1953

The psychiatric social work program in the United States Naval Hospital, Chelsea, Massachusetts.

BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

THE PSYCHIATRIC SOCIAL WORK PROGRAM IN THE UNITED STATES NAVAL HOSPITAL, CHELSEA, MASSACHUSETTS

A Thesis

Submitted by

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(B.S., University of New Hampshire, 1942)

In Partial Fulfillment of Requirements for

the Degree of Master of Science in Social Service

1953

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Chapter I

INTRODUCTION

Purpose of Study

The purpose of this study is to evaluate the development and relationship of the psychiatric social work program to the Neuropsychiatric Service in the United States Naval Hospital in Chelsea, Massachusetts. Social work, as presently administrated in the United States Navy and Marine Corps, is a recent innovation. The study will attempt to emphasize the following questions: 1) What are some significant factors inherent to Navy life that might effect a maladjustment or breakdown of the serviceman? 2) What is the development of the psychiatric social work program in the Neuropsychiatric Service in the United States Naval Hospital-Chelsea?[1] 3) What are some of the distinguishing features of the patient hospitalized in the neuropsychiatric ward at the USNH-Chelsea? 4) What are some types of problems handled by the psychiatric social workers that are distinctive in the Navy setting? 5) What part does the psychiatric social worker take in the out-patient clinic of the neuropsychiatric service of the USNH-Chelsea?

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1 Hereafter designated as USNH-Chelsea.

Scope of the Study and Method of Procedure

This study is concerned with the psychiatric social work program in the neuropsychiatric service of the USNH-Chelsea. It will include the history and development of social work services to the Navy traced from the first attempts of organized civilian aid given to the troops of the Civil War.

It is mandatory to both the purpose and scope of this study to present a descriptive and rather detailed picture of some of the specific aspects of the Navy and Navy life as they are related to the neuropsychiatric service of a Naval hospital. The social work program is to be considered in its position to a specific Naval hospital which is an integral functioning unit of the United States Navy.

The material pertinent to the study of the patient on the neuropsychiatric service was obtained from the social service records. The patients included in the study were those men admitted to the psychiatric and neurological wards within a three-month period and those dependent out-patients who were referred to social service within the same three-month period. Very brief and incidental social service contacts were eliminated from the study. The months that were arbitrarily chosen for the study included October, November and December, 1952. The cases studied resulted, therefore,

in seventy-eight psychiatric patients, seven neurological patients and eighteen out-patient dependents. The statistical material was gathered from the social service records by means of a schedule[2] to determine distinctive data on the Navy and Marine patient on the neuropsychiatric service. Particular attention was focused on both the setting and the psychiatric patient in the setting, for these are of primary importance in determining the direction of a social work program. The cases were further reviewed as to the types of specific problems that were distinctive to the Naval setting. Six psychiatric patients were presented in case studies as having problems that were distinctive in the Navy setting. A case study of the neurological and dependent groups was also presented. Both were selected because they demonstrated a typical problem referred to the social worker from the Neurological Service and the Dependents Unit of the USNH-Chelsea.

Limitations of the Study

In the study of the psychiatric social work program in the USNH-Chelsea, limitations were present that might be expected to be found in any new endeavor. Civilian psychiatric social work in the Navy is yet in a developmental stage.

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2 See Appendix, p.

The idealisms of the future have been bounded by the realisms of the present. One such realism is the absence of secretarial help assigned specifically for the social work staff. Another limitation is due to the newness of the program, for there is no literature as yet available on social work in a Navy setting. Certain limitations in the presentation of material were imposed because of restricted Naval information.

Plan of the Study

The plan for the development of the study is as follows: Chapter II will present the history and background of the United States Naval Hospital at Chelsea, which will include the type of hospital and the services offered. Chapter III will contain a presentation of the Neuropsychiatric Service in the USNH-Chelsea which will be preceded by the important considerations of psychiatry in the Navy and general aspects of Navy life as it relates to the study. Chapter IV will cover the history and development of Social Work in the Military, with the specific development of the psychiatric social work program in the USNH-Chelsea. In Chapter V will be contained the pertinent and specific aspects of the neuropsychiatric patients presented in this study. Chapter VI will illustrate distinctive types of problems handled by the psychiatric social worker on the neuropsychiatric service by case summary presentations. Chapter VII will cover the conclusions and summary.

Chapter II

THE UNITED STATES NAVAL HOSPITAL, CHELSEA, MASSACHUSETTS

Brief History[1]

The hill on which the U.S. Naval Hospital stands in Chelsea is an historic landmark. The area, dating back to the days of the Massachusetts Indian, was originally known as Winnisimmet. In 1823, $18,000 was paid by the "Commissioner of Naval Hospitals" to a Boston physician for the 115 acres of land to be used for the construction of a Naval hospital. On January 7, 1836, the United States Naval Hospital in Chelsea was commissioned as the second Naval hospital of the United States government.

The USNH at Chelsea is quite possibly the oldest Naval hospital with respect to continuous commission; its doors have never been closed to its sick or injured at any time. Casualties from every war in which the U.S. has been engaged in the past 117 years have received treatment and care at this hospital. At present, the hospital accepts patients from the Navy and Marine Corps, and in emergency situations admits Army and Air Force personnel who are subsequently transferred to their proper destination hospital.

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1 Commanding Officer Files, History of U.S. Naval Hospital, Chelsea, Mass.

Naval hospitals were originally supported by a Hospital Tax which was livied on all members of the Navy and Marine Corps. This individual taxation method was in effect through a law passed by Congress in 1798 for the Army, which was extended in 1799 to include the Navy. The sum of $.20 per month was deducted from the seaman's pay. This was sent to the Marine Hospital Fund which provided for the establishment and support of hospitals to care for the sick and injured seamen.

The influences of the sea on the USNH-Chelsea were actual, imminent, and inherent from its very beginning. An old document from that era describes the hospital as

> beautifully situated on the left bank of the Mystic River...capable of accommodating 100 sick men comfortably. There are westerly breezes from the river, and the hospital is perfectly protected by the hill, from the northeast storms which prevail for six months of the year.[2]

The hospital was particularly noted for its good location in regard to the treatment of malaria and other tropical diseases acquired by navy men on their cruises. By 1953, the influences of expanding industrial plants have sacrificed the beauty of the site described 117 years ago.

An interesting historical sidelight is that from the site of the present main hospital building the people of the

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2 From Field Director, ARC, Chelsea, Mass., unpublished report.

surrounding countryside witnessed the Battle of Bunker Hill on June 17, 1775. A part of the left wing of the Colonial Army was stationed on these grounds in 1775-1777 during the siege of Boston.

From the handful of buildings that first populated this historic side, there are now some ninety-three structures. The present main hospital building, having a capacity of 1000 beds, was erected in 1914 and commissioned April 24, 1915. In 1945, the Dependents Hospital, consisting of 106 beds, was constructed.

Adjacent to the hospital is the Boston Navy Yard which, besides stationing a large number of Naval personnel, is the docking area for many of the Naval ships on duty from local maneuvers or foreign assignments. The proximity of the Navy Yard to the Hospital allows for convenience in the transportation of those requiring hospitalization or hospital out-patient care.

Complete Hospital Coverage

USNH at Chelsea is approximately a 1000-bed acute general hospital with facilities for every specialty of medicine and surgery for members of our armed forces. Also included in the total hospital services offered is a 106-bed dependent unit for dependent wives and/or dependent relatives of service personnel. This unit includes obstetrical and gynecological cases in addition to pediatric patients. In

addition to the in-patient services, there are approximately 40,000 out-patient visits a year at special clinics, such as surgical, medical, dental, eye, ear, nose, throat, orthopedic, psychiatric, dermatalogic, pediatric, gynecologic, obstetrics, etc.

The USNH at Chelsea is one of the few Naval Hospitals that offers the specialized neuro-surgical techniques and services, which qualifies the hospital as a neuro-surgical center. It offers also an approved residency training in psychiatry in fulfillment of the requirements of the AMA.[3]

Ancillary Services

No Army, Navy, Marine or Army Air Force hospital is without the Red Cross. At the Chelsea Naval Hospital the Red Cross offers recreational and social programming, recreational hall facilities and certain social work services. Additional ancillary services include occupational therapy and physical therapy.

Among the most recent services to be offered within U.S. Naval hospitals is the civilian social work program. At the Chelsea Naval Hospital there are three positions as civil service social workers; a psychiatric social work supervisor, a medical social work supervisor, and a psychi-

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3 BUMED INSTRUCTION 6320.5A, Navy Department, Medical News Letter, April, 1953, p. 28.

atric social worker. The program was initiated on July 1, 1951.

Navy chaplains serve the religious needs of patients of Protestant, Catholic and Hebrew faiths. The chaplains are available for ecclesiastical services and spiritual guidance to all who seek their assistance. The chapel, built in 1945, has a seating capacity of six hundred and is used for worship services, weddings, Holy Day celebrations or any other religious ceremonies.

Chapter III

THE NEUROPSYCHIATRIC SERVICE IN THE UNITED STATES NAVAL HOSPITAL-CHELSEA

Psychiatry in the Navy

It is necessary to have some understanding of what a young man must accustom himself to when he joins the tremendous organization of the Navy in order to realize more fully the implications of a neuropsychiatric service within a Naval hospital. It is the purpose of the first part of this chapter to offer a few considerations of Navy life as it is presented to a young man. General considerations of psychiatry in the Navy shall also be presented.

The Navy is as a separate community--a military community--abounding in customs and precedents and manners of action which are often entirely foreign to the accustomed elasticity of non-military community living. Captain Forrest M. Harrison, M.C., U.S. Navy, has given these introductory remarks in regard to Navy psychiatry and the Navy environment:

> We in the Navy have much to learn about psychiatry from our civilian associates in this field. On the other hand, if the various psychiatric organizations throughout the country are to continue their constructive assistance, they must have a clear conception of the fundamental issues involved in Navy psychiatry, and a definition of our service requirements. There is no corrective equal to a discussion with others...

When a recruit is accepted for enlistment, he is sent at once to one of our large training stations for indoctrination and instruction. Upon his arrival there, he is immediately surrounded by the necessary regulations and restrictions. His hours of sleep, drill, work, liberty and recreation, are all fixed. Discipline is strict, but it must be instilled, along with habits of obedience, promptness and cleanliness. After a brief period of training, he is sent to the Fleet, where the process of making an efficient fighting unit of him is continued.

Life afloat in the Navy is abnormal and unnatural in many directions, even under the most favorable conditions. A modern battleship is perhaps the highest type of concentrated mobile power ever developed by the mind of man. It is a veritable mass of machinery controlled and operated by steam and electricity. Both officers and men are engaged in hazardous duties and occupations at all times, night and day, such as handling boats in bad weather, working in the engine and fire-rooms, drilling with guns and turrets, firing target practice, oiling ship, stowing ammunition, and performing the thousand and one things which go to make up their daily lives. Then, too, the personnel lives in an atmosphere of constant noise, bugle calls, loud speakers, vibration, artificial light and ventilation, and irregular hours, all of which are nerve racking, to say the least. In addition, the frequent contacts of Navy ships with foreign ports the world over, where health conditions are dangerous, mean that everyone in the service is often exposed to all sorts of diseases, which may have some bearing on the development of mental disturbances.

The environment at our training stations and on board ship is fixed, unvarying and non-flexible, and is much more uniform than that of the average civilian community. This has a tendency to mold to a likeness all of the activities of the individuals who compose the organization. There is, in addition, a marked concentration of men, which is necessary in order to satisfy military requirements. The intensity of human intercourse is naturally increased by this density of population. The officers and

> men, therefore, are subjected to exceedingly close social contacts and relationships. There is probably no branch of the armed forces which imposes such rigid demands on its personnel as does the Navy.
>
> It is easy to see that an individual upon entering the Navy must readjust himself to an entirely new and complex environment. The ease and completeness with which he makes this adaptation has an important bearing on his future welfare, and also upon his value to the service. He has perhaps gotten along quite well in civilian life in familiar surroundings and in a job to which he is accustomed. Upon being introduced, however, to the routine of the Navy, he often runs into difficulties, especially during war, and if the strain becomes too severe, he may be overwhelmed and react with a neurosis or a psychosis.[1]

The variance of the patient's background, social and cultural life, therefore, accounts for the gamut of diagnoses that is common to the population of the country as a whole.

> It is natural to suppose that certain types of mental disorders are commonly seen in the Navy, while others are not so frequent, and that the circumstances of war tend to produce characteristic reactions. This is true to a large extent. It must be emphasized, however, that one encounters all sorts of neuropsychiatric disabilities in the Navy, and they present essentially the same symptomatology and clinical course as they do in civilian life.[2]

The incidence of neuropsychiatric disorders varies in accordance with the world situations as they affect the activity of the Navy. The incidences of specific groupings

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1 Frank J. Sladen, ed., Psychiatry and the War, pp. 248-9.

2 Ibid., p. 250.

of neuropsychiatric disorders are presented in Chart I[3] in relation to each other, to the years 1951-1952, and according to the area concentration of men.

> The incidence rate for mental, psychoneurotic and personality disorders during the fiscal year 1952 was 17.1 per 1000 average strength. This is higher than the rate of 14.5 per 1000 for the previous twelve months, and is also slightly above that for calendar year 1945, the highest encountered during World War II. The impact of these conditions, however, varied in different areas. In continental United States the rate increased to 23.8 per 1000 from 18.7 in the preceding year. On the other hand, in noncontinental areas the reverse is true, with the rate declining to 19.2 in 1952 from 23.7 per 1000 in 1951. For ships it may be observed that the current rate of 5.2 is only slightly higher than the 1951 rate of 4.6 per 1000.
>
> The causal factors controlling these variations also differ for each area. Undoubtedly the Korean action has had its effect on the incidence for these conditions in all areas. In continental facilities, where the proportion of new men entering the service is large, mental disorders would be expected to increase, especially among those who fail to adjust adequately to military life. These are usually screened out early. While the incidence rate in noncontinental areas was higher than in continental areas during the first year of the Korean action when the heaviest action was reported, the prolonged experience of the men in that area and the comparative lull during the current year resulting from the extended truce negotiations may have been responsible for the lower rate for that area during 1952.[4]

Inherent in a military setting is the aspect of very close and supervised observation of any one group of men.

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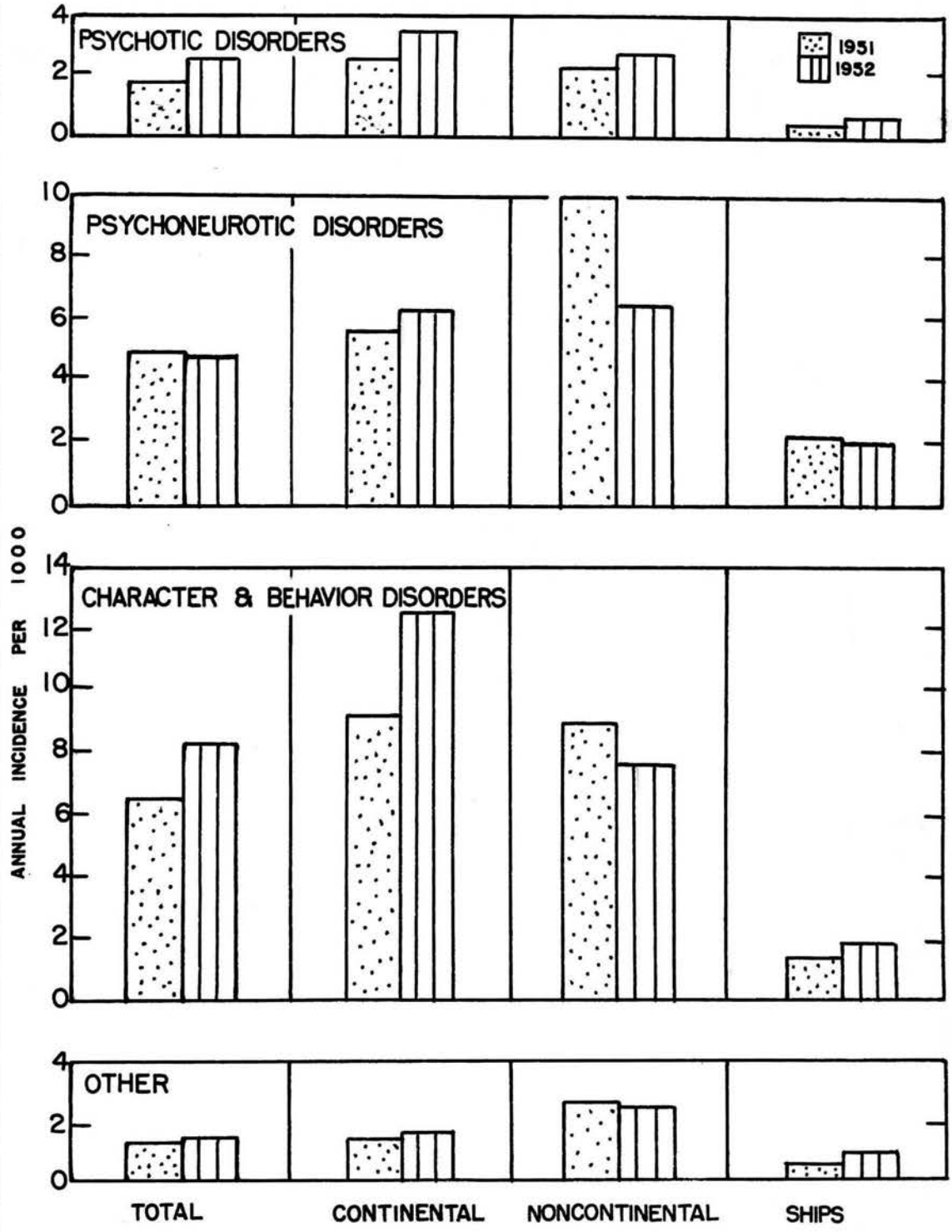
3 Prepared by the Medical Statistics Division of the Bureau of Medicine and Surgery, Statistics of Navy Medicine, November, 1952, p. 13.

4 Ibid., pp. 10-12.

CHART I

MENTAL DISORDERS 1951-1952

NAVY AND MARINE CORPS



This allows for the detection of malfunction or bizarre behavior in any one man where in a less intense situation these factions might go unnoticed.

Another factor in the hospitalization of the Naval patient is that, except in the case of self-referrals, a man is hospitalized by order. Such an order may or may not agree with the ideas of the man towards hospitalization.

> The fact that a patient comes to a psychiatric clinic in an authoritative setting in no way assures that he believes he has a psychiatric problem or that he believes he can be treated at the clinic. The referrer is almost always a person in authority and the referral a tacit command that the patient appear at the clinic.[5]

A good many of the patients were referred because of psychosomatic complaints. A great resistance to referral to a psychiatric clinic arises from the fact that the patient has developed his somatic complaints as an expression of neurotic needs that are not acceptable to the conscious. Often the very act of referral is an assault upon the neurotic defenses against the overt expression of a need which the ego cannot accept. An obvious example is the need for gratifications of passive dependent wishes expressed through psychosomatic illness.[6]

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5 Bertram M. Beck, Short Term Therapy in an Authoritative Setting, p. 8.

6 Ibid., p. 8.

An additional factor in this situation must be considered which is peculiar only to the military. A man is either well, about, and doing his duty; or he is sick, unable to perform his duty and is hospitalized. There is no happy medium for the serviceman in this respect--he is sick or he is not sick--he is doing his full duty or he is not doing any duty at all. In the latter case, then, he is hospitalized, which readily accounts for many instances where hospitalization is ordered much against the wishes of the serviceman. There is no limited duty in this respect to be offered to the serviceman.

These situations (1) detection of malfunction or bizarre behavior of a serviceman through the close and supervised observation of the Navy community (2) hospitalization by order (3) a sick or not sick status--full duty or no duty--point up a situation which allows initially for the hospitalization of many personnel who in a civilian community might not obtain the services of their local family doctor.

Psychiatry in the Navy is further identified by Captain Harrison in the inclusion of the invaliding rates and the etiology of mental disorders.

> While the incidence of mental disorders in the Navy is comparatively low, the story is quite different when it comes to the invaliding rate...
>
> The high invaliding rate results from the fact that once a definite diagnosis of a mental disorder

is made in an officer or man, his separation from the Navy ordinarily follows. It has been found by experience that such individuals do not do very well when returned to duty, and their symptoms are likely to recur, if they are subjected to the same stress and strain which precipitated their original breakdown...[7]

As far as the etiology of mental disorders in the Navy is concerned, constitutional predisposition, whatever that is, plays the most important role. The majority of our cases occur in individuals who since childhood have exhibited ineffective ways of dealing with their conflicts and handling the minor difficulties of life. As a matter of fact, quite a few of our patients give a history of having actually had a definite neurosis or psychosis before enlisting. It has been our experience that the average man in the Navy, unless he is constitutionally predisposed, will not break down with a mental disease, even when he is exposed to the most extreme hardships, both physical and psychological, of service life, and to the most harrowing and terrifying circumstances of modern warfare.

The usual precipitating factors operate in the production of mental disorders in the Navy, both during peace and war, just as they do in civil life. Trauma probably never causes a psychosis or neurosis in the Navy, unless the injury is an insignificant one, and the patient has an unconscious desire for some gain, such as evacuation from a combat zone, or discharge from the service. Almost never do we see mental disorders in individuals who are also suffering from severe physical wounds. From a psychological point of view, the psychoses and neuroses occurring in the Navy during war depend almost entirely upon the coming into play of the instinct of self-preservation...[8]

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7 Frank J. Sladen, ed., Psychiatry and the War, p. 250.

8 Ibid., p. 252.

It is of collaborating interest and information to include data in reference to psychiatric casualties in the Army. Colonel William C. Menninger, M.C., states:

> There are three general groups of psychiatric casualties to be distinguished in the Army. The first are the group of individuals who have always been maladjusted and were erroneously accepted into the Army. There is a second group of individuals whose adjustment capacity is so limited that their maladjustment developed in the training camp. The third group are individuals whose previous history of maladjustment was minimal, who might be regarded as nearly normal as any group might be, and yet under the terrific stress of battle conditions developed neurotic symptoms. In this latter group experience has shown us that immediate and prompt treatment gives extremely gratifying results. On the other hand, without treatment the clinical picture in all three groups may be remarkably similar.[9]

In regard to the present Korean conflict, a study of sixty psychiatric patients who had been evacuated from the battle zone to hospitals in the United States revealed a high incidence of predisposition to emotional illness. Almost half of the group showed either a marked or moderate predisposition. As many as seventy-five per cent showed some definite evidence of predisposition.[10]

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9 Franklin G. Ebaugh, Col., M.C., Chairman of Editorial Board, Military Neuropsychiatry, p. 70.

10 Lionel A. Schwartz, Captain, M.C., U.S.A., and Eugene R. Inwood, Colonel, M.C., U.S.A., "Psychiatric Casualties Evacuated from Korea," United States Armed Forces Medical Journal, July 1952, p. 1000.

There is one consideration which must be placed high in importance in the understanding of a military hospital neuropsychiatric service. It includes the purpose of the service. Colonel William C. Porter, M.C., U.S. Army, has presented it in these words which could be said to encompass the purpose of all military medical services. He states:

> We in the armed services are not unmindful of the need for research and of the great opportunities which the war gives us to deal with large numbers of human beings and to use them for research and experimentation in the field of human behavior, but the demands of war make impossible research into many of the problems by those of us who are performing the military mission which is placed upon us. One must be mindful of what that mission is before discussing what we as psychiatrists or what we as medical officers should do in our present situation. The mission of the medical department is to make men fit for combat or for servicing combatant troops and, failing that, to remove casualties...That is the sole mission. We have no other major directive. The psychiatrist has the problem of selecting individuals who are vocationally fit for service in the armed forces; and having accepted him, to assist him in preserving his mental integrity; and failing in that, to eliminate him from the service. He has no long therapeutic program facing him. There are other branches of the government, both state and federal, as well as private agencies whose duty it is to care for the ex-service man. Our duty is to carry on such therapy as will restore him to a combat or a supply status and, failing that, to make him as fit to live with as possible for the length of time that he remains in the military hospital and then eliminate him from the service and dispose of him in an orderly humane manner.[11]

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11 Frank J. Sladen, ed., Psychiatry and the War, pp. 239-240.

Neuropsychiatric Service Staff

The neuropsychiatric service at the USNH-Chelsea has a staff of psychiatrists which consists of the chief of the service who is a Commander in the U.S.N., M.C. and is a member of the Board of Psychiatry and Neurology. In addition to the chief of staff, there are three full lieutenants and a Junior Grade lieutenant. Also, a naval intern is assigned each month under the rotating internship program of the hospital. The neuropsychiatric service at USNH-Chelsea is accepted by the American Medical Association for internship and residency requirements.

The staff nurses are also officers in the Navy. They, along with the ward corpsmen, who are enlisted men, complete the detail of Naval personnel within the particular neuropsychiatric service at the USNH-Chelsea. The services offered to the patients are further increased by the facilities of civilian staff--two psychiatric social workers, a clinical psychologist, a consultant in psychiatry and a consultant in neurology.

The psychiatric social workers and the clinical psychologist are maintained as full time members of the staff, attend and participate in all departmental conferences, and have frequent discussions and regular consultations with the psychiatrists in regard to the patient's hospitalization and disposition.

All staff members participate at the various staff conferences which are held four mornings a week. On Tuesday afternoon there is a staff conference with the civilian consultant. The ward physicians are responsible for the case presentations of the in-patients, while the social work staff assumes responsibility for the out-patient presentations, which include the dependents. Other staff members who attend the dependents' staff conference include the medical social work supervisor, the Red Cross Field Director, and the Red Cross social worker.

In addition to the in-patients, the neuropsychiatric service maintains an out-patient clinic for dependents and offers psychiatric treatment on a selected case basis. Group therapy or case work services are offered by the social work staff as indicated. The psychiatric social workers are available to the hospital personnel for consultation and referral as needed.

Since there are no facilities for the treatment of dependent children on the neuropsychiatric service, they are referred to community agencies and resources.

There are four wards for in-patients in the neuropsychiatric service which include three wards for the psychiatric patients (two open wards and one closed ward) and one ward for the neurology patients.

The previous paragraphs have presented specific aspects of Navy life in order to understand the specificity of the setting of a Naval neuropsychiatric service. Captain Harrison gives these words in relation to psychiatry in the Navy:

> In conclusion, let me emphasize the fact that the primary function of psychiatry in the Navy, in peace or war, is to keep personnel of the Fleet at the topnotch of mental health at all times. The only excuse for its existence is that it shall accomplish results in this direction. If the events of the last World War and the present one are to be taken as criteria, the utility of psychiatry in the Navy has been clearly established. Psychiatry has developed tremendously during the last quarter of a century, not only in the number of trained psychiatrists, but also in the deeper knowledge of etiology, examination techniques and treatment procedures. The Navy has kept pace with this expansion, and has been utilizing psychiatry in all its phases throughout the service. Whatever may be its shortcomings, psychiatry has made good to such an extent that it will always be a major specialty in the Medical Department of the Navy, and it will forever occupy a prominent and permanent place therein.[12]

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12 Frank J. Sladen, ed., Psychiatry and the War, p. 263.

Chapter IV

SOCIAL WORK PROGRAM IN THE UNITED STATES NAVAL HOSPITAL-CHELSEA

History and Development of Social Work in the Military Setting

Wars have been present in our civilization down through the ages, but it was only with the turn of the last century that any recognized, organized, or large-scale civilian facilities were provided in addition to the military services and in accord with the military authorities for the purpose of aiding and caring for the health and welfare of the military personnel.

A voluntary organization which was known as the United States Sanitary Commission was founded in New York shortly after the outbreak of the American Civil War. One of the most valuable services performed by this pioneering organization was in the evacuation of the wounded troops from the battle grounds by providing the evacuation hospital trains with litters, mattresses, linen and food facilities. Although the government sanctioned their creation, no funds were allotted for their operational expenses. They appealed directly to the public for funds, for clothing, and during a scurvy epidemic, asked specifically for fresh fruits and vegetables. This one organization cared for the wounded and performed services for the troops of both the Union and

Confederate forces of the Civil War. From these many acts of mercy and brave attempts at organization came eventually the American Red Cross.[1]

With the grant of the congressional charter of 1905, The American National Red Cross was officially recognized as the only voluntary relief agency with permission to work with the armed forces in wartime. This charter, besides providing the auditing of all Red Cross accounts by the War Department and for the transmission of an annual Red Cross report to Congress, assigned the following responsibilities to the American Red Cross:

> To furnish volunteer aid to the sick and wounded of armies in time of war...
>
> To perform all the duties devolved upon a national society by each nation that has acceded to any of the treaties of Geneva...
>
> To act in matters of voluntary relief and in accord with the military and naval authorities as a medium of communication between the people of the United States of America and their Army and Navy...
>
> To continue and carry on a system of national and international relief in time of peace and to apply the same in mitigating the sufferings caused by pestilence, famine, fire, floods, and other great national calamities, and to devise and carry on measures for preventing the same.[2]

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1 The American Red Cross, A Brief Story, p. 4.

2 Ibid., pp. 9-10.

So began organized civilian services to our men in the armed forces. By 1917 the Red Cross was training and assigning field directors and staff members for their services in military hospitals and stations both in the United States and overseas. Such services included volunteer aid to the sick and wounded men and instigated the first official, reliable and efficient service of communication between the serviceman and his family when other normal facilities were not available. As the charter directs, the Red Cross personnel worked closely at all times with the military authorities.

The USNH at Chelsea was the first Naval hospital in which Red Cross medical social services were initiated. It was in 1918 that medical social services were requested by the Commanding Officer. From the expansion of medical social services there developed the recreational program which has today reached such prominence within the total services of the American Red Cross Program.[3]

In 1928 the Red Cross withdrew from the VA Hospitals according to plan in a previously drafted statement to the effect that the VA was to take the responsibility and financial burdens of a program similar to that of the Red Cross at a time feasible for the change.

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3 Personal communication, Field Director of American Red Cross, USNH-Chelsea.

In 1942, shortly after the start of World War II, there were further attempts to fulfill the tremendous social service needs of the armed forces. Elizabeth A. Ross[4] describes these attempts in her article entitled Early Efforts of the War Service Office and says:

> During 1942 the Military and Naval Hospitals Division of the National Office of the American Red Cross was well launched on one of its successive waves of recruitment for highly qualified medical, recreational, and psychiatric social workers... Should the Red Cross attempt to staff the contemplated increase in Army Consultation Services with psychiatric social workers? Was that the best use of limited, skilled personnel? Such a plan, obviously, was consistent with similar staffing in hospitals. Too, it would seem to fit with the Red Cross desire to help the Army, by freeing combat material--good Army talk for men--for combat. What were the chances of obtaining enough workers to cover the job?...
>
> As these and related questions were being discussed, the Red Cross acting consultant in psychiatric social work suggested in December, 1942, to the Chief of Army Psychiatry that before decisions were reached he might wish to get in touch with the WSO,[5] on the chance that the WSO had, or could obtain, data relevant to the use then being made of Army social workers. During the early months of 1943 it was learned, through the first WSO inquiry of soldier social workers, that even then a few civilian trained Army men were serving as psychiatric social workers in station and general hospitals, and in the Army's program of rehabilitation for its prisoners. Had the Red Cross been able to recruit enough psychiatric social workers

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4 Elizabeth A. Ross served as Secretary of the War Service Office, American Association of Psychiatric Social Workers.

5 Designation used hereafter for War Service Office.

> to approximate the Army's estimated need for 1941-43, or had it thrown over its standards of professionalism, or had it made rash estimates of potential recruitment of psychiatric social workers, it is improbable that the Army would have developed an officially approved plan to use soldier social workers in neuropsychiatric settings.[6]

The Navy Story as written by Elizabeth Ross explains in these brief words the Navy's considerations of the use of military psychiatric social workers during World War II:

> When the WSO's plan to approach Navy psychiatry was discussed with the Hospital Services of the Red Cross, we again learned of the size and variety of professional social services provided Navy medicine by the Red Cross...
>
> We first called on the Navy's Chief of Psychiatry in the Bureau of Medicine and Surgery in October, 1943, to ask whether naval psychiatry contemplated a program which would utilize its own personnel who were trained social workers... We were informed that if Navy psychiatry should use its own men as social workers, they would have to be officers and persons who qualified as psychiatric social workers at the highest civilian standards. The high standards were emphasized as basic to a workable professional team. Moreover, we were advised that there was little reason to consider a sizable program because Navy psychiatry was satisfied with, and appreciative of, the quality of social service being provided their neuropsychiatric services through the Red Cross.
>
> But, because of the chance that the Navy might occupy areas (islands were not being mentioned aloud then) where it might be inappropriate to send women, the Chief of Navy Psychiatry indicated that there might be advantages if the Navy knew more about the current assignments of its own highly trained psychiatric social workers.[7]

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6 Henry S. Maas, ed., Adventure in Mental Health, pp. 178-9.

7 Ibid., pp. 22-3.

There were intermittent conferences, exchange of letters, and many discussions around the subject of Naval Psychiatric Social Workers, but the war was ended before any formal action could be taken.

Limitations of Red Cross Social Work Services in 1950

In a letter distributed to all Red Cross Field Directors by the specific local administrator there was this directive:

> At a meeting March 27, 1950, The Board of Governors of the American Red Cross under the leadership of General George A. Marshall directs that plans be made to discontinue the medical and psychiatric social work services in military hospitals and requests the staff to work out a program to accomplish this by July 1, 1952.[8]

The reason for this directive was to transfer the tremendous financial burden incurred by these services in view of the gigantic development and growth of the armed forces of today.[9] By this directive, therefore, medical and psychiatric casework services of the American Red Cross were limited but accorded plans that the Red Cross would continue a limited program of social services to patients.

The American Red Cross is an agency that not only maintains, but is obliged to maintain, a liaison between the serviceman and his family throughout every community in this country and in every country overseas where there

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8 Letter from Area Manager, American Red Cross to Area Staff, American Red Cross - Directive of April 7, 1950. Subject--in regard to discontinuance of medical and psychiatric social services in military hospitals.

9 Personal communication, Director of ARC, USNH-Chelsea.

are stationed American servicemen. In reference to this obligation, therefore, and to other traditional services of the American Red Cross, their social services program includes these functions:

(1) to obtain health and welfare reports of the serviceman's family at the request of the serviceman, including verification of emergency leave when necessary;

(2) to obtain medical or psychiatric social history at the request of the attending physician in the case of hospitalized serviceman;

(3) to fulfill requests of the serviceman for comfort articles and make small financial loans in emergency situations;

(4) to aid the serviceman in filing VA claims pending his discharge from the armed services.[10]

Establishment of Civilian Social Work Program

In accordance with the Red Cross directive, therefore, plans to discontinue medical and psychiatric social work were carried out as quickly as possible. The Red Cross social work personnel had the choice of maintaining their Red Cross association or of accepting social work positions as civil service employees.

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10 Red Cross Service Record, pp. 55-60.

The program in the Navy, initiated as recently as the latter part of 1951, involved the use of civilian personnel as social workers. This plan was, therefore, distinctly different from the other programs serving the armed forces of the United States which undertook, as far as possible, to commission social workers. Many of the basic functions and philosophies of social work, of course, are not to be considered as the distinction between this program and others, for there is no intention of making such distinction. However, the specificity of each branch of the service, with its proud customs and precedents, does account for certain distinctions of programming.

An outstanding comparison between social work in the Army and Army Air Force Hospitals and social work in the Navy is the distinction of a civilian psychiatric social worker as opposed to a military psychiatric social worker. The various positions of military rank of the social worker could conceivably produce a reaction from the serviceman who is particularly bothered by problems of authority and rank. However, the civilian psychiatric social worker in the Navy is not involved with these considerations. For example, in an instance where the psychiatric social worker was assigned duty with the rank of private, many considerations had to be evaluated:

> There are other facts which affect the MPSW[11] as they do every soldier. There is, first of all, the period of his own living--through the separation from family, civilian work and pursuits; his moving into Army life and becoming a soldier, a soldier by every standard the Army has created. He may find himself sometimes not enough of a person, in military terms, to be recognized as one by his patients once he is assigned as MPSW. The Private soldier comes to see authority and power in terms of rank. Thus, a Private-patient may say with freedom to a Private MPSW, "You're no higher than I am. I don't have to talk with you." It is just one of the complications for the MPSW![12]

A counterpart to the reaction of the serviceman to the authority invested in the MPSW, however, is the fact that as a military person, the MPSW is aware of the minutiae of life in the military which may be an aid in the establishment of a relationship with the enlisted man. In such a relationship the soldier may feel he is talking with a peer as well as a sympathetic listener, and he is thus given an opportunity to release feelings which he could not express in the ordinary routine of Army life.[13]

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11 MPSW - Designation used hereafter for Military Psychiatric Social Worker.

12 Clara Rabinowitz and Elizabeth A Ross, "The Military Psychiatric Social Worker," The News Letter, Summer, 1944, p. 15.

13 Private Nathan Hurvitz and Private Ralph M. Kramer, Bulletin of U.S. Army Medical Department, p. 79.

Military psychiatric social work has been defined as:

> A professional service practiced in direct and responsible working relationship with military psychiatry, designed to assist military personnel as individuals to achieve within their particular capacities and desires a more efficient military service. This objective is reached by 1) effecting through social casework skills more awareness on the part of the individual patient of the part he can take in adapting his desires and capabilities to his military environment, and 2) effecting through mental hygiene activities a deeper appreciation on the part of military personnel of the wide range of individual, personal, and social needs and desires.[14]

It is noted that the definition given for military psychiatric social work makes frequent use of the word "military" and points out that one of the goals of military psychiatric social workers is to help the soldier adapt his desires and capabilities to the military environment. In this respect it is necessary to understand that any endeavor within a military organization, whether it be medicine, social work or any other activity, must be primarily concerned with the individual as a member of a military unit. Therefore military social workers must consider the effectiveness of their task in terms of the over-all effectiveness to the military unit of which the individual is a member. The existence of social workers as professional people in a military setting;

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14 Captain Francis J. Ryan, "Social Work in the Military Setting," Journal of Psychiatric Social Work, March, 1952, p. 142.

> ...leads us to the realization that if psychiatric casework can be effectively practiced within the military framework two fundamental propositions must be true: 1) psychiatric casework can be practiced effectively in a setting where the primary focus is on the welfare of the group; and 2) psychiatric casework can be practiced effectively in an authoritative setting.[15]

Development of Social Work Program at USNH-Chelsea

A social work service which has been functioning for less than eighteen months must be considered as a very recent development. True, the programming of a recent service has the benefits of the experiences of the pioneers in the field. However, each new endeavor has its own particular requirements, and in this respect, the civilian social work program in the Navy must meet the requirements of Navy qualifications and standards. Foremost among the requirements is that only accredited graduates of approved schools of social work are qualified for the positions as social workers as directed by and in accordance with the United States Civil Service Commission.

In the USNH at Chelsea, the Commanding Officer requested authorization for three civilian social workers from the Bureau of Medicine. The Neuropsychiatric Service requested two psychiatric social workers which included one psychiatric social work supervisor; one medical social work supervisor was assigned to the Medical Service.

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15 Ibid., p. 142.

The Civil Service Commission in the directive for the psychiatric social work supervisor states:

> Under the professional cognizance and administrative control of the Commanding Officer and the chief of the NP Service and in collaboration with the Red Cross Field Director, develops operating policy and procedures for the psychiatric social case work program in accordance with the needs of the installation. Develops and recommends detailed working plans for the assigned function, including such considerations as space and staffing requirements, working relationships with hospital staff members and related channels of communication, and the establishment of records and reporting systems.[16]

In the development of the social work program at the USNH-Chelsea the decision was made that the civilian social workers would be directly responsible to their respective chiefs of staff. In practice, the psychiatric social service supervisor and the medical social service supervisor work in close cooperation in maintaining the availability of social casework to the demands of the entire hospital. They work in collaboration in the adoption of current casework practices as well as in maintaining a uniform, mutual record control system. The proximity of their adjoining offices further embraces the possibilities for the integration of the social work program at the base.

All members of the psychiatric social work staff attend and participate in the ward rounds, admission and disposition

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16 Civil Service Position Description, No. 644.

conferences on the Neuropsychiatric Service in order to contribute from their knowledge of the social components in illness and to keep abreast of diagnostic thinking. Casework services are suggested and requested at the staff conferences. The psychiatric social work supervisor is responsible for the presentation of the dependents' cases at designated staff conferences. The position entails responsibility, also, for the orientation of other personnel on the base--nurses, interns, residents and corpsmen. With the professional staff, the training consists of interpretation of the social situation and social work on an individual case basis through frequent discussions. With the corpsmen on the neuropsychiatric service there are meetings which serve to increase their understanding of mental diseases and handling of patients.

With the permission of the Commanding Officer, there have been two graduate students from the School of Social Work, Boston University, who complete their required and approved field work training as student members of the social work staff.

It is a civil service directive for the social workers to keep well informed on the resources and regulations of Federal, State and local social and health agencies whose assistance could be utilized in the program.

Psychiatric social work has become an essential part of neuropsychiatric practice in all hospitals, civilian as well as military. At the USNH-Chelsea, the team approach of psychiatrist, clinical psychologist, social worker and ancillary personnel is used. The psychiatric social workers on the neuropsychiatric service are concerned with the social aspects of the patient's illness--with family problems that may affect the patient's response to treatment or his adjustment to a disability, with the patient's attitude towards his hospitalization or his illness, his reactions to authority situations and with problems which are of concern to the patient who is being discharged from the service.[17]

Every patient on the neuropsychiatric service is seen on admission by the psychiatrist who is his therapist throughout his hospitalization. Each patient is given a series of psychological tests as the case warrants. On admission each patient has an initial interview with a psychiatric social worker as an administrative referral. At any time during the hospitalization of the patient special requests for pertinent information or services may be given to the social workers by the doctor, nurse, patient, or interested person. There is a one-hundred per cent patient

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17 Civil Service Position Description, No. 644.

coverage by the psychiatric social workers of the neuro-psychiatric in-patients with varying intensities of casework service as indicated. The psychiatric social worker, besides being the initial admission interviewer, is the patient's caseworker throughout his hospitalization, maintaining a close relationship between the patient and doctor, conducting independent sustaining interviews and helping the patient in all problems pertaining to his discharge.

In very few settings are such wide possibilities of social and cultural values open to study and evaluation by the social worker.

> We can no longer take it for granted that we understand the way of life of other people. It is essential to learn and interpret their behavior patterns and problems and relate them to the way of life of their group.[18]

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18 Pauline V. Young, Social Case Work in National Defense, p. 66.

Chapter V

STATISTICS AND CONSIDERATIONS OF PATIENTS STUDIED

Introduction

This chapter includes a presentation of statistics on the seventy-eight psychiatric patients in the study. The patient presents several distinctions to the hospital setting as he is bounded by the specificities of the Navy and Marine Corps. The armed services exist on specific requirements which become inherent entities to the organization thereby tending to unify and mold men to a unique solidification of personnel. Conversely, by the very nature of the organizations, men are drawn from every conceivable walk and station of life, which tends to present a variety and scope of personnel not found in any other one organization.

For the most part only male patients are accepted on the neuropsychiatric service of this Naval hospital. Since there are relatively few Navy and Marine Corps women personnel stationed in the district, there has been no need to establish in-patient psychiatric facilities for women. In the rare instances where hospitalization is required for women personnel, they are admitted to the Dependents Unit and a special watch is assigned if close observation is needed. Except for these situations, women are seen only through the out-patient neuropsychiatric clinic, as dependents to the serviceman and only for consultation and

referral. There are no in-patient neuropsychiatric facilities for children at this hospital. The in-patients are, to all intents and purposes, men who are under military authority and military order, which includes their admission to the hospital and their disposition from it. There is an occasional retired serviceman who by virtue of his disability privileges is entitled to hospitalization.

Referral Sources

It might be best to enumerate first the various means by which a patient is admitted to the neuropsychiatric service. Referral may be suggested by a doctor, nurse, chaplain, Naval relief, Red Cross, outside agencies; or he may request self-referral. He may be admitted from his ship through the medical officer or commanding officer, from other military hospitals, military bases, the brig, or from home.

Table I shows the numbers and percentages of men in each branch of service that have been admitted to the psychiatric service of the USNH-Chelsea and have been included in this study. The U.S. Air Force men that are hospitalized at a naval hospital are admitted only as emergency or temporary patients and are transferred to their respective or destination hospitals as soon as transportation can be arranged.

TABLE I

BRANCH OF SERVICE

Branch	Number of Patients	Per Cent
Navy	66	85
Marines	10	13
U.S. Air Force	2	2
Total	78	100

Age

The majority of the patients fall within a rather limited age group. Table II shows the ages of the group of the patients included in this study.

It is found that fifty per cent of the patients studied were between the ages of seventeen and twenty-one years, inclusively, which gives approximately twenty-one years of age as the median of the group. It is interesting to note that the median age of the patient studied in the three-month period compares remarkably to the median age of the entire service personnel. The median age in Table II can be compared with the median age of the entire Navy and Marine Corps given in Table III.

TABLE II

AGE

Age at Time of Hospital Admission	Number of Patients	Per Cent of Each Age	Quartile [1] Groupings
17	3	4	
18	8	10	
19	9	12	
			25.6
20	11	14	
21	9	12	
			25.6
22	11	14	
23	6	7	
24	2	3	
			24.4
25	7	9	
26	2	3	
27	4	5	
28	1	1	
29	1	1	
30 and over	4	5	
			24.4
Total	78	100	100.0

1 Figures given are actual percentages for each grouping, rather than corrected to exact percentages of twenty-five.

TABLE III[2]

MEDIAN AGE BY TYPE OF PERSONNEL,
NAVY AND MARINE CORPS: 1926-1950

Year	Enlisted[3]	
	Navy	Marine Corps
1946	21.7	20.5
1947	21.7	19.8
1948	22.2	20.7
1949	22.8	21.9
1950	22.9	21.9

These figures do not include the years 1951-1952; however, the increase in the strength of the Navy and Marine Corps due to the Korean conflict had a lowering effect upon the age group due to increased enlistments and the Marine Corps requirements of supplement enlistments through the use of inductees obtained from Selective Service channels.[4] The median age of the patient on the neuropsychiatric service at USNH-Chelsea studied within the three-month period was not significantly distinguishable from the median age of the entire Navy and Marine Corps as given in Table III.

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2 "Medical Statistics," Eighty-Sixth Annual Report of the Surgeon General of the United States Navy, 1950, p. 5.

3 Excludes female personnel.

4 Statistics of Navy Medicine, November, 1952, p. 2.

Marital Status

TABLE IV

MARITAL STATUS

Marital Status	Number of Patients	Per Cent
Single	54	69
Married	21	27
Divorced	3	4
Total	78	100

Table IV shows that the majority of the men in the group studied were single. Of the forty men who were within the first and second quartile in age (which included half of the men in the study) only five were married.

Table V presents data on age and marital status, which further identifies the patients that were included in the study.

One might conjecture from such data, and in absence of further substantiating data, that since the median age of the enlisted man is roughly twenty-one years, his military duty requirements at this time have preceded his considerations of marriage.

TABLE V

AGE AND MARITAL STATUS

Age Groups	Number Single	Number Married	Number Divorced	Total
17-21	35	5	0	40
22-30 and over	19	16	3	38
Totals	54	21	3	78

Length of Service

Table VI gives the length of service of the seventy-eight patients studied at the time they were hospitalized.

TABLE VI

LENGTH OF SERVICE AT TIME OF HOSPITALIZATION

Length of Service	Number of Patients	Per Cent
6 months or less	9	12
6 months to 1 year	12	15
1 year to 2 years	14	18
2 years to 3 years	10	13
3 years to 4 years	4	5
4 years to 5 years	10	13
5 years to 6 years	4	5
6 years to 7 years	4	5
7 years to 8 years	4	5
over 8 years	7	9
Total	78	100

The median length of service in this group of men is about two and one-half years at the time of hospitalization. Of further interest in examining the length of service at the time of hospitalization is the group that includes those men who have served one year or less in the Navy and Marine Corps. There are twenty-one men in this group which means that twenty-seven per cent of the men in the study were so unable to adjust to the military service that they required neuropsychiatric care before they had served longer than one year in the Navy.

Days of Hospitalization

Table VII presents data on seventy-six of the seventy-eight patients studied in the three-month period. Two patients were omitted inasmuch as they were still in the hospital at the time the figures were compiled. However, at that time one had been hospitalized for fifty-nine days, and the other had been in the hospital for one-hundred and fourteen days.

The median of Table VII falls between forty and forty-one days of hospitalization. It is of interest to note from the entire patient personnel of USNH-Chelsea: "For active duty Navy and Marine Corps patients the length of stay during the second and third quarters of 1952 was

about forty-one days.[5] On inspection, there is a sharp decline in the number of patients who are hospitalized longer than seventy days.

FIGURE VII

NUMBER OF DAYS OF HOSPITALIZATION

Number of Hospital Days	Number of Patients	Per Cent
1 - 20	12	16
21 - 40	21	27
41 - 60	18	24
61 - 80	9	12
81 - 100	9	12
101 - 120	3	4
121 - 140	1	1
141 - 160	3	4
Total	78	100

Fifty-eight patients were hospitalized for seventy days or less. They make up seventy-eight per cent of the seventy-six patients of the group presented in Table VII.

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5 Prepared by the Medical Statistics Division of the Bureau of Medicine and Surgery, Statistics of Navy Medicine, January, 1953, p. 3.

This would seem to be a relatively short period of hospitalization for the neuropsychiatric patient. It is an area where the goal and purpose of the military psychiatrist are evidenced rather clearly, for the inherent nature and demands of the military preclude a lengthy hospitalization.

> Flexible methods of procedure are especially applicable in military psychiatry, since treatment is in many cases extremely brief. Discovering the dynamic basis of the neurotic reactions as quickly as possible is a vital necessity...[6]

The percentages of the diagnostic categories in this study follow the general percentage trends of mental disorders of the entire Navy and Marine Corps. Reference is made to Chart I which gives the mental disorders categories of the entire Navy and Marine Corps. Since Chart I and Table VIII are not computed on the same numerical or percentage basis, they cannot be compared for more than the general trends that they signify. In this respect they compare favorably, and indicate that the patients in the study include a sampling of the mental disorders found in the entire Navy.

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6 Franz Alexander, M.D., and Thomas Morton French, M.D., Psychoanalytic Therapy, p. 325.

TABLE VIII

DISCHARGE DIAGNOSES[7]

Discharge Diagnosis	Number of Patients	Totals	Per Cent
Psychotic disorders		10	13
Schizophrenic reaction (simple and paranoid)	10		
Psychoneurotic disorders		13	17
Anxiety reaction	4		
Dissociative reaction	1		
Neurotic depressive reaction	6		
Psychogenic reaction	2		
Character and behavior patterns		49	63
Pathological personality types:	10		
Schizoid personality	3		
Inadequate personality	2		
Antisocial personality	2		
Sexual deviate	2		
Immaturity reactions:			
Emotional instability reaction	10		
Passive dependency reaction	12		
Passive aggressive reaction	2		
Aggressive reaction	2		
Immaturity with symptomatic habit reaction (enuresis)	3		
Alcoholism	1		
Transient personality disorders due to acute or special stress		3	4
Acute situational maladjustment	3		
Psychiatric observation	1	1	1
Convulsive disorder	1	1	1
Neuropathy	1	1	1
Grand total	78	78	100

7 Joint Armed Forces, Nomenclature and Method of Recording Psychiatric Conditions, June, 1949, pp. 1-2.

The data presented from the statistics on the psychiatric patient within the prescribed three-month period would indicate an adequate cross section of the types and numbers of the patient population of the USNH-Chelsea neuropsychiatric service.

CHAPTER VI

Case Studies

It will be the purpose of the case presentations to identify problems that are distinctive and specific to the military setting. The cases that are to be presented in this chapter have been selected because they best typify particular groups of patients whose problems are peculiar to the Navy or whose problems are handled in a manner distinctive to the Naval setting because of the inherent nature and purpose of the organization. Thus the cases selected do not necessarily indicate the most prevalent problems.

Although a substantial number of patients go back to duty after their hospitalization on the neuropsychiatric service, the more complete social work services are found to be required by the more disturbed patient. The cases selected for presentation, therefore, are those patients who most often required discharge from the Navy or Marine Corps. Six psychiatric cases will be presented to illustrate types of problems that are distinctive to the Naval setting. The seventh case to be presented typifies the neurology patient referred to social service. The final case presentation will typify dependent referrals.

CASE I: REACTION TO DUTY, HOSPITALIZATION AND DISCHARGE

Nineteen year-old, white, single, corporal, was admitted to this hospital with symptoms of tension, irritability, aggressiveness, and a fear of guns. His symptoms began as he left Korea in February, 1952, to return to the States.

Following a recent impulsive act of destruction of government property at the Marine base, he was sent to the hospital.

Marine is an only child. When he was fifteen years old his mother and father mutually agreed on a separation for they argued and quarreled constantly about "finances." Marine stated that his mother was a warm, young, good-looking and easy-going person. He felt that he and his mother had a brother-sister relationship, but admitted that she had a tendency to be over-protective of him. Father was seldom at home, for he always went out to meetings and club functions which caused further strife in the home. There was so much arguing between his parents that he never paid any attention to it. When his parents separated, he went to live with his mother because he felt that he should take care of her.

Marine left school at sixteen years of age. He worked for four months as a counterman when he impulsively decided to join the Marine Corps.

While he was in Korea he drove a supply truck and, although not subjected to intensive enemy attack, he did travel over mined areas. Although he said he was never afraid in Korea, he did admit to "butterflies in my stomach at times."

He was very hostile when admitted to the hospital and was furious about being in the locked ward. He insisted on week-end liberty to "clear up some personal business." Eventually he divulged that his girl had accused him of being responsible for her pregnancy, so he wanted to make plans to marry her. It made him proud to think that he might be a father. When it was learned that the girl was not pregnant, he thought it might be best to delay the marriage because he had been feeling so "shook."[1]

At first Marine found it very difficult to express any hostility when speaking of his family but later was able to say that he became very irritated at times with his mother when she treated him like a little boy. He also admitted hostility towards his father for not supporting his mother.

During his hospitalization he received intensive, supportive interviews by the social worker in addition to psychiatric treatment. He brought out to the social worker that he was afraid to go back to duty and yet was very reluctant

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1 This is a common term used by the Navy and Marine Corps men to indicate rather intensive feelings of anxiety.

to leave the service for he feared that he would "lose something." Civilians were just "ordinary people," whereas the service "gives me a feeling of being someone." He spoke of his self-consciousness with people and his feelings of inferiority. He expressed fear and difficulty in handling guns and standing inspection. Through treatment, the patient was able to tolerate better his frustrating situations, gained back some of his self-confidence and was able to look more objectively at his feelings and relationships with his parents.

It was felt that this Marine possibly might make further adequate adjustment to military service if he were returned to his base with the recommendation of limited duty as far as guns and inspections were concerned. Because of his feelings of "being someone" while in the service, and the support that he found in the service, he was sent back to duty after two and one-half months of hospitalization. Two weeks later, however, he was readmitted to the hospital because his feelings of tenseness and anxiousness soon returned.

As soon as the patient returned to the hospital, he quickly regained his previous improved state. Upon further consideration, it was decided that duty was too threatening, and discharge from the service was recommended. Marine began to feel somewhat better about the future where previously he became frightened at the thought of discharge. He refused help in looking for a job while he was still in the hospital because he said that he planned to leave the state to find work.

He was hospitalized for a total of eighty-eight days and his diagnosis was emotional instability reaction under the character and behavior category.

His case was reviewed at the Physical Evaluation Board and he was granted a thirty per cent disability. When he left the hospital, he was much improved symptomatically and said that he felt much more confident now than he had been feeling prior to hospitalization. He doubted if he would need any further help at a VA Mental Hygiene Clinic where he would be eligible for treatment because of the veterans' benefits accorded him.

This patient presented symptoms of tenseness, nervousness and aggressiveness following non-combat duty in Korea.

He also expressed fear in handling guns and felt he could not stand inspection. He reacted with considerable hostility to the fact that he was hospitalized following a destructive episode while on duty. He more or less volleyed back and forth with this projection of hostilities between his duty to the Marines and his hospitalization. He was virtually unable to express any feelings of hostility against his family, except on rare occasions.

With the realization of possible discharge from the service, he expressed strong desires and needs to remain in the service. However, in spite of considerable support he was unable to maintain duty status for more than two weeks. This necessitated a readmission and preparation for discharge which he eventually was able to accept.

CASE II: REPEATED AWOL'S WITH SUICIDE ATTEMPT

One of the problems that is ever present in the armed forces is that of unauthorized absence from duty. The problem includes many complications. It is not an infrequent occurrence to find suicidal attempts involved in some way with this situation. In the Navy, psychiatric evaluation is almost always recommended, frequently with prolonged hospitalization to determine whether the man is fully competent and responsible for his actions.

Twenty-six year old, white, single, intelligent, RMSN,[2] USN, with over seven years total military service, was admitted from the brig where he turned himself in following an extensive period of AWOL. This was his second lengthy AWOL, both of which followed suicide attempts of apparently serious intent. Patient was facing charges of desertion at the time of his hospitalization.

Serviceman's family background was significant because of severe deprivations of affection, food, clothing and shelter. His parents were divorced when he was seven years old; he was the third child of five siblings.

After two years of high school he left to go to work in order to help support the family. When he was seventeen years old he joined the Navy because "it was a living."

Serviceman has seen considerable combat experience and participated in active guerilla warfare for over a year in Greece. While overseas he became particularly attached to an officer and his wife who seemed to accept him as a member of their family. He stated that this was his first and only experience with a happily married couple. Shortly following their transfer to another duty, he attempted his first suicide attempt. Because he felt the men on the ship "talked" about this he went AWOL for ninety-seven days.

On his admission to the hospital, he was depressed and tense. He kept pretty much to himself, choosing to read rather than to mingle or talk with the other patients. He felt that he had nothing in common with them--their interests were basal and their talk offered nothing of any merit. After several weeks on the ward, the situation became intolerable for him. At this time his disciplinary status allowed him to be transferred to the open ward.

It was felt that his primary defenses against impulsive acting out appeared to take the form of universalistic thinking and abstraction. He was quite capable of suicide and could be considered close to a frank break with reality. As a result of the psychiatric evaluation, his case was sent to the Bureau of Medicine in Washington with the recommendation that his charges be dropped and that he be discharged.

Serviceman was hospitalized for ninety-four days. His discharge diagnosis was neurotic depressive reaction.

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2 Radioman, seaman.

While "waiting out" his dispositional decision he was able to understand and accept his need for treatment following his discharge from the Navy and accepted referral to the appropriate community psychiatric clinic. He presented no problems in regard to finding a job since he had several offers waiting for him.

This case represents an AWOL situation complicated by suicidal gestures which were of serious intent. It was early evident that patient's disposition would involve discharge from the service. His hospitalization was involved, primarily, in attempts toward helping him form positive relationships as far as he was able to accept them. Considering that his relationships with women had always been ambivalent and guarded, he showed a marked improvement in being able to tolerate a warm and meaningful relationship with a female social worker.

CASE III: ENEURESIS

Eneuresis is considered to be a rather common problem in society. The armed services, because of their living arrangements, present a situation where the problem is quickly evidenced. Although a known eneuretic is not accepted for military service, there are those cases which lack detection upon enlistment. Eneuresis presents a problem which cannot be tolerated by the Navy because of the very nature of the circumstances of the living accommodations.

Twenty-year old, single, white, SA,[3] USN, was referred to the neuropsychiatric service from his ship. He had been

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3 Seaman apprentice.

assigned aboard ship ten days previously, upon completion of boot camp training, and each night had wet the bed.

Patient stated that he was embarrassed by his problem and while aboard ship had tried every means he knew to avoid wetting the bed. Previous to this time he had not been referred for psychiatric treatment. Local doctors had unsuccessfully treated his condition with medication.

He was born in a small, rural, southern town and was the twelfth of fourteen siblings. Since his mother's death two years ago, his father has been living with one of the married daughters. Patient shifted among his siblings and worked in a factory until his enlistment. He felt that his parents were easy-going people, but without much affection. He expressed considerable devotion towards his mother, who had "changed his sheets" and looked after him.

Patient stated that he is the quiet type of person who almost always stays by himself, but does have a few friends. Although he has been going with a girl at the present time, he stated that he does not plan to marry her because of his eneuresis.

Patient would have liked to stay in the Navy, but could readily understand that this was not possible because of his problem. Attempts were made by the social worker to have him accept limited interpretation of emotional components of the problem, which he was able to do to a remarkable degree. At the time of discharge, he accepted a referral to a local psychiatric agency for out-patient treatment.

He was hospitalized for twenty-four days and was given the diagnosis of immaturity with symptomatic habit reaction classified under the character and behavior patterns.

Where a symptomatic habit disorder is evidenced by eneuresis, the problem is handled only for attitudes and feelings relative to immediate discharge with emphasis placed on attempts to accept referrals to psychiatric clinics. It has been found that psychiatric treatment for such a long-term problem must be prolonged and intensive, and is not suited to the brief period of hospitalization possible in the Navy.

CASE IV: REACTION TO AUTHORITY

Nineteen year old, white, single, SA, USN, was admitted from his ship which he stated he could not stand. He complained of an overwhelming desire to run and escape from it. Serviceman acted out by going AWOL, or by smashing his fists against the walls. It was stated on his admission note that he was completely unable to accept authority.

He had been over-indulged by a socially prominent mother and felt that his step-father always had enough influence to get him just about anything he ever wanted. His father died when he was twelve years old.

Serviceman formed a relationship in which he cast himself as the college man in attempting a social acquaintance with the social worker. He did shift his contacts to requesting concrete counselling in order to help with his plans for a college education and a congenial vocation. He also attempted, at first, to use the social worker as a foil for the doctor. In time, however, he was able to respond to a more firm and realistic approach to the relationship, and stressed that he had certain responsibilities which the social worker would not help him to evade.

He returned to his ship to await an administrative discharge but soon requested readmission to the hospital for he stated he was sure that his officers had forgotten to act on his papers. His jubilant arrival was soon changed to periodic temper outbursts when he found he had to be readmitted through the closed ward.

He had a total hospitalization of ten days. Emotional instability reaction was his discharge diagnosis.

Serviceman was found to be competent and responsible and did not require hospitalization for psychiatric reasons. His second discharge from the hospital was to the brig to serve out a sentence for AWOL, with the understanding that he would receive an administrative rather than medical discharge.

Serviceman, although evaluated as competent and responsible as far as the Navy was concerned, was discharged because his rebellion against authority extended to the degree that he was prevented from carrying out satisfactory duty.

Casework in the hospital was directed toward helping him to accept some responsibility for his impulsive acting out, and, hopefully, to seek help in achieving a more satisfactory civilian adjustment.

CASE V: HOMESICKNESS

Homesickness could conceivably be called a problem that is dealt with in one way or another by the majority of the members in the armed forces. However, there is a group of servicemen that are so dependent upon the familiarity and protectiveness of their home environment that they are unable to perform their military duties adequately.

Eighteen-year old, single, white, SA, USN, was admitted to the neuropsychiatric service from his ship because he had been unable to adjust to the Navy routine. His ship had just returned from a four-month duty abroad. During this time he was noticed to be crying a lot and had stated that he was very unhappy in the Navy because of his separation from his mother. He just sat and thought of home and cried.

Serviceman is an only child. His mother left his father when the son was five years old. His mother remarried when he was ten years of age. Step-father has been unable to work because of a "bust" appendix.

The family live in a culturally, educationally and economically deprived community in the South. Serviceman left school at age sixteen after he was unable to complete more than five grades successfully. He stated that he is unable to read or write, therefore was most appreciative of the offer made by the social worker to write to his mother concerning his hospitalization. The mother, in turn, took advantage of the opportunity to correspond with the social worker about her son as she had a good deal of concern about him.

Serviceman was discharged after twenty-four days of hospitalization with the diagnosis of an acute situational maladjustment under the category of transient personality disorders due to acute or special stress.

Serviceman was literally unable to handle the simplest responsibility without the social worker's support. He had to be aided in planning his trip to his home upon discharge from the service. Plans were made to have another ex-serviceman, who was travelling in the same direction, accompany him on most of the trip.

He had been a carpenter before his enlistment and he planned to go back to the same trade.

Serviceman was able to function adequately in civilian life where his extreme dependency needs were being met. In a setting which disrupted these requirements he was very unhappy, cried a good deal, and was unable to perform his duties satisfactorily. Essentially he presented no problem other than his extreme dependency upon his mother and the environs of home. Without these he was completely inadequate. There was no attempt to reach the underlying problem of this patient.

This case exemplifies "casework by mail," a technique frequently utilized in this setting because the relatives are not within visiting distance and do appreciate a direct contact with the hospital.

CASE VI: RETURN TO DUTY

Twenty-four-year old, single, white, HM_2,[4] USN, was admitted to the hospital while on leave from his ship. He had taken over fifteen nembutal and benzadrine pills after his girl had "jilted" him.

Serviceman could not believe that he belonged in the hospital and said that he was sent only on the insistence of a waitress in the bar where he took the excess medication. He felt that it was not right to be hospitalized

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4 Hospitalman, second class.

against his wishes. He considered his suicide attempt silly. He was "disgusted and angry and did not use good judgment," and he tended to minimize it as suicide. He could not accept any reason whatsoever for his hospitalization and only wanted to return to his ship.

When he was fifteen years old he left home. He stated that his mother still worried about him as if he had never been away. Only if his hospitalization extended for more than two weeks would he write to his mother to let her know of his whereabouts. He said that he would not dare delay longer than two weeks before writing to her because once she had the Red Cross check on him when he had failed to write during that time.

Serviceman's parents are living and well. He felt that his mother has been loving and understanding of him. His father used to be very irritable but recently has become more placid. He gave some vague indications of family conflicts but would not discuss them to any appreciable degree.

When he left home at fifteen years of age he lived alone for three months. He then returned home and enlisted in the Navy, lying about his age. Serviceman stated that he has always been restless, nervous, and has worried about his high blood pressure. He made a previous gesture of suicide by sleeping tablets when another girl he knew was killed in an automobile accident.

He felt his first big mistake was to enlist before he finished high school. Between enlistments he spent twenty-three months at home and was within four months of high school graduation when he re-enlisted. He regretted this also.

Serviceman went into considerable discussion and detail about his job in the treatment room on the ship. He expressed a great deal of hostility against the men with minor injuries whose only intentions were to get out of some work.

He admitted, after some time, that he becomes "easily shaken" emotionally. He took his leave for that purpose, because he felt that he needed to get away from the ship for a few days. He never objected to cruises if they had a definite objective, but if the ship was just out on maneuvers "steaming around for fifteen days" it got on his nerves to see the same old faces.

In the psychological tests, he refused to take the Thematic Apperception Test because he thought it was silly.

He said that he had no imagination, but later admitted that he was sometimes frightened by his imagination. There were two or three pictures about which he wondered what he would have said (the sexual pictures). It was quite evident that instead of having a faulty imagination, he had been panicked by his fantasy.

Throughout his three weeks of hospitalization, he remained fairly resistant to any therapy. It was apparent that he was a boy who presented problems and possibly was involved in a rather disturbing fantasy life. He handled himself by working compulsively, and by moving around continuously. His relationships with women have been laden, probably, with a good deal of hostility inasmuch as his two suicide attempts centered around his girl friends. He admitted an inability to establish a really meaningful relationship with the worker. He denied having any problems with which he needed help and pleaded to be allowed to return to his ship before she went on a cruise. As it seemed that no gross pathology was evident, and since his motivation was so good, it was decided to return him to duty. He was given the diagnosis of passive dependency reaction.

This patient was hospitalized against his wishes following a suicidal attempt which he termed as "silly and a mistake," and said that it was poor judgment on his part to react in that way. He could never accept any reason for his hospitalization. Psychiatric evaluation determined that he was fit for further duty. His persistent denial of problems that required any help limited any utilization of help offered him. Casework centered on helping him to accept hospitalization during the evaluation of his status. He eagerly returned to duty.

Serviceman was virtually unable to establish any meaningful relationships during his hospitalization and felt that his admission to a psychiatric service was a threat to his emotional balance.

CASE VII: NEUROLOGY PATIENT

Twenty-one year old, single, white, SN,[5] USN, appeared greatly panicked by his diagnosis of epilepsy. Patient's initial reaction to the diagnosis was filled with all possible misconceptions and myths about epilepsy. Patient was to appear before the PEB[6] and was referred to social service for help with pre-discharge planning.

Patient's parents are both living and well. His father worked up to the position of superintendent of a state institution for the criminally insane. Patient received his first ideas of epilepsy in this setting. His associations to it were with being an outcast, of doing what you were told to do, and of committing murder under the influence of an attack.

Patient and his eighteen-year-old sister are the only living children of four. Patient stated that "we are all that our parents have now." He told, with much feeling, of his older brother who died at eleven years of age of pneumonia. The brother was always closer to father and liked to go hunting and fishing with his father. Patient said he couldn't stand those activities. His father mourned so much when his brother died that the family thought he would have to go to a rest home. There was one other child, a sister, who died at birth.

Parents were financially able to send patient to college but he preferred to join the Navy. He always wanted to work to receive spending money beyond the allowance that he received. His father did not approve of the work as a radio announcer that patient wanted to pursue, but wanted him to be an undertaker because it offered more financial security. Patient felt that he was too gay to go around picking up dead bodies. He stated, however, that his father would stand by him in whatever job he chose to do.

Patient said that he felt very badly when first informed of his diagnosis. However, after reading an article on epilepsy at the recommendation of the doctor, and by talking with the social worker, thereby understanding more about it, he felt that he became better able to accept it. He guessed it was something that you probably got used to in

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5 Seaman

6 Physical Evaluation Board - determines amount of disability awarded to serviceman.

time. Patient was soon quite able to accept his discharge, beside his need for medical supervision for a while. Also he felt that he could handle his family's reaction to the diagnosis. Patient welcomed, however, worker's offer to write parents at greater length about his diagnosis and resulting discharge.

His rights and privileges as a veteran were discussed. Considerable time was spent in going over his vocational plans which involved inquiries regarding his G.I. Bill. He had over two years' credit towards schooling. Patient was given the name of a reputable training school for radio work as a starting point for inquiries regarding particular radio work and particular radio schools.

This patient had emotional problems in accepting the meaning of the diagnosis of epilepsy. Also, he had fears that his mind might be affected eventually so that he would not know at all times just what he was doing. Because he was in the Navy and far away from home, interpretation to his parents had to be carried on by correspondence. This involved the handling of previously conceived ideas of epilepsy along with the assurance that because he was being discharged from the service, it did not mean that he was handicapped in regard to a vocation, marriage, or a well-adjusted life. It was merely that the Navy could not accept the risks often involved with a man who has epilepsy.

CASE VIII: DEPENDENT REFERRAL

Those dependents who were referred to the neuropsychiatric out-patient clinic included both the dependent wife of the serviceman and his dependent child. The case to be presented was selected because it typified a situation where

both the child and the wife were involved. In this case, Mrs. R., the wife of a Navy lieutenant, was seen by the psychiatric social worker for a psychiatric history. Her daughter, who was being referred to the clinic, was seen by the clinical psychologist.

Mrs. R. was an attractive, intelligent, and well-dressed woman of thirty-five, whose ten-year old daughter, Anne, was referred to the out-patient clinic because of increasing uncooperativeness in the home and "constant needling" of her mother. Her increasingly severe temper tantrums caused distraction, frustration and strong attitudes of rejection on the part of Mrs. R.

Mrs. R.'s parents separated when she was four years old--she cannot remember her father. Her sister, who is four years older, made patient feel inferior and discriminated against as far as clothes and favors were concerned. Both girls were unable to attend college because of financial reasons.

Twelve years ago, when Mrs. R. was twenty-three years old, she met her Navy husband. Their marriage has been satisfactory in every way. At the time of their marriage, Mr. R. was an enlisted man--ten years ago he was commissioned an officer at the age of twenty-five. She felt he has done remarkably well in the Navy, but wondered if it wouldn't be much better if he weren't so extremely meticulous in their home. She stated that he has considerable concern over an inferiority complex. Although she cannot understand why he should feel inferior, she thought that he should see a psychiatrist. Since both she and her husband had "complexes" she felt something should be done for Anne so she will not develop "complexes."

Anne was a full term, well-developed infant and was described as a "perfect child." Her development and training were considered uneventful, although she had asthma since birth. When she was seven years old she had to be hospitalized because of it. At this time Mrs. R. was caring for a neighbor's child. It was between this time and the birth of Anne's sister, Judy, one year later, that the temper tantrums were first noticed.

Recently Anne has been saying things to Judy like, "I hate you," "I'm going to kill you." Mrs. R. feared at times for Judy's safety during the tantrums.

Anne was always a bright child, learned very quickly, and for these reasons Mrs. R. felt that possibly she and her husband expected too much of Anne. Not until Anne was three years old did Mrs. R. ever entrust her care to anyone else. It was at this time that Lt. R. first arrived home from war service.

Mrs. R. stated that she and her husband always tried to be fair to Anne, but realized something had gone wrong.

It was felt that there was considerable conflict in the emotional make-up of both Lt. and Mrs. R. which was evidencing itself further in Anne's reactions to her family situation. Anne was psychologically tested to be a bright child. It seemed that she was giving a normal reaction to her home environment.

In view of the fact that there are no facilities at this hospital for the long-term child guidance treatment that would be needed for Anne and her mother, it was recommended that they be referred to a local child guidance clinic. This recommendation required several interviews before Mrs. R. was able to accept the referral.

This case represents evaluation and referral services that are brought about through the social workers. Mrs. R. realized need for help in the family situation but was reluctant to involve herself. Therefore, casework services involved primarily attempts toward her acceptance of the involvements necessary before any improvement in the situation could be realized.

CHAPTER VII

SUMMARY AND CONCLUSIONS

The purpose of this study has been stated as an attempt to evaluate the development and relationship of the psychiatric social work program to the Neuropsychiatric Service in the United States Naval Hospital, Chelsea, Massachusetts. Because of the nature of the study, it has been mandatory to present a descriptive and detailed picture of some of the specific aspects of the Navy and Navy life as they bear some relation to the neuropsychiatric service of the hospital. Through this study it was hoped that an emphasis on the material presented might result in some findings concerning: 1) significant and specific factors inherent to life in the Navy or Marine Corps which would effect a maladjustment or breakdown; 2) the development of the psychiatric social work program in the USNH-Chelsea; 3) some distinguishing characteristics of the neuropsychiatric patient in the USNH-Chelsea; 4) some problems distinctive to the military that are handled by the psychiatric social workers; 5) the part of the psychiatric social workers in the out-patient clinic of the neuropsychiatric service of the USNH-Chelsea.

In regard to inherent factors of Navy life that might effect a maladjustment or breakdown, it was stated that the majority of psychiatric casualties presented mental incapacitations prior to their enlistment in the Navy which

could be detected perfunctorily by the types of general problems that were presented.

> Experience in the last war demonstrated that neuropsychiatric casualties were an important problem, especially in the expeditionary forces. It was found also that in a large percentage of these casualties neuropsychiatric symptoms had been present for several or many years before these men had been inducted into the service.[1]

Men who would seem to have had no predisposition to a maladjustment or breakdown have been affected adversely by the natures of their new life. All servicemen are subjected to at least those stresses which are usually considered as minimal.

> Change of occupation, separation from family and submission to a new form of discipline form the initial stresses...Meaningless petty restrictions, in the absence of any opportunity to retaliate, lead to emotional tension in those unaccustomed to submission.[2]

A distinctive factor in the hospitalization of the serviceman involved the situation that "most of the patients who see the psychiatrist are ordered to do so, and come without enthusiasm."[3] This resulted from the very close and supervised observation of the serviceman as he became a member of a unified group. As such a member, the incompatibilities of his emotional life readily show themselves within

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1 Harry C. Solomon, M.D., and Paul I. Yakovlev, M.D., Manual of Military Neuropsychiatry, p. 19.

2 Emanuel Miller, M.A., M.R.C.P., D.P.M., ed., The Neuroses in War, p. 4.

3 Solomon, op. cit., p. 157.

the unit. Besides causing considerable discomfort to the serviceman, there is danger that the morale and balance of the total group might be affected.

It was found that the psychiatric social work program in the USNH-Chelsea has had a long course in development with its origins dating back to Red Cross coverage from 1918 to July, 1951. The present civilian psychiatric social work program, established in August, 1951, is found to be still in an embryonic and growing stage. However the "pains" so often associated with the developmental years have been minimized by careful planning, cooperation by all persons concerned, and acceptance of the services so ably offered.

Material was presented which endeavored to show some of the characteristics of the patient studied. The patients were studied as a group for specific data that could be compiled and readily demonstrated as a statistical presentation. For the most part, the identifying information on the patients studied presented few features that were discernable from the personnel of the Navy at large. The social work services in these cases, therefore, were essentially similar to those of any psychiatric social work program in a general hospital with an out-patient psychiatric clinic.

However it was found that the military setting presented distinct and specific means of handling problems that are not necessarily in themselves distinctive, but

placed within the restrictions of the Navy and Marine Corps became problems related strictly to the military.

Problems found to be distinctive to the Navy setting which were handled by the social worker included repeated AWOL patients, epileptic, eneuretic, and homesick patients, in addition to those men whose problems involved rebellion against authority. The social workers took initial responsibility for presenting the cases of the dependents who were referred to the psychiatric service.

Another outstanding feature of the hospitalized neuropsychiatric patient in the Navy was the relatively short duration of his hospitalization. Since it was found that forty-one days was the mean number of days in the hospital, short-term therapy, intensive relationships, and meaningful counselling were mandatory tools of the psychiatric social worker in the Navy setting.

The purpose of military psychiatry was found to be different from civilian psychiatry in that the effectiveness of therapy must be directed primarily to the over-all considerations of the total group.

Approved:

Richard K. Conant

Richard K. Conant
Dean

SCHEDULE

IDENTIFYING INFORMATION

Name:

Age:

Marital Status:

MILITARY SERVICE

Branch of Service:

Length of Service:

Rate:

HOSPITALIZATION DATA:

Admission:

Discharge Date:

Discharge Diagnosis:

Referral - By whom?

Chief Complaint - Type of problem?

Discharge Disposition:

ADDITIONAL DATA

Problems Distinctive to the Navy Setting

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