difficulties given by thirteen social workers who remembered a negative working experience with a psychiatrist can be divided into three groups, as shown in the following table.
TABLE 3
REASONS FOR CONFLICT BETWEEN PSYCHIATRIST AND SOCIAL WORKER

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personality of the psychiatrist</td>
<td>13</td>
</tr>
<tr>
<td>Professional orientation of the psychiatrist</td>
<td></td>
</tr>
<tr>
<td>(more interested in the organic aspect of mental illness than psychotherapeutic aspect; sees social worker's function solely as history taking, job finding, etc.)</td>
<td>5</td>
</tr>
<tr>
<td>Residents and psychiatrists new to the work with social workers</td>
<td>7</td>
</tr>
</tbody>
</table>

Personality problems of the psychiatrist were defined by the social worker in terms of the psychiatrist's own insecurity, overcompensated by an exaggerated use of his authority, and his personal immaturity and irresponsibility in his work with the client, leaving it to the social worker to straighten things out for him. One social worker felt that:

The insecure psychiatrist is threatened by the social worker. He runs away from her or tries to cut her out of treatment. Insecurity, rivalry and displacement of the psychiatrists are fundamental for the negative work with them.

Two social workers mentioned an experience with a psychiatrist who did not show up for his appointments with the patient. The problem was described by one of the workers in the following way:

The psychiatrist had a personality problem due to his emotional immaturity. He was casual and irresponsible in treating cases. For instance, he went on vacation without preparing the patient, who showed up for his appointment when the doctor was not there. I then had to see the patient and explain to him. When the doctor was reminded about it he laughed it off. However, he did easily share information on a patient with me.

Other cases show the psychiatrist's use of his authority at the wrong
place and the wrong time and his mistrust of the social worker's ability
to do a good job.

The social worker saw the mother of a teenage girl patient in
order to evaluate the mother's attitude and relationship with her
daughter. After the social worker started seeing the mother, the
psychiatrist initiated a call to the mother and talked with her
in an authoritarian manner, without having consulted with the social
worker. This destroyed completely the relationship between the
mother and the social worker.

One psychiatrist had his nurse interview the relatives of a
patient after the social worker had seen them. At one point the
nurse came into the social worker's office when the worker was
going to interview the family, indicating that she wanted to be
there during the interview.

It is clear that such incidents do not help to promote a smoother coopera-
tion between the two professions.

Where the problem was seen as one of the psychiatrist's orientation
it was also stated that very little communication existed between the social
worker and the psychiatrist, the latter not being interested in the material
the social worker was able to obtain, e.g. data on the patient's relation-
ship with his family and environment. The use these psychiatrists made of
the social service was restricted to arranging transportation, discharge,
financial problems and obtaining specific information from the patient's
family or community. The following case may serve as an example of the
complete lack of communication between the psychiatrist and the social
worker, although they were working with the same patient.

The social worker saw the patient in a mental hospital two or
three times a week for about a year before the psychiatrist on the
ward started to see the patient occasionally. At one point the
psychiatrist permitted the patient to go out for work and the pa-
tient subsequently escaped. The social worker, who from her knowledge
of the patient was expecting an escape, mentioned this to the psychia-
trist, when she learned about the new arrangement. The psychiatrist
showed no interest in consulting with the social worker. After the
patient's escape the psychiatrist discussed the case for the first
time with the social worker, in order to find out what could be done
to bring the patient back to the hospital, but left it to the social
worker to work out the final arrangements with another doctor. Once
the patient was back in the hospital the psychiatrist lost interest in the case. The social worker continued her contacts with the patient.

In those instances where the difficulties stemmed from the resident's and new psychiatrist's handling of a case, the social workers all felt that the problem was a temporary one which could be worked out easily with the psychiatrist by explaining to him the clinic's or hospital's policy and the social worker's functions. The problem in this group were mainly the psychiatrist's interference with the social worker's job by contacting the family, community or schools without the worker's knowledge. As one social worker put it:

Some times the psychiatrist in training contacts the school or family physician without the parent's permission and without previous consultation with the social worker. He not only interferes with the social worker's work but also usurps the family competence. Such problems can be handled easily in an informal conference.

The following table shows the type of social work function interfered with by the psychiatrist:

<table>
<thead>
<tr>
<th>TABLE 4</th>
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</thead>
<tbody>
<tr>
<td>TYPE OF SOCIAL WORK FUNCTIONS INTERFERED WITH BY THE PSYCHIATRIST</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Type of Function</td>
</tr>
<tr>
<td>Intake with family</td>
</tr>
<tr>
<td>Discharge of patient</td>
</tr>
<tr>
<td>Contact with family, community, school, etc.</td>
</tr>
<tr>
<td>Insistence that social worker should get specific information from client regardless of how it affects her work with the client.</td>
</tr>
</tbody>
</table>

Some examples of cases may best illustrate these complaints. The following illustrates a psychiatrist's interference with the intake process:

In one hospital the social worker does the intake interview with the family. After the social worker had had her intake interview with the family, the psychiatrist in charge of the patient
asked the relatives to his office and interviewed them for two and
one-half hours, getting the same information as the social worker.

In all three instances where the social worker felt there were problems
around the intake interview, they mentioned that the psychiatrist's inter-
ference was due to his lack of trust in the information the social worker
could obtain and his feelings that he had to do it himself in order to have
it well done.

Conflict and bad planning around discharge is shown in the following
two cases:

The psychiatrist discharged a patient who the social worker
felt was not yet ready to go back to work. The social worker was
asked by the psychiatrist to find a job for the patient and did so,
although she made it clear that she did not agree with the psychiatrist's
decision. The psychiatrist insisted and the patient was discharged
but was back in the hospital a few weeks later.

The social worker went along with the psychiatrist's decision despite the
fact that she was not in agreement with it, as she felt that the psychia-
trist would learn from his own experience by seeing the patient come back
to the hospital. In other cases, the problem becomes more intricate.

An older patient in a mental hospital was discharged by the
psychiatrist and sent home alone without having previously con-
tacted the patient's family or the social service. All family
members were at work and nobody was at home when the patient ar-
rived there. The family was surprised to find the patient home
in the evening. The next day they brought the patient back to
the hospital complaining to the social worker about the handling
of the discharge. The social worker then was asked by the psychia-
trist to make other arrangements for the patient's discharge.

Such problems around discharge do not seem to be too unusual. Most of the
social workers who stated discharge as one of the problems they encountered
in working with psychiatrists mentioned similar experiences of being left
out of the discharge planning until it had failed. Many also spoke of
patients with whom they had been working for a long time being discharged
by the psychiatrist without being told about it. In connection with dif-
ficulties around discharge a social worker gave the following opinion:
Psychiatrists often naively invade social situations of which they know nothing. When the psychiatrist is through with therapy he wants to discharge the patient and the social worker should help find a job. However, the patient is still disoriented and incapable of working. He presents himself for job interviews in the most unfavorable light and is scared to death, as he is socially not yet able to go back. The psychiatrist should not discharge a patient without giving him reassurance and guidance, and planning closely together with the social worker. Many employers also ask for a doctor's written statement that a patient is well enough to work which the psychiatrist often is unwilling to give. The psychiatrist should not make any social opinion without taking responsibility for it.

As for the other two problem areas it seems that they occur more frequently with psychiatric residents who have not yet gained a clear understanding of their's and the social worker's respective functions. The psychiatrist's overidentification with the patient appears often to be a source of difficulties in the working relationship, as it leads to an inability on the part of the therapist to accept an objective picture of a case. This problem was described by a social worker in the following way:

At the beginning the psychiatrist has a tendency to tell the social worker what to do because he overidentifies with the patient. The social worker then has to convey to him that this does not work. Sometimes it is hard for the psychiatrist to tolerate the mother's behavior. In these cases discussion on a supervisory level can help because there are two people who are more objective, since each worker has a tendency to identify with his client.

How are these conflicts generally solved? There are some settings where social service is perceived as one of history taking and specific practical actions. In those instances the social worker is carrying out the psychiatrist's requests for the patient. There is little communication between her and the doctor on the patient and she has almost no part in the treatment. In case of conflict, there is little a social worker can do in such a setting other than offering better services if contacted in time.
In those hospitals and clinics where the concept of team-work exists, e.g. of communicating and sharing information on a case with each other, the social worker will try to come to an agreement with the psychiatrist by discussing her different viewpoint first with him. If this does not work the matter is usually taken before the supervisor. It seems very rare that an agreement cannot be reached on a supervisory level. However, if this is the case, the hospital's or clinic's administrator is consulted as a last resort. Two senior social workers expressed their readiness to go along with a young psychiatrist's decision, even if they disagree, since they feel that he will learn more from his own mistakes than from an argument with them. They feel that their working with the doctor is more important for the patient than to fight with the psychiatrist on minor issues. However, they too recommend that a major conflict should be discussed on the supervisory level.

A last suggestion to avoid arguments with the psychiatrist was to avoid working with a psychiatrist with whom the social worker had a bad previous experience. Many social workers are able to accept or refuse a case assignment and one of their criteria for this decision is the psychiatrist with whom they are supposed to work on a case. The following two comments on this subject may serve as an illustration:

If I feel that the psychiatrist will not consider me I am not going to be active on a case.

At our hospital we have the choice of the psychiatrist we want to work with. If I had an unfavorable experience I do not want to risk to work with him any more. Therefore, I have had mostly good experiences with psychiatrists.

When we asked about the differences in working with a young or older psychiatrist, seven social workers felt that it was not so much the age as the amount of experience a psychiatrist has had with social work that
mattered. Good cooperation is more quickly established with the experienced psychiatrist than with the psychiatrist to whom social work is a new field. Four social workers commented on the greater ease in working with older psychiatrists. Five social workers said that they could not make the comparison. Zander states that "it is the less confident psychiatrist who is most ready to minimize the competence of the social worker." We may well assume the psychiatric resident to be less confident than the psychiatrist who is well established within his profession. We also noticed the social worker defining the psychiatrist's personality difficulties in terms of his insecurity. This makes us believe that Zander's statement helps us to understand some of the difficulties in interprofessional relationships which we have discussed in this study.

**Psychiatrists' attitudes towards Social Workers as described by the social workers**

Despite the negative experiences and certain feelings around the psychiatrists' understanding of social work, which the social workers interviewed might have had, their first and general response to the question about psychiatrists' attitudes towards social workers was a positive one. The psychiatrists' attitude was described as a friendly one, showing respect and recognition for the social workers' contribution in working with human beings and their problems. The psychiatrists' higher professional status was pointed out and appeared to be for all social workers a well accepted fact.

However, the social workers criticised the psychiatrists for not trusting them enough in their ability to work with a client around certain problems and situations. One social worker mentioned the psychiatrist's

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agitation when a client of hers showed signs of pathology; the psychiatrist suggested that this client be referred to a psychiatrist although he knew perfectly well that a psychiatrist was not able to do more with the client at that particular point than what the social worker was doing. This reaction by the psychiatrist was termed by the social worker as "not an unusual experience." Remarks made by psychiatrists such as "your intuition is right", or "I will not be able to do much with this patient, let's send him to the Family Service Association to find him a job", give the social worker the impression that the psychiatrist tends to devalue her work and professional knowledge.

Another objection raised was the employment of social workers as a substitute for psychiatrists. The resulting attitude towards the social worker is then one as towards a second-rate psychiatrist. In general, the social workers made a clear distinction between the psychiatrists' and their own contribution. Social work was perceived as a separate field from psychiatry, even though both professions have the same goal of helping people. Social workers resented their being mistaken as second-rate psychiatrists and they also resented the psychiatrists' expectation of them to do sometimes more in terms of therapy than what they feel capable and willing to do. They generally agreed that although doing psychotherapy under the close supervision of a psychiatrist is an interesting experience, it is not the social worker's function and should not be confounded as such by the psychiatrist. This was expressed in the following two comments:

I worked with a patient under the psychiatrist's supervision. I felt like in the depths of stupidity. He was helpful in clarifying the dynamics but literally led me by the hand. I finished by doing rather the work of a doctor than of a social worker. It was an unusual and interesting experience.

Sometimes psychiatrists hope that social workers could do more
than we are really equipped to do. For instance I remember a case where the psychiatrist wanted me to get into unconscious repressed material which he thought should be brought out. It is necessary for the psychiatrist to realize that he has to work along in terms of what a social worker can do.

However, the social worker is often left to work with those patients whom the psychiatrist considers "unworkable" and refuses to take into treatment. Even though such a referral is often made for good reasons, - for instance the patient may be able to make use of some help with his environmental adjustment but not with psychotherapy - this is not always the case and the social worker is sometimes left with a client whom the psychiatrist considers not good enough for his efforts. This is quite frustrating for the social worker and she feels often threatened by these very trying patients who ask a great deal of her in terms of time and effort with little obvious results. One social worker expressed her concern quite clearly:

It can be discouraging for the social worker if the psychiatrist refuses to take up a case because the patient is too sick. Then the social worker either has to continue on her own or the case is thrown back into the community. Many deeply disturbed patients do not accept referral to another clinic. The psychiatrist does not make home visits and the patients who cannot come to the hospital are only seen by the physician or the social worker even if they have deep emotional problems which need treatment.

Other social workers were more accepting of working with the "unworkable" cases. The following two comments may illustrate this:

Some social workers work with patients who are not in therapy - often with psychotic patients. There the social worker is free to develop her case as she likes. We often try to pick up the schizophrenic patient on the ward who because of the degree of his sickness is often the "lost soul" in a hospital.

The doctor turned the treatment over to me because he was a chronic patient who needed a lot of community planning and did not function on an intensive therapy level. In that case I was thought to be of more benefit to the patient although these are in no way easier cases. In these cases we get just social work supervision, which usually is enough.
The social workers' response to the question about the psychiatrists' attitude towards them was generally a rather positive one. The following comments may serve as an illustration:

The psychiatrist's attitude towards the social worker ranges from necessary evil to very helpful.

Status-wise the psychiatrist regards the social worker as lower on the totem pole, however, he shows respect for the social work profession and for its contribution.

In general the psychiatrist sees the social worker as performing a useful kind of service; but he is not always aware of the extent of the social service's functions.

Psychiatrists show a great deal of respect - there is a feeling that social work has something different to offer.

Rather condescending - sometimes the psychiatrists seem to have to prove their own status.

On the whole positive, in accepting social work as part of the game.

Acceptance in terms of their feeling that it makes their job simpler.

Psychiatrists do recognize social work contribution. They make full use of it. I get many referrals from the psychiatrists.

Psychiatrists regard social workers as respected colleagues with areas of competence which overlap with psychiatry. There is a fairly mild degree of underlying and unrecognized tendency to regard social work by virtue of its non-medical status of lower status. This is not bad in itself. Social work does not need to be treated or regarded as alike or equal to psychiatry.

In this section of the chapter we have of course to keep in mind that the social workers' responses were influenced by their personal perspective of the social work profession and its role in relation to psychiatry.

Zander et. al. discuss this aspect in their book Role Relations in The Mental Health Professions. They point out that the social worker who "has a high professional knowledge and skill relative to psychiatry demands from the psychiatrist greater admiration and respect; she wishes to be treated more as an equal. When she perceives herself to be low in ability she is
willing to assume a more dependent relationship". 7 From our study we got the impression that the social worker who had a senior position was in general less alarmed by negative experiences with psychiatrists. Her attitude towards these experiences was one of trying to improve the teaching of social work to the psychiatrist. She also was more apt to deny any problems of her own in regard to the working relationship with the psychiatrist and to stress the differences between psychiatrists and social workers. The less experienced social worker seemed to expect more leadership from the psychiatrist and to be more openly frustrated when this leadership did not come forth. Her readiness to blame difficulties in her relationship with the psychiatrist on his use of authority and unwillingness to try to understand social work functions, rather than to blame it on his personality structure, was greater. Also, she seemed to have a greater tendency to stress the teaching functions of the psychiatrist to the social worker than the more experienced social worker. However, these observations cannot be taken too seriously in a small study of sixteen interviews. The limitation of our sample does not permit us to draw any definite conclusions.

**Conclusions**

In reviewing the material presented in this chapter we can see that social work is trying to find its place in relation to the profession of psychiatry. Some of the social workers interviewed were employed in settings which were highly organized in regard to interprofessional relations, where there was an excellent understanding of social work and the other related disciplines and where the cooperation was based on a mutual respect.

7 Zander, op. cit., p. 25.
for each other's contributions. However, the social workers' experiences showed that this is not yet the case everywhere. Many a hospital and many a psychiatrist still conceives of social work as carrying out specific tasks for the client. Social work is still trying to define its own role and to interpret its functions to the other disciplines. Most of the interpretation takes place in the hospitals and clinics. Through an increased emphasis on the team approach, social work has been able to do its interpreting and teaching right on the job, and thus to obtain greater acceptance of its contributions from the psychiatrists. If we look through the literature on the professional relationships between social work and psychiatry we will find that most of the articles written on this subject deal with the division of functions in the team. The clear perception of the areas of work and competence of related professions certainly is of importance in helping to achieve smooth cooperation. However, the number and variety of articles on this subject is an indication of the controversies and difficulties inherent in it. Our study shows that some overlapping of functions can hardly be avoided and sometimes even redounds to the benefit of the patient-client. The writings on interprofessional relationships contain relatively little material on methods of communication, authority relationships and areas of controversies, although an understanding of these factors seems to be as important to a good working relationship as a clear understanding of each profession's respective functions.

Another aspect of the relationship between the psychiatrist and the social worker which has not yet been fully explored is the use by an agency of a psychiatrist as a consultant. More and more agencies are employing psychiatric services and consultation for their staff and clients. Although the problems of interprofessional relationships are in this case
not as intricate as in a team approach, certain questions as to how to use consultation best, and when to use it, arise. Our study did not permit a thorough investigation of any of these questions. But it seems to us that these areas might be of interest for further research in the field of interprofessional relationships.
CHAPTER IV

INTERPROFESSIONAL RELATIONSHIPS OF SOCIAL WORKERS
WITH CLINICAL PSYCHOLOGISTS

Introduction

When social workers talk about the mental health professions, they usually mention psychiatrists, clinical psychologists, and social workers in one breath. The importance of professional relationships among these "big three" is also recognized in other ways. For example, psychiatrists, psychologists, and social workers make up the membership of the American Orthopsychiatric Association.¹ Professional and other literature deals with these groups. Thus, it is appropriate to investigate the relationships between two member-professions in this group, the social workers and the psychologists. As a way of limiting scope so as to deal more thoroughly with the topics, this study speaks mainly from the social workers' point of view. The discussion will deal with the sample, settings and division of functions, authority (or equality) relationships, the communication process, attitude and prestige factors, noteworthy experiences and problem areas, and a comparison of this study with other literature.

The Sample

Seventeen respondents answered, in interviews lasting from one and one-half to two and one-half hours, a two-part questionnaire. This chapter

covers only the first part of the questionnaire. The second part will be discussed in Chapter VI. The last fifteen respondents answered a questionnaire which was somewhat altered from the questionnaire administered to the first two respondents. In other words, a "pre-test questionnaire" governed the first two interviews. A slightly altered, but in the main similar, "revised questionnaire" governed the last fifteen interviews. A copy of the revised questionnaire appears in the appendix and will hereafter be referred to as the questionnaire. All the respondents' answers are felt to be valid and so are included in the sample.

What are the characteristics of the sample group? In regard to personal characteristics, fourteen of the seventeen social workers interviewed are female, and twelve of the seventeen are currently married. Fourteen hold master's degrees in social work; three do not. But all have had at least one year of graduate study in a school of social work. The range in years of social work experience is from 27 years at one extreme to 1/2 year at the other. The median number of years of experience is 6. (These calculations do not include social work experience prior to professional training). As a group the respondents have had contact (and this may mean either written, telephone, or face-to-face) with psychologists on 2,197 cases, according to their estimates. This includes a range from 427 cases to 1 case, with the median estimated number of cases being 50. Referring to totals, the estimated number of psychologists they have had contact with ranges from 60 to 1, while the median number is 10. One complication arises in regard to this last set of figures: some respondents regarded psychology trainees (people working towards the master's or Ph. D. degrees in psychology) as psychologists with whom they had contact about a case. In ranking professional groups according to amount of on-the-job contact they have
had with their members, they placed the psychologist fourth when compared with nine other professions: lawyer, minister, nurse, occupational therapist, physician, psychiatrist, school teacher, social worker, and undertaker.

It is pertinent to know the backgrounds of the social workers whose reactions to psychologists are investigated here. Ten actually worked in another field besides social work or had some training in another field. All but four of the social workers can be said to be satisfied with their profession; that is, they said that if they had to make the decision over again they would decide to go into social work. Significantly, none said he would choose psychology when remaking the decision.

No more than two workers were interviewed in any one agency, with one exception. The eighteen jobs held (for one worker was simultaneously employed in two agencies) included four in clinic settings, four in child placing agencies, three in mental hospitals, three in family service agencies, and one each in a general hospital, vocational rehabilitation agency, public welfare agency, and in an agency serving a group of disturbed children with a special handicap. Four agencies are located in St. Louis; the other thirteen are located in Boston. No differences due to the section of the country are noticeable. This, then, covers the current employment of the respondents from which most of the examples and data are taken. Most of the workers had had experiences in more than one type of agency, however, and the other agencies in which they worked had some influence on their views. So, including both present and past employment, eight reported work in child placing, six in a clinic, six in a mental hospital, six in family service, four in public welfare, four dealing with special classes of handicaps, two in research, two in school social work, two in a general hospital setting, and one in vocational rehabilitation.
Settings and Division of Functions

Patterns of Relationships

Close inspection of the data reveals that in many instances certain characteristics of settings and division of functions are associated. Some of the related factors are the type of agency, the service offered there, the number of psychologists and social workers employed, the frequency of interprofessional contacts, and therapeutic methods. The type of relationship between social workers and psychologists seems to be affected by all these things. Hence, on the basis of qualitative and quantitative differences in these characteristics, different patterns of relationships emerge. Six clusters of related factors, or patterns, are distinguishable. Though the patterns involve such things as type of agency and different ways of doing therapy, the most important feature of the patterns is the type of relationship between the social workers and psychologists. The ways in which social workers and psychologists relate are abstracted (idealized) in the patterns. The idealized patterns, however, are based on relationships actually described by the respondents. In actuality one agency may be at the same time employing more than a single pattern. In the sample, only one agency exemplified fully the relationship of the idealized fourth pattern, though several agencies had a number of the characteristics of pattern IV. The other patterns (idealized representations of factors from the data) are based on more cases.

Pattern I. This relationship pattern occurs in an agency where social work is the primary service offered, and the worker refers cases to psychologists, who are in public or private agencies or in private practice. Referrals are mainly for testing. The social worker has few face-to-face contacts with the psychologists used, but the number of different psycholo-
gists with whom there is some type of contact (especially written or telephoned) may be greater than the number of psychologists workers come in contact with under pattern II. In pattern I, money is paid to the psychologist for each person he sees. The psychologist is a consultant only. It is up to the social worker's discretion when to refer to a psychologist and how many of his suggestions to follow.

**Pattern II.** This relationship pattern also occurs in an agency where social work is the primary service offered. But for convenience, a psychologist is employed by the agency (usually part-time) as a consultant on certain cases. The social worker decides when to consult the psychologist (although a psychiatrist or supervisor may help the worker decide) and how many of his suggestions to follow. Or the agency may have set up some criteria so that cases falling within certain categories are automatically referred. But the social worker decides what to use from the psychologist's material. Contact is usually by phone or written, for most of the workers, but there may be one or two semi-supervisory social workers whose job it is to read all the test reports that come from the psychologist. Most of the workers will have few contacts with a psychologist about a case, and the number of psychologists they know will be quite small as the agency will employ only one psychologist at a time. This pattern may be found in family service or child placing agencies, for example.

**Pattern III.** This type of relationship is affected by the fact that social work is one of several services which may be offered to clients. Psychiatrists and psychologists also offer service to patients; in addition, depending on the specific setting other groups may also serve clients. Social workers, psychologists, and psychiatrists might all do therapy, but a single client would have only one therapist. Or, the different disciplines
may offer different services (as well as therapy) so that a patient or client would be seen by more than one of the professions concurrently. The latter would be particularly true of the intake procedure. Despite the fact that all of this is going on, the social worker uses the psychologist only as a consultant, as did the workers in patterns I and II. However, contact is more likely to be face-to-face, and consequently there are more opportunities for informal contacts. There are a number of psychologists employed, so the worker's acquaintance with psychologists as a group may be large, though the number of psychologists with whom the social worker has contact about a case may remain relatively small. As before, the social worker decides (perhaps with the help of others) when to use the psychologist and the extent to which his suggestions should be followed. This pattern would often be found in a hospital or clinic.

Pattern IV. The type of relationship designated as pattern IV is also affected by the fact that the services offered by the social workers are among services offered by other professional groups. But the relationship is different from the pattern III type, for two therapists, who may be social worker and psychologist, work with different members of the same family and confer with each other as they go along. They meet fairly frequently over a long period of time. Each has primary responsibility for the family member he sees, but the therapists feel they benefit from communicating with each other. There will be a number of psychologists in such a setting, increasing social workers' opportunities for contacting them informally and about cases. Ideally the two therapists are equals. If one therapist tries to be boss, trouble develops. The different professions are not distinct, though testing remains a unique function of the psychologist. But testing is not the psychologist's primary function here.
In this study there was only one agency that fully conformed to the pattern IV relationship, a child guidance clinic. The mental hospitals, however, had some of the aspects of pattern IV.

Pattern V. Because group therapy is offered, a different type of relationship from those described earlier results. The requirements of group therapy influence the ways in which the psychologist and social worker work together. The social worker, who is a group leader or group observer, is performing tasks which the psychologists (and sometimes others) also perform. Main responsibility for the group therapy program would not be taken by the social worker. Contacts are usually face-to-face, and there are many opportunities for contacts. One mental hospital gives an example.

Pattern VI. As in pattern V, the relationship between social worker and psychologists is affected by the practice of group therapy. But within pattern VI their method of working together differs from the above in that the tasks of the social worker and psychologist remain differentiated. The social worker sees the patient in individual casework treatment but the patient is also a member of a group which is led or observed by a psychologist. The social worker and psychologist must agree about the treatment of the patient. Thus, the method of working together and consequent relationship has resemblances to pattern IV as well as to pattern V. A clinic in the sample gives an example of the relationship developed within pattern VI.

Functions Performed by Social Workers and Psychologists

What are the functions performed by the social worker and the psychologist working as individuals? When social workers and psychologists work together, how are their functions divided? Basically, most of the respondents said that social workers did social casework. A few mentioned history-taking as a special function. Two social workers were doing work with groups at the time. One social worker mentioned evaluation as a specific social work
task and another mentioned social action in this way. One social worker, when asked what the psychologists mainly did and what the social workers mainly did, answered by enumerating tasks of the psychologist, but told about social workers' jobs in terms of process and goals. She explained the difference in her descriptions by saying, "I guess I view social work less objectively; I have more experience with social work." The viewpoint verbalized by this respondent could also be attributed to other workers in the sample, on the basis of their replies.

In regard to the work usually done by the psychologist there was much agreement. Testing was the answer given by every respondent who was asked the question. And when this question was not asked the respondents indicated in other parts of the questionnaire that they regarded testing as the psychologist's work. Even a social worker who had never referred one of her own clients for testing, but worked with psychologists who did therapy, responded with the stereotype of testing. A lesser number of social workers said that psychologists did individual therapy, in addition to testing. Two mentioned the psychologist's function in group therapy, and three mentioned his position as researcher. Two workers said the psychologist had a teaching function, and one mentioned his part at staff meetings. Obviously, the social workers were in part reflecting the way they worked with psychologists rather than describing all the things psychologists really did. For example, one social worker with almost no personal contact with psychologists (she was from a pattern II setting) seemed surprised when asked about psychologists doing treatment. She said she had never thought of it before because she had thought of the psychologist as having "a specialty of testing." Thinking about it, she said, "I've never considered the psychologist as being familiar with treatment. Probably she is. She
would have to be." What social workers see psychologists as doing differs
from what psychologists see themselves as doing. 2

As would be expected from the previous answers, the modal reply to
the question, "When the social worker and psychologist work together, what
jobs are usually done by the psychologist and what jobs by the social
worker?" was that in working together social workers did casework and psy-
chologists testing. Following this the question, "Is this satisfactory or
should there be some better way of dividing up the functions?" was asked.
The majority of workers who answered this question found the status quo
satisfactory.

A more detailed and accurate picture of functions is obtained by ask-
ing the respondents about the last occasion they had to work or consult with
a psychologist about a client. Why was that last contact made by each worker?
Some of the contacts were for combined purposes. But, singly or combined
with other services, testing was the service requested by fourteen social
workers. Of these, eleven social workers were interested in diagnostic
testing; two were interested in vocational testing; and one was interested
in both. The other purposes concerned miscellaneous matters. In addition,
as a check, the workers were asked if their last contact with a psychologist
had been for a reason typical of the reasons for which social workers con-
tact psychologists. Most of the respondents felt the last contact was for
a typical reason.

2 Richard Boyd, "Clinical Psychology," Paper submitted to
United States Congress through the Joint Commission on Mental Illness
and Health, 1957, p. 2.
At one time or another, most social workers insisted that diagnosis by a psychologist must be only a supplement to and not a substitute for their own diagnosis. Thus, some time would elapse before a psychologist received a referral from a social worker. As one worker put it:

I don't get Minnesota Multiphasic Personality Inventory (MMPI) results until I have my own clinical picture, developed in four interviews. Or if I feel I have none I can get the psychologists. I don't want to depend too much on psychologists.

In replying to questions about the reasons for which social workers contact a psychologist and vice versa, eight workers indicated they used the tests to verify their own ideas. Here are some comments:

I got the psychologist to reinforce my own feelings.

To help verify diagnosis.

Tests were available to confirm it if you think there is a problem.

Social workers apparently do not believe a test can do anything that they cannot do.

Other reasons for contacting the psychologist included finding a therapist capable of achieving rapport with a client, discussing group therapy, talking to a psychologist on a team, or referring a client for therapy.

There was more consistency among the respondents when they gave the reasons why a social worker contacts a psychologist than when they gave reasons why a psychologist would contact a social worker. Social workers are more familiar with the former situation. Fourteen respondents indicated that they were the ones to make the first contact with a psychologist on the last occasion they had to work or consult with a psychologist about a client. In the three remaining cases, however, the psychologist did not initiate contact. Rather, the contact came about through a third party or as part of a regularly scheduled meeting.
Only a few social workers agreed on any one reason for a psychologist to contact a social worker. The reasons on which there was some agreement are: talking to a social worker about a research or group therapy project, referring a client who needs casework, getting information from the social worker about the patient, asking a social worker about a community resource, and discussing or consulting the worker about treatment or issues.

Still another cue to the division of functions comes from the way workers said they would describe the profession of psychology to a lay person. Here there is a wide range of answers. Of the ten workers who had this question put to them, nine said the psychologist was a person who did testing, and some of them stressed it especially. Only five respondents, when they answered this question, described the psychologist as doing therapy. Yet this idea had been brought up earlier in most of the interviews. Four respondents mentioned the psychologist as a research person. Four mentioned his powers as a diagnostician. Four mentioned in a general way that psychology studies people and behavior – the closest to acknowledging its scientific aspects.

To discover where functions are similar and where they overlap, the question, "Do you feel you could do any of the things a psychologist does?" was asked. Eight workers bluntly said they could not do testing. But two workers thought they could give simple tests, having had some training. Yet despite the fact that most of the workers did not feel capable of doing testing, there was a reluctance to trust testing to the psychologist. One social worker said, "I want the technical data [from the tests] even if I don't understand it." This worker wanted the raw data, not merely the psychologist's interpretation of it, even though the worker admitted not understanding the data. Two other workers said they could do nothing at all
of the things done by a psychologist. Obviously, they were not thinking of
the psychologist as a therapist similar to themselves. Both of these
workers were in pattern I and pattern II settings and had had little per-
sonal contact with psychologists. Eight workers said that they could do
individual therapy as the psychologist would do, and three workers said
the same thing about group therapy.

As the replies to various questions having to do with social work and
psychology functions show, there is some confusion about the role of the
psychologist. Sometimes a particular respondent mentioned therapy or re-
search or other roles in an answer to one question whereas he would leave
it out elsewhere. The one idea that is firmly fixed in the minds of the
social workers, however, is that the psychologist is a tester.

Authority Relationships

Several questions were asked of the respondents in order to focus the
authority relationship picture. To the question, "Does the psychologist
ever make plans for clients you are both working with?" all the respondents
who were asked this said he did not. It was reiterated that the psycholo-
gist never makes plans; he only makes suggestions which the worker is free
to accept or reject. In many cases the suggestions would be only vague and
general.

Most of the workers felt that the suggestions psychologists did give
were realistic. How they would handle unrealistic suggestions, however,
might give some indications about authority relationships. What did
workers say about this? A worker in a pattern I setting indicated she would
not pay much attention to unrealistic suggestions. She has some control
over the psychologists, however: "I have to get the letter or I can't pay
the bill." She could pick the psychologists she wished to employ. By and
large, suggestions regarded as unrealistic are simply ignored. Here is an illustration from a worker in a pattern II setting:

A recommendation was made by a psychologist after a test on a retarded child. Regular counseling was recommended. I saw her infrequently because she was highly excitable - I felt it was treading on dangerous territory. My supervisor supported this.

What would happen in a different setting? More direct action on unrealistic suggestions is seen in a pattern IV setting:

If (it) were not in the way of the case, I would point out the pitfall. If it actually is a bad fault, I would admit it to the parent, as, I feel has made a mistake and I don't agree with him.

When psychologists do not give satisfactory reports in a pattern III setting, there seems to be no tendency to report this to the psychologist's supervisor although this could theoretically be done. Social workers in the sample liked to feel they were equal in power to the psychologist and free to accept or reject what he says, on the basis of the worker's own judgement. In pattern I, II, and III settings this is easily done. In pattern IV and VI settings it is more necessary to cooperate. Hence the one pattern IV worker would go to the psychologist about an unrealistic plan. Another worker (in a pattern VI agency) said:

There are joint decisions and conferences. The psychologist and social worker would decide equally. This refers to cases when the client is in individual therapy with a social worker and group therapy with a psychologist. The social worker and psychologist would have small conferences about it. They always manage to agree. They would talk it over until they did agree. They can't go on with a basic difference of opinion between them. But this has never happened - they always agree.

The social workers denied that psychologists had authority over them. This was demonstrated in the previous question. In one case a social worker said that social workers doing group therapy were supervised by psychologists, but made light of this. It seems that even when psychologists have
some measure of authority social workers are reluctant to accept it. One respondent said, in regard to psychologists exercising authority over social workers:

No, I've never seen this. The only thing close to it is in research. The psychologist heads it up and gets after us to get data in on time. I do not think of it as real authority. But we are responsible to him. Oh, I guess if we didn't get it done he'd go to the chief social worker, she'd get after us.

Another respondent in a pattern III setting said:

I have never been in a place where psychologists had authority on paper over social workers. But I have worked where there was a recognition the psychologist was the head of the project and we paid attention to what he said....The psychologists started group therapy. Someone had to take the lead.

One social worker stated definitely that it is the psychiatrist who has the authority, rather than either the social worker or psychologist, and other workers echoed this. That would be typical of a pattern III setting, for example.

Another measure of authority might be how readily the social worker can get hold of a psychologist when he wants him. All social workers answering this question with but two exceptions said that psychologists were easy to get hold of. Some social workers remarked that they themselves were more difficult to get hold of than was the psychologist. In answering the question, "Is it easy or hard to get hold of a psychologist if you want to discuss something with him?" a selection of the workers said:

Easy. The most recent case was tested the same day. We had a brief discussion the first day. I had the full report in three days. Just this week I asked to look over certain things in the test for certain dynamics....He said, "Sure, any time." They're right there ready to do it. They don't have as much pressure as we do, and he responded very nicely.

It is much easier than with other people. Because they're next door and more often in their offices than doctors.

Very easy. I call the switchboard. I ask if Dr. ___ is
testing. That was when her office was on a different floor from mine.... Now that we're on the same floor I just drop in.

In one setting, where the worker described how easy it was to get hold of a psychologist, the second worker interviewed said, "Very difficult."

He then gave an example:

A psychologist was supposed to help me select criteria for selecting patients for my groups. The time we were to meet was set at a party. (We were both a little under the influence). The next day he didn't keep the appointment. We made another appointment which he didn't keep.

Possibly some projection enters into this worker's opinion as the second worker did not like psychologists as well as the first worker.

Another possibility in judging authority, although one to be used with caution, is by means of looking at the required recording, finding out who has access to the records, and by examining the attention paid to what each professional person says.

What about accessibility of the data? Seeing data can be considered a privilege. Certainly it means that the person allowed to see records is trusted and respected. How do psychologists and social workers compare on this important point? Six workers replied that data are more accessible to the social worker. Workers who said this represented patterns I and II. Five workers (the others were not asked this question) said that data are equally accessible to both. They represented patterns II, III, IV, V, and VI. This is what one pattern II worker said: "The record is never available to the psychologist but it is made available to the psychiatrist."

In another place she said, "The psychologist would never see [the full study and diagnostic treatment statement]." A pattern I worker reported:

The psychologist doesn't ask me for information. I just tell Mr.____ a few things. I talk on the phone to Dr.____. I feel free in conversation with her. But I don't really have a great deal of private information. When I do have private
In theory it is confidential. But it would vary. I might tell the psychologist. I have to resist gossip. But it is almost beyond me not to hint. When it is colorful it is awfully hard.

In many cases, as in many pattern III settings, all the information about the patient is kept in one folder, available to all professional people who help the patient. No worker said that any data was more accessible to a psychologist than to the social worker. It stands to reason that when the social worker mainly uses the psychologist in referrals of her own patients, records are equally available to both.

The attention paid to the material recorded by each professional group might also be a mark of authority and of prestige. Nine social workers were specifically asked about this. Two said that more attention was paid to material recorded by the social worker. One said that social workers themselves paid more attention to social service reports, but that other people, such as doctors, might not. Three workers stated a belief that more attention is paid to the psychologist's report.

That is because his material is more tangible and concrete.... From the psychologist's report at a glance you can get the IQ, factors in the personality and diagnosis. His material is more concise and more decisive. But the social work recording seldom comes up with something you would just pick out of the recording, said one respondent. Five workers thought equal attention is paid to the material of both. Thus, on this point, equality of authority and prestige is suggested by the social workers' replies.

The Communication Process

In talking about the communication process, there will necessarily be overlapping between this and other topics, such as authority relationships. The picture that social workers have of the psychologist's functions, presented earlier, is based in part on the communication process. Recording,
also discussed earlier, is another example of this interrelatedness, for recording is an important method of communicating in the mental health professions.

One aspect of communication concerns the amount of time social workers and psychologists spend communicating. When queried about the last case on which they worked or consulted with psychologists, the workers told how many times they saw the psychologist about the client and the total amount of time spent with the psychologist (or making a written report for the psychologist). Some workers were also asked about the amount of time they planned to spend on it in the future, with the psychologist. The number of times there was contact with the psychologist ranges from 16 to 1. Sixteen, however, was an unusual number. It was reported by the worker in the pattern IV setting. The median number of times there was contact with the psychologist is 1.5. The total amount of time that had been spent on this last case ranges from 240 minutes (by the pattern IV worker) to 5 minutes (by a pattern I worker). The median is 55 minutes. Some of the workers talked about the time they anticipated spending with psychologists on the case in the future. The pattern IV worker said, "I anticipate three years on the case." Figuring on conversations approximately once a week for about fifteen minutes each, that would bring the anticipated total expenditure of time up to about 43 hours. The other workers who anticipated spending more time with the psychologist about the case estimated from 2 hours to 5 minutes more. It can be seen that most contacts are relatively brief.

The respondents were asked about formal and informal communication. Eleven workers reported formal contacts by means of individual appointments. Nine workers (all of whom also had individual contacts) reported that they attended some type of meeting regularly with psychologists. Other
professions might be included, as at grand rounds at a hospital. Eleven workers reported various types of informal contacts with psychologists such as eating lunch together. One worker remarked that psychologists were more enthusiastic about getting together with social workers than psychiatrists were. The psychologists would show up in the greatest numbers at parties. On the other hand, another social worker remarked that there was not much social mixing of social workers and psychologists; he regretted this. The worker who talked about the many parties is in a pattern III setting; the worker who regretted paucity of informal contact is in a pattern I setting. Three workers reported either very few contacts with psychologists or said their only formal contacts were of a written nature. The data support the patterning of relationships, as described earlier in the chapter, when the patterns were first introduced.

What kind of communication does this time spent produce? Ten respondents were asked how many psychologists they thought had a good understanding of the social worker's role. Collectively, they knew about 117 psychologists and estimated that 103 of the psychologists understood the role of the social worker. In the same vein, a question was put to the workers about the number of psychologists (estimated) with whom they felt they had a good working relationship. A group of nine workers who had carried cases resulting in contacts with 146 psychologists estimated they had a good working relationship with 130 of them. This is a good percentage. One worker described it this way:

I had a good working relationship... We would set up the thing for tests and so forth. We talked together about the time difficulties (if I had to have it by a certain time). We would make conversation and so would they. That helped. We talked about the tests in regard to what we were looking for and what made me particularly interested in having it done.... As I got the test results I would put the conclusions of the results into practice - the psychologist helped me do this. They would
suggest different little things they felt would be particularly helpful. (She gave an example described as "noteworthy."

If you know someone pretty well and you know how they think and feel, you feel freer in talking; there is less constraint and more—well, they have a better idea what you need to know and you know what they want to go on. . . . The five [psychologists] would say, 'I think you'd be particularly interested in hearing the responses to this item in the test.' They told me particular stories to the TAT cards. They could see it had meaning. . . . The psychologists I did not know well would say, 'The general response to the test was . . . . This lacked the intimate details. The ones I knew well shared things like, 'He seemed nervous and squirmed in his chair with me; did he do that with you?' They often gave me little tidbits of history. I got only a perfunctory understanding from the [psychologists] I did not know well.

Social workers were specifically asked if it ever happened in their experiences with psychologists that they talked past each other. Most of the social workers responded to this question by telling about the difficulties or ease of understanding psychologists. Few looked at it from the psychologist's viewpoint, considering the difficulties they might be giving the psychologist. Here is an example given by a worker in a mixed setting (III, V, VI, and some IV), who discussed "talking past" from her own point of view:

I have a patient in individual therapy. I had a drawing that she had done. I know a psychologist who is interested in drawings by patients. I took it to him because I hoped he would give me some diagnostic information and because he was interested. We weren't communicating. I didn't get across my goals and he didn't talk about the drawing in a way I could find helpful.

He said it was an "angry drawing." I knew at the time she was angry—it was no great revelation. She was angry because I was going on a vacation. He said she'd been angry and that she will be; he threw cold water on my efforts to do anything.

About the symbolism I had some personal association of my own. The psychologist explained why it was all anger and not sex as I assumed. I tried to tell him she was talking about her mother and it was concerned with the transference to me. He saw things like targets and arrows. I saw life and death, madonnas, and other things like that. We had different ideas about what the symbols in the drawing were. There were ideas he did not elaborate on too much in regard to shading and
My associations were more personal. He based his on a knowledge of symbolism and how it is used (more intellectual).

As well as disagreement (which a few workers confused with lack of communication, perhaps on the grounds that if they understood they would agree) there seems to have been a difficulty in getting ideas across. The above worker did not learn what shading and intensity meant. Where stimuli are vague, the chances for misunderstanding are, of course, greater. But not all the workers felt they had difficulty understanding psychologists.

Some social workers said they did not understand psychologists very well but could not think of any specific thing they had not understood. Some said they did not understand psychologists' vocabulary but could not give any examples. Do social workers underrate their own abilities to understand psychologists? Are social workers responding to a stereotype that psychologists are difficult to understand?

Some social workers can remember what confused them in the speech of psychologists. One wondered what WISC meant. He knew it was the abbreviation of a test name, but he didn't know what the letters stood for. Another social worker mentioned the code used in marking the Rorschach test as confusing and did not understand the meaning of F+ or F−. Another social worker said he did not know the meaning of Gestalt, though he could remember having looked it up. One social worker did not know the meaning of interference-proneness; this word was included in the title of a lecture to be given by a psychologist.

How do the social workers handle these confusions? Some stated they would ask the psychologists questions when they did not understand. Others would go to someone else, their supervisors for instance, for clarification, or they would just use their own judgement.
The pattern or setting in which the social worker was working did not seem to be related to misunderstandings. Closer contacts evidently do not guarantee good communication.

What social workers know about psychologists on the subjects of their training, theoretical orientation, and testing procedures is both a measure of how much communication takes place and a guide to why social workers understand or misunderstand psychologists.

Most of the workers either admitted they knew little about the training psychologists received or expressed incorrect or incomplete ideas about it. But their confusion on this matter is understandable because there has been a lack of uniformity in the training of clinical psychologists. Communication would have to be very good indeed for them to have a grasp of practices in that rapidly growing field.\(^3\)

Many of the workers felt they understood the theoretical orientations of psychologists, and some expressed the idea that the theoretical orientation of psychologists was similar to that of social workers. One worker explained, "Some of their interpretations are similar to what you get from social workers." She read from a letter written by a psychologist, concerning testing on the worker's client, "Immature superego. Behavior motivated by certain things. Self-concept. How she looks on the world: cold and rejecting. [It is] what we get from the social history."

Twelve social workers felt they understood psychological tests. This is understandable in the light of the type of contact social workers usually have with psychologists. A number of workers specifically mentioned that

\(^3\)Boyd, *op. cit.*, p. 9.
they had seen tests demonstrated or had taken college courses in psychology, either as under-graduates or in graduate school.

**Attitudes of Social Workers to Psychologists**

Two attitudes that come through in great force are that psychologists are intellectuals and that psychologists, while they may have knowledge about inner dynamics, are definitely lacking in knowledge about the outside world. In addition, social workers hold the attitude that psychologists are testers; this attitude was described in a previous section.

Replies by ten of the social workers could be classified as indicating that they think psychologists are intellectuals. Here are some of their comments:

When psychologists present cases....they seem a little removed from the patient. They describe patients like out of a book: compulsive isolation.

The psychologists stress the intellectual and orthodox psychological approach (sexuality ideas).... The social worker ties dynamics in with current social functioning. The psychologist ties it in with the intellectual.

Some psychologists like to use big words to sound impressive.

He [The psychologist] is a real brain.

...their orientation is more towards the academic than towards the practical and clinical....

Psychologists' personalities differ from social workers'. They approach things more intellectually.... They are more intelligent and verbal as a group.

They have a more intellectual orientation.

Psychologists have a more intellectual approach to their groups and do not want to talk about their feelings.

Basically and wholly theoreticians.

I have known psychologists who were bumptiously intellectual.

The attitude that psychologists are intellectual was widely echoed by social
workers in the sample.

The other major attitude is that psychologists fail where social
workers excel - in the area of the outside world. Below are illustrative
comments:

The psychologist was resistant to thinking there might be
another approach, though I have knowledge about family relation-
ships.

Are they back at the outside world again? They need knowledge
about it.

They don't take the family into account or problems outside
the patient.

They have theory but practical experience is too limited.

I know many things about foster care and children on welfare
and ADC and from broken homes. Things that they don't know be-
cause they have never been in a welfare agency. They don't know
the heartaches of budgets or the guilt of people who were work-
ing while on welfare. Their focus is on the psychological and
dynamic level. I had to come up to the level of dynamic apprecia-
tion and they had to come down-up to the level of reality.

Intrapsychically they are clear, definite, and precise. But
on personality dynamics related out in the intercultural aspect,
they fail.

From a practical view, I have not found them of value. They are
not fruitful for problem solving. But in theory they are very satis-
fying. What they say is of theoretical interest: interesting and
stimulating, but not practically helpful. The worker goes on to
give an example.

In dealing with epileptics. The president of a society for
epileptics was a clinical psychologist. The psychological theory
is sound and based on psychological needs, such as need of under-
standing them, letting them talk out their problems, need of being
accepted, or removing stigma. This is sound psychological princi-
ple. But in face-to-face casework relationship most epileptics
want jobs. No amount of reassurance or working through their own
dilemmas on psychological grounds places the social worker in an
advantageous position with the client in helping solve a practical
matter. It is damaging as you can't do it and have no recommenda-
tions to make. Because the law is such as it is. So the psycholo-
gical approach as they recommend it is worse than useless....

Social workers were asked about the attitudes of psychologists to social
workers. No doubt some of the answers were projections of the social workers'
own feelings about themselves and about psychologists. (Some of the
respondents commented to that effect as they answered). The seventeen respondents voiced seventy-seven responses about this topic. Of these, thirty-three were positive, thirty-three were negative, and eleven were neutral.

For example, on the negative side they said:

Another psychologist didn't think social workers knew very much.

But before they work with us, they see us as social - as superficial, surface, getting resources.

They are critical of us for not being able to talk of what we do - our principles underlying social work, our operating principles.

On the positive side, social workers said:

They like us. They are friendly with social workers. They respect them. They are interested in the treatment. At staff they show interest by asking about a case - how it was done.... they eat, talk, party together. At the parties social workers and psychologists show up in the greatest numbers. It is always this way. ....They show respect by listening to us, questioning, and not criticizing (except realistically....).

Respect. They see us as competent in our ability to help people and do casework and more involved types of treatment. I have heard that in some settings there is conflict and jealousy - I have never seen it. [How do they show this?] The way they have discussed patients. They ask our opinion. They ask social workers to participate in group therapy. By saying that social workers (some social workers) can do psychotherapy on about any level. They say social workers can have more responsibility than they are given.

(Included under neutral were such remarks as don't know, that attitudes of psychologists vary according to the agencies where they work, that different psychologists hold different attitudes, etc.).

Social workers' views of psychologists, and their impressions of psychologists' attitudes toward them, are factors involved in ideas the social workers have of their own prestige relative to that of psychologists. For the most part, the respondents attributed equal rank to social workers and psychologists, or perhaps ranked psychologists slightly higher
in prestige. Even social workers who tended generally toward unfavorable views of psychologists conceded that psychologists might outrank them in the agency setting. One worker, for example, revealed an ambivalent viewpoint, in first commenting, "The psychologist can't do anything a skilled caseworker can't do," and then admitting that, "The psychologist knows more about diagnosis than the social worker.... I learn more from them on the average than from most social workers."

A social worker in a pattern I setting (where social workers would have prestige, if any place, since they are in charge) said:

A psychologist will tell this woman her child is brilliant, so all the things I did for her don't show immediate results. She likes to hear the kid is brilliant. Only the kid comes to know us and appreciate us and think we are on the same level as the psychologist and psychiatrist. The child thought of the social worker as punishing him first (takes him away from his mother and father). Kids are thrilled by tests. Parents always tell me what the psychologist said from the tests. They have lots of faith.

**Noteworthy Experiences and Problem Areas**

Some of the social workers thought that psychologists were easy to work with. Numerous reasons for this are given. Here are reasons that were listed by two or more social workers in answer to the question, "Now state which groups are particularly easy to work with and which particularly hard. Why?" They said that psychologists are interested in the social workers' clients; psychologists are not authoritarian; it is easy to communicate with them; social workers and psychologists are experienced in working together; the two professions share understanding of dynamics; as professionals they know how to work together; psychologists have a lot to offer and can answer questions for the social workers; they do excellent testing; they are cooperative; psychologists are personal friends.

Those who say psychologists are difficult to work with attribute the
difficulty to: lack of contact; clashing personalities; a feeling by the social worker of lack of respect; a feeling by the social worker that psychologists are too theoretical and intellectual; the fact that the social workers discussed the psychologist's reports not with the psychologist but with some other person. This list includes only difficulties recognized by more than one person and stated in answer to the question above.

A guide to good relationships might be the experiences with psychologists that the respondents considered to be noteworthy. Fifteen workers could describe such "noteworthy" experiences. Eleven of the noteworthy experiences were around individual cases but other types of experiences were also regarded as noteworthy: research projects, lectures, and discussion groups. Most of the examples, however, involved psychological testing.

Following are some examples of what social workers considered noteworthy experiences:

At the court clinic we get studies from psychiatrists. Last week a boy came from the court, without a psychological report. The psychiatrist and the probation officer and a social worker and I felt that we couldn't be sure he was of average mentality (the boy was flunking school). Could he accept freedom? The psychiatrist and I just saw the boy for an hour or so. We placed him where he did have freedom. We were wrong. He acted out in three different instances - he shot a BB gun in a neighbor's window, accepted money from a man in town, and threw over a bench in the playground. Therapy was recommended after the psychologist made his report. Also therapy was recommended as a result of this placement. But if we had had the psychologist's report first and knew that his IQ was 130-135, we would have had the tendency to believe he was crying for more controls. We had considered him to be average - he looked average. He flunked Latin. So the psychologist's report is invaluable.

Until this year I was half-time attached to a research project on the problem of school phobia. The team consisted of me (social worker), one psychiatrist, and two clinical psychologists. I carried a number of cases with the same person and got to know
them and their work. The most gratifying and successful cases have been those I carried with one of the clinical psychologists. Because we can talk a kind of short-hand, we have a close collaboration. It is possible to exchange information following interviews and think of meanings of it. In one case we worked three years together. Last year we were quite discouraged; we saw no movement by the child or the mother (whom I saw). The child was age sixteen and out of school six years. A combination of things put new life into the case. The other clinical psychologist on the team got interested in seeing the father. The help of another social agency was enlisted and a group social worker there has formed a club around this girl. There was a move toward outside activities by her. The close working relationship made this possible.

Social workers are pleased and regard it as noteworthy when psychologists back them up:

I had worked with this patient on an individual basis and he later became a group member. I was more aware of this patient than any one else because I saw him for two years. I recommended to the ward physician to take certain steps. The psychologist backed me because he was acquainted with him from the group. The psychologist encouraged me.

There was a section 100 investigation. The psychologist was extremely helpful. He was able to give his diagnostic findings on this patient who didn't look sick on the surface. (The patient was a rebellious adolescent, which was why he looked like he needed punishment). The psychologist pointed out that he was borderline and needed psychiatric treatment. The patient was here because he had physically abused his parents and wouldn't work. So they charged him. The psychologist gave me new ideas. I wouldn't have been willing to say he was borderline myself without more to back it up.... The boy now, after two to three years, is officially schizophrenic.

I had a noteworthy experience on a research project.... It was especially fascinating in terms of seeing changes. The patients were tested after they started therapy and then a few months later. It proved the value of our work to us. It gave us something to hold on to, to substantiate our claims.

In one case I wanted a better indication of how upset the person was. He had been tested some time previously. The consultant and I asked for a re-testing. The client was regressing. Was the standstill a regression, and also, what was the aspect of the potential for acting out? We wanted to see what strengths the person had to work on. The test was helpful. The test showed there were some strengths. There was not too much variation between the first and second tests, so he was not going down hill. The test added something to my thinking; it showed the potential that I thought the client had. It made my work different and gave me more hope.
The psychological tests often revive hope. They can highlight - so you can see the thing concretely worked out. There is more substantiality. It gives a feeling of a scudder backing.

Discussion of Selected Literature

Walter Hart, in his article, "Use of a Clinical Psychologist in a Casework Agency," describes how the Family Counseling Service of America makes use of psychologists; the agency which he describes would fall into what is called in this study pattern II. Hart says the Counseling Service employs a part-time psychologist to aid the caseworkers through consultations. The psychologist tests for purposes of vocational guidance, estimating intelligence, ego strengths, emotional relationships, etc. but does no direct treatment. The caseworkers consult with the psychologist either before or after psychiatric consultation or may use the psychologist as the "advisor of choice." After hiring the psychologist for two and one-half years on a trial basis, the two consulting psychiatrists and the social workers decide the psychologist is valuable and should be continued as a regular service. At staff meetings all staff decide the criteria of referral and methods of advising clients of the service. Before the psychologist was employed gains were foreseen primarily in saving time. After working at the agency, the psychologist is actually found to be valuable in four main ways:

1. Providing a supplementary understanding of dynamics to be used both before and after psychiatric consultation.


3. Clarifying educational and vocational potentials in relation to total personality. This is done after psychiatric consultation has been held.

4. Making diagnosis, determining insight or discovering significant data (sometimes before the caseworker can use it).
Hart feels that using psychological services gives better understanding of the client and provides more effective help for those with difficult personal problems.  

The agency Hart describes conforms to pattern II. Except for baby testing, the agencies in this sample would not use the psychologist before the psychiatrist or as "the advisor of choice." Saving time does not seem to be the object of using a psychologist in any of the agencies involved in this study, at least as described by the workers. But the workers would use the psychologist in the four main ways listed.

Hartman and Hurn discuss, "Collaboration as a Therapeutic Tool." They define collaboration as "the cooperative efforts of two or more therapists (caseworkers, psychologists, psychiatrists) in planning treatment on behalf of a family that has come to an agency... for help." In other words, the idea is that more than one family member will be in treatment at the same time, each under a separate therapist. This creates a more complex situation than the one client-one therapist relationship. Although collaboration is more difficult, it can also be satisfying and effective.

Seven reasons for collaboration are listed:

1. Therapists can exchange factual information about a family.

2. Therapists can tell, by comparing notes, if feelings of the patients are based on reality or are strictly internal.

3. Therapists find it diagnostically and therapeutically useful to see if moods, subject matter, changing relationship to treatment or parent and child are the same in treatment sessions the same week.

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4. Therapists get different impressions of family members not in treatment.

5. One therapist can prepare his patient for coming changes in the other patient.

6. One therapist can help his patient understand the treatment of the other (for example, explain to the mother why the psychiatrist gives candy to the child).

7. Each therapist has increased personal confidence in his own treatment plan when he knows the other therapist’s diagnosis and treatment.

The pattern IV setting would be an example of "collaboration" as they define it. Of the seven reasons for collaboration, the pattern IV worker in this study spontaneously mentioned three of them. But this definition of collaboration seems to fall short because it does not take into account the pattern VI type of setting where the workers would also do many of the seven listed operations.

Haselkorn’s article, "Some Dynamic Aspects of Interprofessional Practice in Rehabilitation," underlines some of the things brought out by respondents in this study. Haselkorn says that it is difficult for social workers to integrate with other professional people when social workers are still searching for differentiation from other professions. She says that in considering interprofessional collaboration attention should be given to the following areas: motivation for collaboration, vested interests of various professions, status problems, and communication barriers. She says that when interprofessional practice in rehabili-

tation is a goal there are certain implications for education. Students should receive cross-disciplinary teaching. Supervisors should be models in conducting interprofessional relations. Also, objective recording methods for teams must be developed.

Respondents in this study who have had courses in psychology seem to be helped by them. This fits in with Haselkorn's idea. However, one of the supervisors in the study told about her efforts to be a model in conducting interprofessional relations and her attempt was not too successful.

A survey has been made under the auspices of the Membership Study Committee of the American Orthopsychiatric Association; it deals with the use and coordination of services of psychiatrists, psychologists, and social workers. They say that although each setting shows variation ("It is obvious from these data that there are no uniform concepts of coordinated service among psychiatric organizations"), five modes of coordination stand out:

1. Staff members of the three disciplines offer separate services, in sequence. Staff share pertinent information.

2. Interchange of counsel, advice, or information between the three disciplines.

3. "Collateral relationship" - the disciplines are subordinately connected, with the psychiatrist usually in the lead.

4. "Collaboration" - each profession, retaining its distinct identity, works with the other professions toward a common objective. No one profession directs. Each guides the service he gives.

5. "Integration" - knowledge of all the disciplines is pooled and then used to plan a total program. Lines between professions are not sharply drawn. They also say that better coordination results if the full staff works out a written manual of policy and procedure. Unified administration promotes coordination; if each service is administered separately the tendency is toward isolation of services. 7

This study is in agreement with the Orthopsychiatric study in regard to lack of uniform concepts of coordinated services. In this study the six patterns may seem fairly clear-cut, but it must be remembered that more than one pattern at a time may be employed in any given agency. There is an additional complication: not all workers in the agency may be participating in each of the patterns represented in the agency. There is, for example, a worker in an agency with pattern V who has no part in this at all; indeed, she resists becoming involved in group therapy.

The five classifications found by the Orthopsychiatric group differ from the five patterns found in this study. The Orthopsychiatric group does not allow for pattern I at all, as they were interested in examining only agencies employing all three professions represented in the Orthopsychiatric membership. Except at intake, services are not generally offered in sequence in any of the agencies in the present sample. Interchange does apply to sample agencies. The "collateral relationship" is not investigated here. "Collaboration" might describe what goes on in patterns I, II, and III if several criteria are deleted. For example, in collaboration all the services of each profession are not used routinely.

In child placing agencies, however, all babies for adoption will routinely be tested. Also, under collaboration, each guides the giving of his own service. However, in psychological testing especially, the psychologist will be guided by questions the social worker wants answered. And he must put the answers in an acceptable written form, especially in pattern I and pattern II agencies. "Integration" is a good description of the pattern IV setting.

Shaffer, who writes about "Guidance and Counseling" would include both social workers and psychologists under the title, "counselors." He describes counseling as emotional adjustment of individuals in their day-to-day settings. Primary goals are the development of skill, objectivity, maturity, and self-responsibility within the individual in order to enable him to become a self-directing, integrated, purposeful person. This sounds like limited therapy. Shaffer cautions against the therapist's going beyond his skill.8

The latter is something which social workers are very concerned about. Several say they would refer to a psychologist in private practice if he had sufficient training. Seeing psychologists go beyond their skill (or what social workers regard as their skill) makes social workers angry. They add that they would feel the same way about a social worker who did the same things.

Whitehouse, in his article, "Professional Teamwork," writes a theoretical, idealistic article about the nature of teamwork. He describes neatly

the things which determine variation in teams. They are: purpose, setting, focus, nature of the team (stable, rotating, or assembled ad hoc), structure of team (clinical, community, inter-agency, intra-or-inter-disciplinary) constitution of the team, level of operation, case load, time available for meetings, opportunity for communication. 9

It might be worthwhile to comment on the variation in agency inter-professional relationships from these standpoints. Some of these variants were used to describe the different patterns of relationships while others were not taken into consideration.

Whitehouse also describes the good team, what makes it, what it provides, what characterizes it. He says a good team is noted for:

1. Common philosophy stemming from faith in the method
2. Democratic leadership
3. Equality of the status pattern
4. Clinical freedom
5. Maturity

He says that a good team provides opportunity for communication; specific sessions for self-examinations of its process and educative exchange; realistic setting for client-testing, trial, and observation; full and sufficient time for the clients to respond and progress. In addition, a good team is characterized by: freedom of discussion, consensuality of its decision, good personal relations between members, respect for opinions and sufficient accommodation for minor differences, provisions for research, flexible and dynamic planning, an interpretive nature in its reporting.

careful selection and stability, experience in the process, and "the life-term architecture of its projection." 10

This might be something to aim for. Not even the pattern IV team would live up to all these provisions. Whitehouse, however, feels that even the worst team is better than no team. 11 Further, one thing that comes out of this thesis study is the contributions made interprofessionally even when many of the criteria for "good team-work" are absent. Even when psychologist and social worker are unfriendly, the social worker is able to use psychological contributions.

In the book, Role Relations in the Mental Health Professions, Zander, Cohen, and Stotland examine in several chapters the relations between psychiatric social workers and clinical psychologists.

Zander, et al. point out that social workers assign a stereotype to psychologists, whom they describe as scientific, insightful, likeable, and mature, but also defensive. 12 These findings fit in well with the findings of this study, for the respondents frequently said psychologists were intellectual and defensive.

In the Zander study it is found that, "Social workers state that psychologists can provide knowledge primarily about psychometrics." This was also a frequent response by the respondents here. Also, as Zander, et al. point out, social workers did not see the psychologist primarily as a

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10 Ibid., p. 157.

11 Ibid., p. 153.

12 Alvin Zander, et al., Role Relations in the Mental Health Professions, pp. 92–93.
diagnostician or therapist (though the former was mentioned more often than the latter). 13

Zander, et al. find that the greatest proportion of social workers believe their power is equal to that possessed by psychologists in community contacts and diagnosis and therapy. The workers in this study, too, felt equal in power to psychologists. 14

The sample in this study differs from the Zander sample. The majority of social workers here did not have as frequent professional contact with psychologists, if by that is meant contact that is face-to-face, in regard to a case, and on a more or less formal basis. However, it seems to be true in this sample that, "The more frequently interactions occur on the job, the more a social worker feels accepted and respected, and the greater is the likelihood that she feels positive toward psychologists," as Zander, et al. find. 15

Zander, et al. say that eighty-two per cent of the social workers believe they are equal to or better than psychologists in professional knowledge and skill. 16 Many of the social workers in this sample also voice their belief in this equality, although this was not entirely so.

"The large majority of social workers are well satisfied concerning their relations with psychologists," according to Zander. 17 The situation in this sample seems to be more mixed, with some of the workers being satisfied with the present division of functions and some dissatisfied.

13 Ibid., p. 93.
14 Ibid., p. 95.
15 Ibid., pp. 97-98.
16 Ibid., p. 98.
17 Ibid., p. 99.
Say Zander, et al., "The average responses of the social workers reveal in a number of ways that they place more value on psychiatrists than on psychologists." Many of the respondents in this study spontaneously mentioned the psychiatrist. General examination of the data seem to reinforce Zander's position. Two workers in this study said they would become psychiatrists if they could choose their career over again; none said he would become a psychologist. This is in agreement with Zander, et al.

The respondents mentioned here were not asked to give the amount of contact they had with psychiatrists in quantitative terms, but they did make rough estimates. Fifteen respondents ranked ten professional groups according to amount of on-the-job contact with their members. The mean, median, and modal position of psychologists was fourth. But for psychiatrists, the modal response of the social workers was to rank them second; that was also the median. The mean was 2.9. This is in line with Zander's statement, "Social workers have more frequent contact with psychiatrists than with psychologists."¹⁹

**Summary**

Many dimensions of the interprofessional relationships of social workers and psychologists are discussed in this chapter. The data tend to support some generalizations, though no predictions can be made to a wider population as the sample was not chosen randomly. The basic scheme is, first, the presentation of the six relationship patterns, and then the discussion of settings and division of functions, authority relationships, etc.

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¹⁸ Ibid., p. 115.

¹⁹ Ibid., p. 116.
the communication process, and attitude and prestige factors, in terms of the patterns. It is shown that social workers tend to think of psychologists primarily as testers, and to view them as intellectuals whose knowledge about the environment is limited. The findings described in this chapter are corroborated in the literature.
CHAPTER V

INTERPROFESSIONAL RELATIONSHIPS OF SOCIAL WORKERS WITH MEMBERS OF THE CLERGY

Some General Thoughts About Religion and Social Work

From religion has come the primary motivation for the social agencies we have today, whether secular or non-secular, and from religion we have also drawn certain important beliefs that the clergyman and social worker hold in common: "respect for the dignity and rights of the individual, awareness that man does not live by bread alone, the urge to develop man's inner resources and capacities toward a better and a fuller life". Not only does modern social work trace its origins to the Judaeo-Christian faith with its concern for the dignity of man and his inherent needs as a spiritual being, but present day social work still draws upon much that is basic to that religious faith. Leonard W. Mayo, a social worker who is Chairman of the Department of Social Welfare in the National Council of Churches of Christ in the U. S. A. states:

I believe that in the past decade there has been a growing appreciation on the part of social workers that ours is essentially a spiritual profession, that we must act in accordance with that concept, and that our methods and programs are means to the end that man may be helped to rediscover himself as a spiritual being with not only a place, but a purpose, in the universe.

And yet with regard to the actual relationships between social workers

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1 "Members of the clergy" refers to Catholic, Protestant, or Jewish clergymen.


and clergymen, there is not often as close coordination as the preceding discussion might imply. Social work regards the faith of religion as irrelevant, though not necessarily irrational, and from the Judeo-Christian viewpoint social work seems unguardedly open to secularism. The secularist does not always deny God; he simply is not interested. His interests are here...simply because casework never inquires into what it means by faith, it is quite liable to settle for a philosophy of its autonomy unrelated to anything deeper than the democratic social process. It tends to become an anti-religious religion which regards the Judeo-Christian faith as irrelevant both to its outlook and to its practical purposes.

The biggest obstacle...to incorporating religion and religious values into social work's philosophy of life, theory of personality, standards of values, and resources is the suspicion that religion is incompatible with the operating principles of acceptance, self-determination, and the nonjudgmental attitude.

Cooperation between the two professions has been advocated by many social workers and clergymen alike - as highly desirable and necessary. The person in need is at once a social being, a psychological being, and a religious being; he is related to others, he has individual needs, and he desires to see life as a whole. Each profession has its important contribution to make. The cleric is a guardian of morals and values, being a spiritual leader and pastoral counselor. His role provides for a unique continuing relationship between himself and the congregation, for he is at hand to offer help in good times and bad, in joy and sorrow, as well as to

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2 Ibid.

3 Ibid.


5 Bigham, op. cit., p. 118.
perform religious rites. However, as social work has evolved into a professional counseling discipline, specializing its functions in order to do its job more effectively, the clergyman ideally can and should discriminate among types of problems that he is more competent to treat in pastoral counseling and those which the social worker is better prepared to deal with. According to the situation at hand, the social worker draws upon his own skills and those of other community resources, which he should know well. He stands ready to serve in times of special need, for he is trained to help on the basis of his psychosocial diagnosis and understanding of dynamics.

Explanatory Notes on the Chapter

Among the four professions discussed in this thesis - physicians, psychiatrists, psychologists, and clergyman - it can easily be seen that the clergy represents a separate category of interprofessional relationships with social workers. The clergy are in a unique position among the "helping" professions for they have essentially a theistic rather than a scientific orientation. Two main points of difference are that (1) both the clergyman and social worker place a greater emphasis than does either the physician, psychiatrist, or psychologist on helping or treating the individual through environmental manipulation or in terms of his relationship with the environment, and (2) the "team" approach or even just the close proximity that may exist between representatives of different professions is rarely seen between the social worker and the clergyman. I am referring in this instance to the fact that there is less opportunity for a social worker and a clergyman to have relatively close professional contact with one another, partly because the latter is not so directly involved with treatment centers -
whether they be psychiatric or medical - or with social agencies. However, despite the fact that this chapter is concerned primarily with the distinctive features of interprofessional relationships between social workers and members of the clergy, the similarity of relationships between social workers and members of other professional groups will inevitably appear. This is due to certain common factors appearing within all these groups.

Sample

In the introduction to the thesis, it was indicated that the sample for the whole thesis would be selected for the purpose of eliciting attitudes and impressions about interprofessional relationships involving social workers. The social work agencies that were visited by any one of the four members in this group project tended to be those agencies that it was hoped would be most helpful in providing information about relations with a particular profession - in this case the clergy. For this chapter both sectarian and non-sectarian family service agencies were most frequently visited, since it was expected there would be both greater quantity and variety of contacts with members of the clergy in these than in other settings where social work is practiced.

Among the total sample of eighteen social workers interviewed, ten, or more than half, were employed in family service agencies. Two of these workers were in sectarian agencies, where service was rendered exclusively to Catholic clients in one instance and to Jewish clients in another. Besides family service agencies three workers were interviewed in the same sectarian agency, where child placing services and casework for unwed mothers is provided for clients of a Protestant denomination. One worker was employed by a non-sectarian child placing agency, three workers were
in medical settings, and another worker was in a preventive social work agency (Big Brother Association).

Three of the eighteen workers were interviewed during the "trial run" of the first questionnaire. The revised form of this questionnaire was utilized in the remaining fifteen interviews, but the revision was not such as to prevent the inclusion of many of the findings from earlier interviews.

According to the criteria set up for selecting the sample of case-workers, the requirement for at least one year of graduate training was fulfilled by all respondents. In fact, only two lacked degrees in social work; one had met all requirements for the degree except to submit a thesis, while the other (with thirty-six years of social work experience) had not completed field work requirements. All but two other workers had completed two or more years of full-time employment. One had completed close to two years and the other over one year of such experience. Eight of the remaining sixteen workers had from two to nine and one-half years' experience. The mean for this group is approximately four years of experience, but the median and mode are each two years. Of the other eight, who had from eleven to thirty-six years' experience, the mean is approximately twenty years, and the median is also twenty years.

Five of the above eighteen respondents carried varying degrees of executive responsibilities. Two of the five were executive directors, another was an administrative assistant, and the remaining two were district supervisors. However, each of these respondents gave examples of contacts with members of the clergy at some time in their own experience (including in some instances their contacts as non-administrative workers) and sometimes from the experience of other workers in the agency.
It should be pointed out that the respondents were encouraged to
give accounts of any contacts they may have had with clergymen, including
experiences in other agencies where the worker may have been previously
employed, and social or non-professional contacts as well. There were
several workers who had been formerly employed in social service depart-
ments in medical and mental institutions, including clinics. Two workers
were at least once involved in disaster work, two were in group work set-
ings, and one was in public assistance work.

Limitations

In addition to the general limitations mentioned with regard to the
total research efforts put forth by the group, there are some pertinent to
this chapter specifically. However, it would appear that the general limita-
tions are the most important ones to keep in mind, and the exploratory nature
of the whole undertaking cannot be over-emphasized.

Interprofessional relationships between clergymen and social workers
have been studied here primarily with reference to family service-type
agencies. Whether or not the agency setting, e.g. family service or psychia-
tric, influences such relationships is a moot point.

One of the questions put to all eighteen respondents was "Have there been
any differences in the kinds of interprofessional relationships you have had
with members of the clergy, depending upon the agency you worked with?" The
total number of responses included seven answers in the affirmative, and nine
in the negative with two respondents passing the question entirely. Thus,
the finding as to whether or not the agency setting tends to influence rela-
tionships is rather inconclusive, as it would be on the basis of the small
sample alone. However, it would appear that there may be an influence of
this nature in some instances. Even though the combined experiences of the respondents showed a wide variety of agency affiliations both in the present and past, there were a few social work agencies that were barely represented, if at all. Only one worker, for instance, mentioned having had experience in public welfare.

Since most of the respondents were interviewed only after it was established that they had had a number of experiences with clergymen, this could be expected to have an effect on the findings. However, a dearth of such contacts would tend to increase the influence of bias. The picture of relationships presented here is admittedly affected by each worker's own opinions and attitudes, as some freely acknowledged to the interviewer.

Although an attempt was made to have these respondents include contacts with clergymen from Catholic, Protestant, and Jewish faiths, there are extremely few instances where contacts with rabbis were mentioned. This may be related largely to the ratio of churches and synagogues in the Boston area, as there are 253 Protestant, 81 Roman Catholic, 38 Jewish and 7 others of other places of worship. Therefore, as it is logical to assume that with each place of worship there may be one or more clergymen in charge, the ratio of clergymen in each of the three major faiths might be approximately the same as the number of places of worship for each religious group. However, this is a rough estimate, and it should be borne in mind that there are some clergymen who are not serving in a pastorship of one particular church or synagogue.

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Factors Leading to Interprofessional Contact

Before investigating the reasons as to how and why interprofessional contacts come between members of the clergy and social workers, it may be helpful to first describe the amount of such contacts that exist between the two groups. All fifteen of the social workers who were interviewed in the final survey for this study were asked to rank ten professional groups in the order of the amount of on-the-job contact each respondent had with their members. Ten cards were handed out, each representing a professional group and filed in alphabetical order: Lawyer, Minister, Nurse, Occupational Therapist, Physician, Psychiatrist, Psychologist, School Teacher, Social Worker, Undertaker. It can be seen that the representatives of the ten professional groups include almost all such persons with whom social workers may have on-the-job contact. The term Minister is used in the ranking rather than Clergymen, although the latter would seem to be the less restrictive term of the two; however, most respondents apparently considered the term Minister as including Jewish rabbis, Catholic priests, and Protestant pastors. A few respondents who did ask about the term were told that it included religious leaders of any faith.

Since the main concern of the thesis is with the reasons for ranking rather than the actual ranking itself, a presentation of the latter material is being given here only in brief form. Furthermore, the sample was picked on the basis that the workers to be interviewed would be those who had some or a lot of contact with the clergy. And in large part the

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9 See appendix for questionnaire entitled, "Relationships Between Social Workers and Members of the Clergy."
contacts would differ according to the agency setting as well as types of work involved. Therefore, the number of on-the-job contacts between fifteen social worker respondents and persons from other professional groups will be presented here in a rough comparative way only. The mean rank of the amount of on-the-job contact with each of ten groups is the rank by which they are listed in Table 5.

**TABLE 5**

**AMOUNT OF ON-THE-JOB CONTACT**

**BY FIFTEEN SOCIAL WORKERS**

**WITH OTHER PROFESSIONAL GROUPS**

<table>
<thead>
<tr>
<th>Professional Groups</th>
<th>Mean Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Worker</td>
<td>1.6</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>3.1</td>
</tr>
<tr>
<td>Physician</td>
<td>3.9</td>
</tr>
<tr>
<td>Minister</td>
<td>4.8</td>
</tr>
<tr>
<td>Nurse</td>
<td>5.3</td>
</tr>
<tr>
<td>Lawyer</td>
<td>5.9</td>
</tr>
<tr>
<td>Psychologist</td>
<td>6.3</td>
</tr>
<tr>
<td>School Teacher</td>
<td>6.3</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>8.2</td>
</tr>
<tr>
<td>Undertaker</td>
<td>9.7</td>
</tr>
</tbody>
</table>

It may be significant that the position for clergymen is approximately at the halfway point. From this study it appears that, on the whole, fifteen respondents had moderate to greater contact with this group than with six others. Only Physician, Psychiatrist, and Social Worker rank higher in terms of the respondents' on-the-job contact with their members.

The three social workers who were interviewed for the "trial run" of the first questionnaire also rated on-the-job contacts with clergymen in
the same relative position, although they were given only eight categories in which to rank (Social Worker and Undertaker were not included).

With regard to the above contacts between clergymen and social workers, who initiates them more frequently? Partly in an attempt to answer this question, each of the eighteen respondents was asked about the last time he worked or consulted with a clergymen by phone or face-to-face in which the details of such contacts could be recalled. The following results were obtained with regard to who most frequently initiated the first in a series of contacts: Clergymen were the initiators in ten of the cases, and social workers in eight cases.

This does not present an accurate picture with regard to who usually takes the responsibility for contacting the other, whether it be clergymen or social worker. Whoever initiates the first in a series of contacts tends to be the one who is usually more apt to be interested in securing some particular service or help from the other. It would be expected, then, that clergymen would more likely be a referral source than the social worker, because of the former group's "grass roots" contact with people. The social worker is not as often the first professional person to be approached for help as would apply in the case of the clergymen - with the result that it would be logical to expect more referrals to social workers from the clergymen, who has a greater number of "first contacts" with people seeking help. A more accurate picture of the reasons behind who usually contacts whom could probably have been demonstrated by asking who initiated the last in a series of contacts around the same "case". Then perhaps it would have been possible to investigate what underlying factors in the interprofessional relationships might tend to make one professional person the initiator and
the other the respondent.

A more general question, asking who usually contacts whom about a person that both the clergyman and social worker are trying to help, resulted in these findings: Six workers stated that they usually contacted a clergyman more often than he contacted them; seven workers indicated that it would be hard to tell whether a clergyman or social worker was more active than the other; three workers stated that the clergyman usually contacted the worker. No answer was given by the two other respondents among the eighteen who were asked this question. One of these two had worked only a little over a year in a full-time social work position and felt her experience was insufficient to warrant making a general statement.

Reasons for contacts between clergymen and social workers will be described here with reference to the responses given in all eighteen interviews. An important consideration to bear in mind is that the social worker may be found in many different types of settings and may even function in a different way from that of other workers in the same setting, e.g. intake worker, administrator, etc. On the other hand, despite the fact that the clergyman's role is functionally diffuse, he is seen by the social worker primarily as being religion-oriented.

It appears that clergymen do refer more often for counseling (individual, family, or marital) than they do for financial aid, although some workers felt that many ministers still are unclear about the meaning of casework service. Consequently there are numerous referrals primarily for financial help. Those clergymen who do recognize the competence of professionally trained social workers will initiate contacts for purposes of consultation about a case. Several instances of this were cited, and along with such contacts there were those that were geared primarily to ask about
the advisability of a psychiatric referral. A number of respondents indicated that a clergyman will follow up or attempt to maintain a cooperative relationship with a social worker where both are involved in the same case. In several instances this was felt to be due to the pastor's concern as "father of his flock".

With regard to communication with the clergyman as initiated by the social worker, by far the most important reason for such contacts is in situations where religion plays an important role. Need for the client to see a clergyman or to have an affiliation in a religious group promotes such contacts. Closely related to this is the need of a client to have the supportive help that his own religious leader can often very well supply. Workers quite frequently contact clergymen for background information about clients or their families or to investigate resources known to a clergyman. Also financial aid often is procured through the help of clergymen who know of appropriate resources.

There are numerous other reasons for contacts between the two professions besides those mentioned above. Furthermore, it is impossible to single out particular reasons for such contacts without considering others. The above listing of reasons is one that utilizes somewhat arbitrary categories, but it seemed helpful to present them that way, for they are the reasons that were most frequently cited. For further information on the motivating factors for contacts between clergymen and social workers, any comprehensive writing on the subject, such as certain of the works listed in the bibliography, can be referred to.

The particular religious affiliation of the various clergymen with whom the eighteen respondents came in contact is given in Table 6.
## TABLE 6

SOCIAL WORKERS' CONTACTS WITH THE CLERGY OF DIFFERENT RELIGIONS AND SECTS

<table>
<thead>
<tr>
<th>Religion of Clergyman</th>
<th>Number of Contacts</th>
<th>Per Cent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>18</td>
<td>19.1</td>
</tr>
<tr>
<td>Catholic Chaplain</td>
<td>5</td>
<td>5.3</td>
</tr>
<tr>
<td>Jewish</td>
<td>3</td>
<td>3.2</td>
</tr>
<tr>
<td>Protestant*</td>
<td>34</td>
<td>36.0</td>
</tr>
<tr>
<td>Protestant Chaplain</td>
<td>3</td>
<td>3.2</td>
</tr>
<tr>
<td>Baptist</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Congregational</td>
<td>3</td>
<td>3.2</td>
</tr>
<tr>
<td>Episcopal</td>
<td>20</td>
<td>21.2</td>
</tr>
<tr>
<td>Episcopal Chaplain</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Lutheran</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Methodist</td>
<td>2</td>
<td>2.1</td>
</tr>
<tr>
<td>Unitarian</td>
<td>3</td>
<td>3.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>94</strong></td>
<td><strong>99.8</strong></td>
</tr>
</tbody>
</table>

*denomination unknown

Where it is known that a Protestant minister belonged to a particular sect, he is listed under a specific category; otherwise he is placed under the broad classification "Protestant." Since some respondents indicated that contacts with chaplains are somewhat different from contacts with a clergyman in a parish, chaplains are listed separately.
It may be significant that there are so many Protestant clergymen listed in Table 6, because of the fact that Boston has a comparatively large Catholic population. Unfortunately, there is no one well-recognized source that gives statistical information on the percentage of Catholics, Protestants, and Jews in the Boston area. The only way to get such figures is to refer to publications by each of the three religious groups, and the way of reporting "membership" varies markedly according to each group. However, again we might refer back to the ratio of "churches" of each of the three groups, with three times more Protestant churches than Catholic churches, and twice as many Roman Catholic churches to the number of Jewish synagogues. 10 If this can be used as a gauge of the relative number of clergymen representing each group in the Boston area, then perhaps the ratio of Protestant clergymen found in the sample is not so surprising. However, this is an inaccurate means for estimating the relative number of clergymen of each faith in Boston.

There could be another influence on the apparent discrepancy in the ratio of Catholic to Protestant clergymen. Most interviews were made in agencies that had no sectarian affiliation, while out of four sectarian agencies visited only one was a Catholic agency. Where sectarian facilities are available, clients of certain sects or religious groups may possibly be encouraged by their church to use them, rather than the non-sectarian agencies. This may suggest why there appears to be a lesser amount of contact with Catholic clergy than with Protestant clergymen. However, another reason may be considered as having a possible bearing on the situation. It

10 Information Please Almanac, 1958, op. cit., p. 291.
may be that, on the whole, Catholic priests tend less to recognize the services that casework can provide than is the case with Protestant ministers. This could indicate a feeling on the part of Catholic clergymen that all counseling should be provided by the church. Also, the findings as given in Table 6 are admittedly open to close questioning, for they are very approximate and are based on a small, non-random sample. Therefore, considerable exploration is needed before any definitive statements can be presented as reasons for the discrepancy between the above findings and the findings that might be expected.

Again, the small number of contacts with rabbis can be remarked upon, although this is perhaps not so noteworthy as is the contrast between the numbers of Catholic and Protestant clergymen. Nevertheless, there is an apparent dearth of contacts with rabbis according to Table 6, as only a few respondents cited contacts with rabbis. However, because there are several Jewish agencies in the Boston area, and only one was included in this survey, it is understandable that this had an influence on the number of contacts with rabbis.

Division of Functions

A Unitarian minister has made the statement:

...the person with a religious problem has a disturbance in his personality; the person with a family problem likewise needs aid in the area of his own personality. The boundaries cross and recross one another because we are dealing with a total human being, not a 'patient' or 'case' or a 'parishioner'.

This clear statement that there is an unclear dividing line between the function of the clergyman and that of the social worker can be easily seen to be the case. The following is the first example cited by one respondent when asked to give some noteworthy experiences with the clergy.

---

A Protestant minister had one Negro couple among the membership of his church. Their membership was to him a tremendous "feather in his hat". The wife was a good trainer of Sunday School teachers, sang in the choir, and was really an active church member. However, she had a problem with alcohol. The minister felt compelled to "paddle around" in their problems because of his stake in their membership, and for this reason contacted this agency, which had the case. It was difficult for the agency to sift out the minister's rightful concern from his desire to do more than his religious concerns dictated. He often called me about the case, and I would explain what I was doing and why. I also mentioned our consultations with a psychiatrist regarding this case. The psychiatrist felt that I should continue working with the woman, because I had established a relationship with her, and no one could clear up the symptom of drinking. The psychiatrist also felt that casework best treats this kind of character disorder, because of the need for a great deal of support, including home visits, etc. The minister wanted to talk to the clients on his own about their problems at home and to get information from the agency that it wasn't necessary for him to have, such as psychiatric impressions. A joint conference between the two workers involved, this older minister and a young assistant minister (who was a great deal more understanding) helped to straighten out the matter of roles. This was accomplished through delicate handling of the minister's feelings and explaining to him that his manner of handling the wife and her problems only helped to make her feel more guilty. He would tell her, "God will love you anyway".

Another example of this problem of overlap is seen in the following case, where again the clergyman's lack of special training in behavior produces certain negative results.

There is the case of a young "eager beaver" Protestant minister who had had some courses in counseling - and those are the worst. He is a chaplain at a juvenile court, and as chaplain his role is amorphous; furthermore, he is unclear about his role. He was wanting to do treatment, and after coming in contact with a teen-age girl at the court he asked me if I would supervise him. This I consented to do, but he became over-involved in the case as he worked with the girl. The girl was lining up the chaplain with her and her boyfriend against her mother. The girl was quite seductive, and the minister gradually began to see that she wasn't really asking for help. He did not pursue the case further when she broke her appointments, and he was later able to see what had happened.

The next example of overlap is one in which a positive or beneficial result is achieved. Here the "counseling" ability of a priest was of advantage to a boy who relates better to a religious functionary.
There is a Catholic clergyman, head of a Catholic social agency, with whom I have had a very comfortable working relationship. There is a difficult teen-ager in a family that I am seeing. The boy was referred to a psychiatric clinic once, and he won't come to the agency. However, he went to a Catholic summer camp and got to know the above clergyman. When the boy got badly burned and was in the hospital, I asked this Catholic priest to visit him. The boy manifests a very positive feeling towards the clergyman, and for this reason I am glad to have the clergyman work with him. This priest is a nice individual and is clear as to his priestly status. He knows that I have a good deal of respect for the Catholic church. (Worker is Protestant).

The following is another example of the advantage of having both social worker and clergyman function in "counseling" roles. The respondent described this as "a shared case, with good working together".

The family was known to the agency for four or five years off and on. They were known to the minister for an even longer period. The husband and wife were both seen at the agency, and both were essentially immature though they met each other's needs pretty well. The wife was the stronger of the two and was manager of the family. The husband, or father, was an alcoholic, and under pressure would drink. He was a passive person but was also abusive towards his wife. After numerous appearances in court, due to his abusiveness, he was sentenced to three months at a penal institution. A neighbor of the family was concerned that the family didn't have enough food and went to talk to their minister, whereupon he entered the picture. He brought some food to the house, but the wife was a very proud person and didn't want to be dependent, though she accepted the food. At this time she stated that she would return to continue seeing me again, after a couple of month's break in our contacts. I helped her towards getting ADC, and because she needed a legal separation for this she did make the move to secure it. The husband contacted the prison chaplain and requested that word be sent to his wife to have her write him. The chaplain forwarded the request through the above minister. Eventually the husband asked to see his minister at the prison. Before making the visit, the minister came to see me, and I explained that the wife was not ready to take her husband back. The minister went along with this opinion and also accepted my suggestion that he work with the husband and help him to be accepted in the YMCA. The matter of a job for the man was discussed also, and the minister was to be the go-between here too. After the minister's prison visit, he shared his information about the husband with me.

In each of these examples it is apparent that the clergyman is functioning essentially in a non-religious role, offering professional counsel, giving emotional support, and acting as the "good father figure". This is his
pastoral duty.

A few respondents actually described the conflict area between social workers and clergymen as that area of overlap of the two where there is a concern for alleviating problems of the individual as a personality and as social being. This situation was put down variously and often vaguely by several respondents as "competition", "conflict", "overlap", "duplication", etc. However, out of all the workers interviewed, only two stated categorically that they were unable to recall a "noteworthy bad experience" with the clergy. One had had eight years' experience as a social worker, while the other had been a medical social worker for twenty-three years and stated that she hadn't had any great amount of contact with clergymen. All the other respondents quoted some degree of negative experience with clergymen, and this was almost invariably related to the area of "competition", described above.

Among the noteworthy experiences with clergymen that were recounted to the writer, the following case example is perhaps the best illustration of such a conflict.

A Catholic priest provided me with a negative experience working with a clergymen. The case involved a family with seven children (including two sets of twins), a promiscuous mother who had been in a school for the feeble-minded, and a father who drank heavily. He had been divorced from his first wife and later remarried. It was known that he beat his children and had threatened his wife with a knife on several occasions. The family had been known to the parish priest prior to the time that the case was referred to the agency from the school attended by the children. Through my work with the father, I was able to help him stay sober and begin to work regularly, because it initially appeared that this was the real basis for difficulty in the home. However, when the father was helped to become a good provider, the mother began to regress. She had been projecting the problems in the home situation onto her husband's drinking, whereas her own instability was the real basis for the trouble. This became increasingly evident as in an incident reported by one of the children that her
mother had once left the gas on without lighting it. I discussed commit-
mittent of the mother with the priest, pointing out to him that this
was an emergency situation and that the mother should be taken to a
mental hospital. The priest responded, "Who said it is?" He then
suggested that if I wanted to talk further about getting funds to
pay for a psychiatrist, I could do so with the person in charge of
dispensing money from a charitable fund, who would be contacting me.
I expressed my desire to have this contact as soon as possible, but
nothing came of it. The priest had made the referral ostensibly
because he was to take a vacation. However, he was not absent from
the parish when shortly thereafter I attempted to contact him again,
and I think what he had told me was possibly a move to get me off
the case. On my second meeting with him regarding the case, I ex-
plained again the real necessity for action but got no response un-
til I threatened to procure money from a Protestant minister. The
priest then consented to the request for funds, and he himself was
to ask a psychiatrist to see the mother and make an evaluation.
Nothing came of this agreement either, so I arranged to have a doc-
tor see her, and she was committed to a mental hospital on his ad-
vice, where she remained for about two months.

It should be pointed out that this is an example that presents a very
negative experience that a worker had with a clergyman. In that sense it
is somewhat atypical of the "usual" variety of "bad" or negative experience
that some of the respondents quoted. However, it was the most detailed
example provided in this context.

Here is a more typical kind of example that was given to me in which such
conflict is a feature.

They are sometimes competitive - this is the principal dif-

culty with them. A young Protestant minister who entered into
the discussion at a meeting stated that he felt a certain case
which was to be referred to a social agency might just as well
be taken care of by a clergyman. This especially reflects the
thinking of a particular Protestant group.

The following is one more example of the competitive relationship
another worker experienced. This also is more typical as an illustration
of the degree of conflict that was described by some respondents as
existing in interprofessional relationships with clergymen.
A large family in which there were small children was having financial difficulties. The mother had applied for help from a special charitable fund, and an investigation was made of their needs to assess whether hers was a legitimate request; this was done by a home visit. An unfavorable report was made, as the house was found in disorder, it was felt, and the husband was earning enough. I visited the parish priest, and he was interested in hearing my opinion that financial help was very much needed and that I felt that the investigators did not get the whole picture. However, he did question why I was in on the case and asked me, "What can you do that I can't do?" He later supported the family's need for financial aid.

There appear to be many divergent views and attitudes that members of the clergy and social workers show towards one another. Actually, however, with regard to attitudes of social workers, most of the respondents tended to have the same general conception of the clergyman's role. This can be adduced from a few representative statements given by the respondents in answer to the question, "How would you define the responsibility of the clergyman and that of a social worker in regard to those persons with whom they may be dealing?" Here are some answers:

It is cut and dried: the clergyman helps with religious problems, broadly interpreted, and the worker handles the overall picture. The clergyman has an area that is primarily, or pretty exclusively his - theological concerns. The social worker's relatively large area of concern is with the environmental aspects of the client's well-being. They share the rather large area of social, psychological, interpersonal area of functioning - with the particular concerns of each.

The minister works with the person from the standpoint of where he should be, morally and ethically - working more with the individual's will power rather than his background and personality development. The social worker works from the standpoint of personality development in the framework of how he is. They both have in common the development of the total personality. The role of the social worker is to help with the development of inter-personal relationships and with the way a client handles his environment. The minister also does this but should do so in the two areas only: where the problem is not deep or where the problem involves need for increase of the person's spiritual development and insights.

The minister gives strength and belonging, whereas the social worker is more technical and goes deeper than the minister. The
minister is a father figure; the social worker is treatment-oriented.

...the clergyman's role is that of giving advice, being supportive, comforting, and a kind of person who is very important when there is sickness or death in the family.... His role is less effective when he tries to be a psychiatrist or social worker and tries to understand motivation and dynamics, due to lack of insufficient training in this and it's not being his primary job.

From the above it can be seen that clergymen are recognized by some social workers as having (1) a theological, ethical, and spiritual concern and (2) offering help through counseling that is not "deep". As for the attitudes and opinions clergymen have about social workers, only a second-hand impression of these could be obtained - by way of the respondents - so that the writer will not attempt to present an analysis of them in the same way. Rather, the clergyman's attitudes will be discussed later by way of pointing up some of the general aspects that merit special comment.

With regard to Table 6, in which chaplains were listed separately from clergymen in parishes, it may be recalled there was the statement made earlier that some respondents seemed to place chaplains in a separate category. The reasons for this are not clear, and it is largely by implication that this situation becomes apparent. However, one interviewee points up the definite possibility of a difference existing in the role between the clergyman who functions as a chaplain in a medical, psychiatric, or court setting, and the clergyman who serves in a parish. The respondent commented that the role of chaplain is a relatively new one and is ill-defined; however, his orientation was felt to be more around psychology than theology. Another respondent described the chaplain's role as "amorphous".
Twelve Social Workers' Opinions

<table>
<thead>
<tr>
<th>Per Cent of Clergy who Understand</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
</tr>
</tbody>
</table>

There were differences of opinion as to whether or not a chaplain was harder or easier to work with than other clergymen.

Besides the fact that these interesting findings could bear further investigation, there are other areas in which there might well be profit from additional study. How well defined is the "average" clergymen's role today in contrast to former times? What effect does modern theological training, with its inclusion of studies in psychology, have upon his role today? Linked with this question would be one asking if the younger clergyman is easier to work with than the older clergyman, in terms of relations with social workers.

**Understanding Between Social Workers and Clergymen**

The most important problem that exists between the two professions is the need for greater understanding. However, this is seen by the social worker as more the clergyman's need rather than that of the social worker. Unfortunately the only question in the interview schedule pertaining to understanding was that which asked, "Among the members of the clergy with whom you have had contact, how many would you say understood the role of the social worker?" Therefore, the answers tended to leave social workers out
of the picture, and it was only answers to other questions that could by implication show how some social workers also lacked understanding of the clergyman's position as a pastoral counselor along with being a religious leader.

Table 7 (page 117) indicates the range of opinion given by twelve of the eighteen respondents with regard to the approximate percentage of clergymen who understand the social worker's role. The remaining seven responses included three "no answer", two who stated that none of the clergymen understood fully, and one who said that only a minority did. Thus, even though not all the answers were given in percentages, it is easy to see that there was little homogeneity of opinion. It is true that no percentage was given lower than 25 per cent, however, and the "none fully" answers reflect more upon the difficulty of interpreting the ambiguous term "understood", as it is used here, than they indicate any chartable response. Some respondents questioned if "understood" meant complete understanding of the social worker's role by a percentage of clergymen they may have come in contact with or if it meant an average degree of understanding of the social worker's role by a percentage of the clergymen known to the respondent. In any event, the findings do indicate that social workers feel there is a need for further understanding on the part of clergymen with relation to the role of the social worker. Clarification and interpretation of social work to clergymen is at least just as necessary as it is with relation to any other group.

Interestingly enough, out of case examples that were cited by the respondents to illustrate interprofessional relationships between workers and members of the clergy, there were few detailed illustrations that shed any light on the lack of understanding of social work that many
clergymen were said to have. Rather, the writer found that the respondents tended to make brief statements about this situation as in this case:

The majority of ministers are not too well informed about the therapy we do. They think we are a relief-giving, home-finding, or employment agency. However, the agency wants to know what the real needs of the client are. In one instance, a woman trying to find work contacted her minister. He referred her to us without going more deeply into finding out what the problem was. Every minister should have at least one course in casework.

Others didn’t go into this much detail:

Such a small proportion of clergymen understand the worker’s role.

Generally, there is a lack of understanding of our work.

None fully understood, but about one-third understood enough to utilize the services of the agency effectively; another third lacked a considerable degree of understanding, but this didn’t impair their working together with the agency; and the final third didn’t make proper referrals, because of no understanding or improper understanding.

Little more than half are cooperative, with real feeling and trying. If there is a crisis situation in which a client needs money, clothes, or placement, the minister wants action first and study later. If they don’t know the worker, they won’t refer.

Ministers usually think of the social worker in environmental manipulation only, instead of helping the personality development on a long-term basis (this is the basis for lack of understanding of social work on the part of all professions).

Several respondents mentioned that the clergyman’s misunderstanding was due to his conception of the social agency as that of primarily offering material help. However, most respondents didn’t illustrate clearly, if at all, what they were referring to when they spoke in terms of the clergyman’s understanding or not understanding the role of the social worker. There are some examples of "bad" relationships that were attributed to lack of understanding but actually seem to be attributable
largely, if not entirely, to other factors as well. These will be discussed later on.

There were several detailed examples given of "good" understanding of the social worker's role on the part of clergymen. These also can be used as examples of factors other than understanding that have a bearing on interprofessional relationships. However, it is extremely difficult to isolate one from the other, and it does seem that the following cases exemplify the beneficial results that can accrue from a relatively good understanding on the part of clergymen for the role of the social worker.

In the first case, the minister helps to interpret the role of the social worker. On the other hand, the worker recognizes the greater tolerance and patience that the clergyman had.

A family with a teen-age boy came before the court. The mother was a moron, and the father was physically disabled from service-connected injuries and rather dull (not moronic). There were many children in the family. For some unknown reason the parents were using the boy as a scapegoat for their own inadequacies, that they projected onto him, and openly rejected him. His delinquent behavior consisted of minor offenses: he was behind in school, was truant, was running away, and was involved in petty larceny around the home. The probation officer referred the parents to the agency for placement of the boy. The parents' objective was to get rid of him and move to Florida. They couldn't understand the function of the agency in helping them, or the boy, were disinterested and had no idea about working out any plans. The problem was to "reach" the parents in any way, and they were hostile because the agency was attempting to do this. They said they had no money for placement and didn't want, as it appeared, to have the placement succeed. They found the agency wanted to help the boy in the best way possible (as conceived by the agency) and could not tolerate this. The family lived twenty miles from Boston and refused to come into the agency.

There had been established a fairly meaningful relationship between the family and their minister, and he was willing to come into Boston to talk with me. He would visit the home with me and help interpret to the parents what I was trying to do. He maintained close contact with me, as his frequent trips to Boston show, and he kept in touch also with regard to his own contacts with the family during which he made an effort to interpret the help that could be given. It worked out well because the minister was the kind of person he was - with a real interest
in the family. The family was able to accept a great deal more help from the minister than from me, partly because his role had more meaning, and he was disassociated from demands of the agency around placement of the boy. The minister had greater acceptance of the family than I did.

The following example is a testimony of one respondent's praise for a clergyman who functions in a way she believes to be suitable to his role.

There is a young Protestant minister with whom it is a pleasure to work, because he makes very appropriate referrals. He is clear who he is and what he can do. He doesn’t want to be a social worker. There was a young woman in his parish who seemed very depressed, and he sensed something was emotionally wrong. He referred her to the agency, where she was then referred to a psychiatrist. She then went to a private mental hospital, and the minister visited her there. Visiting her was a part of his function, because she was ill and in his parish.

Another less detailed example serves to illustrate the good impression that a different clergyman made upon one respondent.

A priest was involved in a case in which the wife wanted a separation and the husband was probably a psychopath. The priest was able to get a letter of permission for a legal separation from the church, and she went through with it. He was one who didn’t see social work and religion as clashing, being undefensive and understanding. He was willing to talk with me and to have an exchange of ideas on a professional basis. He was sympathetic to the husband as well as the wife. I had initiated the contact with the priest for the sake of the wife, who was illiterate and scared.

The important benefits that result from the social worker's understanding of the clergyman's role are implied by the one example that was given for the "other side".

I was active in a church parish where the minister was my fiance. Because I identified with him, this helped me towards understanding the minister’s role in a local parish and the problems with parishioners. The minister has to get personally involved with the parishioners much more often than the social worker does. The social worker tends to keep his personal life out of professional contacts, whereas the parish knows all about a minister's family. The chaplain, on the other hand, can keep his personal life away from his professional contacts.
The Clergyman's Position

Another aspect of relationships with clergyman is that concerning the clergyman's role as an important authority figure, having greater prestige than the social worker (see Chapter VI). Clergymen have traditionally been helping persons to whom their parishioners, or congregants, could turn for help. It is understandable, therefore, that social workers are not the first ones to be approached for help when a clergyman is available. This in turn affects the authority and prestige attributed to, and felt by, members of the clergy. The following case example is illustrative once more of an instance in which the strong positive feeling towards a religious functionary, who is this time a rabbi, works to the advantage of a social worker who was involved in the case.

A sixteen year old boy was truanting, involved in car stealing, and having a great deal of trouble with his parents. The case was referred by a group work agency, and the caseworker who was assigned the case had a great deal of difficulty working with the parents. He called up the rabbi, who then worked with the mother and father over a period of two months with several contacts and was able to convince the parents to come to the agency. This evolved through the relationship that the rabbi had with the parents and the identification they had with their religion. That is, religion can be meaningful as a resource to be trusted for help.

The higher status claimed by members of the clergy was felt by some respondents, on the other hand, to be a source of conflict in interprofessional relationships with social workers. As one respondent put it, many clergymen "kind of supervise". They may remain actively interested in a case until things are going better, even after the case has been referred. Those respondents who have experienced this do not necessarily feel that it is completely unwarranted, however. It is thought to be a normal tendency of anyone who has an interest in a case and wants to follow
through to see how the referral has evolved towards helping the client. Also, the clergyman feels he has an almost personal responsibility for his parishioners, being concerned with all aspects of a person's life. Still, there seems to be resentment about this characteristic exhibited by some clergyman that, in essence, they feel more important than the social worker.

The following is a somewhat extreme example of a clergyman's refusal to acknowledge the usefulness of advice that a social worker was attempting to give.

A little thirteen year old girl living in a rural setting was disturbed and withdrawn from contacts with her schoolmates. She was doing nothing at school and had on occasion a couple of real outbursts, in which she was exceedingly excited and stated that she saw visions and heard voices. She was a "schizy" kid. The teacher referred her to me, and I then made a home visit. The clergyman was there at the time, and I tried to talk to him about the need for a psychiatric referral. The parents wouldn't hear of it, and the clergyman said that psychiatry was no good but rather that prayer would help this girl. I then spoke to a psychiatrist, who observed her in school and talked with her. It was his feeling that she was disturbed, with a good chance of being schizophrenic.

Another example is more typical of the ways some clergymen may appear to take an authoritarian stand, as in the following case from a child placing agency. (This example is similar to one used previously to illustrate something else).

One minister was critical of our agency for not giving a child to a childless couple for adoption. He thought that they should have a child, although the couple had not asked for one nor did they want one.

It is sometimes difficult to isolate evidence of a clergyman's authoritarian attitude from the factor of his personal involvement, and both of these can produce the effect of making the clergyman less amenable towards accepting social work help for his parishioners. The following is an example of what one respondent felt was an instance of over-identification.
An example of a not-so-good working relationship was with a minister who was over-sympathetic towards the husband in a case of marital discord. The wife walked out of the home leaving five children, but some time later she returned with two new babies (not by her husband) and wanted reunion. Although the minister involved in the case knew that the agency was handling it, he didn't work with me very well and did not fully consult with me. He took a stand opposed to that of the agency's and discouraged the husband from taking his wife back, saying that she would "do it again" and continue in the same unreliable way as before. Although I realized that the minister's opinion of the wife's unreliability was, to a great extent, true, I felt that there was a possibility things might work out better, as the agency maintained its contact with the wife. Also the agency felt there was a definite need by the children for their mother, which she alone could fill. The couple is together now.

The same minister was involved with the same family in wanting to place the children in a summer camp, and again did not work it out with me. I felt it was better to keep the children in the foster home, where they had been placed following the mother's leaving home. Also the children's lives had been so disrupted already with losses that placing them in a summer camp would be harmful to them at this point. They were not removed from the foster home for summer camp placement as it turned out.

In the next example the element of personal involvement has a rather strong influence on the minister's failure to refer the case, according to the respondent's opening statement:

I have been involved with a case in which a minister was caught up in a transference relationship. The minister's personal life interfered with his ministry. He and his wife were for many years close to one of the women of the church, though they were older. The woman's mother died of cancer, and she had a traumatic reaction; her father later remarried. The minister's wife died of cancer at the same time that the woman's husband was being unfaithful. The minister visited her often after his wife died. Then he remarried and no longer visited her, possibly because he may have felt guilty about his wife being a little jealous of his close relationships. The client couldn't use him to help her with her problems, because she felt angry towards him (she was rejected by a father-figure). He was unable to talk to either one of the couples about their marriage problem probably because he was embarrassed about discussing marital infidelity. The family doctor referred the case to the agency. I am seeing both husband and wife, after the referral that followed the wife's discovery of the "other woman".

The following is a brief statement about some clergyman's tendency to be personally concerned with the welfare of their parishioners.
Most priests and ministers have a kind of fatherly respect for their flocks. If the nature of the problem is not within their competence to deal with, it is hard for them to refer elsewhere. They do not know other resources very well, and they evidence the feeling that there is some competition.

It should be mentioned here that there are only a few examples of problems caused by a clergyman's excessive concern for the religious aspects of a situation. There were instances, however, where clergymen stood firm on their opinions when they considered families as "good" prospective homes for adopted children on bases other than behavioral factors, i.e. regular church attendance and good morals were apparently the criteria used in a few instances. Also it will be recalled that in two case examples given within this chapter, the ministers told their parishioners that only God alone could help them in their trouble. In the case of the Negro couple, the clergyman made the wife feel more guilty by reminding her that God would forgive her; in another case a clergyman refused to accept the help that social work or psychiatry might offer, maintaining that prayer alone would help.

Comments on the Respondents' Attitudes

Before summing up the general attitude of social workers toward members of the clergy, there are a couple of points that should be mentioned. In many instances the respondents emphasized the need to consider the influence that some individuals within a profession bring to bear upon one's attitude towards the whole profession, i.e. one tends to judge all clergymen on the basis of one's contacts with certain individual members of the clergy. Several respondents pointed out to me that they were unable to give an unbiased answer to questions aimed at eliciting attitudes about clergymen in general. Rather, they often had to qualify their opinions about the profession as applicable to certain
clergymen only. Some were more understanding or less understanding than others, some were judgmental and others were not, some were quite unwilling to have contacts with social workers, whereas others went out of their way to seek out social work help.

Another point that was stressed by some respondents was that with a greater amount of contact with members of a particular profession, one tends to find them easier to work with. Thus, most of the eighteen respondents ranked social workers as the easiest to work with. Although one interviewee made the statement, "The greater the contact, the easier to work with," it would be well to question if there might not be other reasons to consider besides frequency of contact. For instance, social workers have a unique philosophy and similar attitudes, so that they would tend to band together. However, an argument for "ease of working with," as related to the degree of contact, can be seen when one realizes that there would not be greater contact with another profession on a long term basis unless the contact was satisfactory for the most part. Referring again to Table 5, it is interesting that the respondents ranked on-the-job contacts with social workers first and psychiatrists second, just as they ranked ease of working with social workers first and psychiatrists second.

On the whole, most respondents exhibited a favorable attitude towards clergymen on the basis of personal experiences, despite some mention of conflict, competition, or other negative aspects of relationships between the clergy and social workers. Actually, all except five of the eighteen respondents reported "good" working relationships with clergymen, when asked to rate their opinions about such contacts.

Conclusions

There were many different attitudes apparent with regard to details of interprofessional relationships, and the importance of considering that
attitudes about a profession are more strongly influenced by contacts with individuals in the profession rather than by the group as a whole was stressed.

This offers hope for better interprofessional relationships between members of the clergy and social workers, because such conflict as may exist between the two groups is not that much of a deterring factor. However, if both are to serve their respective "charges" in the fullest way a greater understanding of each other's role is vitally necessary. At the present it appears there is some competition that works to the detriment of the person being helped, simply because one profession or the other feels it should have the complete jurisdiction in certain areas, without considering who is best qualified. It would appear that this refers most often to members of the clergy - but this is in the opinion of respondents who were social workers.

Several different opinions were expressed about the clergyman's role, other than his serving as a religious functionary. Some respondents felt that he should be trained in the dynamics of behavior to the extent that he would be able to do counseling in the most effective way. Others felt that clergymen should observe a "hands off" policy in this area, sticking close to their role as religious functionaries and leaving all "counseling" to social workers. Thus, some felt that "overlap" was good and necessary, whereas others maintained that it was unnecessary, wasteful, and the cause for too much conflict.

The clergyman does tend to be the important authority and prestige figure in relationships between social workers and members of the clergy. This seems apparent from the way in which some of them "supervise" or tend to be overly "possessive" of a case that should be referred for
casework or psychiatric help. However, clergymen also make use of social workers as consultants, and many likewise refer for casework help.

It is interesting to note that from the answers given by the eighteen respondents, it appeared that there was a lesser total amount of contacts with Catholic priests than with Protestant ministers. Also there were extremely few contacts with rabbis among the workers interviewed. These findings may be a significant indication of the need to determine more accurately why there is not greater contact with clergy of some sects or faiths.
CHAPTER VI
INTERPROFESSIONAL PRESTIGE

One important aspect of interpersonal relationships is the relative prestige of the professionals who are interacting. Prestige may be thought of as the invidious value which is attached to a status, such as an occupational or professional status, independently of who occupies that status or of how the requirements of that status are carried out.1 Lindesmith and Strauss, in the book, Social Psychology, point out, "The hundreds of occupations in our society are roughly graded in a prestige hierarchy, and within each business or profession there is also a similar grading."2

Many consequences of relative prestige among psychiatrists, psychologists, and social workers are made explicit by Zander, et al.3 Kadushin feels that the prestige of profession affects each social worker's self-concept, relationships with persons in other jobs, and his feelings about his own job.4 He presents a number of reasons why the prestige of social work is important. He feels particularly that prestige partly determines effectiveness in offering social services as well as the patterns of obeisance and deference on professional teams.5 Kadushin's article, which presents

1 Kingsley Davis, Human Society, p. 93.
3 Alvin Zander, et al., Role Relations in the Mental Health Professions.
5 Ibid., pp. 37-38.
excellent theoretical statements concerning the meaning of prestige, is based on generalizations from many other research studies. The present study differs from Kadushin's in that the data are the responses given directly by social workers to the authors of this thesis. In particular, this chapter is mainly based on the second part of the questionnaire, a uniform set of questions directing the respondents to rank the professions of lawyer, minister, nurse, occupational therapist, physician, psychiatrist, psychologist, school teacher, social worker, and undertaker in terms of the general prestige they have in our society, the opportunity they present for initiative on the job, their ability to help people, and the respect the average members of these occupations accord to the people they help. On each question, the respondents ranked the professions from 1 (for the occupation with the most prestige, greatest opportunity for initiative, etc.) to 10 (for the occupation with the least prestige, least opportunity for initiative, etc.).

The data summarizing the findings of this thesis research study on interprofessional prestige and related matters are presented in Table 8. Only five professions are included: minister, physician, psychiatrist, psychologist, and social worker, for these are the occupations this thesis is mainly concerned about. In the table it is noted that a total of 81 respondents replied to at least one of the questions. But for some questions the number of respondents is fewer, varying between 78 and 80.

Examination of the table points up certain of the interprofessional issues outlined in earlier chapters. For example, social workers rank themselves higher than ministers on ability to help people. When the social

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6 See "Questionnaire: Second Part" in the appendix.
TABLE 8
SOCIAL WORKERS' RANKINGS OF FIVE OCCUPATIONAL GROUPS WITH RESPECT TO
SEVERAL CHARACTERISTICS a

<table>
<thead>
<tr>
<th>Occupations</th>
<th>General Prestige</th>
<th>Opportunity for Initiative on the Job</th>
<th>Ability to Help People</th>
<th>Respect for the People Helped</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minister</td>
<td>3.4</td>
<td>4.3</td>
<td>4.6</td>
<td>3.3</td>
</tr>
<tr>
<td>Physician</td>
<td>1.4</td>
<td>3.1</td>
<td>2.6</td>
<td>3.7</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>3.1</td>
<td>3.8</td>
<td>2.4</td>
<td>2.7b</td>
</tr>
<tr>
<td>Psychologist</td>
<td>5.9</td>
<td>6.0</td>
<td>5.6</td>
<td>5.6</td>
</tr>
<tr>
<td>Social Worker</td>
<td>6.8</td>
<td>4.0</td>
<td>2.7</td>
<td>2.7c</td>
</tr>
</tbody>
</table>

Number of respondents varies from 78-81, with the mean determined accordingly.

b 2.68
c 2.73
workers discussed ministers' functions as contrasted to social workers' functions in helping people, they tended to refer to ministers as providing help that was less "deep," and this perception seems to be reflected in their ranking of ministers as shown in Table 8. Likewise, the social workers rank themselves higher than psychologists on ability to help; on this dimension psychology is last. This probably reflects the social workers' stereotype of the psychologist as a tester. Psychiatrists, however, are ranked first on ability to help people. The chapter dealing with psychiatrists points out that the psychiatrist often acts as a consultant to social workers and is perceived by social workers as helping them to help others better.

We can also see, in examining Table 8, that the social workers rank physicians much lower on respect for the people they help than they rank physicians on any of the other criteria. This may reflect the social workers' opinions that the physician often thinks strictly in terms of the physical illness, without considering the social and emotional components of the illness. As this is contrary to the values of social workers, it could create conflict between social workers and physicians. The psychologist, however, is ranked even lower than the other professionals on respect for the people helped. This is consistent with the social workers' view that the psychologist is an intellectual. As an intellectual, he might be thought to devalue the people he serves. For example, one social worker related the psychologist's "intellectual defense" with their not really caring about the people whom they see, in contrast to social workers and doctors who care about and feel responsible for their clients or patients. It is noted that social workers rank themselves relatively low on prestige and relatively high on ability to help people. This could lead to interprofessional difficulties
if the social worker attempts to act on the basis of superior ability he feels he has while the representative of another profession is better recognized in terms of his general prestige standing. As well as pointing to sources of conflict, however, the relationships apparent in the table can also be interpreted in the light of social work values. The influence of such values upon the rankings is brought out in the following comparisons.

The prestige rankings social workers give to the five professions are in accord with the rankings made by the stratified sample (which was a miniature of the American civilian population fourteen years and over) in the National Opinion on Occupations survey. Social workers rank physicians first, followed in descending order by psychiatrists, ministers, psychologists, and social workers. It must be remembered here that the workers were trying to rank the professions according to their general prestige in our society rather than according to the social workers' personal views of their prestige. The survey gives the ranks in this order: physician (first), minister, psychologist, welfare worker for a city government. The profession of psychiatry was not included in their list.7 The social workers' list agrees with the order of the list by the stratified sample. (Professional persons in the survey on National Opinion on Occupations also gave the four occupations in the same order).8 Thus, there is consistency in the general, professional, and social work populations in ranking the professions.

The workers in the present study were not asked what standards they used in arriving at their prestige rankings, but this problem has been considered

8 Ibid., pp. 46-55.
in another study. When the National Opinion Research Center conducted the nation-wide survey of opinions on occupations, one of the objectives was to find general standards of judgements people say they use in evaluating the status of occupations. The criteria for giving an occupation a standing of excellent were found to be (in descending order): good pay, service to humanity, difficulty in preparing for the occupation, social prestige, high standards for the job, requirements of intelligence and ability, security, good future, safety and ease, best chance for initiative and freedom.

The social workers in the present sample may have used similar criteria, since their judgements are like those reported in the survey.

Social workers rank the professions quite differently on "ability to help" people than on "general prestige they have in our society." Social workers put psychiatrists first in ability to help people, followed by physicians, social workers, ministers, and psychologists in that order. Thus, the social worker is placed third instead of fifth. Social workers feel superior to ministers and psychologists in ability to help people though recognizing that they have a lower prestige.

Polansky, et al. deal with this same phenomenon. In their sampling study they find that social workers ranked themselves sixth in accordance with the question:

In the community, who of the following, (carpenter, clerical worker, doctor, lawyer, plant executive, plant foreman, salesman, school teacher, social worker, store owner) taking a typical person in that occupation, has the most prestige?

9Ibid., p. 3.

10Ibid., p. 109.

But on the dimension of power to help people, his social workers ranked themselves second (putting only doctors ahead of themselves). Polansky interprets the results as showing the value that social workers place on helping others; it is an important source of satisfaction to them. Further, most of the participants in Polansky's sampling study said helping clients and training workers were major sources of satisfactions, but only three workers mentioned low prestige when they were asked to give sources of dissatisfaction. Thus, both the study by Polansky, et al. and this study reflect the values of social workers; indicating that they value the ability to help people more than they value their general prestige. Other evidence of this may be gathered from the many definitions of social work which bring out the goal of helping people.

Another value social workers repeatedly affirm is that of respecting the people who come to them for help. On this characteristic social workers rank themselves just below psychiatrists (the means of the ranks are almost identical); they rank ministers next, then physicians and psychologists. The value of respecting the client is reflected in social work literature, where the clients' rights to self-determination are emphasized. Two introductory texts to the field of social work make this clear within the first few pages:

Social work as a profession seeks to offer a service to the individual and to the community that may be accepted or rejected upon the basis of the needs that it meets or fails to meet.

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12 Ibid., p. 79.


The objective of social welfare is to secure for each human being the economic necessities, a high standard of health and decent living conditions, equal opportunities with his fellow citizens, and the highest possible degree of self-respect and freedom of thought and action without interfering with the same rights of others.\(^{15}\)

If Table 8 is judged as showing subjective feeling as well as objective fact, it can be said to show that initiative on the job is less valued by social workers. That is to say that they rank themselves lower on "initiative" than on "helping people" or "respecting clients," and this may indicate that they place less value upon their opportunity for initiative on the job than upon their ability to help people and the need to show respect for those they help.

Many of the social workers interviewed made angry complaints about filling out this second part of the questionnaire, yet there were only a few workers who either refused altogether or quit after a few attempts. Some attributed their reluctance to difficulties in discriminating sufficiently to rank the ten professions. But their unwillingness to answer may also reflect something further about the values of social workers. In addition to placing a high value upon helping and respecting their clients, social workers also place a great deal of emphasis upon democratic values. In a sense, their concern about "the worth of each individual" stems from their democratic ethic and therefore makes it important to stress that clients must be respected as individuals. In being asked to rank professional groups, the social workers were, in effect, being asked to put aside their concern for each individual within the professional groups. It was therefore understandable that some of their objections to the ranking questionnaire were couched in terms of the differences that actually exist among

\(^{15}\) Friedlander, op. cit., pp. 4-5.
individuals in any professional group with regard to their general prestige, ability to help people, etc.

To sum up, almost all of the workers did answer the ranking questionnaire, and with enough consistency to make the data meaningful. These rankings help to substantiate some of the qualitative data about social workers' attitudes that have been presented in previous chapters; and they also give us some important clues about social work values.
CHAPTER VII
CONCLUDING REMARKS

A total of sixty-three respondents were interviewed on the subject of interprofessional relationships between social workers and some other profession. The latter included four groups: physicians, psychiatrists, psychologists, and members of the clergy. On the basis of material that was presented in the foregoing chapters from original research findings, the following points would seem to merit special attention here in the concluding remarks. The factors of (1) prestige and authority and (2) understanding and communication can be adduced as two pairs of important components of the interprofessional relationships covered by this study. In addition it was found that there appeared to be a direct correlation between the amount of experience the respondents had with other professions and the positive feeling that was evidenced, on the whole, towards the members of those same professions.

The four "base" chapters of the thesis, or the ones in which interprofessional relationships were discussed in the most detail, are the primary ones from which the concluding remarks are drawn. Because of the exploratory nature of the research work done, the comments presented here are to be taken only as tentative generalizations. Some of the findings are supported by other studies of interprofessional relationships, but the writers of the thesis feel that several of the results of the study do warrant special comment. They realize that there is a dearth of material on interprofessional relationships that involve social workers and hope that this survey may stimulate further studies on this important subject.
Several respondents appeared to evidence some concern for, or a definite awareness of, the low prestige of their profession. This seemed to be manifested in several ways, and the status rating of social work was pointed up quite clearly in the chapter on prestige as one that is lower than that of physicians, psychiatrists, psychologists, or clergymen. Because the writers' findings in that chapter (and the other chapters) are based solely on the statements of social workers, it is quite natural that there should be some concern shown by the respondents for the comparatively low prestige of the profession. Such examples as the following ones seem to attest to this concern for the prestige of social work, which appears to be a "sore spot" for some workers: the strong feelings expressed about the lack of recognition paid to social workers; the indication that social workers are more often the ones to maintain contacts on a "case"; the subordinate position of social workers in several "team" settings (whether recognized by the workers themselves or not); and the strong hostility that was quickly expressed in some instances about one or two "bad" experiences with other professions.

Another concern of many respondents, and closely related to prestige, was that around authority relationships. Many workers in "team" settings, such as hospitals or clinics, freely admitted or implied that their position was ancillary to that of the doctors and seemed to be satisfied with this arrangement. On the other hand, there were some workers who seemed to chafe under the arrangement, and who cited several instances where doctors did not recognize the social worker's role and either overlooked it entirely or misused it. Several social workers indicated that because of their special training in the social aspects of problem situations they were, therefore, the authorities in that area, rather than the doctors — whether psychiatrists
or physicians. In the same way many social workers maintained their domain of authority over the area of social problems when there was a psychologist or clergymen involved. In practice, however, social workers do not always have exclusive rights with the social aspects of a problem situation, because all of the other four professions have a concern with the "total person" just as social work does.

The issue of understanding was presented by most respondents as it was related to a lack of knowledge of social work on the part of many representatives of the other professions. However, it was apparent that there was also a lack of sufficient understanding about other professions on the part of social workers. Thus there appeared to be a need for a greater mutual understanding between professions in order that each might provide better service to the person needing help - whether he is to be called "patient", "client", or "congregant". That is, there should be a drive for more understanding of other professions by all parties concerned, in order to be more certain that the offering of each might be used to the full benefit for the person seeking help.

Communication was felt to be a problem area primarily as it was related to the over-all contact between the professions. Several respondents expressed their feeling that a need existed for more contact between professions than there is at present. The communication process which does exist, however, appeared to be successful at least in terms of getting across the language or jargon barrier.

Besides the above findings about the important factors operating within interprofessional relationships, there were some interesting results obtained on the "feelings" of one profession towards another, especially on the part of social workers. It appeared that some workers, and especially
those who had a minimal amount of contact with certain professional groups, had some rather stereotyped opinions of these groups. For example, the spiritual concerns of the clergyman and the testing duties of the psychologist were at times exaggerated so that the clergyman was seen only as a "religious leader" and the psychologist only as a "tester." This is further evidence that social workers, as well as other professionals, need to have a better understanding of the other professional groups with which they work.

Several workers who had had contacts with a variety of other professional people thoughtfully remarked that it was necessary to judge one's relationship to another profession on the basis of working with or meeting individuals of that professional group. It was, therefore, difficult for some of the respondents to talk about their attitudes toward a professional group as a whole. At times, however, it seemed clear that what was referred to as a conflict of "personalities" actually represented a fairly common example of interprofessional conflict.

By and large, the respondents stated that they had a good working relationship with the profession that they were expressly interviewed about. They apparently did not feel that the "bad" experiences were typical of the total relationship but rather that these conflicts were due to a lack of sufficient understanding or communication or to problems of authority or prestige. It was felt that these "lacks" were not always insurmountable, and in addition it was felt that even currently the interprofessional relationships were on the whole fairly satisfactory.
APPENDIX

THE INTERPROFESSIONAL RELATIONSHIPS OF SOCIAL WORKERS WITH PHYSICIANS

For interviewing social workers who have had:

a) at least one year of graduate school of social work training;
b) at least two years of full-time social work experience.

1. What graduate school of social work did you attend?

2. Did you get your Master's degree in Social Work?
   Yes   No

   When did you get your degree?

   For how long did you go to graduate school?

   (If at least one year) When were you going to graduate school?

3. Have you been trained in or worked in another field prior to social work training?
   Yes   No

   What was your undergraduate major?

4. How many years of experience have you had as a full-time social worker?

5. What are the different social work jobs you have had?

<table>
<thead>
<tr>
<th>1st job</th>
<th>2nd job</th>
<th>3rd job</th>
<th>4th job</th>
<th>Present job</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
<td>Agency</td>
<td>Location</td>
<td>Dates on the Job</td>
<td></td>
</tr>
</tbody>
</table>

6. Rank the following professional groups in terms of the amount of on-the-job contact you have had with their members.
1. Lawyer
2. Minister
3. Nurse
4. Occupational Therapist
5. Physician
6. Psychiatrist
7. Psychologist
8. School Teacher
9. Social Worker
10. Undertaker

7. Which of the following professional groups do you find it particularly easy to work with?

[ ] Lawyer [ ] Occupational Therapist
[ ] Medical Doctor [ ] Psychiatrist
[ ] Minister [ ] Psychologist
[ ] Nurse [ ] School Teacher

Particularly difficult to work with?

Why did you put [ ] as easiest to work with?

8. What have been some of the noteworthy experiences you have had with physicians?
9. a) Of the physicians you have had contact with, approximately how many would you say understood the role of the social worker?

b) How many of these physicians would you say were sympathetic to their patients?

c) With how many of these physicians were you able to develop a good working relationship?

10. Have there been any differences in the kinds of interprofessional relationships you have had with physicians depending upon the agency you worked with?

   (If yes) What kinds of differences?

11. Think back to the last time you had occasion to work or consult with a physician about a patient?

   a) What was the total number of contacts?

   b) Who first contacted whom? Contacted

   c) How was the contact made? Mail Phone Face-to-face

   d) Was it planned or by chance?

   e) Where did you meet? Your office Physician's

   f) What was the reason for the contact?

   g) Is this a typical reason for a to contact a ?

      Yes No

   h) What other reasons are there for such contacts?

   i) What are the reasons for which a contacts a ?

      (reverse order)

12. What requirements are there for the physician and the social worker in the recording of information on a patient-client?

   a) Who would usually record more information?

   b) Would there be any differences in the attention paid to the material recorded by physician and the material recorded by the social worker?
13. What jobs usually done by the physician, and what jobs by the social worker, when they work together?

Is this a satisfactory arrangement, or should there be some better way of dividing up the functions?

Satisfactory_________________ Should be a better way_________________

What better way would you suggest of dividing up the functions?

14. Physicians sometimes make plans for patients that are not realistic, considering the social and emotional condition of the patient. Has this ever happened in your experience?

Yes________________________ No________________________

What was it that happened?

Has this ever happened to anyone you have known?

(If yes) What was it that happened?

(If still no) What would you do if such a thing were to happen to a client of yours?

15. What means of communication are there between you and the physician at this job?

a) Regularly scheduled meetings?

b) Informal contact?

16. Have you ever come to address a physician with whom you have worked by his first name, or some term other than "Dr. so and so"?

(If yes) What term did you use?

Has this happened with other physicians?

How did this come about?
17. Has a physician with whom you have worked ever come to address you by your first name, or some other than the term Miss (or Mr.) "so and so"?

(If yes) What term was used?

Has this happened with any other physicians?

How did this come about?

18. Is it easy or hard to get hold of a physician if you want to discuss something with him?

19. Does the physician usually contact you, or do you usually contact him about a case you are both working on?

20. Sometimes, in talking to other people, we are not really communicating but are talking past each other. This is especially likely to happen where the people are of different professions and have had a different background and training. Has this ever happened to you in your experience with physicians?

(If yes) Could you give an example of what happened?

21. Who would have the final authority in decisions about a treatment plan for a patient-client - the physician or the social worker?

22. Does the physician ever exercise his authority over social workers in those areas where the social workers have the most professional competence?

(If yes) How does he do this?

23. In general, what attitudes do physicians have toward social workers?
24. Sex: M _______ F _______

25. What is (or was) your father's occupation? ____________

26. Marital Status:

27. If married, what is your husband's (wife's) occupation? ____________

28. Do you have any close friends who are physicians?

29. If you had to make the decision over again, would you decide to go into social work or into some other profession?
   Social Work ________________
   Some Other ________________ If so, why? ________________

30. How do you feel interprofessional relations could be improved?

31. What do you think is the most important single thing for a young person to consider in choosing his life's work?

32. Name of worker interviewed, and agency.
THE INTERPROFESSIONAL RELATIONSHIPS OF SOCIAL WORKERS
WITH PSYCHIATRISTS

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   When did you get your degree?

   For how long did you go to graduate school?

   (If at least 1 year) When were you going to graduate school?

3. Have you been trained or (and) working in another field before going into social work?

   Yes   No

   What field were you in?

   Why was your reason to change for social work?

4. How many years of experience have you had as a full-time social worker?

5. What are the different social work jobs you have held?

   Present job:

   1st job:

   2nd job:

   3rd job:

   etc.

6. Rank the following professional groups in order of the amount of on-the-job contact you have had with their members. Place the professional group with which you have had the most contact on the top, the group with which you have had next to the most contact second, and so on. The professions are: lawyer, minister, nurse, occupational therapist, physician, psychiatrist, psychologist, school teacher, social worker, undertaker.
7. Which of these professional groups would you say are particularly hard or easy to work with?

8. What have been some of the especially noteworthy experiences you have had with psychiatrists?

9. Of the psychiatrists you have had contact with, how many of these would you say understood the role of the social worker? (Examples)

How many of these psychiatrists would you say were sympathetic to their patients? (Examples)

With how many of these psychiatrists were you able to develop a good working relationship? (Examples)

10. Have there been any differences in the kinds of interprofessional relationships you have had with psychiatrists depending upon the agency you worked with?

(If yes) What kinds of differences?

11. Think back to the last time you had occasion to work or consult with a psychiatrist about a patient.
   a) Who first contacted whom? Social Worker ______ Psychiatrist ______
   b) How many times did you see the psychiatrist about this patient? ______
      Total amount of time involved? ____________
   c) Was the contact planned or by chance? ____________
   d) How was the contact first made? Mail ______ Phone ______ Face-to-face ______
   e) Where did you meet? Your office ______ Psychiatrist's office ______
      Other ______
   f) Why was the contact made? ____________
   g) Is this a typical reason for a ______ to contact a ______? ____________
      Yes ________ No ________
   h) What other reasons are there for such contacts? ____________
   i) What are the reasons for which a ______ contacts a ______? ____________
12. Does your agency employ a psychiatrist as a consultant, as a member of a regular team, or other? 

If consultant, how often do you have consultation? 

What is the psychiatrist's function in his role as a consultant? 

What is the social worker's function? 

13. What jobs are usually done by the psychiatrist and what jobs by the social worker when they work together? 

(for 12 and 13) Is this a satisfactory arrangement, or should there be some better way of dividing up the functions? 

Satisfactory, should be a better way, what better way would you suggest of dividing up functions? 

14. Do you see a difference in the understanding of social work when working with a younger or older psychiatrist? 

Yes, no. 

What seems to be the difference? 

What do you see as the reason for it? 

15. Is there any means in your agency other than individual case consultations (research project, in-training - staff meetings) to increase the mutual understanding between social workers and psychiatrists? 

Yes, no. 

(In both cases) what do you think about it? 

16. Psychiatrists sometimes make plans for patients which seem to endanger the emotional health and stability of the other family members or do not sufficiently consider the emotional and material situation of the patients. Has this ever happened in your experience? 

Yes, no. 

What was it that happened? Has this ever happened to anyone you have known?
17. Is it easy or hard to get hold of a psychiatrist if you want to discuss something with him?

18. Does the psychiatrist usually contact you, or do you usually contact him, about a case that you are working on?

19. Sometimes, in talking to other people we are not really communicating but are talking past each other. This especially is likely to happen where people are of different professions and have had a different background and training. Has this ever happened to you in your experience with psychiatrists? (If yes) could you give me an example of what happened?

20. Who would have the final authority in decisions about a treatment plan for a patient-client? The psychiatrist or the social worker?

21. Are some of the social workers supervised by psychiatrists in your agency? (If yes) how do you feel about this?

22. Does the psychiatrist ever exercise his authority over social workers in those areas where the social worker has the most professional competence? (If yes) how does he do this? (Examples)

23. In general, what attitudes do psychiatrists have toward social workers?
24. Sex: M _______ F _______

25. What is (or was) your father's occupation?

26. Marital status:

27. (If married) What is your husband's (wife's) occupation?

28. Do you have any close friends who are psychiatrists, psychologists or work in a field related to social work?

29. If you had to make the decision over again, would you decide to go into social work or into some other profession:

   social work___________
   some other___________

   (If some other) what profession would you enter?__________________

30. What do you think is the most important single thing for a young person to consider when he is choosing his life's work?

31. Name of worker interviewed and agency.
THE INTERPROFESSIONAL RELATIONSHIPS OF SOCIAL WORKERS
WITH CLINICAL PSYCHOLOGISTS
(REVISED QUESTIONNAIRE)

1. What graduate school of social work did you attend?

2. A. Did you get your Master's degree in social work?
   B. When did you get your degree?
   C. For how long did you go to graduate school?
   D. When were you going to graduate school?
   E. Have you been trained in (or have you worked in) another field before social work?
   F. Why did you change to social work?

3. How many years of experience have you had as a full-time social worker?

4. What are the different social work jobs you have held? For each job, list position, agency, location, and dates on job.

5. Rank the following professional groups in order of the amount of on-the-job contact you have had with their members. Place the professional group with which you have had the most contact on the top, the group with which you have had next to the most contact, and so on. The professions are: lawyer, minister, nurse, occupational therapist, physician, psychiatrist, psychologist, school teacher, social worker, and undertaker.

6. A. Now state which groups are particularly easy to work with and which is particularly hard.
   B. Why?

7. What have been some of the especially noteworthy experiences you have had with psychologists?

8. A. On about how many cases have you worked, at least to some extent, with psychologists?
   B. With about how many different psychologists have you had at least some contact about a patient or client? If you can, try to remember the exact number of psychologists. (If the respondent can't) Well, with approximately how many psychologists have you had some contact?
   C. Did the psychologists understand the role of the social worker?
   D. With how many of the psychologists did you develop a good working relationship?

9. A. Have there been any differences in the kinds of interprofessional relationships you have had with psychologists depending upon the agency you worked at?
   B. What kinds of differences?
10. Think back to the last time you had occasion to work or consult with a psychologist about a client:
   A. Who first contacted whom?
   B. Was it planned or by chance?
   C. How was the contact first made? (Mail, phone, face-to-face).
   D. Where did you meet? (Your office, psychologist's office, other).
   E. Why was the contact made?
   F. Is this a typical reason for a ______ to contact a _______?
   G. What other reasons are there for such contacts?
   H. What are the reasons for which a ______ contacts a ________?
   (Reverse order)
   I. How many times did you see the psychologist about this client?
   J. What was the total amount of time spent?

11. A. What requirements are there for the psychologist and the social worker in the recording of information on their joint client?
   B. Who would usually record more information?
   C. Would there be any differences on how accessible the data of each is to the other?
   D. Would there be any differences in the attention paid to the material recorded by the psychologist and the material recorded by the social worker?

12. A. What type of work does the psychologist usually do?
   B. What type of work does the social worker usually do?
   C. When the social worker and psychologist work together, what jobs are usually done by the psychologist, and what jobs by the social worker?
   D. Is this satisfactory, or should there be some better way of dividing up the functions?

13. A. Does the psychologist ever make plans for clients that you are both working with?
   B. Is it ever intended that you should carry out these plans? Or does the psychologist carry out the plans? Or do both of you?
   C. In the light of your own knowledge of the social and emotional conditions of the clients, are these plans made by psychologists usually realistic?
   D. Has it ever happened that the psychologist made a plan that was not realistic? (Or) have you ever heard of a psychologist making a plan that was not realistic? What would you do?

14. A. What means of communication are there between you and the psychologists on this job?
   B. Do you have regularly scheduled meetings?
   C. Do you have staff meetings where you can discuss cases?

15. A. Are there any informal contacts between you and the psychologists on this job?
   B. With whom do you eat lunch? Has a psychologist ever joined your lunch group? Have you ever joined a psychologist at lunch? Did you feel comfortable?
15. ....continued

C. Have you ever attended a party to which the psychologists you work with were invited? Who gave the party? Did the psychologists and social workers mix? Did you feel comfortable?

16. Is it easy or hard to get hold of a psychologist if you want to discuss something with him?

17. Sometimes, in talking to other people, we are not really communicating but are talking past each other. This is especially likely to happen where the people are of different professions and have had a different background and training. Has this ever happened to you in your experience with psychologists?

18. A. Is the psychologist ever in a position where he exercises authority over social workers?
B. How about in regard to decisions about a treatment plan?

19. A. Does the psychologist exercise authority in areas where the social workers have the most professional competence?
B. How does he do this?

20. In general, what attitudes do psychologists have toward social workers?

21. In this age of specialisation it is not easy to become thoroughly informed about one's own field, much less about still another field. Yet, sometimes we do manage to pick up some information about other fields.
   A. Do you know anything about the training prescribed for the psychologists with whom you work?
   B. About their theoretical orientation?
   C. About psychological testing?
   D. Do you think it is (or would be) helpful to know about training, theory, and tests of psychologists?
   E. Do you feel you could do any of the things a psychologist does?

22. How would you explain this profession to a lay person?

23. Sex of respondent

24. What is (or was) your father's occupation?

25. Marital status

26. (If married) What is your husband's (or wife's) occupation?

27. A. If you had to make the decision over again, would you decide to go into social work or into some other profession?
   B. What profession would you enter?

28. What is the most important single thing for a person to consider when choosing his life's work?
RELATIONSHIPS BETWEEN SOCIAL WORKERS AND MEMBERS OF THE CLERGY

For interviewing social workers who have had:

a) at least one year of graduate training in a school of social work.

b) at least two years of full-time social work experience.

1. What graduate school of social work did you attend?

2. Did you get your master's degree in social work?
   Yes _____ No _____
   When _____
   For how long did you go to graduate school?
   Dates __________________

3. Did you ever train for and/or engage in work within another field before going into social work?
   Yes _____ No _____
   What field were you in?
   What was your reason for changing to social work?

4. How many years of experience have you had as a full-time social worker?

5. What are the different social work jobs you have held?

| Present: |
| Agency |
| Location |
| Dates on the job |
| 2nd Prev.: |
| 3rd |
| 4th |
| 5th |
| 6th |
| 7th |
| 8th |
6. Rank the following professional groups in order of the amount of on-the-job contact you have had with their members. (Cards to be handed out in alphabetical order: Lawyer, Minister, Nurse, Occupational Therapist, Physician, Psychiatrist, Psychologist, School Teacher, Social Worker, Undertaker.) Place the professional group with which you have had the most contact on the top, the group with which you have had next to the most contact second, and so on.

7. *(Using the same cards) Which of these professional groups do you find it comparatively easy to work with? ________________________________
    (Reasons)

Which of these professional groups do you find it comparatively hard to work with? ________________________________
    (Reasons)

8. *What have been some of the especially noteworthy experiences you with clergymen?

9. Among the members of the clergy with whom you have had contact, how many would you say understood the role of the social worker?
    ________________________________ (Example)

How many of them would you say were sympathetic towards the clients in the cases you worked on with them?
    ________________________________ (Example)

With how many of these clergymen were you able to develop a good working relationship?
    ________________________________ (Example)

10. Have there been any differences in the kinds of interpersonal relationships you have had with members of the clergy, depending upon the agency you worked with?
    Yes  No

What kinds of differences?

11. *Think back to the last time you had occasion to work or consult with a clergymen:
    a) How many contacts were there on the case concerned? ________
    b) How much time was involved, approximately, in each contact? ________
11. ....continued

   c) Was each contact planned or by chance? 
   
   d) Who first contacted whom? ___ contacted ___ 
   
   e) How was this contact made? Mail ___ Phone ___ Face to face ___ 
   
   f) Where did you meet? Your office ___ Pastor's study ___ Other ___ 
   
   g) Why was the contact made? 
   
   h) Is this a typical reason for a ___ to contact a ___? Yes ___ No ___ 
   
   i) What other reasons are there for such contacts? 
   
   j) What are the reasons for which a (reverse order) ___ contacts a ___? 

12. 

   a) How would you define the responsibility of the clergyman and that of a social worker in regard to those persons with whom they may be dealing? (Reasons for the answer). 

   b) Are there any other responsibilities that the clergyman sometimes takes on? 

      (Examples) 

   c) Is this a satisfactory arrangement? (i.e., Who seems better qualified for counseling, generally speaking?) (Reasons) 

13. Is it easy or hard to get hold of a clergyman if you want to discuss something with him? (Examples) 

14. Does the clergyman usually contact you, or do you usually contact him, about a person that you are both trying to help? (Reasons)
Sometimes in talking to other people, we are not really communicating but are talking past each other. This is especially likely to happen where the people are of different professions and have had a different background and training. Has this ever happened to you in your experience with the clergy?

Yes_________ No_________

(Example)

16. Does the clergyman tend to keep, rather than refer, a client?

Yes_________ No_________

(Examples)

17. In general, what attitudes do the clergy have toward social workers?

(Details, e.g., get examples of clergy's actions which reflect the attitudes. Record elsewhere.) How do they seem to conceive their role as opposed to that of social work?

18. What is (or was) your father's occupation? __________________________

19. Marital status:

Single____ Married____ Separated____ Divorced____ Widowed____

20. (If married) What is your husband's (wife's) occupation? _________

21. Do you have any friends who are clergymen or who are wives of clergymen? (Examples)

22. What is your religion? Protestant____ Catholic____ Jewish____

Other (specify)_______________________________________________________

23. If you had to make the decision over again, would you decide to go into social work or into some other profession?

Social Work_______ Some Other________

What profession would you enter? ______________________________________
24. *What do you think is the most important single thing for a young person to consider when he is choosing his life's work?*

**Identifying data (not to be used in thesis):**

Miss, Mrs., Mr.  

Agency of worker  

*Designates those questions that are important for comparison of answers with results from the other three questionnaires.*
QUESTIONNAIRE: SECOND PART

Please rank the following ten occupations in terms of the general prestige they have in our society. Place a 1 beside the occupation you think has the most prestige, a 2 beside the occupation with the next most prestige, and so on down to a 10 beside the occupation with the least prestige.

Lawyer
Minister
Nurse
Occupational therapist
Physician

Psychiatrist
Psychologist
School teacher
Social worker
Undertaker

Now please rank the following ten occupations in terms of the opportunity they present for initiative on the job. Put a 1 beside the occupation you think presents the most opportunity for initiative, a 2 beside the occupation that presents the next most opportunity for initiative, and so on.

Lawyer
Minister
Nurse
Occupational therapist
Physician

Psychiatrist
Psychologist
School teacher
Social worker
Undertaker

Now rank the following ten occupations in terms of their ability to help people. Place a 1 beside the occupation you think is most able to help people, a 2 beside the occupation that is next most able to help people, and so on.

Lawyer
Minister
Nurse
Occupational therapist
Physician

Psychiatrist
Psychologist
School teacher
Social worker
Undertaker

Now rank the following ten occupations in terms of the respect the average members of these occupations accord to the people they help. Please place a 1 beside the occupation whose members, on the average, accord the most respect to the people they help, a 2 beside the occupation whose members, on the average, accord the next most respect to the people they help, and so on.

Lawyer
Minister
Nurse
Occupational therapist
Physician

Psychiatrist
Psychologist
School teacher
Social worker
Undertaker
Does anybody who is close to you hold one of the above ten occupations?

Yes

No

If yes, who? (e.g., father, wife, very close friend)

Which occupation?

What is your occupation?
BIBLIOGRAPHY
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Books


Articles


Articles...continued


Pamphlets

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