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CURRENT TRENDS IN ARMY SOCIAL WORK.(U)
MAR 74

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CURRENT TRENDS IN ARMY SOCIAL WORK

11 Mar 74

REFINEMENT OF ARMY SOCIAL WORK PROGRAMS TO MEET TOMORROW'S CHALLENGES

(12) 198 p.

ACADEMY OF HEALTH SCIENCES
UNITED STATES ARMY
FORT SAM HOUSTON, TEXAS
78234

391 261

4-8 MARCH 1974

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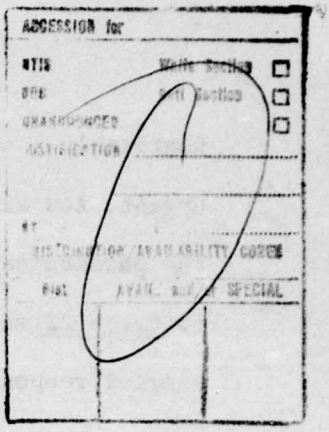

INTRODUCTION

by

COL Edward L. Maillet, MSC
Chief, Behavioral Science Division
Academy of Health Sciences, United States Army
Fort Sam Houston, Texas 78234

Each of us in the Academy's Behavioral Science Division, whatever his AMEDD discipline, looks forward with genuine pleasure to the Current Trends in Army Social Work Course as a stimulating gathering of family. The 1974 Course justified that expectation.

A great deal more than meets the eye is involved in planning, organizing and conducting a current trends course. If you want to assure that a complex job like that gets done well, give it to a busy man. I test that paradoxical theory regularly on John Kisel, and it is by now amply validated. We are all indebted to him. We are also very indebted to the 150 participants and guest speakers, because in the final analysis it was their enthusiastic involvement and spirit of cooperation, more than anything else, that assured success for the Course.

We are at a critical juncture in our history. There is no self-evident reason to expect that a sixteen division force will need less or lower-quality human services than does a twelve division force. Indeed, one might be excused for arguing the contrary. Yet all of us in the human services, broadly defined, are being required to absorb major resource cuts. New ideas to meet this challenge must be explored and exchanged. This is one of the major functions of the Current Trends Course.

Regretably, at the very time that the need for this course is especially urgent, its existence as an annual event is in serious jeopardy precisely and paradoxically because of those same resource cuts. Clearly, a sequel to Catch-22 must be written! As a mental health professional I have a special responsibility not to foster paranoia. I should, therefore, add that this threat to the Current Trends Course represents no whimsical assault on Army Social Work. Decision-makers were placed in a very difficult bind. Many other important courses were also curtailed, combined or even eliminated. Fortunately, we have in LTC Paul Darnauer a strong advocate to work on this and other tough problems. We wish him success.

No written document can ever accurately capture all of importance that occurs in an alive, week-long learning experience. We hope, nevertheless, that these proceedings, edited by Captain Bob Gemmill, will be useful to those who did attend the Course, as well as to those who could not leave the firing-line. The reader should understand that the views expressed in this collection of papers do not purport to reflect positions of the Academy of Health Sciences, or any other agency of the Department of the Army.

NOTES FROM THE SOCIAL SERVICE CONSULTANT

by

LTC Paul F. Darnauer, MSC
Social Service Consultant
Office of the Surgeon General
Washington, D.C. 20314

Although no formal "State of the Army Social Work Program" presentation was included in the 1974 Current Trends in Army Social Work Course schedule, the Course Director suggested and it seems appropriate to include a few observations in this documentary to that event.

"Current Trends" was again testimony to the vitality of the Army Social Work career field. Although central funding was available for only about 50 participants, 139 persons were awarded certificates of attendance. Several more individuals attended some portion of the course. There was representation from each of the groupings associated with Army Social Work: active and reserve 3606s, 91Gs, and Department of the Army civilians. Of special note was the attendance of some of our retired component. The course content was of necessity varied in order to address the diversity of activity in which Army social work personnel engage. The value of the Course lies both in the extent to which participants learn as well as contribute to the learning of others. The Course was designed to that end and feedback suggests that the design attained the desired goal.

Any comment about "Current Trends" would be deficient if it did not recognize the contributions of COL Maillet, LTC Kisel and other members of the Behavioral Sciences Division. The Program, the setting and circumstances under which it was conducted, and this document are the result of their persistent and committed efforts. These efforts demand the gratitude of all participants.

An innovation at Current Trends was the involvement of a National Association of Social Workers representative. It is anticipated that this almost last-minute inclusion of NASW will be formalized and expanded at future courses.

Fiscal year 1974 was the occasion for a number of changes affecting Army Social Work. Most notable among these were the creation of three new major Army commands: the Health Services Command, the Training and Doctrine Command (TRADOC), and the Forces Command (FORSCOM). In each a social work consultant position was created: in HSC the consultant is concerned with social work in Army Medical Department activities while in TRADOC and FORSCOM the consultants have responsibility with the Army Community Services (ACS) program. Also within each command there is a social work staff position in the Drug and Alcohol program. Finally, a social work position has been established in the Human Resources Division of Personnel and Administration Combat Development Activity (PACDA) at Fort Benjamin Harrison. All of these suggest an increased awareness within the Army of the need to deal more effectively with social and behavioral aspects of military life. These events take on even greater significance when it is recognized that the Army is rapidly drawing down from its Vietnam-mobilization strength.

It can be predicted that additional changes will occur and that some of these will be regressive. The Congress and the Administration are carefully scrutinizing the military health care delivery systems. A variety of changes in the CHAMPUS program have occurred and more are in the mill. There is new effort within the Department of Defense to reduce headquarters staff size. The impacts of these concerns cannot be predicted but undoubtly all components of the Army will experience some change. For the present, it appears that it is business as usual with our social work programs. Nevertheless it would be foolish to believe that we will not have fewer personnel and other resources in the days ahead. We in social work will be required to accept our share of across-the-board cutbacks when these occur.

From a personnel perspective the Army Social Work program is experiencing good times. Although some reductions in officer authorizations have occurred these have been modest. The procurement goal for 3606s is about 320. There appears to be ample applications to fill authorized positions for Social Work officers. As of 28 February there were 307 on duty as follows:

	TOTAL
06 -	5
05 -	25
04 -	40
03 -	166
02 -	71
	307

Of these 298 were male and 9 were female. From a racial perspective 42 or 13.6% are from minority groups.

Some other statistical information that may be of interest is included in the attached tables. Contrary to some information, Career opportunities continue to exist for 3606 personnel, although there have been fewer appointments in the Regular Army, applicants are being selected. Because competition is keen, non-selection is not to be considered an adverse personnel action. Those who fail of selection are encouraged to reapply in accordance with guidance in the applicable regulations. Similarly, social work personnel are being approved for voluntary indefinite (VI) status. Applications are being screened more carefully than in times past in line with experience with promotion boards and other relevant activities. It perhaps goes without saying that only personnel with records (e.g., OERs and other evidence) that are competitive with those of other MSC personnel are being selected for VI status.

Some reduction in the numbers of MSC personnel being approved for long term civilian training (LTCT) has occurred. During FY 1974 there were 60 new LTCT starts. This number diminished to 20 for FY 1975. The outlook for the near term is that these numbers will not increase. At the same time the program has not been terminated and short course opportunities exist at the same levels as previously. Personnel with specific questions about educational opportunities or other matters are encouraged to consult directly with the consultant whose autovon extension is 223-0950.

DUTY ASSIGNMENTS

AS OF 1 MAR 74

1.	AMEDD - Med, Psych, MHCS	165	175
	- Drugs	10	
2.	Divisions - MHCS	12	14
	- Drugs	2	
3.	ACS		48
4.	Correctional Facilities		15
5.	Staff: OTSG -1 DCSPER -2 FORSCOM - 2 PACDA -1 HSC -3 TRADOC -2 OSD - 1		12
6.	Research: WRAIR -2 USARB -1 CPWS -1 COMPSY -1		5
7.	Race Relations		5
8.	AHS		12
9.	Long-Term Civilian Tng (LTCT)		11
10.	Military Schools: C22 -5 Family Studies - 5		10

OVERSEAS ASSIGNMENTS:

USAREUR	32
IRAN	1
PANAMA	2
ALASKA	5
HAWAII	5
OKINAWA	5
THAILAND	3
JAPAN	2
KOREA	4

SOCIAL WORK OFFICER CHARACTERISTICS

	RA	VI	OBV	TOT	CAU	BL	O	FEMALE	MALE
O-6	5	-	-	5	5	0	0	0	5
O-5	16	9	-	25	20	4	1	0	25
O-4	30	10	-	40	32	6	2	1	39
O-3	20	73	73	166	147	10	9	7	158
O-2	3	-	68	71	61	9	1	1	70
	74	92	141	307	265	29	13	9	397
	166					42			
						(13.6%)			(3.0%)

DUTY ASSIGNMENTS

AS OF 15 SEP 74

MEDDACS (hospitals, MHCSs, Drug Programs)	171
Divisions	15
Army Community Service	46
Corrections	16
Research (WRAIR, COMPSY, CPWS, USARB)	5
Race Relations	3
Academy of Health Sciences	8
Long Term Civilian Training DSW - 5 Bootstrap - 1 MSW - 2	8
Military Training:	
Advanced Course	7
Advanced Program in Fam Studies	6
Other:	
HSC Staff	4
OTSG Staff	1
DA Staff	3
TRADOC	2
DOD	1
FORSCOM	2
PACDA	1
DRRI	1
	15

OVERSEAS ASSIGNMENTS

Germany	27
Italy	1
Belgium	1
Iran	1
Panama	2
Alaska	5
Hawaii	5
Okinawa	5
Japan	2
Korea	4
Thailand	2
Total	55

DEMOGRAPHIC CHARACTERISTICS*

		Component			Race			Sex	
	Total	RA	VI	OBV	White	Black	Other	Female	Male
COL	5	5	-	-	5	-	-	-	5
LTC	22	14	8	-	17	4	1	-	22
MAJ	49	39	10	-	40	6	3	1	48
CPT	166	13	85	68	144	17	5	8	158
1LT	58	2	0	56	49	6	3	-	58
TOTALS	300	73	103	124	255	33	12	9	291
%		24%	34%	42%	85%	11%	4%	3%	97%

*Personnel who have been selected for promotion are identified with the grade to which they will be promoted.

CURRENT TRENDS IN ARMY SOCIAL WORK, FY 74

Theme: Refinement of Army Social Work Programs to Meet Tomorrow's Challenges

Course Dates: 4 thru 8 March 1974, with registration on 3 March 1974

Course Site: Minuet Room, Menger Hotel, San Antonio, TX

Course Program:

Sunday, 3 Mar 74

Registration in lobby of Menger Hotel from 1530 to 2200 hours

Monday, 4 Mar 74

0715 - 0800 Registration for Late Arrivals in Hotel Lobby

0800 - 0820 Administrative Announcements

LTC John G. Kisel, MSC, Chief, Community Sciences Branch,
Behavioral Science Division, Academy of Health Sciences, USA

0820 - 0830 Welcome

MG Edward H. Vogel, Jr., MC, Superintendent,
Academy of Health Sciences, USA, Ft Sam Houston, TX

LTC Edward L. Maillet, MSC, Chief, Behavioral Science Division
Academy of Health Sciences, USA

0830 - 1000 Implications of DA Reorganization for Social Work Practice

Moderator: LTC Paul F. Darnauer, MSC, Social Service
Consultant, Office of the Surgeon General,
DA, Washington, D.C.

HSC: COL Vern M. Williams, MSC,
Social Work Consultant,
Health Services Command, USA,
Ft Sam Houston, TX

FORSCOM: MAJ James A. Walsh, MSC, Army Community Service,
ODCSPER, HQ, FORSCOM, Ft McPherson, GA

TRADOC: MAJ Donald A. Myles, MSC, Army Community Service,
ODCSPER, HQ, TRADOC, Ft Monroe, VA

1000 - 1030 Coffee Break

1030 - 1230 Program Reports in Social Welfare Specialty Areas

Moderator: COL Vern M. Williams

Alcohol and Drugs:	LTC Harold E. Allen, MSC, DAPE-HRA, HQ, DA, Washington, D.C.
Equal Opportunity/ Race Relations:	LTC Frank F. Montalvo, MSC, Defense Race Relations Institute, Patrick AFB, FL
Army Community Service:	LTC Raymond M. Marsh, MSC, DAPE-HRP, HQ, DA, Washington, D.C.
Corrections:	LTC Edgar J. Habeck, MSC, Director of Mental Hygiene, US Disciplinary Barracks, Ft Leavenworth, KS

1230 - 1330 Lunch

1330 - 1700 Specialty Seminars in Designated Rooms

Tuesday, 5 Mar 74

0800 - 1000 CHAMPUS: Changes and Consequences

COL Jack C. McPhee, USAF, Director of Health Services (Deputy Director Designee), CHAMPUS, Denver, CO

1000 - 1030 Coffee Break

1030 - 1200 Social Work Officer Career Planning Considerations (with record review)

COL George R. Krueger, MSC, Chief, MSC Career Activities Office, Personnel and Training Directorate, OTSG, DA, Washington, D.C.

1200 - 1300 Lunch

1300 - 1430 National Association of Social Workers and Army Social Work

Mr. Irwin S. Bahl, Member of National Board of Directors, NASW

1430 - 1700 Specialty Seminars in Designated Rooms

1700 - 1830 Open Time

1830 - 2200 Dinner Meeting

Guest Speaker to be Announced

Wednesday, 6 Mar 74

0800 - 1000 91G Career Development and Utilization Issues

Speaker: LTC J. D. Pantalone, Chief, Medical Branch, General Support Division, Enlisted Personnel, Directorate, U.S. Army Personnel Center, DA, Alexandria, VA

Panel: MAJ David L. Garber, MSC, Chief, Social Work/ Psychology Branch, Behavioral Science Division, Academy of Health Sciences, USA

SFC Thomas A. Frank, Social Work/Psychology Branch, Behavioral Science Division, Academy of Health Sciences, USA

SFC John Rank, Social Work Service, Tripler Army Medical Center, APO San Francisco, CA

SP5 Gary E. Smith, Social Work/Psychology Branch, Behavioral Science Division, Academy of Health Sciences, USA

1000 - 1030 Coffee Break

1030 - 1230 Abortion and Sterilization: Ethical and Legal Considerations Which Impinge on Clinical Practice

Speaker: Julius Paul, PhD, Professor of Political Science, State University of New York, Fredonia, N. Y.

Discussants: COL Guy D. Plunkett, MC, Chief, OB-GYN, Brooke Army Medical Center, Ft Sam Houston, TX

LTC Fred E. Nelson, Chief, Social Work Service, BAMC, Ft Sam Houston, TX

CH (LTC) David W. Polhemus, Instructor, Clinical Chaplaincy, Health Care Administration Division, Academy of Health Sciences, USA

1230 - 1330 Lunch

1330 - 1700 Specialty Seminars in Designated Rooms

Thursday, 7 Mar 74

0800 - 0900 Social Work Advanced Program in Family Studies at WRAMC: The Future

CPT Benito M. Arellano, MSC, Director, Social Work Advanced Program in Family Studies, WRAMC, Washington, D.C.

0900 - 1000 Availability and Utilization of Army Psychiatrists: Its Implications for Social Work and Psychology Career Fields

COL Stewart L. Baker, MC, Psychiatry and Neurology Consultant, OTSG, DA, Washington, D.C.

1000 - 1030 Coffee Break

1030 - 1230 PW/MIA Experience and Lessons Learned

Speaker: CPT Hamilton McCubbin, MSC, Prisoner of War Studies Center, Naval Medical Neuropsychiatric Research Unit, San Diego, CA

Panel: COL Stewart L. Baker

COL R. F. Wells, MC, Chief, Gastroenterology, Brooke Army Medical Center, Ft Sam Houston, TX

LTC Larrie D. Wanberg, MSC, Fitzsimmons Army Medical Center, Denver, CO

CPT Robert L. Jupe, MSC, Letterman Army Medical Center, San Francisco, CA

1230 - 1330 Lunch

1330 - 1700 Specialty Seminars in Designated Rooms

Friday, 8 Mar 74

0800 - 1000 Army Social Work Research Activities

Moderator: LTC Paul F. Darnauer

Family Research: LTC Donald R. Bardill, MSC, Department of Psychiatry, WRAIR, Washington, D.C.

Survey of Family Clinics: 1LT LaMont G. Olsen, MEDDAC, Ft Leonard Wood, MO.

Human Resources: LTC James M. Timmens, MSC, HRDD, PACDA, Ft Benjamin Harrison, IN

COMPSY: CPT John D. Wells, MSC, COMPSY, WRAMC, Washington, D.C.

1000 - 1030 Coffee Break

1030 - 1145 Consultants' Open Forum

COL Vern M. Williams
LTC Paul F. Darnauer

1145 - 1200 Graduation

Specialty Seminars (Students sign up on the provided rosters to attend any four of the 10 seminars)

1330 - 1700 Monday, 4 Mar 74 and repeated Wednesday, 6 Mar 74

1. ACS Programs

   Leader: LTC Raymond M. Marsh

   Location: Roy Rogers Room #252

2. EO/RR Programs

   Leader: LTC Sherman L. Ragland, MSC, Chief, Race Relations and Training Branch, WRAMC, Washington, D.C.

   Location: Minuet Room

3. Hospital Social Work Programs

   Leader: LTC Fred E. Nelson

   Location: Renaissance Room

4. Disciplinary Barracks and Corrections Programs

   Co-Leaders: LTC Edgar J. Habeck
   CPT Ray V. Smith, Directorate of Mental Hygiene, USDB, Ft Leavenworth, KS

   Location: Ming Room

5. MHCS and Command Consultation Programs

   Co-Leaders: LTC John G. Kisel
   CPT Michael R. Doolittle, MHCS, Brooke Army Medical Center, Ft Sam Houston, TX

Location: Cavalier Room

1300 - 1700 Tuesday, 5 Mar 74 and repeated Thursday, 7 Mar 74

6. Treatment of the Family

Co-Leaders: LTC Donald R. Bardill
LTC Jerry L. McKain, MSC, Chief, Social Work Service, Madigan Army Medical Center, Tacoma, WA

Location: Cavalier Room

7. Small Group Techniques

Leader: MAJ George J. Trick, MSC, Behavioral Science Division, Academy of Health Sciences, USA

Location: Ming Room

8. 91G Issues and Utilization

Co-Leaders: MAJ David L. Garber
CPT Robert J. Thorsen, MSC, Behavioral Science Division, Academy of Health Sciences, Ft Sam Houston, TX

Location: Minuet Room

9. Child Protection Boards, Laws, and Proposals

Leader: LTC John K. Miller, MSC, Chief, Social Work Service, William Beaumont Army Medical Center, El Paso, TX

Location: Roy Rogers Room #252

10. Alcohol and Drug Abuse Programs

Leader: LTC Harold E. Allen

Location: Renaissance Room

ATTENDEES AT THE CURRENT TRENDS IN ARMY SOCIAL WORK

ALDRIDGE, RONALD	CPT
ALLEN, HAROLD	LTC
ARNOLD, BARRY	1LT
BARDILL, DONALD	LTC
BARDARD, JOHN	MAJ
BARNWELL, WILLIAN	SP5
BAUMANN, ROGER	CPT
BECNEL, HARRY	CPT
BEVILACQUA, JOE	LTC
BRENNER, PAUL	CPT
BREWSTER, JAMES	CPT
BREWSTER, LARRY	CPT
BUDNY, JOHN	1LT
CALDER, WILLIAM	CPT
CLARKE, MILTON	1LT
CLAYTOR, ROBERT	CPT
COBB, ELSIE	CPT
COOK, DAVID	CPT
COOLBAUGH, GERALD	CPT
COPELAND, TERRY	1LT
CREEL, JOE	CPT
CROUSE, LINDA	Civilian
COWDEN, THERESA	ER
CUNNINGHAM, SAMUEL	CPT
DARNHAUER, PAUL	LTC
DAVID, JAMES	MAJ
DIER, BRUCE	E4
DINGEY, MARTHA	CPT
DOOLITTLE, MICHAEL	CPT
D'ORONZIO, PAUL	MAJ
DUGGINS, SAMUEL	MAJ
DUN, ERNEST	CPT
EISERMANN, ROBERT	E5
ELBERT, HARRY	E7
ETTEN, JOHN	MAJ
FAHEY, THOMAS	MAJ
FELLOWS, SAMUEL	CPT
FERGUSON, ROBERT	1LT
FIELDS, BOYCE	CPT
FINCH, NATHANIEL	MAJ
FRANK, THOMAS	E7
GAINER, CICERO	1LT
GARBER, DAVID	MAJ
GATES, KENNETH	1LT
GERARD, JOSEPH	1LT
GIGLIONE, JACK	LTC
GILES, JOE	CPT
GRADY, MILTON	MAJ

GRANT, THOMAS	1LT
GREAVES, CRAIG	CPT
HABECK, EDGAR	LTC
HAMMOND, LAURIE	E2
HAWKS, MARSHA	1LT
HAWKS, THOMAS	CPT
HOLDEN, JOSEPH	CPT
HUFF, RICHARD	1LT
JEFFERS, JOHN	1LT
JENTSCH, DAVID	LTC
JOHNSON, DONALD	1LT
JONES, ROBERT	1LT
JOSTEN, DAVID	CPT
JUPE, ROBERT	CPT
KARKLINS, MAREEL	CPT
KEARNS, JAMES	MAJ
KELLEY, HUBERT	LTC
KISEL, JOHN	LTC
KNEISLEY, KENT	E5
LASATER, JAMES	CPT
LEE, BOO	CPT
LITRIO, JOHN	LTC
MAILLET, EDWARD	COL
MARCHAND, FRANCIS	MAJ
MARSH, RAYMOND	LTC
MARTIN, JAMES	CPT
MARTIN, LARRY	CPT
MARTIN, HERMAN	CPT
MARWEDEL, LARRY	CPT
MC KAIN, JERRY	LTC
MC KEE, DAVID	CPT
MC INTYRE, BEN	CPT
MC NELIS, PETER	MAJ
MERRITT, NATHAN	1LT
MICHALOWSKI, PAUL	LTC
MILLER, JOHN	LTC
MONTALVO, FRANK	LTC
MOMIYAMA, AUGUSTINE	MAJ
MORTIMER, STEPHEN	CPT
MYLES, DONALD	MAJ
NELSON, FRED	LTC
NEPTUNE, CALVIN	CPT
NEWBORN, JESSE	1LT
NEWBY, JOHN	MAJ
NORMAN, ERNEST	MAJ
NUFFER, ROBERT	CPT
OLSEN, LaMONT	1LT
PATTERSON, TERENCE	CPT
PAYNE, NEWEL	CPT
PEACOCK, JACKY	CPT
PEHRSON, KYLE	CPT
PRICE, D	E5
PRINCE, ROY	COL
POTTER, CLIFFORD	MAJ

PURCELL, JACKSON	MAJ
QUINN, FRANK	CPT
RAGLAND, SHERMAN	LTC
RANK, JOHN	E7
REYNOLDS, ARTHUR	CPT
RICHARDSON, JAMES	CPT
ROSENFIELD, JAMES	1LT
RUCKER, NEHEMIAH	CPT
RUSSELL, CHARLES	SP4
SARNECKY, GEORGE	MAJ
SETTI, GLORIA	Civilian
SELLARDS, ROBERT	CPT
SEXTON, JAMES	E7
SCHLIE, JAMES	CPT
SHALETT, JOHN	CPT
SHROCK, JOHN	CPT
SIKORA, GREG	CPT
SIMPSON, HARRY	CPT
SMITH, RAY	CPT
SOMA, DAVID	CPT
SOMERICK, JOEL	CPT
STAGLIANO, RICHARD	CPT
STROHACKLER, LAWRENCE	E6
SULIKOWSKI, ANTONI	CPT
TARTLER, ANDREW	CPT
TESSIE, PAUL	CPT
THOMPSON, JAMES	CPT
THOMPSON, SARAH	MAJ
THORESEN, ROBERT	CPT
TIMMENS, JAMES	LTC
TREVOR, BEVERLY	CPT
TRIM, BARBARA	E6
VAN VRANKEN, EDWIN	CPT
WALSH, JAMES	MAJ
WANBERG, LARRIE	LTC
WARREN, JAMES	E5
WELLS, JOHN	CPT
WILLIAMS, VERN	COL
WILSON, JOE	MAJ
WOODRUM, JAMES	COL
YARYAN, ROBERT	CPT
ZELL, JAMES	CPT

US ARMY HEALTH SERVICES COMMAND

by

COL Vern M. Williams, MSC
Social Work Consultant
Health Services Command, USA
Ft Sam Houston, Texas

Prior to the recent reorganization of the US Army, there were three separate agencies involved in directing the health care delivery system in the United States.

1. The Continental Army Command managed the Class I hospital system consisting of 36 US Army Medical Department Activities, the four Army Area Medical Laboratories and five Veterinary Food Inspection Activities.

2. The Surgeon General (TSG) of the Army commanded eight general hospitals, five of which were located on Class I installations and three on AMEDD command installations, four regional dental activities, as well as other Class II activities.

3. The Deputy Chief of Staff for Personnel (DCSPER), DA, was responsible for the hospital at the US Military Academy at West Point. On 1 Jun 1972, the Comptroller of the Army (COA) presented to the Vice Chief of Staff of the Army the following recommendations from a study which had been initiated by the TSG.

a. Establish a medical command consolidating CONUS health care delivery systems into a single CONUS medical command as a major subordinate command to HQ DA.

b. Reorganize the Office of The Surgeon General (OTSG) to primarily perform the function of an Army Staff Agency.

c. Remove OTSG from sole staff supervision of the DCSPER.

d. Consolidate all medical training under a single command.

The Vice Chief of Staff approved the COA "CONMED" study and directed it to be incorporated into the ongoing CONUS Army reorganization effort under the program manager for reorganization. This then led to the reorganization of the Army Medical Department in CONUS, including the reorganization of the Office of the Surgeon General and the formation of the U.S. Army Health Services Command at Fort Sam Houston, TX.

The Command became operational on 1 April 1973 by assuming command and control of a portion of the Surgeon's Class II System.

As stated earlier, the US Army Health Services Command is a major subordinate command to HQ DA. The Surgeon General transferred his command and operational functions for those Class II elements which provided and supported the direct patient care mission but retained those Class II activities required for him to carry out his role as the primary advisor to the Chief of Staff and the Secretary of the Army on matters affecting the health of the Army worldwide. The Health Services Command then is on equal plane with the newly created Training and Doctrine Command (TRADOC), the Forces Command (FORSCOM) and the other major Army commands.

The mission of the United States Army Health Services Command is to:

a. Plan, direct, supervise, and perform health services for the Army, and as directed, for other departments, agencies and organizations in the Continental US (CONUS).

b. Command all non-TOE Health Service organizations, units, facilities, and activities in CONUS, as the Chief of Staff, US Army, may direct.

c. Plan, direct and supervise medical, professional education for the Army with policies established by the Surgeon General.

d. Perform technical review and evaluations of non-medical material to determine possible health hazards.

The principal functions of the US Army Health Services Command are:

1. To provide Army Health Services, including those provided under the Preventive Medicine and the Occupational Health Program as prescribed by AR 40-5, to all authorized personnel in CONUS, except that provided by medical units organic to non-medical TOE units and except as otherwise directed by the Chief of Staff, United States Army.

2. To provide advice to non-medical commanders without an organic medical section on Health Services and the health of their command.

3. To program, budget and provide resources for the operation of all US Army Health Services Command facilities, activities, organizations and installations.

4. To operate command-unique automatic data processing systems and programs for the provision of health services, and management information and biostatistical historical date.

Medical Education

The Commanding General, US Army Health Services Command, plans, directs and supervises medical, professional education for the Army within policies established by the Surgeon General. Through the Academy of Health Sciences, United States Army, he directs systematic, progressive education of officer and enlisted personnel of the Army Medical Department, members of other

services and allied nations, to include advanced individual training (AIT), in the field of Health Sciences. This training and education includes coordination with civilian institutions of higher learning for undergraduate, graduate and post-graduate level education which pertains to the Army Medical Department and the Army related health care disciplines.

Combat Development/AMEDD Study Program

The Commanding General, US Army Health Services Command through the Academy of Health Sciences, US Army, develops the concepts, doctrine, materiel requirements, and organization of the Health Care System in support of the Army in the field in all combat environments. He conducts a vigorous study program aimed at improving the organization and management of health care delivery and performs the AMEDD portions of the force development/combat development process as requested by the US Army Training and Doctrine Command (TRADOC) in accordance with the provisions of AR 5-5, the Army Study System.

Organizational Chart, USAHSC

The HQ, US Army Health Services Command, is organized as a General Staff. In addition to the functions and responsibilities normally associated with a major Army Command, certain coordinating and special staff members have areas of responsibility which are unique to this command.

The Deputy Chief of Staff for personnel has the added responsibility for the Army Medical Department Officer Procurement Program and for the Alcohol and Drug Abuse policies within this Command.

The Deputy Chief of Staff, Operations (DCSOPS) is responsible for patient administration throughout the command which includes the supervision of Evacuation/Transportation requirements for patient movements within CONUS, as well as medical statistical summary reporting.

The DCSOPS is also responsible for monitoring the Army Medical Department portion of the Training and Doctrine Command (TRADOC) force development/ combat developments program in accordance with policies and task-directives of HQ and HQ, Dept of the Army. He provides a study coordinator to monitor and coordinate all studies conducted within the Health Services Command to insure compliance with the provisions of AR 5-5, the Army Study System. He conducts liaison with the Office of the Assistant Chief of Staff for Force Development, Department of the Army, and the Office of the Surgeon General on the Department of the Army Pamphlet -- Staffing Guide for US Army Medical Activities. He coordinates the training of reserve units and individuals in command medical facilities with Forces Command (FORSCOM).

The Deputy Chief of Staff, Professional Activities establishes and monitors the entire spectrum of medical professional standards and practices for the delivery of health care throughout the Health Services Command and advises the Commanding General of this command on aspects of health care relating to medical, professional matters.

He is also the principal advisor to the Commanding General on the health and welfare of the US Army Health Services Command.

Effective 1 April 1973, the US Army Health Services Command became operational and assumed command of a portion of the former OTSG Class II system.

Effective 1 July 1973, HSC assumed command and control of all US Army Medical Department Activities (MEDDACs) in the continental United States formerly under the United States Continental Army Command (USCONARC).

The US Army element, US Naval Hospital, Great Lakes, IL, as well as the former CONARC Veterinary Detachments and the Army Medical Department Procurement Agencies also became part of this command's responsibility as of 1 July 1973.

In addition to USCONARC's assets, the Health Services Command assumed command and control of the US Army Hospital at the US Military Academy, West Point, from DCSPER, DA, and assumed command and control of Fort Detrick, MD, from the Commanding General, US Army Medical Research and Development Command. Also, the United States Army Medical Training Center at Fort Sam Houston, TX, was transferred to the US Army Health Services Command effective 1 July 1973, and integrated into the Academy of Health Sciences, US Army.

Each Medical Department Activity (MEDDAC) has been assigned a geographical area and conducts the provision of Health Services within the area, other than those provided by certain TOE units.

With rare exceptions, the area of responsibility of the MEDDAC's correspond to the area of responsibility assigned to the Army installation. With the exception of the MEDDACs at Fort MacArthur, CA, Fort Sheridan, IL, and Fort Monroe, VA, the basic element of these organizations is a US Army hospital.

The hospital commander and his staff "double hat" as the Commander of the MEDDAC and direct the provisions of medical support within a delineated area in accordance with appropriate directives. Medical centers also have a MEDDAC responsibility for assigned areas.

Because of the vast distances over which the command must carry out its responsibility, it was decided to utilize the medical skills and capabilities of the US Army Medical Centers to assist in the technical supervision of the delivery of health care within a geographic area. Thus, the concept of regional coordination was conceived. Due to the large geographic areas of responsibility (all of CONUS with 45 MEDDACs) the Commanding General, Health Services Command, will have six regional coordinators responsible for the professional technical supervision of the delivery of health care and their regions.

In describing the mission of each medical regional coordinator, it is essential to bear in mind that the regional coordinator's duties will be additional duties assigned to a selected MEDDAC within the region. He will represent the Commanding General Health Services Command, in his assigned geographic area with particular emphasis and interest in medical professionalism and standardization of health care delivery, with the exception of his

MEDDAC, he will not have command authority over any of the MEDDACs in his region nor will he be engaged in resource management outside of his own MEDDAC.

IMPLICATIONS OF DA REORGANIZATION FOR SOCIAL WORK PRACTICE FORSCOM

BY

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The United States Army Forces Command (FORSCOM) with headquarters at Fort McPherson, Georgia, was officially activated on 1 July 1973 with one clear-cut mission -- READINESS. This mission requires the management of unit training and readiness for combat of all deployable combat, combat support and combat service support forces of the active Army, the Army National Guard and the US Army Reserve stationed in the continental United States, the Commonwealth of Puerto Rico, and the Virgin Islands. Recent developments indicate that FORSCOM will expand its area of command even further in fiscal year 1975.

To put the principle features underlying the reorganization into perspective, a brief review is in order. As the Vietnam conflict drew to an end, it was evident that a need existed to change the Army structure to reflect its peacetime role. The most significant change was the requirement to place more emphasis on unit training and readiness. During Vietnam, efforts were concentrated on providing trained individual replacements for units in combat. Now, however, it is necessary to balance our individual training requirements with the need to maintain units at a high state of training and combat readiness.

National policy is permitting a reduction in the size of forces stationed overseas, but it clearly requires the maintenance of combat forces ready for deployment anywhere in the world. Traditionally, it has been the inclination of this country to reduce the size of our defense establishment after a war. There is a smaller Army and every means must be exhausted to insure that it is well-trained, forward looking and thoroughly professional.

One way to achieve this objective is to organize resources effectively. The reorganization is an effort to do just that. For the first time, the Reserve Forces were not reorganized as has been done so frequently in the past. The Army Materiel Command, which has the responsibility for our wholesale logistics support, was retained but two other commands, the Combat Developments Command and the Continental Army Command, were eliminated. In their place are the Forces Command and the Training and Doctrine Command.

The Forces Command is the home of the combat soldier. This command includes the Reserve Components and all of the active Army combat troops. In addition, it provides direction for, and supervises training of, the Army National Guard. To illustrate the magnitude of FORSCOM, it has an active Army of about 230,000 people, about 260,000 members of the Army Reserves and supervises about 400,000 members of the Army National Guard. Combined, that is a force of approximately 900,000 people. In addition, there are about 50,000 civilians who work in the command. Another category which impacts directly on us should be added, the dependents, who number about 325,000. Annual military and civilian salaries total more than three billion dollars and the combined total land area of FORSCOM installations would make a land space slightly larger than the state of Vermont.

As part of this relatively new structure, one management layer between Headquarters, Department of the Army and major tactical and supporting units was eliminated by removing the Continental Armies from the chain of command of the active Army forces. That chain is now major unit or installation to FORSCOM to Headquarters, Department of the Army. The three remaining Continental Armies, First, Fifth and Sixth, are major extensions of FORSCOM in the command and training of US Army Reserve units and in the supervision of training of the Army National Guard. Continental Army commands have the support of nine Army Readiness Regions (ARR) which in turn have Army Readiness Groups (RG) tailored to meet the needs of the reserve units they support and advise.

What may be data of special interest to us as members of the Army Medical Department is that about 53,458 people or roughly 12.4% of the total strength of the reserve components are medical personnel. The ARNG currently consists of 122 medical groups, 8 medical battalion detachment headquarters and other battalion, company and detachment units. As of 30 Sep 73, there were 8 social work spaces in the ARNG, with 4 officers assigned. The USAR has over 300 medical units including 9 medical general officer commands, 7 medical groups, 4 medical battalions and 103 USAR hospitals. As of 30 Sep 73, there were 90 authorized social work spaces, 87 officers assigned, and 56 officers in inactive control group status.

All of this, the people, organizational structure, money, have the one single mission -- READINESS -- in common. Army Chief of Staff GEN Creighton W. Abrams, referring to this mission has said, " - - on short notice, a strong, modern and balanced active Army force must be capable of deploying and fighting wherever our government has determined its national interests are threatened - -." Former Secretary of Defense Melvin R. Laird said, "The strategy of realistic deterrence has made it possible for us to reduce the size of our forces and to withdraw large numbers of troops from abroad, but it requires that the smaller forces that remain be modernized and upgraded, well-trained and provided with the best equipment available. It means more emphasis on the National Guard and Reserves so that these elements of our defense force will be ready for effective action in any emergency that requires augmentation of the active forces." READINESS then is clearly FORSCOM's reason for being.

The task requirements of this paper requested description of mission and organization and the attempt has been made here to fulfill that requirement without belaboring it. What was also requested was the impact of reorganization on social work practice. As the Army Community Service (ACS) Officer at FORSCOM, it is difficult to address specifically implications for social workers in the Army Divisions or Reserve Components. Some homework has been done so that if there are questions in the discussion relating to these areas, an attempt can be made to respond to them. What does seem appropriate to address is the impact on FORSCOM ACS activities brought about by the reorganization.

The primary impact is a dramatic increase in visibility. A visibility of both the installation ACS center's operation, program and problem solving activities and of major commands' active interest in each ACS center's functioning.

Prior to the reorganization, Continental Army Command (CONARC), with approximately 44 ACS centers in the United States, had staff responsibility for the centers. This overload precluded a continual, personal and direct involvement in each ACS's operations by the CONARC ACS officer. With the reorganization, both TRADOC and FORSCOM have about half that load or approximately 23 and 20 centers, respectively. This reduced number of centers gives the ACS Staff Officer a more manageable area of concentration and permits the development of deeper ties, strengthened relationships and a fuller understanding of each center in his scope. In addition to written and telephonic communications, a visit to each center, at least annually, by a representative of the major command is now not only possible but an unwritten policy.

This heightened visibility at the major command level increases the ability to deal with funding, staffing and policy considerations on the basis of more immediate knowledge of a center's individual needs. At FORSCOM, G4000 (ACS) funds are managed by the ACS Staff Officer who recommends action on installation budget requests of ACS and attempts to justify unfinanced requirements. Similarly, manpower survey recommendations regarding ACS centers are reviewed and recommendations made including concurrence or non-concurrence. To represent an installation's needs best, immediate knowledge of the center is vital.

This heightened visibility also impacts directly on an ACS center's functioning. In the past, ACS's have concentrated their activities at their installations with little interrelating among one another regarding common problems or programs. With certain exceptions, the publicizing of a center's contributions has been limited to its own installation. Competition rather than cooperation among ACS's has been evident. In some ways, the now defunct Army ACS Awards program contributed to that competitive spirit pitting small centers and large centers against one another for the awards. Traces of this competitiveness still linger with the predictable question continually asked by ACS officers during a staff visit, "Where do we stand compared with other centers?" Not, "What is your evaluation of where we stand in relation to our community's needs?"

The data emerging from this new visibility is being related to command-wide and Army-wide needs. ACS's are encouraged to communicate freely with one another and to share experiences and problems in working toward resolutions, and to cooperate rather than compete. The goal of ACS, improvement in the quality of military life, is being intertwined with the Army-wide priority effort to create a more positive recruitment and retention attitude. Improvement in the quality of military life increases retention and people leaving the military with a less bitter taste in their mouths helps the image necessary for recruitment.

ACS centers are being encouraged to tie into these priority efforts and make known their contributions. Such tie-ins can increase the priorities necessary for ACS's to obtain the manpower and funds to continue meeting the needs of their communities.

The described impact of the reorganization is only beginning to be felt. The concern for improvement in military life is genuine and is being promoted throughout all levels of the military. The personal interest of major commands in ACS activities devoted to meeting community needs is real. There seems to be no evidence that this concern and interest is diminishing in any way but rather the contrary; that ACS will experience continually increased encouragement and support to meet their tasks, while at the same time those tasks are being expanded.

IMPLICATIONS OF DA REORGANIZATION FOR SOCIAL WORK PRACTICE: USA TRAINING AND DOCTRINE COMMAND

by
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This paper has three objectives: (1) to briefly describe the United States Army Training & Doctrine Command (TRADOC) which was established as a result of the reorganization of the United States Army Continental Army Command (CONARC); (2) to identify the role responsibilities or duties of the TRADOC Army Community Service (ACS) Officer; and (3) to discuss the impact of DA reorganization on social work practice, especially as it occurs in the ACS Program.

USA TRADOC

The handouts which have been distributed to you and the slides which you are about to view will give you an adequate understanding of the US Army TRADOC. Some detailed discussion is required, however.

On 11 January 1973, DA announced plans for a major reorganization of its field activities in CONUS. The name of this plan was "Operation Steadfast." The reorganization was aimed toward the attainment of a higher state of readiness of active Army and reserve components deployable forces, merger of schools and combat development activities, and improved quality and responsiveness of Army management. The objectives of reorganization were as follows:

(1) More efficient and effective use of funds and manpower

(2) More effective work in developing weapons and equipment

(3) Smaller active Army--bulk in CONUS

(4) Reliance on reserves

(5) More responsive combat developments process

In order to reach these objectives, TRADOC (located at Fort Monroe, Virginia) was given responsibility for the individual training of officers and enlisted personnel and for development of doctrine and associated organizations and materiel requirements. United States Army Forces Command

(FORSCOM, located at Fort McPherson, Georgia) was given responsibility for command of all active units, command and training of US Army Reserve units, and supervision of training of the Army National Guard. Each of the new headquarters command their own installations directly with no intervention from other Army headquarters. Three mid-management functional centers have been established and assist TRADOC by providing the schools guidance and direction in promulgating new doctrine and organization, and in developing materiel requirements and functional systems. These centers and their specific functions are:

(1) Combined Arms Center (Fort Leavenworth, Kansas)--consolidates input primarily from the combat arms branches of Infantry, Artillery and Armor;

(2) Logistics Center (Fort Lee, Virginia)--consolidates input primarily from the Quartermaster, Ordnance and Transportation Corps; and

(3) Administration Center (Fort Benjamin Harrison, Indiana)--digests input from the Adjutant General and Finance Corps.

TRADOC manages the ROTC program through a newly dedicated ROTC organizational structure of 4 ROTC regions.

Major Walsh has described the organization and mission of FORSCOM. What follows is a discussion of the organization and mission of TRADOC. TRADOC is comprised of four organizational elements: first, the Combat Development Center, made up of the three functional centers (previously discussed); second, the 19 TRADOC installations; third, the TRADOC schools, which include 3 military schools and colleges (Defense Information School, Defense Language Institute, C&GS College), 16 branch schools, and 4 specialist schools (Aviation, Institute for Military Assistance, School of Music, Sergeants Major Academy); and fourth, the 4 ROTC regions.

The missions of TRADOC are basically:

(1) Training and educating the individual soldier;

(2) Introducing new concepts, materiel requirements and organizations; and

(3) Developing and disseminating training and doctrinal literature.

Commanding General, TRADOC, is responsible for management and supervision of individual training of all active Army and reserve component personnel, ROTC, and National Defense Cadet Corps organizations. Professional training for the soldier is provided by TRADOC through its 23 service schools and 7 training centers. Combat Development is concerned with equipping, organizing, and training the Army with the most modern weapons, equipment and systems to fight effectively. In being responsible for combat development, TRADOC develops new concepts, materiel requirements, organizations and doctrinal and training literature.

As a result of the reorganization, installations have been given a dominant and expanded role in managing resources because CONUS armies are no longer involved in installation management. The installation commander is the central figure in the new reorganization.

Army Community Service in TRADOC

To describe ACS in TRADOC, it would seem best to identify where ACS is in the command structure. Keeping in line with guidance contained in AR 608-1 (Army Community Service Program, 15 November 1973), the ACS program is the responsibility of the TRADOC DCSPER. To be more specific, the ACS Officer is assigned to the Morale & Welfare Branch, Personnel Services Division, DCSPER. The ACS Program is the only formal, ongoing program for which Morale & Welfare Branch has responsibility. The branch chief, therefore, has vested interest in keeping a viable ACS program. (In many ways, it is his "bread and butter!")

The ACS officer officially has responsibility for monitoring the Command's ACS program on a "management-by-exception" basis. This means his major (official) role is "putting out fires" (or flushing out and shooting down problems) as they occur in the Command's program and at the ACS centers located on TRADOC installations. Although the TRADOC ACS officer's duties would seem narrow by official definition, in reality the TRADOC CG and DCSPER turn to him as the staff officer responsible for services, problems, merits and faults of the ACS centers located on TRADOC installations. Therefore, the ACS officer's major duty responsibilities include the following:

(1) Serving as staff officer to the Chief, PSD and DCSPER on Command ACS matters and in other areas related to the general welfare of the soldier and his family;

(2) Serving as consultant to ACS center officers and personnel on questions and matters concerning program policies, policy implementation, staff development, operational problems, and the management of difficult or unusual personnel/dependent crises;

(3) Conducting staff visits to installations to carry out above duties;

(4) Developing new policies and programs, with approval from Headquarters, Department of the Army, to improve the ACS program; and

(5) Implementing new ACS policies or directives when requested by Department of the Army.

In addition, the ACS officer (TRADOC) is responsible for monitoring policy guidance and actions for the following programs: Army Emergency Relief, Survivor Assistance, Red Cross, Dependent Welfare and Nonsupport, Veteran Referral Services, and Movement of Dependents under Emergency Conditions.

An effective working relationship has been established between the TRADOC ACS officer and the Social Service Consultant, Office of the Surgeon General whereby joint planning and consultation on recommendations for social work officer assignments in ACS (within TRADOC) occur regularly. Also, the management of social service programs and problems concerning utilization of social work officers in ACS are mutually reviewed.

Impact of Reorganization on Social Work Practice

From a major command standpoint, the reorganization has realined responsibility for command guidance and consultation of 40 ACS centers by one ACS officer (under old CONARC) to 17 (FORSCOM) and 19 (TRADOC) centers for each command ACS officer respectively. This has resulted in more effective management of ACS services through more frequent installation visits by the command ACS officer, expanded consultation and technical guidance on developing and implementing social service programs, and more direct contacts between social work officers at the installation (ACS) and major command levels.

The reorganization has expanded channels of communication which have become an effective means for making major commanders and their key staff personnel more aware of social service needs of soldiers and their families and social work activities carried out in their behalf. As an example, problems and service programs which have been brought to the attention of key staff and command personnel at TRADOC have included day care facilities, child abuse and advocacy/prevention programs, needs of families of personnel detained in confinement facilities, junior Army wives and minority group participation.

The reorganization has clearly defined specific target populations with unique characteristics and needs at which parallel social work programs must be aimed. For TRADOC, the population blocs of major concern are the young unmarried trainee and the young married trainee with his family.

Trainees are basically a transient group, especially in the early days of their Army life. They are forced to struggle with relocation problems, family disruptions, moving expenses, and frequent readjustments to new communities. For many, these problems become more critical when services meeting special needs are interrupted, e.g., special ongoing services for handicapped dependents. Further complications arise when the trainee and his family are not eligible for on-post housing. Many young soldiers and their families are isolated in civilian communities, detached from military facilities and services, and live in inadequate housing. Young wives left behind by their husbands (trainees) and wives suddenly placed in a new community (whether it be military or civilian) lack knowledge of what life in an Army community is all about and are very often unaware of military benefits, services, facilities, etc.

The trainee today is paid a higher monthly salary than ever before. The hope is that he is spending it wisely and appropriately.

Social work services must be focused on these problems and designed to meet the needs of the trainee population. Counseling services directed at people with feelings of alienation, tensions and discords in young marriages, and parent-child conflicts are examples of such services. Family life education services--to include home management courses, budget/financial counseling and parental training--can be effective sources of primary prevention against potential personal and family problems. Community relocation services can effectively reduce, if not prevent, conflicts associated with reassignments and moves. These services may include: orientations on Army helping services, rights and benefits, and the nature of Army life and the significant role of the Army wife, and actions to involve trainees and wives early in post and community activities such as volunteer services, wives' clubs, neighborhood councils and other community action programs. All these services must be extended beyond the gates of the installation and reach out to soldiers and families located in isolated areas of civilian communities!

Delivery systems for social work services must "be in tune" with trainee schedules. Services have to be available to the greatest number of potential users at hours convenient to their schedules. Evening and Saturday hours will have to be considered and scheduled as required.

As the Army continues to undergo reorganization and remain a changing Army, social service programs can not afford to become institutionalized or ends in and of themselves. The impact of reorganization on any social work service is basically this--services must remain responsive; strategies for organizing and providing services must be guided by existing needs of people rather than by pre-conceived, rigid agency ideas of what people need.

A closing comment on the impact of DA reorganization on social work practice in ACS seems warranted. As reorganization continues, one fact is quite clear--resources, both manpower and funds, become more scarce! As an alternative to manpower losses and shortages, paraprofessional personnel are called upon--now, more than ever--to provide social work services. To guarantee effective utilization of these personnel to their maximum capacity and ability, social work must establish and conduct in-service and cross-service (agency) training/development programs for paraprofessionals. The social worker as ACS officer will be required to spend most of his time on budgeting, resource procurement, staff development, and effective program management (of resources and manpower) activities.

CONCLUSION

This paper has presented a brief overview of the organization and mission of the USA Training and Doctrine Command. The role responsibilities of the ACS officer assigned to HQ TRADOC have been identified. In the last section of the paper, the impact of DA reorganization on social work practice was discussed.

THE ARMY ALCOHOL & DRUG ABUSE PREVENTION & CONTROL PROGRAM

by

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The purpose of this talk is to provide an overview of the Army Alcohol & Drug Program (with the primary focus on alcohol), to describe how the policy was developed, how it has gained support, become operationalized, and lastly, to express some concern for the future and more specifically for our future as social workers.

I would hope that the outcome of this would be information regarding the Alcohol & Drug Program. Secondly, some attitude change from the group and lastly, an individual call to action.

The Army Alcohol & Drug Program has changed its philosophy from one of discipline and order to one of treatment and rehabilitation. This is evidenced not only in policy but also in organizational structure. Initially the Alcohol & Drug Program was in the Directorate of Discipline and Drug Policy in which the Drug Abuse Control Division was located. Currently the title has changed to the Directorate of Human Resources Development of which the Alcohol & Drug Policy Division is a part. This indicates a real change in basic philosophy.

As with any program, it is important to know something of its history. I might say that as a social worker it has been a valuable opportunity for me to integrate clinical practice, administration and management, and research methodologies with overall policy design. I was assigned to this program in June 1971 when the chief concern was the heroin epidemic in Vietnam. The program lacked credibility for many reasons; however, its chief problem was that the primary drug of abuse - alcohol - was not within our mandate. Within the drug scene it was important to include alcohol - the major drug abused - as a part of the overall drug program.

Initially, however, there was no interest and in fact denial of alcoholism as playing any part in the drug scene. It was necessary to do some homework early on and learn that on 31 December 1970 Congress had passed Public Law 91-616, subject: Comprehensive Alcoholism Prevention, Treatment and Rehabilitation Act. This added some emphasis to including alcohol as a part of the program. Additionally the Government Accounting Office studies were completed; one in September 1970, which focused on an Alcoholism Program for civilian employees and declared alcohol as the 4th rated health problem in the United States. The second study was released in November 1971, titled: Alcoholism Among Military Personnel. These studies stated the

number of alcoholics in the civilian and military work force to be between four and eight per cent. Little attention was given to these studies until late 1971.

An initial meeting of the DOD Alcoholism Task Group was held in March of 1971, and the second meeting had not been called until October of that year. Because of my expressed interest and concern regarding Alcohol as a drug, I was assigned as a member of this Tri-service Task Group to develop policies on alcohol abuse. At about this time, Army Drug Abuse Control Office had prepared Drug Abuse Prevention & Control Plan. Because of repeated emphasis on Alcohol, the title was changed to Alcohol & Drug Abuse Prevention and Control Plan and was published in September 1971. This was the forerunner of current DA Circular 600-85 (June 1972) subject: Alcohol & Drug Abuse Prevention & Control Program.

By January 1972, the draft directive 1010.2 DOD Alcoholism Program was submitted. This directive 1010.2, "Alcohol Abuse by Personnel of the Department of Defense" was published in March 1972 directing the services to develop an alcohol plan within 60 days. Consequently in June 1972 DA Circular 600-85 was published and established policy on alcohol abuse and alcoholism. The last document to be completed in the alcohol area was DA Pamphlet 600-17, a Commander's Supervisor's and Physician's Guide to Alcohol Abuse & Alcoholism, Sep 1973. I was privileged to be the primary author of this document.

It's one thing to develop policies, but it is more important to make a program believable. The question could legitimately be raised, "Do we have problems with alcohol abuse in the Army?" Again if we look to history we find that traditionally soldiers have been drinkers. Alexander the Great is reported to have died after one of his major battles as the result of celebrating with spirits. In more current times (and because we are meeting in Texas) it is reported that Sam Houston in the major battles in the Mexican Campaign was under the influence of the demon rum. It has been traditional among sea-faring men (our Naval friends) to have rations of grog on long trips. In World War II it was common practice to provide Air Force pilots a two-ounce shot after combat missions to relieve tension. We all are familiar with tradition practices of wetting down parties, pro-rated affairs, happy hours, beer busts, all of which have become a tradition within the services. I think this established the fact that the service man does drink however to what extent has never been fully known. In order to define the problem of drinking within the Army an alcohol research study was begun in June 1972. The study randomly selected 10,000 male personnel between the grades of E3 and O1 from 49 Army installations world-wide. The study was completed in Dec 1972 and the following definitions were utilized:

(1) heavy and binge drinkers - five or more drinks a day, four or more days in a row, or drunk for more than one day at a time.

(2) problem drinkers - having serious social consequences within their lives, e.g., driving while intoxicated, wife threatened to leave or left, promotion denied, etc. Based on these definitions the findings were that 20% of the officers answering the survey were heavy or binge drinkers and 17% problem drinkers. Of the enlisted 32% were heavy or binge drinkers and 35% were problem drinkers. The locus of the problem, however, focused

on the younger officer and enlisted groups as having the most difficulties with drinking. If the sample group findings were projected to the Army population in September 1972, the actual cost to the Army is one division lost a month and one division ineffective for a year.

Anyone interested in obtaining this study may contact HQ, DA, ATTN: Alcohol and Drug Policy Division, Pentagon, Wash D. C. 30210. This study provided hard facts to substantiate alcohol programs for Army personnel. Thus we see empirical data being substantiated and used to develop creditable alcohol policy.

The policies as developed for the alcohol program are found in DA Circular 600-85 but is more readable in Chapter 2 of DA Pamphlet 600-17 (a copy has been furnished each of you). Briefly the policy is as follows:

(1) To provide preventative services, to increase education, law enforcement (AR 190-5 indicates all driving while intoxicated will be referred to an Alcohol Treatment Facility) and community involvement.

(2) Treatment/rehabilitation services - detoxification of 3-10 days, resident live-in care for 14 days with a follow on live-in workout program for as long as 60 days. Non-resident care is then provided for a 10-month period. Recidivism can be expected with the Alcohol & Drug rehabilatee and the individual can be treated more than once for his problem. If rehabilitation continues to be unsuccessful it is necessary to declare the individual a rehabilitation failure and move toward his elimination from the service. Individuals who are rehabilitation failures (providing that no charges are pending against them) are given a general discharge under honorable conditions and are referred to the Veterans Administration for continuing care. The Army Alcohol & Drug Program provides services to the servicemen, retirees, and their dependents, and DA civilians. AR 600-300 covers the program for the DA civilian. As treatment personnel you may be interested to know that the DA civilian may be cared for in an Army hospital or half-way facility for his alcoholism or alcohol abuse. DA civilians are currently being treated in Army hospitals and in resident and non-resident care facilities.

(3) The Army Alcohol and Drug Program is a de-centralized command program. It was established in this fashion recognizing that alcohol & drug use is endemic to the society. No narrow segment of the community, e.g., medical or legal, can, by itself, cope with this problem and thus, it is a command program. This allows the total resources of the community to be utilized in support of the program.

(4) For the duty soldier and the DA civilian the Alcohol Program is founded upon the industrial model of job performance. The supervisor is not responsible nor is he qualified to declare an individual an alcoholic or an alcohol abuser. He is however, qualified and responsible for the individual's job performance and when observing deteriorating job performance should counsel a man. If problems related to alcohol are determined to exist and this is affecting job performance, the worker should be referred for appropriate assistance.

(5) Alcoholism is defined as a social, psychological, and medical condition for which the individual can be treated and rehabilitated. The

disease model is not accepted as it narrowly defines the problem of alcoholism into one area - medical. The alcoholic's problems are broadly based and affect facets of his life - occupational, economic, social, marriage, to name a few. If the individual requires care for any facet of his life situation this service is quickly and efficiently provided to him.

(6) The Alcohol & Drug Program provides for detoxification/ treatment in Army hospitals, and treatment/rehabilitation services in Halfway House Facilities (resident and non-resident care) and in "Rap" centers. As of March 1974 world-wide treatment was being provided in 61 hospitals, 40 Halfway Houses and 131 Rap centers. These facilities are staffed by a total of over 1400 military and civilian personnel. As of March 1974, there were 6,326 personnel receiving care for alcoholism problems, and 11,604 for other drug related problems. During FY 74, 39.5 million dollars were allocated for this program; FY 75 slightly over 40 million have been programmed.

I was also asked to discuss AR 10-10 which is currently being staffed at DA. This regulation will change the DCSPER organization. At the installation level. The Director of Personnel and Community Affairs (DPCA) will be divided into human resource agencies (direct service agencies) and into administrative services. This will put the majority of social welfare agencies into the command element. Those agencies providing health care service - hospital and MHCS - will remain MEDDAC functions. The majority of social workers are currently functioning in the health care delivery system. Who then will be providing social welfare services to the remainder of the Army community? For the most part, social workers are not providing social welfare services to the community. A second question is "Are we in a position where the profession of social work provides the best service to the Army population?" It appears that the delivery of human services is becoming a greater responsibility of others e.g., chaplains, physician assistants, guidance counselors, and "personnel officers" and less the responsibility of social work. The question "Should we have more social work officers in Army community services or in future human relation programs?", remains a viable question. It is my opinion that we as social workers must become involved in human resources development programs - not only gain the visibility but accept the challenge and responsibility for new roles within the larger system. This may require redefinition and establishment of different priorities.

My comments in no way indicate that Army social workers aren't doing a creditable job within their defined roles. I only feel the definition of that role is limited and the emphasis should be on our responsibility to the total community.

As social workers I'm sure we'll continue doihg our best. However, I only leave you with the words of Sir William Beveridge, "Never should the good be the enemy of the better." We can be better by being less provincial and more involved in the total military community.

DRRI, RACE RELATIONS AND YOU

by

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It is no secret to many of you here that I have a penchant for trouble. That is, for getting involved in those issues and those problems that, by the nature of the beast, resist solution. In fact, those that even dare you to solve them. This is no special talent that I have, other than being trained as a social worker, to look at things in a special way, to attack problems in a special way, and to measure progress in small increments realizing that the bigger the issue, the greater the resistance to change.

The other thing that keeps us going is that every so often we win BIG--as in 1969 when the DOD used federal poverty guidelines as the floor under which no serviceman shall fall. As a consequence, in one major effort, they did more for the welfare of military families than all our ameliorative programs put together. This was a fundamental preventive attack on a social problem. Yet, it was our "small increments" that brought the problem to light and led to DOD facing the fact that poverty existed. The point is that we can take credit and satisfaction for our small successes--that is, when we are not making "fundamental institutional change"--if we are laying the groundwork, developing the instrument, or revealing the area where major changes should take place. The risk is always that we become so engrossed in our day-to-day winnings that we become addicted to gambling--to "doing our thing" and forgetting that the purpose of winning big is so others can have the opportunity to do their thing. The other risk is becoming unhappy when some one else gets the credit for the "big win", even though you were instrumental in making it happen. Social work is not a make-people-happy business and you are not expected to stick around for the applause, but move on to the next problem.

These big windfalls do not come often, but I was fortunate enough to have a second "big win" in my career in 1971 when the DOD established the Defense Race Relations Institute.

It was big because it forced the Armed Services to maintain a harsh light on the problem of racism and, most importantly, its causes. While we always had problems of discrimination in the service, and equal opportunity programs have grown in their sophistication in "putting out the fires," we never addressed the issue of prevention. Besides, improving the life of

minorities through EO&T was "good works" done by others, for others.

As long as incidents could remain isolated from each other and could be explained and rationalized as unrelated individual acts, the problem remained invisible to the collective conscience of the community. After all, we all know that sick people should be in hospitals and insane people preferable in small towns in the country; poor people belong on the other side of the tracks or the freeway where you can pass by quickly, and minorities most certainly should stay in the "melting pot" and not in a seminar--today, tomorrow, face-to-face, for 18 hours, or "no less frequently than once-a-month," every year, all the time.

When you force the community as a policy to face its victims and communicate with them; inspect its own role in perpetuating the problem; expect its behavior to change accordingly and relinquish its psychological and economic investment; and begin building a level of understanding--when you do this, you have instituted a fundamental change.

All preventive programs are resisted, because they require big investments. And the most important investment that we asked the community to make was psychological--we are asking each member to invest himself in the race relations seminar. While we expect him to give up certain behavior--behavior that hurts others, like all people, he holds on to it very tightly.

As with all big wins, there were "the small increments of success." For example, did you know that the first series of race relations seminars in 1969 were initiated by a psychiatrist (Dr. A. C. Segal) at Ft Benning, who had the delusion that Mental Hygiene Clinics should be more than a personnel processing center? And that Dr. Joe Bevilacqua, who is among us here today, participated in the first world wide DA conference on race relations in 1970? These kinds of steps were instrumental in getting behavioral science concepts and style on the ground floor of race relations. The question I'll be asking is, "Are we going to stay in or be run out, because we have nothing more to contribute."

DEFENSE RACE RELATIONS INSTITUTE

What do we do at DRRI and where do you fit in?

Now, this week LTC Sherm Ragland will lead discussions on operational and operator problems regarding race relations and equal opportunity. I don't want to talk about that.

What I want to address today is:

1. What we do at DRRI and what we expect from students and,

2. What I expect you to do to help us and yourselves.

The school is located in Patrick AFB, Florida. It has the good fortune (some of us say, "curse") of being isolated from the world. It is good only in that for seven weeks students eat, talk and sleep race relations (!). At least the relative isolation creates a crucible wherein the students devote almost all their full attention to becoming a race relations instructor (RRI).

There are about 220 students in each class and we have had as many as 260. Approximately 55% of them are minorities including about 7% Chicanos, Puerto Ricans, Asians (mostly Filipinos), and occasionally an American Indian. There are usually about 7 to 10 women. Generally, over 60% are enlisted men and women, and often the grade difference is as important an issue as racial and ethnic factors. We've trained about 2,500 students so far with an average input of 1200 students a year.

While we have no good model of what an effective RRI should look like, at the end of seven weeks he is "an Expert"; an anthropology expert in seven different minorities (blacks, Chicanos, Puerto Ricans, American Indians, Chinese, Japanese and Filipinos); a psychology expert in individual and group dynamics; a sociology expert in racism; and an expert master teacher. When he first came to us he may have been scraping the bottom of a ship, but at the end he has a certificate proving he is a race relations expert and has ten college credits to authenticate it. Obviously, we pray a lot.

His responsibilities are awesome. I give him much credit for the courage and dedication he displays when he leaves us and faces a group of soldiers who resent being forced to discuss race relations. Remember, he may leave us to develop a program where none existed; to run groups with only basic skills, if that, to face maybe a disinterested commander; and to do it alone without supervision.

Since you are generally familiar with the type of material that we would cover in behavioral science, I will concentrate on the minority studies content of the curriculum.

CURRICULUM

As to the content of the classroom instruction, each student is exposed to 64 hours of study devoted to seven minorities, which we believe provides him with an appreciation of the range of minority experiences in this country. I emphasize "minority experience" because conceptually we wish the student to understand that prejudice and discrimination are not specific to one group, but permeate our entire social structure, and that as long as it exists for one group, it will exist for another. On a practical level, the student also has to be prepared to answer questions related to the similarities and differences of experiences of different groups within the military and of topical events, such as the Wounded Knee incident. Obviously, within a seven week period we can only provide our students with an introduction to minorities. We rely on supplementary readings and guest speakers during the course of instruction, and recommend resources they can use when they return to the home stations.

White Experience

During the course of the past year, it became increasingly evident that most of the students were almost as ignorant of the white majority's history and experience as they were of the minorities. They were taking so much for granted that a special set of stereotypes--sometimes referred to as "mainstream America," WASPs, the Affluent, or simply "they"--interferred with the objectives of the Institute, to develop communication and harmony.

While we were teaching where the minorities were coming from, students didn't really appreciate that the majority was coming from different places, that while racism is the warp in our culture, white Americans are bent differently. Some came from educated, middle-class backgrounds with strong Protestant ethics; some were developing a new white consciousness; some are really poor; and some left urban poverty relatively recently and are beginning to assert their own ethnic identity and are questioning the American Dream. During the past year, we've begun to address these issues directly and have permeated our curriculum with variations of the white experience.

Recently we introduced the students to the world of about 65% of their military audience -- the working class service member. The soldier, airman, or sailor who completed high school, or dropped out, and had the choice of working in a factory or driving a truck on the one hand, or enlisting in the military for security or learning a marketable skill on the other. Many of them are familiar with frustration, invisibility, and lack of self-worth, and become career personnel and supervisors with the potential for resenting the demands of emerging minorities or empathizing with their struggle. In addition to these urban whites, we discuss Appalachians and the southern mountain folk culture as an important and often forgotten poor white rural experience.

Minority Experience

The way we emphasize the "minority experience" is to present the contribution of each group under four conceptual areas: Culture, History, Contemporary Issues, and the Military.

The initial block of instruction in minority studies is 13 hours, describing some of the main cultural roots, values, and attitudes of each group. Thus, for the study area called Latino Studies, the racial roots derived from the Spanish, Indian and African are presented and the student learns about the Aztec civilization, the extended family, religious rituals and practices, the role of spiritualism and witchcraft, the importance of respect and machismo, courtship practices, and the general life-style of Chicano/Mexican-American and the Puerto Rican. Emphasis is placed on the richness of these cultures and the value placed on them by the Latino serviceman.

Similar presentation is made of other minority groups in regard to culture. In the Black Studies area, each student learns about West African civilizations, not only about their early existence and development, but also about the primary roles that marriage, children and family played and how closely this institution was tied to religion.

The main aspect of minority cultures is that it is largely presented in terms of its existence prior to contact with white America, as well as how it exists today as a sub-culture within our society.

In similar fashion, history is approached from the point of view of different minorities, especially events influencing the development of the Puerto Rican, Afro, Mexican, Asian, and native Americans. For the Asian-Americans, for example, we discuss the Chinese, Japanese, and Filipino

experiences as they came to the U. S. in terms of when they came, why they came, and how they were treated. We discuss early Asian exclusion acts and detention camps in WW II. The emphasis is the impact on the minority culture and the self concept of each group.

Once we have provided the students with a feel for the attitudes and values of each cultural group and a sense of its history from their point of view, we begin to discuss across-the-board the principal issues and problems affecting each group today and key more tightly on contemporary life styles.

Accordingly, for the black, we talk about the present quest for survival in the community; the strength of the black family; the contemporary role of religion and the mixed attitudes of youth toward it; leaders such as Martin Luther King, Malcolm X, and Baraka' issues such as being black, growing up in the ghetto, playing the dozens, use of profanity, being cool, the black woman, and self-hate. The desire of the Latino to preserve his language through bilingual-bicultural education; the Indian's struggle for cultural survival by preserving his land and the practice of the Native American Church; the remnants of Chinatown; and the Filipino's economic plight on the West coast -- are some of the issues discussed.

Finally, once the student has begun to visualize the culture, history, and identity of each group and of all minorities, he is introduced to the minority as an airman, soldier, and sailor, and the promise that the minority members feel the service holds for them.

Thus, through an understanding of the minority experience and an appreciation of where different whites came from, we hope to develop <u>Intercultural Competence</u> in the student. By this, I mean the competence to communicate about and with groups and individuals whose sources of experience have not melted into an assimilated mass, but rather, are rich in their differences. To do this he or she must be both knowledgeable and personally comfortable with difference.

<u>YOU</u>

Now that I've given you a brief picture of what we teach our RRI and what he is expected to do, where do you fit in?

As you can see, he needs a good deal of follow-on training to develop those beginning skills we have taught him, especially in the behavioral sciences area.

You can offer a great deal by sharing your knowledge in group dynamics and assisting him in becoming a group facilitator. Invite him to your seminars, let him know what available training workshops are coming up, such as NTL, Tavistock, and others. Since he is not a member of a professional organization the chances are he doesn't know of their existence. Invite yourself to offer him supervision or at least offer him constructive feedback on what you observed in his seminars. Help him evaluate individual behavior patterns in his group and why some people seem to behave the way they do. A special entry point is helping him analyze sources of resistance, how to recognize them and use them constructively.

If you have special interest in research, assist him to conduct surveys and ways to tap into the racial climate of the post. He's expected to do this and often has only a general untried notion as to how he is supposed to go about it:

Most of you have dealth with bureaucracies before and know how to sell a program and what preliminary steps are required. Share that with him. You know about community resources and how they can be used to further his program. Share that also.

Above all, reach out to him, offer your help, and let him know you want to learn from him to do your job better. Many of the ways and areas in which you can help each other will emerge.

Regardless whether its mental hygiene, ACS, drug programs, corrections, or hospitals, you do well to learn about the normative behavior of minorities and cultural relativity as they apply to your practice and to the institution and organization in which you work. The RRI can help you begin gaining that understanding and from my experience, fill an important gap in your training.

In closing, they need your help and in short order you will discover that you have the most to gain.

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OVERVIEW OF THE ARMY COMMUNITY SERVICE PROGRAM

by

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The Army Community Service Program was the first official social welfare program established within the Army that provided the Army social work officer an opportunity to practice professional social work in a non-clinical setting. Members of the "Army Social Work Community" were instrumental in the formation of the ACS program -- influenced the overall thrust of the program -- and continue to have a key role in policy formation concerning the program. Their continued interest and their critical evaluations of program elements and the overall direction of the program are essential to insure that quality social services are provided within all ACS centers.

In providing a brief overview of the current status of ACS, it is accurate to say that the program continues to be a positive one and is supported by most commanders. It is progressing satisfactorily despite the fact that there is "unevenness" among the various ACS centers and there remains the inevitable struggle for more resources to support the program at the installation level.

There are approximately 180 ACS centers and points of contact worldwide. These centers are authorized 414 military and civilian personnel. Of these, 42 are social work officers and 72 are Behavioral Science Specialists. Additionally, there are 23 civilian social workers or social service representatives. Approximately 4,000 volunteers support the efforts of the paid staff.

ACS is an installation level program and consequently, commanders and the ACS staff are permitted the flexibility of developing their own programs -- tailoring them to meet the particular community need. Consequently, programs vary widely, depending upon the commander's desires, the ACS staff capabilities and the available resources devoted to providing community services. The ACS Social Work Consultants have observed that the wide range of these programs and activities may be somewhat dysfunctional for the social worker assigned as an ACS officer. The administrative responsibilities to support a broad range of activities requires expertise that some of the social work officers lack. On the other hand, it has been observed that large centers directed by a "line officer" often lack the expertise for administering the social welfare activities of the program.

DA ODCSPER is aware of this problem and is taking measures to "improve the professionalization" of all ACS staff members through the ACS training course. This problem area remains a concern to all of the consultants however, and further exploration of ways to minimize the dysfunctional consequences in situations where this occurs will continue to be addressed.

A review of the current status of the ACS program would not be complete without a listing of the following significant actions:

a. AR 608-1 has been revised and an opportunity will be provided in the speciality seminar to discuss the implications of the major changes.

b. The Academy of Health Sciences conducted three two-week ACS training courses last year. Approximately 105 students completed the course last year and the same number have been programmed for FY 75.

c. HQ USAREUR is in the process of developing an ACS training program in order to meet their training needs and to supplement DA's effort to improve service in ACS centers.

d. The DA ACS officer is currently staffing a "Child Advocacy" regulation and developing a "DA Social Indicator Report" (to be called Human Readiness Report).

e. A world-wide ACS Workshop was held in Atlantic City last May and was attended by our 200 personnel. The 1974 Workshop is scheduled for 18-19 May, Cincinnati, Ohio.

In summary, it should be said that ACS is a viable social welfare agency. It has been instrumental in promoting a genuine interest, at all echelons, in the general welfare of our Army families. Its activities have served to sensitize the military establishment to the needs and special problems of the military familites. It has broadened the interest of the Army social work community from an orientation of almost exclusive "clinical" practice to an interest and involvement in the social and community problems of the larger military and civilian community. The program is still young and is still developing but it has acquired a durable place in the military community.

ARMY CORRECTIONS

by

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It is the purpose of this paper to present an overview of the Army Correctional System. Four general areas will be covered: (1) Army crime and confinement trends; (2) the recent modification of the Army Correctional System; (3) social work and corrections at the installation level; and (4) opportunities for social work practice at the United States Disciplinary Barracks (USDB) and the United States Army Retraining Brigade (USARB).

Army Crime and Confinement Trends

An analysis of FBI Uniform Crime Reports for 1972 reveal that 50 percent of arrests for crimes of violence, 36 percent of arrests for crimes against property, and 67 percent of arrests for narcotic-drug violations were persons in the 18 through 29 year age group, predominantly male. While this age group represents only 18 percent of the population of the United States, of which one-half is male, this same age group comprises over 72 percent of Army strength, predominantly male. It is also significant to note that over 50 percent of persons arrested for crimes against property were under age 18--all potential accessions to the Army. Army statistics reveal that 96 percent of offenders in the Army were 18 through 29 years old.

Crimes of Violence. Murder, forcible rape, robbery and aggravated assault comprise crimes of violence. Within the U. S. Army, 1,683 crimes of violence were reported in 1st Qtr, FY 69. This number has fluctuated to 2,480 in 1st Qtr, FY 72, and 1,605 in 1st Qtr, FY 74. Army strength has declined during this period, causing rates per 1,000 to remain higher than those reported through 3rd Qtr, FY 71. The rate per 1,000 for crimes of violence was 4.40 in FY 69 and 7.83 in FY 73. Of the total crimes of violence reported for 1st Qtr, FY 74, 46 percent occurred off-post.

Crimes Against Property. Larceny over $50.00, burglary and auto theft comprise crimes against property. Within the Army, 10,072 crimes against property were reported in 1st Qtr, FY 69. This number rose to 17,104 in 1st Qtr, FY 72, and fluctuated downward to 11,592 in 1st Qtr, FY 74. Army strength has declined during this period, causing rates per 1,000 to remain higher than those reported through 3rd Qtr, FY 71. The rate per 1,000 of crimes against property was 28.26 in FY 69 and 50.45 in FY 73. Of the total crimes against property reported for 1st Qtr, FY 74, 12 percent occurred off-post.

Drug Offenses. This group includes all offenses associated with use, possession, sale or trafficking of narcotics, dangerous drugs and marijuana. Drug offenses worldwide have fluctuated from 2,223 in the 1st Qtr, FY 69, to 6,213 in 4th Qtr, FY 71; declined to 3,748 in 4th Qtr, FY 72; rose to 6,181 in 3rd Qtr, FY 73; declined to 2,954 in 1st Qtr, FY 74. Army strength has declined steadily during this period, causing rates per 1,000 to rise even though total offenses have declined for some quarters. The rate per 1,000 was 8.16 in FY 69 and 24.80 in FY 73. Of the total drug offenses reported for 1st Qtr, FY 74,27 percent occurred off-post.

Prisoner and U. S. Army Retraining Brigade Population. The worldwide Army prisoner population, which includes all those confined at the USDB, USARB and installation and area confinement facilities, has fluctuated from over 10,000 in FY 69 to about 5,500 in the 1st Qtr, FY 74. The trend in average daily prisoner population will not be the same as the trend in rate per 1,000 because of Army strength changes. Annual rates per thousand for prisoner population are 6.57 for FY 69; 6.32 for FY 70; 5.64 for FY 71; 6.00 for FY 72; and 5.49 for FY 73. The rate per 1,000 for the 1st Qtr, FY 74, was 6.55.

Of the approximately 5,500 Army prisoners presently confined worldwide, about 1,000 are at the U. S. Disciplinary Barracks and about 1,000 at the U. S. Army Retraining Brigade. The remaining 3,500 are located at installation and area confinement facilities in CONUS and overseas. It is significant for Army social workers that well over half of Army prisoners are presently confined at installation facilities rather than the USDB and USARB and that generally only minimal social work services are provided where they are needed most.

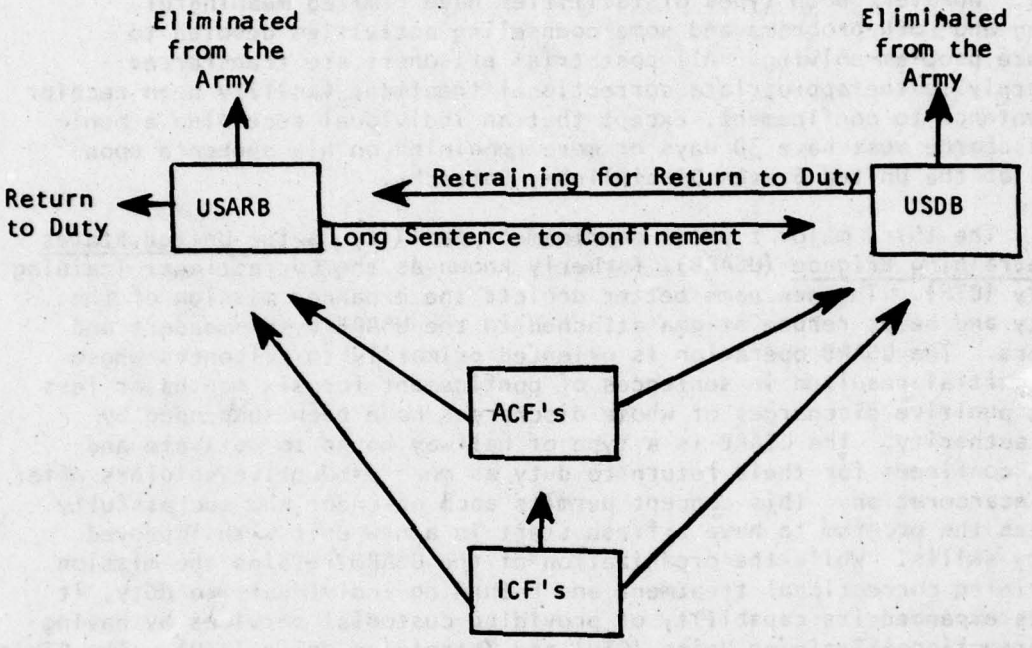
Recent Modification of the Army Correctional System*

What has been known in the past as the Army stockade system was modified during 1973 to form an Army installation confinement system by eliminating the correctional treatment mission at installation stockades. This has resulted in accelerating the movement of post-trial prisoners to correctional treatment facilities, reducing the scope of operations at installations with small demands for confinement space, and providing confinement services on an area basis at other facilities. Use of the term "stockade" has been discontinued and the confinement system consists of the following types of activities:

1. Installation Confinement Facilities (ICF) are transient type facilities providing pre-trial confinement services for prisoners awaiting courts-martial at the installation. They also serve as transfer points for other prisoners pending movement to area confinement facilities, the USDB or the USARB. All post-trial prisoners are transferred immediately after their courts-martial to the USDB or to the USARB unless the court-martial convening authority elects to retain the individual pending post-trial action. Utilization of installation confinement facilities providing pre-trial confinement services at most Army installations has permitted a sizeable reduction in manpower requirements which used to support the old stockade system.

by qualified civilians. Educational opportunities up to the level of an Associate in Arts degree are also available. At the present time the USDB is the only maximum security institution for Army and Air Force prisoners and during the summer of 1974 will begin receiving Marine prisoners as well.

*CORRECTIONAL TREATMENT FLOW



Social Work and Corrections at the Installation Level

It was previously pointed out that over 3,000 or well over one-half of all Army prisoners are presently confined at installation facilities rather than the USDB or USARB and that generally only minimal social work services are provided where they are needed most.

A CONARC letter, dated 23 February 1973, entitled "CONARC Plan for the Modification of the U. S. Army Correctional System Within CONUS" set forth the staffing objectives for the new Area Confinement Facilities. Included in the staffing objectives were the requirements for a psychologist or social work officer for all ACF's. In addition, social work/psychology specialists were to be required for all confinement facilities on the basis of 1 per 50 prisoners. While these objectives have not become a reality in terms of authorized positions for social work officers, some confinement facilities have met the objectives in terms of enlisted social work/psychology specialists. In a number of instances, ICF's and ACF's have social work specialists assigned without the technical guidance and supervision of social work officers.

2. Area Confinement Facilities (ACF) have been established for certain installations to provide confinement services on an area basis for military personnel awaiting courts-martial or for post-trial prisoners pending transfer to the USDB or the USARB. The area confinement facilities are for those persons transferred from installation confinement facilities and for those individuals returned to military control from a dropped-from-rolls status for whom confinement is directed.

At both installation confinement facilities and area confinement facilities, the primary function is to prepare prisoners for court-martial. However, both types of facilities have limited meaningful training and work programs and some counseling activities devoted to immediate problem-solving. All post-trial prisoners are transferred immediately to the appropriate correctional treatment facility upon receipt of a sentence to confinement, except that an individual receiving a punitive discharge must have 30 days or more remaining on his sentence upon arrival at the United States Disciplinary Barracks.

3. The third major type of confinement facility is the United States Army Retraining Brigade (USARB), formerly known as the Correctional Training Facility (CTF). The new name better depicts the expanded mission of the facility and helps reduce stigma attached to the USARB by commanders and prisoners. The USARB operation is oriented primarily to prisoners whose courts-martial resulted in sentences of confinement for six months or less without punitive discharges or whose discharges have been suspended by proper authority. The USARB is a type of halfway house to motivate and retrain confinees for their return to duty as more productive soldiers after their incarceration. This concept permits each offender who successfully completes the program to have a fresh start in a new unit with improved military skills. While the organization of the USARB retains the mission of providing correctional treatment and returning individuals to duty, it also has expanded its capability of providing custodial services by having both Correctional Training Units (CTU) and Retraining Units (RTU). The CTU's provide close custody and control of prisoners and motivational training to prepare them for the correctional/retraining program conducted by RTU's. Additionally, the CTU's prepare nonrestorable prisoners for return to civilian life when applicable. Retraining Units provide correctional treatment, educational programs, and military skill development training for individuals returning to duty. Emphasis at the USARB is on returning military offenders to duty as more productive soldiers in the shortest time possible and prompt elimination from the service those individuals who do not or cannot meet Army standards.

4. The fourth major confinement facility is the United States Disciplinary Barracks (USDB). The Disciplinary Barracks provides custody and correctional treatment for prisoners with sentences to confinement in excess of six months and with at least six months remaining to serve on arrival at the USDB, and prisoners with a punitive discharge and at least 30 days remaining on their sentence on arrival at the USDB. The mission of the USDB remains unchanged, that is, to provide the correctional treatment necessary to return to civilian life prisoners with punitive discharges and in limited cases return to duty selected prisoners as better motivated soldiers through the USARB retraining program. The USDB is staffed mainly by military personnel with civilian support and provides a wide range of vocational training details, furnishing marketable skills and supervised

While it is recognized that confinement facilities should have the proper ratio of social work officers and specialists, it will be some time before manpower surveys recognize and authorize these positions. In the interim, social work officers from installation medical activities should provide behavioral science consultation to the confinement facility, including supervision of specialists.

Until staffing objectives and manpower surveys result in authorized and filled positions, social workers will have to utilize their best command consultation skills in order to define roles and provide services to confinement facilities. The inmate population of confinement facilities should be considered a target client group just like any other client group authorized social services. Unfortunately, in some instances those in a confinement status do not receive the same priority for social work services as do other client populations.

Social workers on posts having ICF's and ACF's can become actively involved in the organization and utilization of 91G's at the confinement facility. In addition, new roles for both the social work officers and the specialists can be explored and developed. This should include providing behavioral science consultation to the command group of the confinement facility. Ideally, the social worker may be considered an adjunct to the confinement officer's staff and thus participate in such activities as staff meetings and decision making. Social work/psychology specialist roles should be expanded.

It is felt that each new inmate should be seen by a 91G and that a social summary be furnished to the confinement officer and included in the Correctional Treatment File. In addition to helping the confinement officer and his staff, the social summary would be useful if administrative separation is contemplated or the inmate is to be transferred to either the USDB or the USARB. Specialized groups can be developed to meet the needs of certain inmates. Inmates who are being sent to USARB at Fort Riley, for example, can be seen as a "Return to duty" group to counteract any negative peer pressure and help create positive motivation. Groups to meet other needs such as drug abuse problems and black awareness could be formed with assistance from post agencies responsible for these activities. It is also felt that social work/psychology specialists can be utilized on custody boards held at the confinement facility.

Finally, social work officers should be providing appropriate in-service training for those 91G's assigned to confinement facilities. In most cases the MHCS appears to be the appropriate activity on many posts to provide this training support.

Opportunites for Social Work Practice at the USARB and USDB

The U. S. Army Retraining Brigade is located at Fort Riley, Kansas, where presently there are eight social work officers providing professional services for about 1,000 trainees. The central feature of the social work program at USARB has been the concept of direct support to the training units, with organization along the modular concept. Social work teams consisting of a social work officer and a social work specialist are assigned to each unit.

Direct support to the unit by the social work team consists of: trainee counseling, providing guidance to cadre, advising the commander regarding the disposition of trainees, evaluating the emotional and mental status of trainees, and conducting specialisted group counseling.

In addition to the primary responsibility of direct support to units, the social work branch also provides formal instruction to both trainees and cadre. Social workers, through the unit social work teams, provide monitors for guided group counseling and assist the group leader in developing knowledge and skills in group processes. Formal instruction to the trainees in the form of motivational conferences presented by the unit social work team is composed of classes in drugs, alcohol, sex, military social resources and a pre-discharge orientation. In addition to classes for inmates, social workers provide in-service training courses on counseling for USARB cadre.

Finally, social workers have had professional conferences with the Fort Riley psychiatry consultant, involving case conferences and clinical training. This has enhanced the ability of the social work staff to meet the increasing demands for formal psychiatric evaluations.

The United States Disciplinary Barracks, located at Fort Leavenworth, Kansas, is the only maximum security institution for Army and Air Force prisoners and in addition will house Marine Corps prisoners beginning in June 1974. The USDB presently has about 1,000 inmates, with a staff of 560 enlisted men, about 125 civilians, and 40 officers. One-fourth of the USDB officer staff consists of AMEDD officers, who are assigned to the Directorate of Mental Hygiene. The Mental Hygiene staff consists of six social work officers, two psychiatrists, two psychologists, four civilian social workers, and eleven 91G's. The Director of Mental Hygiene is a social work officer.

The USDB offers an excellent opportunity for Army social workers to work in a large maximum security correctional institution staffed by Army, Air Force, and Marine Corps personnel.

All behavioral science staff members help toward accomplishing the Directorate of Mental Hygiene mission of providing staff consultation and training, prisoner treatment and services, prisoner evaluations and research. The thrust is on a systems approach, and staff members are encouraged to develop and support innovative programs. Social workers have had major responsibility in developing and supervising an institutional Junior Chamber of Commerce chapter, Seven Steps program, Alcoholics Anonymous, Sickle Cell Anemia Program, Guides for Better Living, and the USDB Drug Awareness Program.

The Mental Hygiene Directorate emphasizes an interdisciplinary team approach in achieving its goals, and staff members learn to appreciate the unique contributions each discipline is able to make.

CURRENT TRENDS, PROBLEMS, AND ISSUES IN THE TRAINING OF 91Gs

by

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As I survey the present scene, review the past and attempt to prognosticate future trends on the paraprofessional side of the Army Social Work Program, I find that an old fable begins to have more and more meaning. Cited in the introduction to Bennis, Benne, and Chin's book The Planning of Change, the story deals with the pain and turmoil of a certain grasshopper. It seems that the grasshopper, after living through several severe, and to him painful winters, decided to seek consultation on how he could avoid discomfort in the winters to come. He sought the advice of the wise and learned owl. After hearing the plight of the grasshopper and reviewing several staff studies on the problem, the owl rendered his advice. "The solution is simple" he said. "All you have to do is turn yourself into a cricket, then you can hibernate during the winter and experience only the pleasure of sleep." The grasshopper was overjoyed at what obviously was a magnificient solution to his dilemma. He expressed the appropriate thanks to the owl and hopped away. He found, however, that the plan was a bit more difficult than he had expected when the time came for its implementation. Frustrated, he returned to the owl for more advice. "How do I accomplish this transformation?" he asked. Whereupon the owl replied, "Look, I gave you the principle. It's up to you to work out the details." Likewise, those of us in the business of training the 91Gs have a lot of ideas about change, but it's the details that are at times very taxing to manipulate. We would like to share some principles as well as the details with you today.

The current trend for the 91G program is change; change of name, change of job description, change in students and, hopefully, change in training programs and informational resources. Accommodating this change, for us, has been akin to working on an auto engine while it is running at full speed. We have seen no let-up in training requirements in the past two years. Students entering the 91G20 course during FY 73 numbered 748 and while our programmed input for FY 74 was projected

to be 482, we will probably end the year having seen close to 640 students. Hopefully, FY 75 will find us catching up with the demand and able to slow the engine down a bit for some needed repairs.

Those of you who read LTC Darnauer's recent letter are aware that as of 1 Mar 74 the name of the MOS has been changed from Social Work/ Psychology to Behavioral Science Specialist. I will not attempt to explain the change as the decision was made elsewhere. We are learning to live with our task of training "BS" specialists and perhaps in time the name will take its place with those other double entendres which connote status rather than derision.

On the more positive side of the picture is the publication of a new job description--one which we hope is more in line with the actual experience of the working 91G than the old one. You will soon find it published as a change to AR 611-201. In essence, the change involves a shift from a job description which characterized the 91G as data collector to one which describes a more active role for the 91G in helping people with the resolution of their problems. The new job description incorporates the task of counseling in a wide variety of settings as central to the 91Gs' job. It is line with data from field surveys and past experience with the highly educated 91G of the draft years. A legitimate question can be raised regarding its relevance to the capabilities of 91Gs turned out during the "drug crisis" and the products of the all volunteer Army who have entered training with minimal educational credentials. The characteristics of this population and their success rates in the course will be discussed in greater detail by SP5 Smith a little later in the program. Needless to say, we are actively engaged in an effort to design a training package that we feel will produce a graduate who, upon reporting to you, can minimally perform those functions which are demanded by the job.

Prior to launching into a discussion of the details of our plan for turning our grasshopper into a cricket, let me say a few words about our present program. In comparing the training of the 91G to other paraprofessional training programs around the country, we find that overall we have one of the best programs going. It is without a doubt one of the largest. Much of the credit for the quality of the program as it stands today belongs to the many of you who have made contributions to it in its 27 years of existence, as well as to the present faculty who have been working non-stop with two classes at a time for nearly three years. One of our problems is that not many of the other paraprofessional programs have as discriminating a clientele as we do, nor do their graduates function in such a wide range of settings. I will not argue with some of the rumblings of discontent I hear from the field about the quality of the "new" 91G. For the benefit of those who feel they haven't seen a "good" 91G since 1960, let me add quickly that if those of you who have given me some positive feedback are telling the truth, many of you are getting some quality help as well.

What then is in the wind? The answer to this question lies somewhere in the combination of our imagination, ability to negotiate the bureaucracy, cooperation from you, a little bit of luck and a lot of hard work.

At the present time, we are staffing a proposed extension of the present course. For a host of reasons, we feel that ten weeks is not enough time to turn the average high school graduate into the kind of product you expect. In fact, we are not sure how much time it will take, but for starters we would like to have the student for 18 weeks. We feel that in this length of time, we could not only teach him the basic skills involved in interviewing but also help him develop a personal equation of the counseling process. The proposed program of instruction provides for ample laboratory time not only to develop skills, but to practice in an environment in which mistakes are not made on live clients. It will also give us additional time to stress remedial work in communication skills and provide a better orientation to the range of settings using the 91G. Before you get too excited, let me add that this proposal has a long and rocky bureaucratic road ahead of it. The most encouraging aspect to date is the fact that given a reduction in the number of students put into the course, we can probably handle the job with no additional resources.

Although we feel that ample justification exists for a longer course and that we have some pretty good ideas about what should go into it, we are proceeding along a second front as well. In keeping with the trend established by the former Secretary of Defense, Robert McNamara, we will soon launch a systems analysis questionnaire to the field. This questionnaire is being developed from the data of prior field surveys of the tasks assigned to 91Gs. It is here that your cooperation will be most important. The systems analysis questionnaire will do us little good if it remains in your in-basket or ends up in your waste basket.

The data from the systems analysis questionnaire will be used to establish the behavioral objectives for a completely new 91G course, designed from the ground up. I am confident, at this time, that a clear and accurate description of the tasks assigned to 91Gs will produce ample justification for an extended and more comprehensive course of instruction. We would like to provide you with a paraprofessional that can be a strong asset to your program. We cannot do this without useful and systematic feedback from you.

A third project is presently in the works which we hope will serve not only the 91G in training, but the 91G in the field and his supervisor as well. As some of you know, the old Social Work Handbook is long overdue for revision. The initial effort started a couple of years ago, produced some very fine papers, thanks to your cooperation. The end product, however, was simply a collection of papers and not a

document which could serve the needs of the 91G as a study and proficiency test reference. In addition, the attempt had a decided bias which, some of our brethren in the allied professions felt, failed to recognize that 91Gs also work with psychologists and psychiatrists as well as social workers.

The replacement of the old manual will be in the form of a special text. This format will help us avoid some of the difficulties inherent in revising a manual published at Department of the Army level. Present plans call for the development of a two volume text which will be published in loose leaf format. Volume I will present a general overview of information which is essential to the 91G in the many settings in which he works. It will deal not only with specific setting information but also with the basic social and behavioral science information and processes which relate to the job of helping people. We cannot, obviously, deal with the total world in depth, but it should provide a basic reference for the 91G.

The second volume of the text will be composed of a series of readings, keyed to Volume I. A number of the papers submitted for the original revision effort will probably appear here. This volume will be designed to allow the individual to explore in depth some of the subjects outlined in Volume I. We will try to pick a number of seminal articles for inclusion in this volume which relates specifically to Army programs as well as others from civilian sources which we think will be useful.

The design, selection of material, writing and editing of a project of this magnitude is a slow and tedious process. Even if those of us involved could devote our complete energies to the special text, it would take time. In other words, don't expect it to be on your news stand tomorrow! We hope to develop a quality product which combines both your inputs as well as the efforts and expertise of the multidisciplinary staff here at the Academy. Represented in this effort will be the contributions of psychology, psychiatry, social work, and most importantly the 91G. We want to produce a useful text as well as one that can be easily changed as programs change and knowledge develops.

A commonly expressed need, particularly among senior 91Gs, is for some type of training program to develop the enlisted leadership in our programs. A proposed 91G40 level course was submitted to the "powers-that-be" a couple of years ago. As you may guess, it was not approved. We continue to recognize the need for a training program which goes beyond the basic level of the 91G20. This is important not only from the standpoint of its obvious utility for the programs in which the senior 91G works, but also from the standpoint of the individual's career development. Although we are now only in the beginning stages of formulating a program, we hope to re-submit a proposal for advanced training in the not too distant future.

An additional source of irritation in the career development picture for the 91G is the limitation of promotion beyond the grade of E-7 in the MOS. There is no doubt that the loss of experienced 91Gs when they are eligible for promotion to E-8 is a detriment to our program. Although we gave it our best shot during a recent Department of the Army study of the MOS structure, we still have the E-7 limitation on the 91G MOS. The prospect for immediate change seems unlikely; however, we don't intend to let the matter rest and hope that you do not either.

Although SFC Rank is going to address this issue specifically, I would like to emphasize to you the fact that we turn out an unfinished product. That means that you must give your attention to the continued development of the 91G. His needs for training are different from those of your professional staff and attention should be given to his development. We are not telling you that you should tolerate incompetence. Surely, the true test of an individual's ability to carry the MOS should be his ability to do the job. We cannot always measure job performance potential accurately in the course. We are, however, asking you to help us build competence in the 91G by attempting a systematic training program for him in your setting. In addition, we ask that you not be nearsighted in your concern with the 91Gs on-going need for training. There are many 91Gs presently working without the benefit of professional supervision, particularly in drug and alcohol programs and area correctional facilities. Please reach out to them as you plan your programs. Given the limitations of our present course, the need for your participation in the training mission is most acute. If you ask me why you don't get quality 91Gs, I will ask to see your program for picking up where we leave off.

If we are to maintain a viable training program for 91Gs at the Academy of Health Sciences, we must have an adequate supply of qualified instructors. I have been accused of "ripping off" the cream of the crop, of raiding the sacred sanctuaries of established programs, but the fact remains that it is hard for a student to be more proficient than his teacher. We have been fortunate in the recent past in recruiting, under trying conditions, some very fine instructors. Many of these poeple were the bright, college educated 91Gs of the draft years. We are losing these people to the civilian community and our experienced faculty becomes subject to orders like the rest of us. We need your help in identifying and releasing those experienced people who have instructor potential for duty at the school. It is not an easy assignment, but we need to have people encouraged to accept the challenge. I realize that it is hard to lose a good person, but the nature of the Army is such that you can't hold on to an individual forever anyway.

I remind you that what we need are people with instructor potential. Competence in the field is not necessarily the only criteria which applies. Teaching involves the ability to conceptualize practice and, in turn, present those concepts in a way which can be operationalized

by the student. Teaching requires a thirst for knowledge. The individual who has done nothing to further his education since graduation from the 91G course probably will make a poor instructor. At a minimum, teaching also involves the ability to present material to a group in a manner which will not put them to sleep or make them uncomfortable while the teacher searches for words. It also involves, in our program, the ability to be creative in the face of change and stress.

I realize that you may wonder where this mythical individual is. The answer is that many of them are at the centers of your programs. If you want more of the same, you will have to help us recruit the trainers.

Let us now step up and have a closer look at the characteristics of our students, the distribution of our graduates and one attempt at picking up where the course leaves off.

AN OVERVIEW OF THE INPUT AND OUTPUT CHARACTERISTICS OF CANDIDATES FOR THE SOCIAL WORK/PSYCHOLOGY PROCEDURES COURSE

by

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The attrition rate[1] of any training course is an ever present problem to the personnel who are responsible for establishing screening procedures for prospective candidates. The more effective screening procedures are designed to insure that the attrition rate of their training program is kept at a minimum. In setting up any screening system two basic problems merit consideration. First, if the objectives of a given training course requires that the training program produce a certain supposedly "qualified" person capable of performing at a predetermined level of competence, then the expectation of a "low" attrition rate might be unrealistic. Second, if a low attrition rate assumes first priority, then the expectations of performance capability at graduation should possibly be revised downward, possibly producing the undesireable consequence of graduates who are not competent to perform as expected. Probably, the best solution to this problem is to insure beforehand that the candidates "possess" the aptitudes and characteristics that successful course completors have possessed in the past while maintaining the relative quality and integrity of the training program. Presently the Social Work/Psychology Procedures Course (302-91G20) is encountering such a dilemma and accordingly a research project has been initiated in an effort to resolve these issues.

The purpose of this paper is to present an overview of the presently constituted input procedures for the Social Work/Psychology Procedures Training Course, and to discuss the problem of the high attrition rate. Also, a presentation of some preliminary findings of cognitive and non-cognitive variables that significantly differentiated between completors and non-completors will be made.

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[1] ATTRITION RATE = $\frac{\text{\# of Candidates Input} - \text{\# of Candidates Output}}{\text{Number of Candidates Input}}$

Unless the Social Work/Psychology Specialist MOS is directly awarded, enlisted personnel who desire to work in the social work setting in the Army are required to attend a 10-week training course at the Academy of Health Sciences, Fort Sam Houston, Texas. For enlisted personnel to be admitted to the course, the following prerequisites must be met: (1) Show "evidence of emotional stability and maturity;" (2) Possess the "ability to communicate effectively orally and in writing;" (3) Obtain a "standard score of 100 or higher in aptitude area GT;" (4) Have "ten months or more of active duty remaining after completion of the course" (DA PAM 350-10, Formal Army School Catalog). Presently there are no defined standards that can behaviorally measure either the enlisted man's evidence of emotional stability and maturity or the enlisted man's ability to communicate effectively orally or in writing. Therefore, the only two measurable prerequisistes are that of the GT score and the time remaining in service. Consequently, the GT score and the time remaining in service are the only criteria that is presently being used for admittance into the course:

After applying for admittance to the Social Work/Psychology Procedures Course, and if an individual meets the prerequisites (GT 100), and barring any administrative complications, entry into the course is virtually assured. The presently constituted ten week course purports to accomplish the following: (1) To train the student to recognize and assess basic social, psychological and psychiatric problems that are likely to be encountered by military personnel and their dependents; (2) To train the student to collect and record relevant data related to specific social, psychological, and psychiatric problems; (3) To train the student to participate in problem solving processes designed to deal with such problems, i.e., crisis intervention; (4) To train the students to interview with sufficient skills to accomplish the preceding objectives and (5) To train the student to conduct a successful intake interview to include a full social history (POI, 1972). In order to meet these basic objectives, the student is required to pass three crucial course objectives: (1) perform an acceptable write-up of an interview; (2) show evidence of acceptable beginning interviewer skills and (3) successfully complete the academics by making at least 70% on the crucial exam. A failure to meet any one of the three crucial objectives results in non-completion of the course. With the presently constituted course requirements and prerequisites, what then, is the resultant attrition rate? How does this rate compare to other MOS producing courses? Is this rate acceptable or should steps be implemented to lower it to a more acceptable level? These questions are germane to anyone affiliated with the field of social work and they merit careful consideration. The remaining portion of this paper will compare the attrition rate of the Social Work/Psychology Procedures Course to other randomly selected MOS-producing courses at the Academy of Health Sciences and them examine various cognitive and non-cognitive variables that might significantly differentiate between completors and non-completors of the Social Work/Psychology Procedures Course.

Table 1 gives the attrition rate of the Social Work/Psychology candidates over the past six fiscal years.

TABLE I

ATTRITION RATE OF SOCIAL WORK/PSYCHOLOGY PROCEDURES COURSE

FOR FISCAL YEARS 1968 - 1973

Fiscal Year	Input of Candidates	Candidates Lost	% Attrition
1968	245	51	20.8
1969	119	45	37.8
1970	101	25	24.7
1971	501	62	12.3
1972	637	157	24.6
1973	748	135	18.0
TOTAL	2351	475	20.2

In order to make a comparison of the attrition rate for the Social Work/ Psychology Procedures Course to other MOS-producing training courses at the Academy of Health Sciences, nine other MOS-producing training courses were randomly selected and the attrition rate for the past five fiscal years were calculated. Table 2 gives a ranking of the attrition rate for the past five fiscal years.

TABLE II

RANKING OF ATTRITION RATE FOR FISCAL YEARS 1969 - 1973

FOR 10 MOS-PRODUCING COURSES

AT THE ACADEMY OF HEALTH SCIENCES

RANK	COURSE	CANDIDATES INPUT	CANDIDATES LOST	% ATTRITION
1	Pharmacy Specialist (312-91Q10)	1453	305	21.0
2	Social Work/Psychology Procedures (302-91G20)	2106	424	20.1
3	Medical Laboratory Procedures (Basic) (311-92B20)	5055	628	12.4
4	Operating Room Procedures (Basic) (301-91D20)	3783	407	10.8
5	Dental Laboratory Procedures (Basic) (331-42D10)	1144	114	10.0
6	Preventive Medicine Procedures (Advanced) (322-91S20)	523	43	8.2
7	Dental Fixed Prosthetic (331-42F20)	131	10	7.6
8	Medical Records and Reports (Basic) (513-71G20)	3334	217	6.5
9	Dental Hygienist (330-91E30)	593	34	5.7
10	Physical Therapy Aide (303-91J20)	718	25	3.5

Of the ten courses that were compared, the Social Work/Psychology Procedures Course had the second highest attrition rate (20.1%) with the Physical Therapy Aide Course having the lowest attrition rate (3.5%). To what factors could the difference between the two rates be attributed? Could it be that the courses with the lower attrition rates adhered to stringent prerequisites for entrance into their course? This area merits further investigation which is beyond the scope of this paper.

What then are the reasons for such a high attrition rate for the Social Work/Psychology Procedures Course? Are there cognitive as well as non-cognitive variates that can be identified which contribute to the completion of the course? For classes that were conducted from February 1972, to February 1974, it was found that when the average rank (pay grade), average age, and average educational level for each class was correlated with the attrition rate for that class (See Table 3), only the average educational level correlated significantly with the attrition rate (See Table 4). The data presented does not answer the questions as to what reasons contribute to completion or non-completion of the course but suggests that the amount of formal education completed by prospective candidates might be a variable that needs to be considered.

TABLE 3

ATTRITION RATE, AVERAGE EDUCATIONAL LEVEL, AVERAGE AGE, AVERAGE RANK FOR SOCIAL WORK/PSYCHOLOGY PROCEDURES COURSE FOR CLASSES FROM FEBRUARY 1972 TO FEBRUARY 1974

Fiscal Year	Class Number	Attrition Rate	Average Education	Average Age	Average Rank
1972	106	12.5	15.2 yrs	21.9	1.8
	107	42.1	13.5	21.0	2.1
	108	24.1	13.4	22.1	2.5
1973	1	31.5	13.0	21.6	2.6
	2	19.2	13.7	21.5	2.2
	3	25.6	13.0	20.0	2.1
	101	17.9	13.3	20.1	XXX
	4	22.2	13.5	20.4	4.8
	102	28.2	13.6	21.0	1.9
	103	17.9	13.4	21.9	2.4
	105	20.5	13.4	21.4	2.4
	106	27.8	13.3	22.0	2.4
	107	33.3	13.0	21.6	2.4
	108	39.4	12.9	23.9	3.1
1974	1	42.1	13.0	22.9	3.0
	2	31.8	12.7	XXXX	3.2
	3	31.9	12.3	23.7	3.3
	4	27.3	11.9	26.0	4.3
	5	XXXX	13.2	23.4	3.4
	6	XXXX	12.8	27.2	4.1

XXXX - DATA IS NOT AVAILABLE

TABLE 4

CORRELATION COEFFICIENTS BETWEEN ATTRITION RATE AND AVERAGE RANKS, AVERAGE AGE, AND AVERAGE EDUCATION FOR SOCIAL WORK/PSYCHOLOGY PROCEDURES COURSE FOR CLASSES FROM FEBRUARY 1972 TO FEBRUARY 1973

	r	p
Average Rank	+.375	+.05
Average Age	+.305	+.05
Average Education	-.513	-.05

To identify cognitive as well as non-cognitive variates that might significantly differentiate between completors and non-completors, thirteen variables were considered. The operational definitions for the non-cognitive variables are as follows:

(1) Sex: The biological sex type: Male or Female

(2) Rank: The pay grade: E-1 through E-9.

(3) Age: The chronological age recorded in years.

(4) Educational Level: The number of years of formal education that was successfully completed. For example, a candidate might have a GED, but only completed 10 years of formal education, then the educational level would be recorded as 10 years.

(5) Length of Time Out of School: The time in years (to the nearest year) since the last exposure to formal education, e.g., attending high school, college, or an MOS-producing Army school.

(6) Length of Service: The number of months spend in the military.

(7) Prior Field Experience: Prior work experience (including OJT as a 91G) in a social work setting but excluding internship in a school setting. Prior experience was recorded as Yes and lack of prior experience was recorded as No.

(8) Facilitating Test Anxiety (FTA): Nine true or false questions taken from the Taylor Manifest Anxiety Scale (1953). The FTA score resulted from the number of questions answered "true". The questions that were answered in the affirmative indicated that the candidate "claimed" to experience the kind of "anxiety" that facilitates acceptable performance on a test.

(9) Debilitating Test Anxiety (DTA): Ten true or false questions taken from the Taylor Manifest Anxiety Scale (1953). The DTA score resulted from the number of questions answered "true". The questions that were answered in the affirmative on this scale indicated that the candidate "claimed to experience the kind of "anxiety" that impedes acceptable performance on a test."

(10) CPI Social Work Completion Scale (CPISWCS)[2]: Forty-five true or false questions taken from the California Psychological Inventory that completors of the Social Work/Psychology Procedures Course answered in a significantly different direction from non-completors. The score is the number of items that were answered in the same direction as that of the completors.

The operational definitions for the cognitive variables are as follows:

(1) Vocabulary: The raw score on the Abstraction Subtest of the Shipley-Institute of Living Scale (1940).

(2) Abstract Reasoning: The raw score on the Abstraction Subtest of the Shipley-Institute of Living Scale (1940).

(3) Conceptual Quotient (C.Q.): The ratio of the abstraction score to the vocabulary score. The C.Q. is the ratio of the candidates abstraction age equivalent to that of the "average" person receiving his vocabulary score. The ratio is multiplied by 100 to eliminate decimals (Shipley, 1940).

Data for both the cognitive and non-cognitive variables were collected from 136 Social Work/Psychology candidates who entered the course from November 1973 to March 1974.[3] All of the data was collected during the first two days of the course.

For analysis of the variables previously described, two groups were compared. A group of completors, composed of students who have successfully completed the course on all respects, and a group of non-completors eliminated because of academic failure, failure to acquire and demonstrate acceptable beginning interviewing skills, administrative skills, administrative reasons (disciplinary or characterological), or voluntary release. Of the 136 candidates, 100 completed the course and 36 failed

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[2]The CPI was given to 296 Social Work/Psychology candidates that attended the course from March 1973, to May 1973. The frequency of "true" and "false" responses for both the completors and non-completors were recorded for the 480 items on the California Psychology Inventory and X^2 were calculated for each item. The items that had X^2 with p-.001 comprised the CPI Social Work Completion Scale. The results identified 45 items which completors answered in a significantly different direction from the non-completors.

[3]The results reported in this paper are for the 136 Social Work/Psychology candidates who entered the course from November 1973 to March 1974. However, collection and analysis of data is currently being processed and will continue to be collected on future classes through the remainder of Fiscal Year 1974.

to complete the course. Of the 100 completors, 36 were randomly selected and this subgroup was compared to the non-completors. A simple one-way analysis of variance was used to identify which of the variables differed significantly for the two groups. Table 5 gives the means for the two groups and the F-ration for the thirteen variables.

TABLE 5

MEANS AND F-RATIO FOR 13 VARIABLES FOR COMPLETORS AND NON-COMPLETORS FOR THE SOCIAL WORK/PSYCHOLOGY COURSE

VARIABLE	MEAN FOR COMPLETORS	MEAN FOR NON-COMPLETORS	F
Non-Cognitive Variables			
1. Sex (0=female, 1=male)	.61	.78	2.368
2. Rank	3.53	4.00	1.029
3. Age	23.56	26.25	3.074
4. Educational Level	12.28	11.69	2.733
5. Time Out of School (Years)	2.64	4.31	3.136
6. Length in Service (Months)	45.58	78.97	3.769
7. Prior Field Experience (0=No, 1=Yes)	.33	.33	.000
8. Facilitating Test Anxiety (Raw Score)	3.33	3.28	.014
9. Debilitating Test Anxiety (Raw Score)	3.81	4.56	1.743
10. CPI Social Work Completion Scale (Raw Score)	33.58	29.97	9.050*

TABLE 5 (Cont)

VARIABLE	MEAN FOR COMPLETORS	MEAN FOR NON-COMPLETORS	F
Cognitive Variables			
1. Vocabulary (Raw Score)	29.86	26.72	8.379*
2. Abstraction (Raw Score)	26.78	23.94	1.905
3. Conceptual Quotient	92.92	92.22	.041

*p-.01

The results of this study identified the CPI Social Work Completion Scale (CPISWCS) and the vocabulary score of the Shipley Institute of Living Scale as the only two variables that significantly differentiated between completors and non-completors of the Social Work/Psychology Procedures Course. The results on the CPISWCS showed that, on the average, the completors answered significantly more items in the same direction as previous completors than did the non-completors. However, with the significant difference, the magnitude of the difference (4 items) was quite small and interpretation of this difference, with respect to this variable, should be done with great caution.

The results on the vocabulary score revealed that the completors answered an average of three more items correctly than did the non-completors yielding a significant difference. However, once again, the small magnitude of the difference between the completors and non-completors warrants careful interpretation. This result presents evidence that there is a possibility that verbal abilities might be a factor that contributes to completion of the course. However, a single measure on vocabulary cannot account for the different factors that constitute one's verbal ability. It is suggested (and is in the planning) that further investigation be conducted with respect to the assessment of verbal ability and how it contributes to the completion of the course.

In addition to the CPISWCS and the vocabulary score, several other variables approached significance and warrant further consideration. These variables included average age, average length in service and average length of time spent out of a school setting.

It must be re-emphasized that the results in this paper are only preliminary results and further collection and analysis of the data is urgently needed before any conclusions can be made as to what factors or variables actually contribute to completion or non-completion of the

Social Work/Psychology Procedures Course. Furthermore, it is felt that other factors such as maturity and motivation play probably an even greater role toward completion of the course. However, unfortunately these variables are extremely difficult to accurately measure.

As the problem of a high attrition rate continues. . . .and continues. . . .can nothing be done about it? Not necessarily! We feel something <u>can</u> be done, and something <u>must</u> be done!

This paper has only been a commencement exercise for a very perplexing problem and we, at the Social Work/Psychology Branch, plan to devote more time and effort in attempting to resolve this problem.

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Selective Utilization and Systematic Development of 91G's in the Field

by

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Effective utilization of 91G personnel in the field is often difficult, but not impossible, to accomplish. "Slotting" an individual into a TDA or TOE manning document does not constitute effective utilization. Many other considerations may arise when the overall mission of the service or section is considered. What skills may this individual possess that he can contribute? What skills does he lack? Does he have expertise in an area that may not be utilized if he is placed in a certain job? What are his interests? Goals? How much latitude should the supervisor allow the individual in defining what he will be expected to contribute? Many questions.

Gradually, over time, and several assignments, I became convinced that regardless of assignment, a person will eventually define for themselves much of how they perform and, to a great extent, supervisor expectations. Perhaps this is as it should be. The thrust of this paper will be toward the notion that expectations and role definition should be approached as legitimate and in an open and above the table fashion in order to avoid the expenditure of much effort in covert and potentially destructive manipulation and/or maneuvering. The job placement of an individual upon his assignment is very important. The needs of the service or section must be a primary consideration, but if the needs and goals of the individual are not explored and met, eventually the section will suffer. A newly assigned 91G has almost no data to use in his evaluation of his potential within the section. He may be anxious to please and to "look good"; he may feel considerable pressure to set his own goals and desires aside because of his insecurity. When this happens, the 91G, who may have had nothing to say (and no responsibility other than his silence) about the assignment may become disenchanted and once he is oriented and more knowledgeable may operate at a very low level of efficiency.

All of this raises an important question. What alternative does the supervisor have? Unfortunately, there is no pat answer. A careful scrutiny of the section will reveal possibilities that would escape

a more casual look. Perhaps a specialist within the section is interested in a change to a different position. If so, this change may open up other possibilities for the new arrival. In my own section, there are two people who are somewhat dissatisfied with their present jobs. However, they know that as personnel changes occur they may be (at their discretion) considered for another position. Even though the moves may cause some administrative burden, the pay-off for the section will more than compensate. These personnel realize that they are not "stuck for the duration" and that they have a legitimate voice in determining their contribution to the service. Along with that voice, they also have had some degree of personal responsibility, in defining their role.

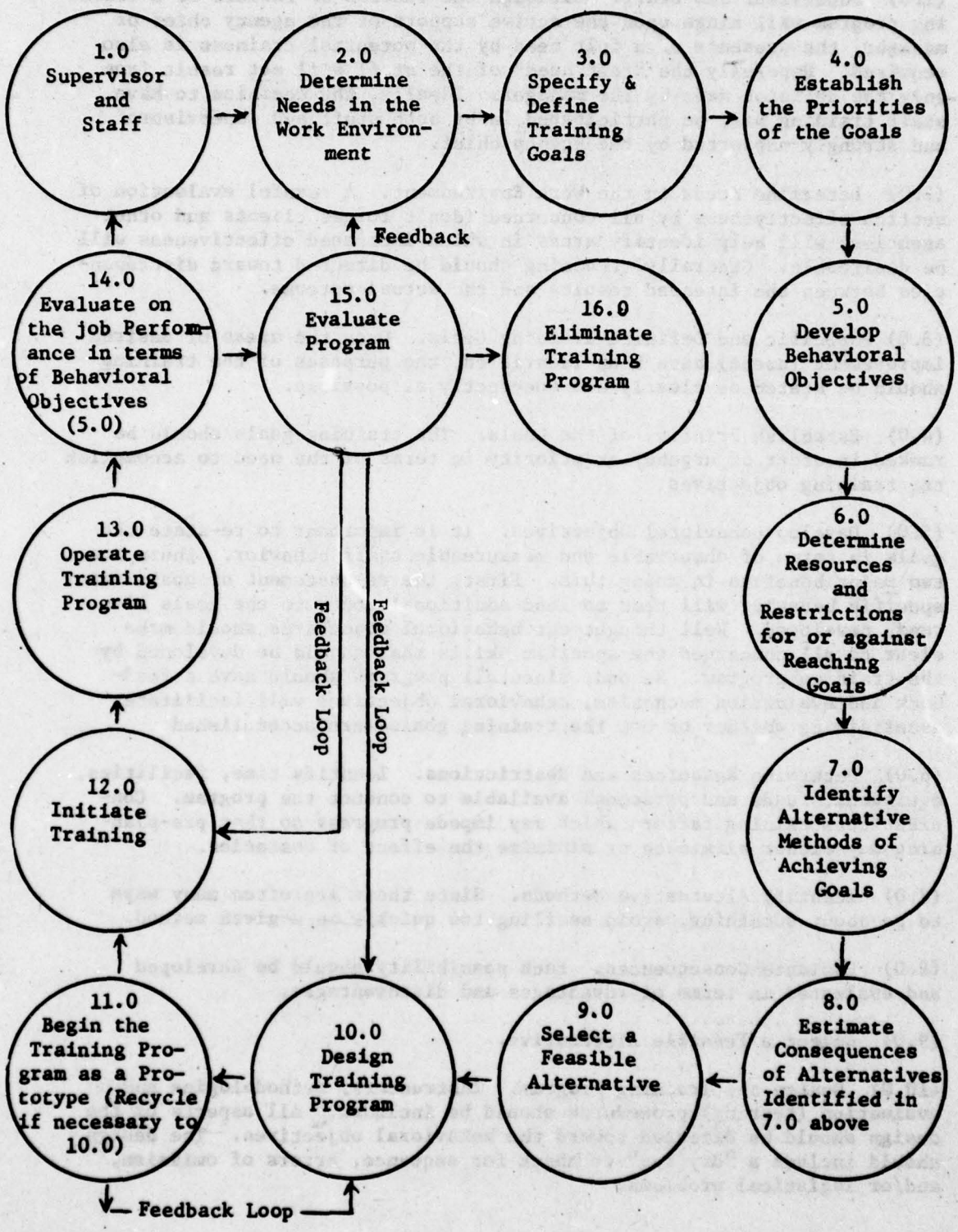
This approach offers the specialist a constructive way to grow through a broader range of assignments and helps to aleviate passive resistance, boredom or feelings of hopelessness that may occur if one is placed by another in an undesirable situation with little hope for a change. Early in the assignment, supervision, rules, roles, definitions, formal relationships, and expectations should be made explicit. The communication channels should be pointed out and every effort made to encourage the newcomer to feel free to use them. The supervisory relationship in successful placement and effective utilization of 91G's cannot be over-emphasized.

Once the initial job placement is made, it is incumbent upon supervisor and supervisee to assess skill areas required and desireable in order that the 91G function adequately and effectively in the position. This leads to the problem of systematic development or continuing education and training of 91G's in the field.

In-service training should (and must in order to be effective) be a multi-faceted approach. Training must be tailored to meet section and individual needs alike. Briefly, a well-rounded in-service training program will be designed to meet the needs of the "here and now" real life work environment. It may include mandatory subject areas for all personnel and flexible, individual 91G supervisor identified subject areas. Additional optional personal growth/development opportunities should be sought out, publicized and encouraged. Personnel should be involved as both students and instructors. Supervisors should be expected to lay their expertise on the line and present material, "outside" consultants may be brought in. Local experts may be invited to present (perhaps on an exchange basis). But, in order to avoid duplication and to maximize the utilization of available resources, the program must be systematically planned, executed, and re-vamped as necessary. A model for implementing a training program using a systems model may look something like Figure 1. A narrative description of the procedures and processes follows:

Figure 1

A MODEL FOR DESIGN AND IMPLEMENTATION OF AN IN-SERVICE TRAINING PROGRAM*



* Adapted from Burks, Herbert M., Jr. Journal of Employment Counseling, September, 1973

(1.0) Supervisor and Staff. Although the success or failure of a training program will hinge upon the active support of the agency chief or manager, the presence of a felt need by the potential trainees is also required. Hopefully the "felt need" of the staff will not result from only the decision made by the manager. Ideally, the decision to have staff training will be participated in by both staff and supervisors and strongly supported by the agency chief.

(2.0) Determine Needs in the Work Environment. A careful evaluation of section effectiveness by all concerned (don't forget clients and other agencies) will help identify areas in which increased effectiveness will be desireable. Generally, training should be directed toward discrepancies between the intended results and the actual outcome.

(3.0) Specific and Definite Training Goals. Once the areas of desired improvement (needs) have been identified, the purposes of the training should be stated as clearly and succinctly as possible.

(4.0) Establish Priority of the Goals. The training goals should be ranked in order of urgency or priority in terms of the need to accomplish the training objectives.

(5.0) Develop Behavioral Objectives. It is important to re-state the goals in terms of observable and measureable staff behavior. There are two major benefits in doing this. First, the re-statement of goals into specific behavior will tend to lend additional focus to the goals already developed. Well thought out behavioral objectives should make clear to all concerned the specific skills that should be developed by the training program. Second, since all programs should have a feedback and evaluation mechanism, behavioral objectives will facilitate ascertaining whether or not the training goals were accomplished.

(6.0) Determine Resources and Restrictions. Identify time, facilities, equipment, funds and personnel available to conduct the program. Consider constraining factors which may impede progress so that pre-planning may either eliminate or minimize the effect of obstacles.

(7.0) Identify Alternative Methods. Since there are often many ways to go about something, avoid settling too quickly on a given method.

(8.0) Estimate Consequences. Each possibility should be developed and evaluated in terms of advantages and disadvantages.

(9.0) Select a Feasible Alternative.

(10.0) Design the Training Program. Instructors, methodologies and evaluation (testing) procedures should be included. All aspects of the design should be directed toward the behavioral objectives. The design should include a "dry run" to check for sequence, errors of omission, and/or logistical problems.

(11.0) Begin training with a Prototype. This involves a mini-program including selection of trainees, pretesting, training, and posttesting. Note that there is a feedback loop at this stage to allow for some redesign before the expense of involving a large number of staff in a high-risk program that has not been tested.

(12.0) Initiate Training. Care must be taken to fully conform to previous planning and to insure for all logistical requirements.

(13.0) Operate Training Program. Begin with the selection of trainees and pretesting. Following the presentation of the instructional sequence, arrange for posttesting. Remember that trainees will be expected to continue effective performance after training.

(14.0) Evaluate Job Performance. The basis for this evaluation should be in terms of whether or not trainees actually perform the tasks required by the behavioral objectives (5.0).

(15.0) Evaluate Training Program. The job performance evaluation should be the basis for evaluating the program itself. Note that behaviors or skills and the program are being evaluated, not people. Hopefully, a training program, particularly one in a mobile community such as the Army, will be a flexible and dynamic operation which uses answers to questions such as: Have all relevant goals been dealt with? Have we really looked at all of the feasible alternatives? Have we really looked at all of the feasible alternatives? Is there a better way? Note the presence of feedback loops which lead to 2.0, 10.0, or 12.0.

(16.0) Eliminate Training Program. Not all programs are a success. We should recognize that from the onset of planning and a provision for failure built in. Assuming that the need for training was genuine, the elimination should be thought of as a last resort. The honest answer to a question at the early stages may prevent program failure. A question like: Why do I want to have this training? And for whom?

If the manager decides unilaterally that there will be a training program and then determines content, format, and length; he is not using his most valuable organizational asset-people.

Training is an expensive and often threatening, anxiety producing activity. It may be difficult for people to lay their reputations on the line and actively become involved at a meaningful level. Threatening, anxiety-producing activities call for a fairly high degree of structure. This model seems to offer that structure. It appears that assigning a high priority to training, using the resources available to us, seeking to actively involve our personnel, and the application of expertise in this area of human behavior should enable us to make some giant strides in the area of staff development.

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Abortion and Sterilization: Ethical and Legal Considerations Which Impinge on Clinical Practice

by

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In speaking to a group of professionals in a field outside of my own, I am acutely aware of the temptation to tell you how you ought to behave; but this is not my function. I am not here to tell you what the solutions of these problems might be, but rather to sensitize you to some of the political, legal, and moral considerations that are involved in any discussion of abortion and sterilization policies.

Under American law, the national and the state governments exercise their police power over health, safety, and morals, and the United States Supreme Court provides the most important guidelines on these matters through its interpretation of the Constitution, the Bill of Rights, and the Fourteenth Amendment. Every major moral question that gets into the public arena and becomes part of our laws eventually becomes a question of rights, and hence, a judicial question that may reach the Supreme Court. Because we are a pluralistic nation, in terms of formal religious philosophies and moral values, it is useful to examine our public policies and court decisions in order to find the guidelines and parameters of behavior that are required for people in the healing and helping professions. Because modern social work relates to so many aspects of individual and group behavior, it is all the more necessary for people in your profession to be acutely aware of the role that you play in the decision-making processes that may seriously affect the lives and the rights of the persons you counsel. Another reason why Army social workers should be more sensitive to these issues is because your work takes place in the entire nation, and your mobility carries you into states with different statutes, precedents, and medical and social work traditions. The interface between Army and civilian social work practice is characterized by the diversity of local, state, and regional influences that I mentioned above. My emphasis in this paper is not on liability questions, but rather on questions of rights, and on the role that social workers can play in safeguarding the rights of their clients.

ABORTION

I begin with a discussion of abortion because it has been a major national public issue since January, 1973 with the decision by the United States Supreme Court laying out the constitutional guidelines for the states to follow if they choose to legislate on this matter. But even before that decision, abortion laws and policies became a matter of energetic public discussion and controversy in the 1960s. A useful starting point might be the model abortion law contained in the Model Penal Code of the American Law Institute (published in 1962). Most state abortion laws up to that time had allowed therapeutic abortion only to save the life of the mother. The model statute, which was adopted in 12 states prior to the Supreme Court decision of 1973, broadened the grounds for allowable abortions to include the health (including the mental health) of the mother, the possible birth of a child with physical and/or mental handicaps (excluded from California statute), and pregnancy resulting from rape or incest.

On the surface, these so-called reform laws might appear to have opened the possibility for abortion "on demand," but in reality they did nothing of the kind. The mathematical possibilities for the birth of a deformed child, and pregnancy resulting from rape or incest, were remote indeed, and hence, the increase in legal, therapeutic abortions came largely through psychiatric indications. With the advent of the women's liberation movement in the late 1960s, the thrust of abortion reform groups turned to a much more drastic attack on existing abortion laws in the states, and this took the form on the state level of new laws in New York, Hawaii, Alaska, and Washington (ratified by a state referendum at the polls) that gave the individual woman a much greater freedom to make this determination for herself. With the battle won in these states, the attack on the constitutionality of the more restrictive state laws was carried in a series of cases that culminated in the January, 1973 Supreme Court decision.

The Court, which had in some earlier decisions dealt with basic areas of personal privacy in cases involving contraception, miscegenation, sterilization, and distribution of birth control information, for the first time in its history came to grips with the thorny abortion question. As in so many difficult areas of public policy, the court walked a tight rope that was bound to make some groups happy and others extremely angry. Its decision broke pregnancy into three trimesters, each different in terms of the constitutional requirements. The first 13 weeks gave women the closest thing to an absolute right to privacy, and almost all of the existing state abortion laws fell as the result of this finding. The only requirement in the first trimester was the medical judgment of the women's attending physician. This is what the enemies of abortion would call "abortion on demand." The second trimester, while not as absolute as the first, did place restraints on what the states could do in regulating abortion in ways that are reasonably related to maternal health (licensing of doctors, requiring hospital abortions, etc.). The compelling point for the Court's shift in its emphasis, from the privacy rights of the women to the rights of the fetus and even of the state, came in the third trimester where the Court would allow the state to protect the viable fetus by proscribing abortion, except where it is necessary to protect the life or

health (including mental health) of the mother. Thus, in the case of the first two trimesters, the Court went far beyond the model abortion statute mentioned earlier.

Supreme Court decisions, as you all may know, do not bring immediate compliance, and sometimes very little compliance at all. Not all states where abortion laws are patently in violation of the Court's decision have taken steps to replace or even to remove their present statute. In effect, a Supreme Court's presedent setting decision is really the beginning, not the end, of the public policy controversy over this question. Battles over state legislation and state and federal court decisions will continue to be fought. Perhaps the most exciting and controversial response to the Court's decision has been seen in the Congress, where efforts to pass amendments to the Constitution (the Buckley and Hogan proposals) to override the Court are still alive. Senator Buckley also proposed an amendment to the Social Security Amendments of 1973, which would prohibit the use of Medicaid funds for abortion, and this is still tied up in a Senate-House conference committee. Senator Church did, however, succeed in getting an amendment passed as part of the Federal Health Programs Extension Act of 1973 which permits any institution that is wholly or partially federally funded to refuse to perform abortions or sterilizations on the basis of religious beliefs or moral convictions. It is obvious that while the Right to Life movement has not succeeded in getting a constitutional amendment through Congress as yet, it has succeeded in the case of the Church amendment; and we are bound to see the abortion issue come up in state and federal political contests. Abortion, like so many of our present forensic medical-moral questions, is not a question of one set of rights, but of a whole series of conflicting rights (the rights of the woman, of the fetus, of the conceiver, of the physician, and certainly, of society), and therefore it is perhaps naive to think that the Supreme Court can decide these difficult constitutional (moral) questions on the basis of a simple theory of equality.[1]

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[1] An example might be the indictments by a Suffolk County grand jury in Boston on April 11th of five doctors. One of them, who is the chief resident for obstetrics and gynecology at Boston City Hospital, was charged with manslaughter in the death of a fetus in connection with a legal abortion performed after 24 weeks of pregnancy; the other four physicians were charged with violating a seldom-enforced Massachusetts law that forbids the carrying away of human bodies or remains for the purpose of dissection. The issue of human fetal research flared up in April, 1973 and resulted in the National Institutes of Health (NIH) declaring a ban on all research involving live aborted human fetuses in this country.

What does all of this mean for the social worker? It means that each social worker must be consciously aware of his or her moral inclinations on this issue, and not use the counseling or decision-making situation as a place for imposing (even in an ever-so-slight unconscious manner) those values on the client. If the policies of the government or of the Army are in conflict with one's own subjective moral values, a resolution of this conflict should be made outside of the counseling setting. While I am not a social worker, I do know from my own research in the area of forensic medicine (especially state eugenic sterilization laws) that it is often easy for the counselor to use persons in certain sensitive situations without even knowing that manipulation, coercion, or duress is present. Often, it is not the malicious, intentional purposes of the counselor, but the counseling situation, and the vulnerability of the counsellee that provides an atmosphere for subtle manipulation. I doubt if the Bill of Rights, or the Constitution, or Supreme Court decisions, can ever completely eliminate that kind of coercion, and the invasion of individual rights in sensitive situations of this kind. But social workers, and all others in the helping and healing professions, must be acutely aware of how easy it is to force people to do things which they may regret for the rest of their lives. The trickiest, perhaps the toughest, issue in this whole discussion in my view, is the question of consent, which I will consider at greater length in my discussion of sterilization. This issue arose with a vengeance during the arguments in the mid-1960s over experimentation on human subjects and the changes promulgated by the United States Surgeon General, the Public Health Service, NIH, FDA, and others following the famous Brooklyn Jewish Hospital of Chronic Diseases case.

STERILIZATION

Historically, the United States was the first nation to legislate on this subject, and most of the state laws passed on this subject were eugenic in purpose and mandatory in character. Beginning with Indiana in 1907, eugenic sterilization spread quickly, and within a decade, one third of the states had legislation on this subject aimed largely at mentally ill and retarded persons. After some initial judicial setbacks, compulsory state sterilization was upheld in a landmark case by the U.S. Supreme Court (Buck vs. Bell, 1927), famous for Mr. Justice Holmes' comment: ". . .The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. *** Three generations of imbeciles are enough. . . ." Today, almost a half century later, there are still 25 states that have these laws on their books, and most of them are still compulsory in character. In the period from 1907-65, there were approximately 65,000 operations performed under these laws.

After World War II, there was a considerable decline in state sterilizations, due to changes in medical and psychiatric attitudes and an increasing degree of interest in the rights of the patient in the mental health movement. However, in the 1950s, there was a whole series of efforts in the states to pass punitive sterilization laws, aimed largely at mothers of illegitimate children receiving AFDC or other welfare support. While none of these proposals succeeded in passing the various state legislatures, the residue of this pressure remained, especially with the lifting of the bars against sterilizations by OEO in 1971. The summer of 1973 was the turning point in what turned out to be a dramatic explosion over the whole issue of welfare, sterilization of

the poor, and the question of consent. It all began in Alabama, following the sterilization by an HEW funded clinic of two Black teenaged girls (12 and 14 years of age). The public furor over this expose led to a freezing of HEW funds for sterilization by HEW Secretary Caspar Weinberger pending the issuance of new guidelines for sterilization operations. He issued these guidelines in July, 1973, but the date of their becoming effective was postponed several times due to criticism by a number of persons and groups, and a pending federal court case against HEW brought by the National Welfare Rights Organization and various members of the Relf family of Alabama. On March 14, 1974, Judge Gerhard Gesell of the U.S. District Court in Washington ordered the government to stop funding and performing sterilizations of minors and mentally incompetent persons, and to bar sterilizations even of adults who presumably consent to the operation until the regulations were redrafted to make it clear that poor persons were not being coerced into consenting to sterilizations in order to avoid loss of welfare benefits.

The Relf case in Alabama and other cases in North and South Carolina in the summer of 1973 brought the issue of coercion of the poor out into the open, and Judge Gesell's decision made it clear that so-called "informed voluntary consent" is much more than a brief conversation and written signature on a document. It should be noted that while compulsory state sterilization has declined in recent years, the use of private sterilization as a means of contraception (permanent) has increased to a point where the 1970 National Fertility Study stated that 16.5% of all married couples between the ages of 20 and 39 had undergone voluntary sterilization in one or the other partner, and HEW's Deputy Assistant Secretary for population affairs, Dr. Louis M. Hellman, predicted that this figure would be 20% by the mid-1970s, especially in view of the rapid rise in the number of vasectomies in the 1970s.

It is estimated that from 100,000 to 150,000 low-income persons are sterilized under federally funded programs (OEO, Medicaid, etc.) and it is these persons that are perhaps most likely to undergo subtle or not-so-subtle pressures to be sterilized, for fear of losing future benefits. Here again, as in the previously-mentioned Medicaid support of abortions for the poor, the role of the social worker or whoever does counseling in these cases can be critical in the decision-making process that may result in an operation. If it is true, as some specialists say, that private sterilization has apparently become the first choice of contraception among couples over the age of 30, then social workers and health workers have a major obligation in making certain (to the extent that this is humanly possible) that these decisions are truly voluntary, and that the implications of sterilization (especially its high degree of permanency) are fully understood by the participants. As in the case of abortion decisions, the medical, religious, and familial variables may be subtle and complex, and the social worker must be especially careful not to impose personal values in what is always a very sensitive interpersonal situation. If welfare benefits are involved, the situation is even more complex, and the social worker (who is often an agent of the government, whether in the Army or otherwise) must be very clear about whom he is serving (the client or the government?). As in the case of government medicine and psychiatry, this is not always easy to determine.

Abortion and sterilization are just two of many issues that are increasingly becoming a part of law and public policy and judicial pronouncements. We cannot expect our state legislatures or Congress or the Supreme Court to "solve" these complex medical and moral questions. Even our sacred U.S. Constitution does not provide us with definitive answers to these questions, and we should not assume that, because inevitably public issues become judicial issues, courts are the final agencies for arbitrating these conflicts. They provide guidelines and parameters (due process of law, equal protection of the law, the right of privacy, etc.). However, at a time when the nation is caught up in what appears to be a rapidly shifting sense of basic social and personal moral values, it is too much to expect any agency of government, including the Supreme Court, to provide the nation with final answers on these matters. Meanwhile, professionals such as yourselves must be aware that you either implement or circumvent these values, and that you are crucial agents in the transmission and elucidation of these values. You cannot remain unconscious either of your own values in relation to your professional role, or of the various impacts that you have on others (your clients, and your counsellees) in defining what you regard as the "rules of the game."

I think we are presently in a kind of civil rights "revolution" and groups of all kinds are demanding through legislatures and courts their place in the political universe. Social workers will continue to play an important part in this fermentation because you relate to a wide spectrum of social, individual and family life in this country. It is all the more imperative that whether in Army or civilian social work, you are manifestly aware of these changing public policies and the impact that laws and court decisions have on your personal values, as well as on your professional role as social workers. For in defining your response to questions of abortion and sterilization, you are really defining your basic notions of human life, and individual and social freedom. The real and perhaps most difficult task is finding a way to merge your personal with your professional values, and if they happen to conflict, where to draw the line without imposing on the individual rights of your client. I opened on a theme of humility, in saying that I wasn't here to tell social workers how to behave. I want to close on much the same theme. I would simply add that you should be aware of your own feelings and biases, and the pitfalls and ambiguities of all public-moral discourse.

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SOCIAL PERSPECTIVES ON THE ABORTION/STERILIZATION DECISION PROCESS

by

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The human social philosophical issues to be dealt with relative to the abortion decision making process are almost beyond the capability of one to comprehend. The "Right to Life" and "Right of Self Determination" issues have only been reintroduced by the abortion question. These issues have been with us in one form or another from the beginning of humankind. I personally, and I believe professionally, have been concerned with the ease of which society has accommodated itself to the acceptance of abortion as the way to go. I am most pleased that the issue is not being taken lightly here at this conference. I do not plan to discuss these philosophical issues, however, except in the context of the decision making process of the client.

The concept of self determination is, as we in social work know, a misnomer. The decision making process is a very complex mixture of conscious, unconscious, personal, social, and family determinants, all coming together in a relatively brief period of time. The client is with child and must decide a matter of life or death. However, usually the client does not view the decision in this manner. For the unwed WAC, it has been often only the question of whether she will be allowed to remain in the service. For some married couples it just doesn't fit their plans for themselves at this time. For some unweds, the process is more one of defiance of parental and societal authority. It is perhaps interesting to note that since abortion has become acceptable, a trend toward keeping the child rather than placing for adoption has emerged. Sociologically, this trend is likely linked with the women's liberation complex of sociological developments as has been single person adoptions and the abortion movement itself. A recent Department of the Army policy change now allows pregnant WAC's to remain on active duty if they can present an adequate plan to provide for the child and be available for world wide duty after delivery. Work will now be required to assist commanders to accept the new policy.

It is imperative that professional medical personnel are careful not to inadvertently impose their value system for or against abortion upon the client or client group. The decision is, and must be, theirs to make as it is they who must adjust to the decision once it has been made. The emotional, social, and cultural involvement in making a decision and later adjusting to it is so complex, however, as to warrant a comprehensive evaluation of the issue by the client or appropriate client-family group under the guidance of professional medical staff properly oriented as to the complex issues involved.

The issue is repeatedly raised as to the participation of that individual professional who, by religious orientation, is against abortion. This issue has often been resolved in the direction of that person not being involved in the abortion process. That decision may be necessary for the physician or nurse who is actually involved in performing the abortion. Although the alternative has been available to social workers at Brooke, none have elected to drop out. The social workers responsible for the abortion/adoption counseling program have come from both biases and have generally moved toward a more middle-of-the-road stance after a period in the program. It is perhaps due to the fact that there has been adequate representation of both points of view that the middle-of-the-road stance has developed. This middle-of-the-road stance is perhaps necessary if a professional is to best serve the client in the decision making process in an ethical manner.

According to law, the decision is to be made by the patient and physician. Let us not forget, however, that the decision ethically is the client's and that our responsibility is that of broadening and deepening the client's awareness of the possible effect of her decision upon herself, her life plan, and her family. Although it is most probably indicated that medical social work be involved with all abortion clients, this approach is generally not feasible due to social work staffing shortages and higher priorities in other patient problem areas. From the point of view of conservation of valuable physician time, it would, of course, be indicated.

With the unwed client, the professional also has the responsibility to make the client adequately aware of the various alternatives to abortion, the social and financial supports available, and the possible complications involved. With the adolescent client it is exceedingly important that the parents be involved in the thinking through process. The conjoint family approach seems to be the most effective. Unfortunately, legal supports to back this approach are not available in that the signature of one parent is all that is required. Locally we have attempted to require the signature of both parents but it has been difficult to implement due to the differences from DA policy, the short time period available from referral to abortion, and the frequent resistances of clients to include both parents. DA policy on this matter should be reconsidered. There is also no established policy requiring counseling by social work for the unwed client. However, historical precedence has been established for this service in that adoption counseling and maternity home placement have been historically the domain of social work. Usually this area of responsibility has been outlined in local hospital directives. It is also outlined in the American Hospital Association booklet, "The Role of Hospitals in Services to Unmarried Parents and in Adoptions." Adaption of hospital directives to include referral of the unwed client regardless of the potential disposition is definitely indicated. However, it is also imperative that the social work service react immediately and consider the referral in the emergency category in order that the abortion possibility time frame be considered.

It should be noted perhaps that the abortion decision time frame is not suited to a consideration of the adoption issue though it is an important alternative method of disposition to be considered. It should be noted also that adoption has seldom been the route for "getting rid of the baby." By the time the client is psychologically ready for a consideration of this

alternative, she has felt life and with few exceptions has developed maternal attachment to that which is now unquestionably "alive and kicking." The client has much more time to consider this decision and the opportunity is there to provide the client with a therapeutic growth experience which assists her to consider her own total life situation as well as the needs of the child. Placement for adoption is generally an unselfish act requiring personal sacrifice and a mourning process in the final decision making.

In contrast, the abortion decision is a speed-up process and the requirement of the counseling interview at Brooke Army Medical Center has generally not affected the decision to abort except in a small percentage of cases. Also, only a small percentage of cases have followed through on the post delivery counseling session appointments. I do not cite these figures as a measure of the success or failure of the program. Our goal is not that of convincing the client to decide one way or the other. It is not to see a large number of patients for follow up counseling. It is more that we attempt to provide an ethically sound abortion counseling program for the unwed client.

With the married abortion client and the sterilization client, our experience has been more limited. Referrals are made at the discretion of the physician and we have not actively solicited such referrals. In the few cases that have been referred, the need for referral was most apparent. The following abortion counseling case is descriptive of some of the complexities and the problematic variables which can be involved.

The wife, age 26, was eight weeks pregnant and presented to OB initially that she did not want the child as it was not part of their family plan. They had two children and did not want any more. The patient was quite guilty, however, about considering the possibility of abortion and was unable to reconcile her feelings and make an abortion decision. From a medical point of view, the decision needed to be accomplished within two weeks.

Two days later, in the initial contact with the social worker, patient advised that she had discussed the matter further with her husband and that they were resolving the matter in the direction of keeping the child. She advised that she had been shocked when she found out she was pregnant and was having an anxiety problem. As she discussed the matter, it became evident that she was not content with the decision to keep it. She stated that she just couldn't feel happy about it. She was feeling more relaxed as her husband had reassured her that he would help her manage the children and household chores. However, she didn't feel that keeping it was the right decision. The doctor had raised the possibility of abortion and she felt she could just look at it as birth control if her husband could accept it. Her husband had a moral feeling against abortion and she felt that she did too to some extent.

She clarified that she was feeling anxious about going through a pregnancy so soon again. She had delivered her last child only eight months previously. She had been trying to cut down on her weight again as she was very discontent with her physical self image. She had been enjoying her new son so much, but since she found out about the pregnancy she could not relax with him. She stated that she had a short temper and that it would be difficult for her to manage him while she was pregnant. She considered herself quite compulsive and stated that she was a person who had to have things just so.

She felt she was not now giving enough time to her daughter, age three. She wanted to continue her close relationship with her son and not cheat her daughter but she felt she would not be able to do so with another child. There were only two children in her family. She was four years older than her brother, a similar family to their own without the additional child.

Both she and her husband were of Conservative Jewish backgrounds but were not active now. Her mother, a Jewish convert, was pro abortion. She had not discussed it with her father.

Her husband apparently had some feelings about rejecting the child as similar to his own situation of his parents divorcing when he was age 5. In a point of anger, he had stated that he felt whatever she did would destroy their marriage.

As husband did not come for the initial appointment, a further conjoint appointment was scheduled. In this session husband was able to move to take appropriate responsibility for his part in the decision. He stated that he felt strongly against abortion and that he could not stand behind his wife if she made the decision to abort. They had planned to have a small family but it was primarily his wife that felt strongly about this. He had come from a large family. As a doctor, he also felt that it would be difficult for him to reconcile the taking of a young human life while he worked so hard trying to keep elderly dying patients alive.

The couple returned one week later seeming to have comfortably accepted their decision to keep the child. They had discussed their feelings in much more depth and felt they were now "much closer together." It should perhaps be noted that both the physician and the social worker during the evaluation process had felt that abortion would be appropriate in light of the mother's anxiety, apprehension, and recent dysfunctional performance in the mother role. It became apparent, however, that this decision was definitely not indicated in light of the husband's strong objections which later became apparent. This case is perhaps descriptive of the need for social work expertise.

In conclusion, I would suggest that social work involvement in abortion/sterilization counseling is most appropriate and indicated due to its special knowledge of personal and family dynamics.

Symposium on Abortion and Sterilization:

Ethical and Legal Considerations Impinging on Clinical Practice

The Practice Component as It Applies to the Chaplaincy Service

by

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To be very frank when they gave me the title for this part of the program, I didn't really know what to do with it. I don't talk like that, and don't really understand that kind of talk--so I've redefined the problem in my words if that's okay with you.

THE PROBLEM: When is it morally okay to interrupt the development of a human fetus between the time it is a gleam in it's daddy's eye and the moment of birth? My job: What can you expect of a Chaplain in dealing with the problem in the day-to-day world?

As perhaps you know through experience, you can't expect too much, and you'll get what the Chaplain has to give whether you want it or not. Before I deal with the chaplaincy per se, I'd like to sketch some ideas on the blackboard, to put it all in perspective. In essence, what I'm going to give you is a quick course in obstetrical theology.

I'd like to take issue with you on a minor point, Dr. Paul, when you state that abortion and sterilization are different issues and ought to be kept separate. That is why I stated the problem as I did. We are dealing with a continum, from gleam to birth, and the discussion is primarily over when it is morally licit to interrupt the process. To look at it, let me draw a time continum here on the board, and mark on it the places of significance in the progress from sterilization to contraception and then abortion. Each of these places are spots where someone says, "Development up to here is all right, but after this you must allow the child to go to term."

-Gleam

-Sterilization

-Preconception contracpetion

-Conception

-Prenidation contraception

-Nidation - 7 days

-Unity and uniqueness, 4-6 weeks

-Looks human - 6 weeks

-Quickening

-Viable fetus

-First breath protected by law

(Moving from point to point on chart) Some say, right here, gleam time is the time to decide whether you want a child or not. Certainly here at sterilization you have made a permanent decision about future children, especially if you have had a tubal ligation or a vasectomy. I'll speak more about that later, as I will the next, preconception contraception. There are those who draw the line here. At the next place, conception, the Catholic Church says that the decision has already been made. In the case of rape or incest, almost all agree that effecting a pre-nidation abortion is morally licit. It is also in this area that the Intra-Uterine Device seems to operate. This results in some saying, "if you allow an IUD, you allow abortion!" Nidation is that time when the fertilized egg becomes implanted in the womb, and begins to grow as a part of the mother. Some say, "Now it's too late." So too with the unity and uniqueness point. After this the fetus has become unique and can be distinguished as a separate entity or twins. So it goes, "Not now, it looks human." "See, there are brain waves, it is starting to think for itself, now." "When the mother feels that child kicking, it is too late." "Certainly you can't kill it after it has become a viable fetus." Dr. Plunkett spoke eloquently of the problems involved there. Finally over here, the little thing has made it and lets out a squall to show his pleasure in not getting "ripped off" some time sooner in the process.

Obviously, I am speaking facetiously to illustrate a point. But, the fact is, that is what we are doing. It would be nice if we could draw out lines with exactitude and then live with them. The truth is

that although the places are exact in general, with each specific person, we find the points of demarcation vague. The result is that we say, "better make our move sooner, so that we won't cross that magic point from morally licit to murder." I suppose that the optimum point we should push towards is the gleam point, recognize it as crucial and abstain from intercourse until we are absolutely sure of what we are doing. However, as a husband and the father of three, my mind boggles at the mechanicalness that would place in the marriage relationship. Enough on that. Let us look at what you can expect of chaplains.

It would be easier if we had an animal called the "Army Chaplain" which was cranked out by the green machine, and we could say, "All chaplains agree at this point, (wherever) is the balance point between moral and immoral." Such is not the base, we come to the Army and to our assignments as representatives of specific denominations, with all the advantages and disadvantages, the freedoms and limitations we have as civilian clergymen. This means that there is apt to be as disparate beliefs on any one subject as there are denominations and possibly seminaries represented. (One consideration to remember is that so far, all of us chaplains are essentially male chavinists when we consider the fairer sex, despite our protestations of equality in the eyes of God.)

To understand what the chaplain does, we need an operational definition which will allow us to measure his effectiveness, or understand his ends. The old story of the group that convened at the Pentagon to see who should be cut from the Army was trying to do just that. "What does the chaplain do, so we'll know how many we need and how much to pay him?" A crusty old General who had gone to many services suggested that since chaplains were involved in "saving souls", that they ought to be funded, "Souls saved per hour." The Roman Catholic position, and that of some others is precisely that--"We must save the maximum number of souls." In a moment, we'll see where this places them on the continuum, but obviously, it is towards this end. At the other end is the chaplain that COL Nelson suggests is a Unitarian, who is primarily concerned with the mother's life and health and says in essence that the fetus does not have the right to deny her freedom as she wants it. He finds that his limits are placed by both law and an idea of when the fetus has some rights--usually at that vague point of viability. Then there are a group of us in the middle that might be thought to be "wishy-washy Charlie Browns." For whatever it is worth, I fall into this catagory.

The two significant points on this line for Roman Catholics are gleam time and conception. (Now I know that <u>whatever</u> I say is the Catholic position someone can come up and say, "I know two priests, a nun, a cardinal and a papal nuncio who disagree with you. That is all right, for it illustrates that the Church is in flux. Simply stated, the Roman Catholic position on sterilization is that unless it is undertaken for health of the whole body or the preservation of life, it is mutilation and is immoral. Obviously, the parents who want some kind

sterilization because they've enjoyed all the kids they can stand will get no support from the church.

With contraception, the rule is quite specific according to the encyclical Humanae Vitae published by Pope Paul VI in 1968 where he said that intercourse is for the transmission of life and the only permissible contraception is that which is natural, that means the Rhythm system and abstinence for all practical purposes.

Cannon 747 suggests that from the moment of fertilization an eternal but original-sin-tainted soul is present. When that is tied with the statement of Father McFadden, "Direct and voluntary abortion is a moral offense of the gravest nature since it is the deliberate destruction of an innocent life...such an action is essentially murder",[2] the balance point becomes obviously at conception, after that it is murder.

It would seem that our Roman Catholic brethern would have their marching orders quite clearly laid out. And they are when there are no complications. What becomes more difficult is when one must choose between two lives, each of which has a moral right to continue living. What does the mother do who is pregnant and finds that she has a malignant ovarian tumor? The Catholics have been in this business long enough to know that you must have a "fudge factor" in any situation. The "fudge factor" the more correct term, casuistry, here is called the rule of "Double-Effect." Four considerations must be met. The first is, that the action in and of itself must not be morally evil. Since the mother will have to have an abortion and a sterilization operation to get rid of the tumor, it would be morally evil, if it were not to save her life. So the first consideration is met. The second is, any evil effects must not be the means of producing a good one. Just the opposite is happening here. The third is, the evil effect must be sincerely unintended. If the mother wanted to carry the child to term, this condition is met. The last is, if the evil side effect were not involved the act would still have to be performed. Pregnant or not, the operation would be necessary, so all conditions are met.[3]

Unfortunately in many other areas about all the priest can say is: "I'm sorry my daughter, but you must carry the child to term." That sounds hard, but we are not guaranteed that life would be easy.

Most other chaplains are not placed in such an either/or position, but have some flexibility of action. The chaplain at the farthest extreme points to a whole list of "goods" that have come in New York State as a result of the liberalized laws. Reduced number of births (which pleases the population control people) a decline in septic abortions, (down 2/3 in three years) a decline in maternal mortality, a decline in infant mortality (if you don't count abortions), a decline in out-of-wedlock births and a decline in public assistance costs. These however are secondary to the fact that the mother now has true control over the use of her body and that abortion is not as evil in his eyes as some of the alternatives. Being a realist, he reasons, if she is determined to have an abortion, it is better to have it under optimal conditions.

Those of us in the center, tend to divide the women wanting abortions into three groups. One says, "I wanted the baby once, but now I don't;" another says, "I didn't want the baby and I don't know how I got pregnant" and the third, "I didn't want the baby and fought the whole way." In this last case, almost all agree that is morally doubtful that she should be forced to carry the child to term if she did not intend to get pregnant or have intercourse, and that therefore she has no responsibility for its continued growth. Rape and incestuous pregnancies are the two times that pre-nidation contraception is morally licit for Catholics.

The other two situations call for more work, and less unanimity of feelings by the chaplains. His job is to work with the mother and the father in assisting them to make a decision. Two areas that he helps them explore are "intentionality" and "responsibility".

Too simply defined, intentionality is "I thought about it and I decided that this is what I wanted to do." Responsibility is "I knew what I was doing and I'm willing to live its consequences." We are called to acts of responsible freedom if we are to bring about God's will in our lives. So we consider the problem, helping the parents work out what they need to do, not necessarily what they want to do, or what I might feel they ought to do.

Sissela Bok gives a good list of the factors to consider in making the right decision. There are seven, and they all are important to consider. None of them has veto power over the others.[4]

*Is the pregnancy voluntary? What was the intent in having intercourse? Was the mother-to-be deceived about the adequacy of the contraceptive used. Was she ignorant of how babys are made? This is assuming that the act of intercourse was a voluntary act.

*What are the importance and validity of the reasons for having the abortion? The span here could be from, "I don't like looking fat," to "I'll die if it isn't done." Also included are genetic and other birth defects.

*How will the abortion be performed, through cessation of life support or through killing? This is similar to the rule of double effect. Are we going to simply deny this fetus the support it needs to live, or will we out-and-out kill it. The idea behind this is that the longer we wait for the abortion, the more it becomes killing. The pressure is towards the first part of this continuum.

*The time in the pregnancy. This is tied in with the question above.

*Does the father concur with the abortion? Under the latest Supreme Court refusal to consider the case of an unwed father wanting an injunction to stop his girl friend from aborting his child, he has no rights. If the woman is married, and she wants an abortion

and the husband doesn't real strains develop. COL Nelson's case history illustrates this beautifully.

*What about adoption? This is especially one that ought to be considered in light of the fact that children are wanted for adoption all over the country. It avoids the problem of abortion, and yet does not require the mother to be the one who raises the child. COL Nelson pointed out some of the difficulties in this suggestion.

*What are the mother's religious views. Although this is last, it could be the overriding factor. If she will be operating with a conviction of sin for the rest of her life, this must be addressed and some resolution found.

All too briefly and rapidly, I've tried to sum what you might expect of a chaplain. Ultimately we are all casuists--trying to interpret God's love to man in as unpolluted a way as we can. We strive to accept our people where they are and hopefully help them bear the burden in the heat of the day. We don't have the easy, final answers, but with God's help we try to find out what needs to be done in each person's life that he might live life to its fullest. Thank you.

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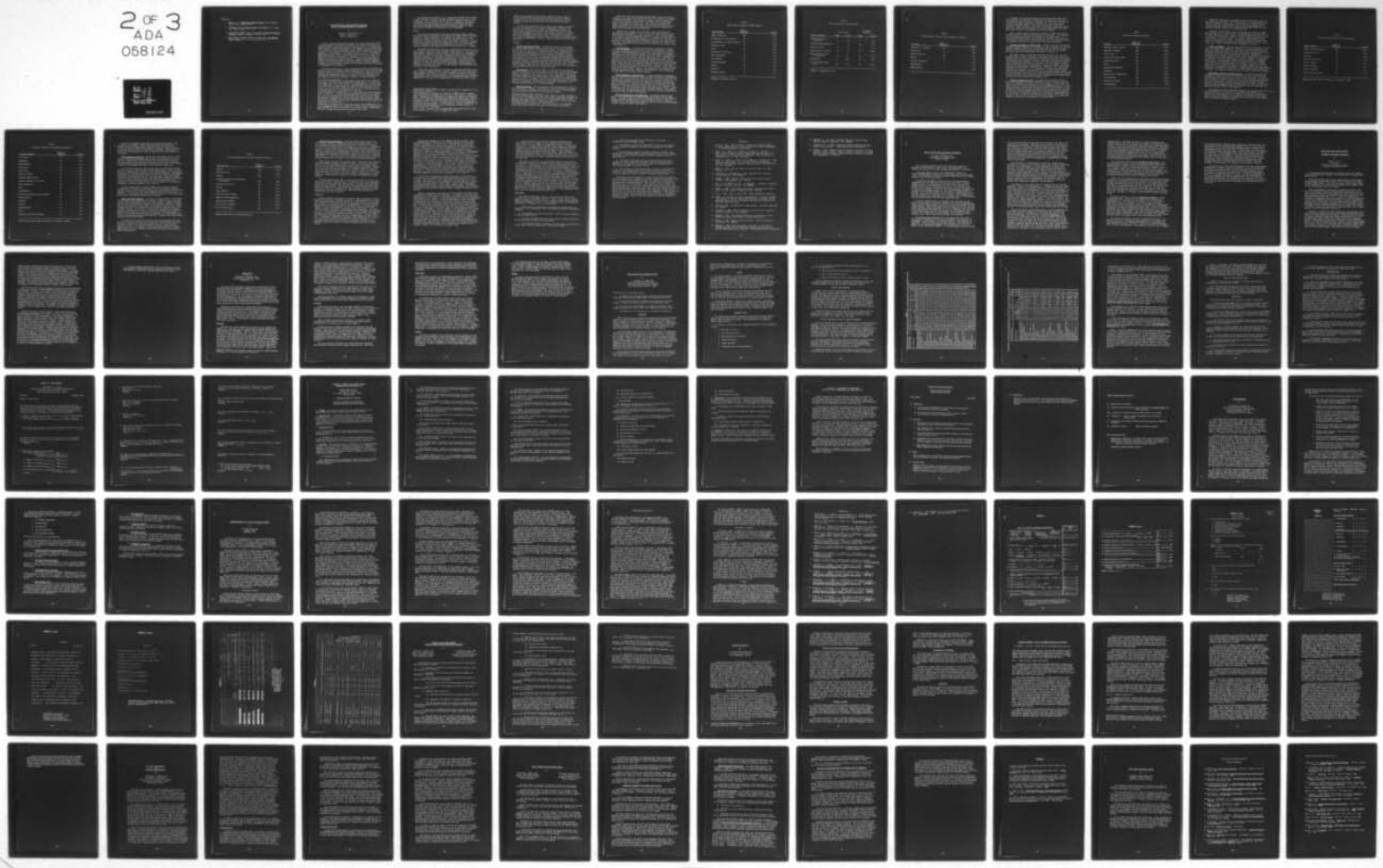

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FAMILY ADAPTATION TO THE PRISONER OF WAR AND MISSING IN ACTION EXPERIENCE: AN OVERVIEW*

by

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There is a paucity of research attempting to answer questions surrounding the adjustment of families of prisoners of war (PW)*** and those of servicemen missing in action (MIA) and the role families play in the long-term rehabilitation of repatriated prisoners. The adaptation of the PW/MIA family to an indeterminate and unprecedented length of father absence has only been alluded to in past research. Hill[9] cited one family in his total sample who experienced the ramifications of a husband missing in action. Even though PW/MIA families were present at Schilling Mannor, Allen[1] in his study of a community of families with husbands in Southeast Asia did not isolate this segment of the group for separate analysis. A recent unpublished paper by Spolyar[18] and published reports by Hall and Simmons[7] and Brown[4] attempted to describe the grieving process, adjustment problems, and coping behaviors of PW/MIA wives and children; however, none of them was based on any systematic assessment of such families.

The study reported here, in part, represents an effort to determine the nature and extent of adjustment problems experienced by families of servicemen missing in action or prisoners of war in Southeast Asia. These families were studied solely because they were in a unique situation of adapting to the prolonged and indeterminate absence of a husband, and not because they had been referred for help with emotional, financial, or medical problems.

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*This study was supported by the Department of the Navy, Bureau of Medicine and Surgery, under work request number WR-18-3-008, dated 1 July 1972, and by the Department of the Army, Office of the Surgeon General, under Military Inter-Departmental Purchase Request No. 549-077-3-00002, dated 27 July 1972. The opinions and assertions contained herein are the private ones of the writers and are not to be construed as official or as reflecting the views of the Navy Department or the Department of the Army.

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Appreciation is extended to Mrs. Lottie Applewhite, Medical Editor, Letterman Army Medical Center, San Francisco, California, for her assistance in the preparation of this manuscript.

***Families of prisoners of war were those listed in that category by the military prior to repatriation of American Prisoners of War in February, 1973. These families are not to be construed to be those of recently repatriated prisoners although some may have participated in this study.

The purposes were threefold: (a) to determine the nature and incidence of social, emotional, medical and legal problems encountered by this group of families; (b) to discover and classify the processes of adaptation to a heretofore unstudied family crisis; and (c) to determine the relative value of existing family support programs and need for future programs. The findings presented in the paper will be limited in scope to a broad overview of the families and the nature of their adjustment.

METHOD

The study was conducted during the period from April 1972 to February 1973 by the staff of the Center of Prisoner of War Studies*(CPWS), San Diego, California. Families included in the sample** were drawn from the total population of PW/MIA families of the Army, Navy, and Marine Corps. The sample, for this part of the total study, was limited to families of procreation (those in which the PW/MIA serviceman had a status of spouse), because of their "dependent" status and the responsibility of each of the armed services to provide them comprehensive care during the serviceman's absence.

The sample consisted of 215 families; approximately 50 percent of the total number of wives of PW/MIA servicemen of each service -- Army, Navy, and Marine Corps. The majority (55.3 percent) of the sample was represented by Navy families, followed by the Army (32.6 percent) and in turn the Marine Corps (12.1 percent). Of the sample, 100 families (46.5 percent) were of servicemen classified as captured in Southeast Asia; the remaining 115 families (53.5 percent) represented those servicemen listed as missing or missing in action. The sample included 405 children. Three-fourths (76.4 percent) of the sample were families of commissioned officer personnel, an additional 2.8 percent were those of warrant officers, and 20.8 percent were families of enlisted personnel.

A structured interview format was used for conducting each family interview. Single in-depth interviews, ranging in length from two to eight hours, were conducted with PW/MIA wives located throughout the Continental United States, Hawaii, Puerto Rico, and Europe. The 215 interviews were conducted by professional staff of the CPWS Family Studies Branch***consisting of a Navy psychiatrist, civilian clinical psychologists, military and civilian social

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**The research design included interviewing all PW/MIA families; however, interviewing was only possible up to the time of repatriation in February of 1973. To maximize the achievement of a representative sample while working towards interviewing the total population emphasis was placed upon conducting interviews in regions of the United States with high concentrations of Navy and Marine families. Families in isolated areas of the United States and in Europe were also interviewed. The Army sample was randomly selected from the total married PW/MIA population with the exception of those families in Europe who were all interviewed.

***Mrs. Inez P. Dunning, A.C.S.W., Former Head, Family Studies Branch; LCDR Philip Ballard, M.D., U.S.N.R.; and Mrs Dorothy Benson.

workers, and assisted by clinical social workers of the U.S. Army*. The Army social workers were selected on the basis of their extensive experience with military families and were given additional training in PW/MIA problems and the application of the structured interview schedule.

The interview schedule was used to ensure the systematic collection of data. The questions elicited specific demographic information and data related to family history as well as psychological, social, and medical factors conceivably related to family and individual adjustment. The interview schedule was revised on two occasions resulting in varying numbers of respondents on particular items. Those families indicating active social, psychological, medical, legal or financial adjustment problems were referred to appropriate civilian or military resources for continuing assistance.

FINDINGS

Population Characteristics**. The ages of the wives in this sample of families ranged from 20 to 49 with an average of 33.2 years of age at the time of the interview. The educational level of the majority of wives was in excess of twelve years; one-third had received college degrees. The majority (55.2 percent) had a marital history in excess of 10 years. Prior marriages were infrequent for both husbands (9.8 percent) and wives (8.4 percent). At the time of the interview, extended families (both or either parent) existed for most of the PW/MIA husbands (91.6 percent) and wives (92.1 percent). Religious affiliations were identical for both husbands and wives and were predominantly Protestant (64.6 percent). While the families averaged two children, one-fifth (20.5 percent) had no children. The 405 children ranged in age from less than one year to 25 years, with the majority (55.8 percent) between the ages of eight to fifteen.

The Situation. The situation common to these families was that each had been confronted with a military report of casualty, listing their husbands/fathers as prisoners of war or missing in action. The length of absence of these men extended from less than one year to over eight years. One hundred thirty-nine (64.6 percent) of these absences had extended over a period from three to six years. In general, the interviews showed that the indeterminate nature of the situation placed a natural strain upon the families; it altered the family organization, influenced the intra-family relationships, and affected the functioning of its individual members.

General Adjustment: Families appeared to seek some degree of stability as to location of residence. The majority of families (71.6 percent) made at least one change of residence since notification of casualty; at the time of interview over 51.6 percent had purchased their own homes.

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**Data Analysis was conducted by Mr. Gary Lester, and Dr. Jerry Goffman, Chief, Data Analysis Branch of the Center for Prisoner of War Studies.

During this period of prolonged husband absence, the wives involved themselves in a wide range of activities which, for the most part, appeared to enhance self-esteem. Participation in national and local efforts to clarify their husbands' casualty status provided a social and emotional outlet for the majority of the wives. Their responses indicated that hobbies, television, and social group functions were additional activities which ranked high, with military service club activities receiving less emphasis than the other four areas mentioned.

Adaptation of the family to its inherent social responsibilities required that family members, the wife in this particular situation, have the authority to negotiate all legal transactions. This area of responsibility proved to one of unexpected difficulty. Although less than one-third of the families emphasized legal problems as a major area of difficulty encountered during the period of husband-father absence, when these problems did occur, they affected the family's financial stability and credibility. Those legal issues most often confronted by the families are listed in Table 1 (See page 80).

Role Adjustments. An analysis of intra-family adjustments indicated that families adapted to new responsibilities and modifications in family roles with accompanying anxieties, frustrations, and feelings of insecurity engendered by the husband/father absence. Not surprisingly, one hundred and twenty wives (72.3 percent) reported the lack of husband's companionship as the most difficult problem with which they had to cope. Concomitantly, difficulties with feelings of loneliness, making decisions alone, lack of suitable social outlets, concern for personal health, and guilt feelings about their change in role were emphasized by the wives as additional problem areas. Both traditional and inherited responsibilities were intensified for the wife tasked with the dual mother-father role. Eighty-two wives (38.1 percent) were employed either on a full or part-time basis. Almost two-thirds of the group (61.9 percent), however, were unemployed. Disciplining of the children, handling of family finances, and the health of the children were cited as additional perplexing family problems.

Wife's Perception of the Marriage. It seems reasonable to hypothesize that the indeterminate separation would have some discernable and differential effect on the wives' perception of their marriage. In contrast with the wives' retrospective assessment of their marriage prior to casualty in which the majority (79.9 percent) rated their marriage as being either satisfactory or very satisfactory, less than half (44.2 percent) of the group felt the same degree of satisfaction with the marriage at the time of the interview. This change may in part be attributable to the large intra-group variance in length of marriage prior to casualty and length of husbands' absence. This change in feelings about the marriage was evident in other areas such as planning for divorces as shown on Table 2 (See page 81).

Physical Adjustment of the PW/MIA Wife. The physical health of the mother is a critical factor in the maintenance and stability of the PW/MIA family. Although personal health was not considered one of the most difficult problem areas for the PW/MIA wives, they did report a variety of physical illnesses which required medical attention during the period since the husbands' casualty as shown in Table 3 (See page 82).

Table 1

Legal Issues Confronted by PW/MIA Families

Legal Problems	Number of Responses*	Percent
Power of Attorney	66	30.8
Purchase/sale of real property	46	21.5
Purchase/sale of personal property	46	21.5
Obtaining credit	27	13.8
Wills	25	13.0
Termination of marriage	21	10.9
Court appearance	20	9.3
Tax problems	15	7.8
Insurance problems	14	7.3
Probate	10	4.7
Law suits	5	2.3
Business ventures	5	2.6

*Number of respondents varied.

Table 2

Wife's Perception of Her Marriage*

	Pre-casualty		At time of Interview	
Wives' Assessment	Number	Percent	Number	Percent
Requested divorce/ separation	3	1.8	1	0.6
Planned divorce/separation	2	1.2	15	9.2
Chronic conflict	8	4.9	2	1.2
Uncertainty of situation	10	6.1	53	32.5
Family difficulty not insurmountable	10	6.1	20	12.3
Satisfactory	31	18.9	14	8.6
Very satisfactory/very close	100	61.0	58	35.6

*Number of respondents varied

Table 3

Wives Physical Illnesses Requiring Medical Treatment

Illnesses	Number of Respondents	Percent
General: flu, allergens	101	47.0
Respiratory	62	28.8
Gastro-intestinal	28	13.0
Hepatic	10	4.7
Biliary & Pancreatic	6	2.8
Genito-Urinary	4	1.9
Cardiovascular	1	0.5

In general, the wives maintained surveillance over their health and, on the average, had received a thorough physical examination within the fifteen-month period preceding the interview. At the time of the interview the wives were asked to evaluate, retrospectively, their health status during the husbands' absence. Data from the interviews showed that a noticeably larger percentage of the wives (13.2 percent) rated their general health as a handicap during the period of husband absence than they would have rated it prior to the husbands' casualty (7.3 percent).

When in need of medical attention for physical ailments the families tended to seek care from civilian resources (40.2 percent). The importance of civilian programs to PW/MIA families gains sifnificance when it is considered that an additional forty percent (41.1 percent) of the families utilized both military and civilian medical services. The remaining families (18.7 percent) obtained care solely from military medical programs.

Emotional Adjustment of PW/MIA Wives. Indices of emotional and psychological adjustment appeared to be an important area of concern. Out of twelve emotional symptoms covered by the interviewer, nearly three-fourths (73.5 percent) of the sample reported having experienced five or more symptoms during the period of husband-absence (See Table 4, page 84).

Additional indices of emotional adjustment noted were that over half the group (58.2 percent) were taking or had taken tranquilizers during their husbands' absence, and 53.2 percent had experienced body weight fluctuations of 15 pounds or more during that period. Almost half the group (48.2 percent) indicated they were nonsmokers. Of those who smoked, 32.9 percent reported they now smoked more heavily than they had prior to the husbands' casualty. Slightly over ten percent were nondrinkers. Among the drinkers 23.8 percent found they consumed alcoholic beverages more frequently since casualty than they had prior to casualty. For 6.7 percent of all the wives interviewed, alcoholism was reported to be a potential if not already existent problem. Over forty percent (40.5 percent) of the group reported frequent feelings that life was meaningless, and 37.2 percent reported entertaining suicidal thoughts at some time during their husband's absence, although only 16.4 percent felt they had ever really seriously considered suicide.

Coping with Emotional Stress. The sample of 215 families reported a wide range of symptoms related to emotional and social adjustment that they found to be moderately or severely difficult to manage. It would seem that the occurrence of emotional problems and related symptomatology in the unique PW/MIA situation is predictable and therefore should be anticipated. In many instances the families did seek professional help to cope with the situation. One-third of the wives depended upon their family physicians (34.2 percent) for assistance with emotional problems and an almost equal percentage turned to the minister or priest (27.4 percent) for assistance. Mental health professionals were consulted by over one-third (35.2 percent) of the wives who sought out psychiatrists, psychologists and social workers.

Table 4

PW/MIA Wife's Emotional Symptoms

Symptoms	Number of Respondents	Percent
Depressed, "Down in dumps"	193	89.8
Jumpiness, "Uptight"	169	78.6
Fitful sleep	149	73.8
Difficulty falling asleep	144	67.0
Waking, not rested	130	64.4
Bored	109	54.5
Rapid mood fluctuations	115	54.5
Headaches	108	50.2
Feeling life is meaningless	85	40.5
Poor digestion	85	39.5
Shortness of breath	56	26.0
Accident-prone	36	17.9

Because of the military's commitment to provide services to families and to maintain continuity in the care provided, it is interesting to note the source selected by the family. Families who did use mental health services reported a slightly greater use of the services offered by the military than those offered by civilian agencies through CHAMPUS (Civilian Health and Medical Programs of Uniformed Services).

Personal religious beliefs were also mentioned as a source of support and consolation for the PW/MIA wives. One hundred and seven wifes (49.8 percent) reported that their religious beliefs had been very helpful to them in coping with the husbands' absence. A minority (20.5 percent) did not find religion a source of support. The degree to which religion proved helpful to the family varied with time since the husband's casualty. Some wives (11.2 percent) found religion to be important initially, but not at a later time. A few (4.2 percent) found the opposite to be true.

Wives in Treatment. Interview data showed that 31.3 percent of the wives were either receiving treatment (6.1 percent) for emotional problems or had been in treatment (25.2 percent) at some time during the husband's absence. Based upon evaluations made by the interviewers which reflected either direct or indirect evidence of disabling anxiety, depression, psychosomatic complaints, guilt feelings, or dysfunctional family interactions, an additional 51.4 percent of the wives appeared to be in need of psychological assistance at the time of the interview but were not then in treatment. If those who could benefit from therapy were added to the number actually in treatment (6.1 percent), it would appear that 57.5 percent of this group of PW/MIA wives would profit from psychological or psychiatric assistance. Further, based upon the interviewers' evaluations of present problems and the wives' reports of anticipated future problems, it appeared probable that approximately 80 percent of the families would benefit from marriage or family counseling at time of the release of the PWs and during the period immediately thereafter.

Adjustment of Children of PW/MIA Families. The physical and emotional adjustment of children of servicemen missing in action or prisoners of war are important indices of both individual and family adjustment. Children's problems represent another source of stress for both the mother and the family unit. Seven of the wives (4.2 percent) reported that the physical health of children presented major problems during the father's absence. The most frequently reported physical health problems among this group of 405 children were the common childhood diseases and accidental injuries. Other physical problems are shown in Table 5 (See page 86).

The children's emotional adjustment appeared to be another area of difficulty for the PW/MIA family. Sixty-nine of the children were judged by their mothers to have displayed significant emotional or behavior problems during the period of father absence. For the families with children, the average number of emotional or behavior problems during the period of father absence was 4.3 per family (See Table 6 page 87).

Table 5

Children Health Problems During Father Absence

Health Problems	Number of Responses	Percent*
Common childhood diseases	164	40.5
Accidental injuries	73	18.0
Surgeries	48	11.8
Enuresis (past age 3)	31	7.6
Acute illnesses	27	6.7
Chronic illnesses	25	6.2
Special handicaps	17	4.2
Other physical problems	17	4.2

*Based upon total number of children in the sample: N=405

Table 6

Children's Emotional and Behavioral Adjustment*

Children's Symptom	Number of Responses	Percent
Cries easily	57	14.1
Nightmares	53	13.1
Rebelliousness	49	12.1
Overly shy	42	10.4
Nail biting	42	10.4
Fear of the dark	42	10.4
Frequent temper tantrums	32	7.9
Enuresis (beyond 3 yrs. of age)	31	7.6
Overly aggressive	20	4.9
Sulky	20	4.9
Sleep walking	19	4.7
Difficulty adjusting to new situations	18	4.4
Destructiveness	16	4.0
Lethargic	14	3.4
Stealing	14	3.4
Speech problems	13	3.2
Drugs	10	2.5
Encounters with law enforcement	6	1.5

*Based upon the total number of children in the sample: N=405

Social and interpersonal adjustment of the children were also areas of concern to the mothers. Thirty-nine (9.6 percent) children were reported to have displayed behavior problems in the school setting and 37 had difficulty with peer relationships (9.1 percent). Behavior problems at home (8.6 percent) and poor relationships with mother (7.2 percent) or other adults (5.4 percent) were areas of additional but lesser concern for the mothers.

Use of Children's Services. The families with children varied in their use of the medical services available to them in providing care for their children. Where physical health problems for the children did arise, over half (56.7 percent) utilized both military and civilian medical resources. One-quarter(29.3 percent) obtained all medical services from civilian sources. A minority (14.0 percent) utilized military medical assistance only.

A portion of the mothers sought the assistance of mental health professionals if they felt their children had emotional problems. However, of the 69 children judged by their mothers to have displayed emotional or adjustment problems, only 37 children had received professional counseling. The remaining 32 children who needed help (46.4 percent of the total number needing help) received no professional assistance. Child adjustment problems gain added importance when we consider that over one-quarter (27.9 percent) of the PW/MIA wives with children expressed concern that the returning husband would experience difficulty in coping with the array and severity of the emotional and behavior problems presented by their children.

The interviewers made a clinical judgment of the children's need for psychological or psychiatric assistance on the basis of mothers' comments and their reports of the children's behaviors and symptomatology during father-absence. On the basis of the clinical judgments made at the time of the interview, it would appear that 102 children (25.2 percent) of the 405 children were in need of psychological/psychiatric counseling.

Family Assistance Programs. To provide continuous service to and liaison with families of servicemen missing in action or prisoners of war, the armed services established a PW/MIA family assistance program. Casualty Assistance and Calls Officers (CACO) were assigned to Navy and Marine families; Family Service and Assistance Officers (FSAO) were assigned to Army families. These selected individuals were responsible for providing and coordinating services to PW/MIA families. As one part of the interview, the casualty assistance program was evaluated by the wives. Almost half the PW/MIA wives interviewed reported they had been very satisfied with the family assistance program. When we also consider those wives who were moderately or to some extent satisfied with the assistance program (25.0 percent), it appears the wives favorably endorsed the assistance program.

In recognition of the important role of family assistance officers and the need for careful selection of such personnel, the interviewers solicited the wives' impressions of desirable qualities and traits for any family assistance officer. The assistance officer's maturity, referral ability, empatny, and ability to establish a professional relationship were strongly emphasized by the wives. Additional desirable characteristics are cited in Table 7 (See page 89).

Table 7

Desired Characteristics of Family Assistance Officers

Characteristic	Number of Responses	Percent*
Maturity	158	96.3
Referral Ability	156	95.7
Empathy	150	91.5
Ability to establish a professional relationship	139	84.8
Volunteer for the job	104	63.4
Married	85	51.8
Career officer	69	42.1
Married with own children	60	36.6
Behavior Science Background	59	35.9
Similar age as husband	52	31.7
Similar rank as husband	36	22.0
Not in flying status	19	11.6

*Based on N=164 due to revised questionnaire

Concerns about Repatriation. The wives' concerns about repatriation are additional indices of adjustment difficulties of PW/MIA families. For the returnee, repatriation would be the time when he would be confronted with the family's behavior during his absence. For the wives, it represented a critical time of accounting for their stewardships during the husband's absence. For other wives, repatriation meant facing the increased possibility that their husbands were not coming back. The wives' primary concern for the post-repatriation period was the husbands' reaction to their wives' increased independence (41.0 percent), handling the finances (23.5 percent), and dating (22.9 percent). A few of the wives (12.0 percent) expressed concern over the husbands' evaluation of the manner in which they had reared the children.

Repatriation also meant the wives must come to terms with their fantasies about the husband's physical and emotional status. The majority (61.2 percent) of the wife group emphasized their concern over the husbands' ability to adjust to the rapid social change which had occurred during their absence. Half the wives indicated concern about their husbands' health and over one-third noted their own anxieties about their husbands' ability to assume the husband and father roles and to continue a career in the military. Of lesser import were the wives' concerns over their husbands' premature aging, sexual inadequacy, violent behavior, problems with in-laws and automobile driving ability.

The wives emphasized the need for family and individual services at the time of repatriation. Heading the list of desired services was psychological counseling for the returning men (59.0 percent). Of nearly equal importance were educational counseling (52.4 percent) and occupational counseling (50.5 percent) for the returnee. Over 40 percent of the wives expressed the need for job retraining for the husband, marriage and family counseling and legal counseling at the time of repatriation. Other anticipated needs were financial and spiritual counseling.

DISCUSSION

Existing research on the general problems of family adjustment to father absence in the military, documents the nature of father-absence and its potentially deleterious effect upon the family, and in particular, its effect upon the children.[2,3] Motalvo's[15] study of the adjustment of fifty-five families whose fathers were stationed overseas spotlighted family assistance programs (medical, social and psychological) and the social value of the military community as major contributors to successful family adjustment. His conclusions that family adjustment to father-absence could be enhanced by maintaining the family in the military community throughout the servicemans' unaccompanied overseas tour was examined and reaffirmed later by Allen[1]. Related studies have emphasized the psychological effects of husband absence on the military wife; in particular, those of men serving on board submarines.[5,16] Exploratory studies[12,17] and descriptive papers[8,14] on family adjustment have continued to emerge and add to our growing knowledge of patterns of family adjustment under a wide range of stressful situations within the military setting.

Husband/father absence within the PW/MIA situation is unique. The unprecedented length of absence and its unknown and unpredictable outcome compound the complexity of the situation. The families were confronted with basic questions which needed to be answered to their personal satisfaction. Should they plan for their husband's eventual return or a confirmation of his death? In most cases families had to prepare for both. Spolyar[18] has noted that complex adjustments in the families' lifestyles were required for some. He further emphasized that the uniqueness of the PW/MIA experience is all too often overlooked. Brown[4] further pointed out the paradox of the PW/MIA situation. The wife, in an attempt to modify a lifestyle while maintaining a role for the husband who might not return, experienced feelings of insecurity, guilt, and a continuous struggle with self esteem. The shifting of the family roles and responsibilities suggest the evolution of a family unit without the father. The closing of ranks within the family was suggested by Hall and Simmons[7] as part of their clinical portrait of PW/MIA families. Hill[9] also noted this pattern of "closing ranks" was a common phenomenon among families experiencing father separations during World War II. While these may be indices of normal adjustment, Hill[9] also noted that the type of reorganization which made for successful separation adjustment appeared to lead to poor adjustment at time of reunion.

The emotional and adjustment problems experienced by the children of PW/MIA families as indicated by the interviewers were considered to be high in number. The French [13] in their assessment of PW families of the Indo-China War found both behavior and academic difficulties among their children long after the repatriation of their fathers. Special education programs were developed specifically to assist these French children. The possible deleterious effects of father separation upon child adjustment was underscored by Gabower[6] in her controlled study of behavior problems of children in Navy families.

The wives' assessment of the family assistance programs pointed out both the programs' strengths and their weaknesses. In general, the programs were judged to be very satisfactory in that they accomplished what they were basically designed to do. However, the gap between families in need of psychological assistance, but not receiving it, and the comprehensive services available to them suggest the limitations of the program. While it should be noted that there were family assistance officers who performed all functions most ably, including family counseling, careful selection of assistance officers as well as training programs are needed to meet the requirements of the PW/MIA situation. There appear to be other reasons for the gap between need and use of psychological services. Families tended to avoid seeking help for reasons ranging from denial to abortive and unsatisfactory experiences with mental health professionals. Additionally, the total system of providing mental health services to families must also be called into question. Hunter and Plag[10] (1973), on the basis of a study of a select group of Navy PW/MIA families, suggested the need for an aggressive program and proposed the development of a more flexible, coordinated, and professionally-based social work program for these families. While the value of an outreach social work program to PW/MIA families remains to be evaluated, the concept has face validity in light of the results of the present study.

A realistic appraisal of the wives' concerns and apprehensions about repatriation also suggested that the anticipation of reunion posed a threat to one or more of the gratifications that the separations provided, e.g., the opportunity to assume greater freedom, an independent income with the latitude to determine its use, and the avoidance of any confrontation with the husbands about the manner in which the wives conducted themselves during the husbands' absence. These apprehensions were also mentioned by Isay[11] in his study of the submariners' wives. The French social workers[13] cited similar problems as major areas of difficulty and contributing factors to family discord following the repatriation of the French PWs.

Variations in the social and psychological hardships experienced by the families indicated that the PW/MIA situation does not produce a crisis in every case. Frequent prior military tours by the husband, resulting in his absence, may have provided some wives the experience needed to cope with the situation. Thus, adjustment may be eased by a sort of rehearsal or "graduated immunization." Family life would continue for that family with only a minimal break in the usual routines. In contrast, totally dependent wives, inexperienced with the responsibilities brought about by the casualty, would be confronted with a crisis, perhaps responding to the situation by withdrawing, thereby neglecting a host of other family responsibilities. The meaning of the PW/MIA situation varied from family to family. If, prior to casualty, husband, wife, and children had been in constant conflict, the father's absence might even be a relief, in spite of guilt feelings about his loss. However, where the family had previously worked and functioned as a unit, sharing responsibilities as well as recreation, the casualty would come as a traumatic shock, and adaptation would be extremely difficult. Where the father's role had been an integral part of the functioning of the family unit, his casualty would be a major loss.

CONCLUSIONS

This paper examines data related to the adjustment of families of prisoners of war or servicemen missing in action. Several major findings appear to emerge from the interview data. Research on family adjustment and the analysis completed to date is in an exploratory phase, and therefore our conclusions of findings are stated propositionally.

1. Basic patterns of adjusting to the absence of husband-father are compounded by the unprecedented length and indeterminate nature of the PW/MIA situation.

2. The probability of major adjustments in family roles and interaction is high for these families.

3. The wives are likely to pursue a wide range of individual and social activities which will enhance their self-esteem.

4. Over a period of time, the families are likely to be confronted with complex legal issues surrounding their rights and privileges.

5. Over time the probability of modification in the wives' assessment of their marriages is high.

6. The emotional difficulties experienced by the wives and children strongly reflect the complexity and difficulty of coping with the PW/MIA situation.

7. The discrepancy between the families' potential to benefit from psychological services and their limited contact with such services suggests the need for a more effective approach for extending these services to PW/MIA families.

8. The families' adjustment during the casualty period and their apprehensions about repatriation and reunion must be considered important components in a formula for the successful reunion and readjustment of each returned prisoner of war and his family.

9. For the family in which the man does not return, the formula must include all the components mentioned in Proposition 8 above, plus the additional factor of the family's acceptance of the man's change of status to died in captivity, killed in action, or presumed killed in action.

Collectively the nine propositions, along with corollary implications, provide the beginning of an empirical portrait of PW/MIA families under stress. There is a need for more information about other aspects of PW/MIA family adjustment and the coping processes. There is also a need for comparative analyses which will provide answers to many questions, which include: Are there discernable family patterns of adjustment unique to each of the Armed Services: Army, Navy, and Marine Corps? What constitutes successful adjustment among PW/MIA families in how they adapt to the situation? Does receiving letters from the PW have any bearing upon family adjustment? Does the proximity of the family to a military installation make a difference in the services the family received? As these and other related questions are answered more completely, a general theory of family adjustment to stressful situations will be advanced.

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ROLE OF SOCIAL WORK IN OPERATION HOMECOMING

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One of the most difficult tasks, when faced with a wealth of material and when limited in time to ten to fifteen minutes, is to summarize an overview of the topic assigned and highlight a few points.

I have been asked to talk on the organizational response to Operation Homecoming and particularly to discuss the role of social work. I will first describe an overview of Operation Homecoming and then comment briefly on each of five main points.

Fitzsimmons Army Medical Center was one of five Army hospitals designated to receive POWs whose home of record was within a 13-state region of Denver. At Fitzgimmons, we received 15 POWs, there were 29 primary next-of-kin, who were generally wives or if not married, were parents of the returnee, 18 secondary next-of-kin, who were the parents in the case of a married returnee (or some other designated relative), and 43 members of the immediate family of the returnee, totaling 90 family members. Social work was charged with the complete responsibility for all care and services to the families of the returnees. This responsibility included transportation, accommodations for lodging, and all individualized care and social services that any family member may need.

The entire seventh floor of the hospital, which included two main wards, were set aside for the POWs. Seventh floor east was designated for POWs who were "bringing charges"; seventh floor west was designated for POWs "under charges". This is mentioned because obviously some of the conflicts between the POWs themselves spilled over to the families of those returnees. Social work moved to the eighth floor to set up a communications center and a comfortable lounge where the family members and the assigned social workers could be very close to the returnees. This facility was manned 24-hours a day, 7-days a week during the time of the reunions.

The organizational preparation for the returnees was that a Team Chief would be responsible for the entire operation at the hospital. At Fitzgimmons, Colonel Franklin, the Executive Officer, was designated the Team Chief. Under him there were two main divisions. One, the Chief of Medicine at our hospital was assigned full responsibility for all the medical care of the returnee himself. In the other main division, the Chief

of Social Work Services was responsible for all services and needs of the families of the returnees. Under the Chief of Medicine, the services of the Departments of Dentistry, Psychiatry, Surgery, and all other medical-type services were coordinated. Under the Chief of Social Work, there were three main sections: one was a staff of professional social workers who were assigned individually to each separate family; a second section was all the Family Service and Assistance Officers (FSAOs), who were under the administrative control of the social worker; and the third section was a special administrative section that was augmented by Headquarters staff to deal with the transportation, accommodations and communication requirements.

With this amount of description as a back-drop, I would like to emphasize the main part of the overview; namely, that Operation Homecoming was clearly an optimum model for social work services or health care delivery. This was a model which could theoretically be duplicated at any facility anywhere, it was one that included social work input at a level where it has the greatest impact; it was one that was based on a maximized common professional goal and, therefore, on minimal organizational conflicts between administrative and professional sections; it was one that could be applied within an organization at several different levels, such as at an executive level for policy-making, in a pediatric clinic for maximum team effort, and on a hemodialysis ward where the patient and family's need integrated professional care and services.

The elements of this optimum model are summarized in the following dimensions. First, it was comprehensive. A 70-page elaborate plan listed clearly the objectives, outlined all aspects of cares and services that we required and was fully comprehensive. Secondly, it was continuous. In brief, this means that it had the continuity of outreach in the beginning stages, intervention in the crisis or reunion stage, and follow-up or follow-through as the final stage. Third, it was fully integrated professionally. This means that it actually involved all the professional and administrative resources necessary. Fourth, it was family centered. The patient and the family members were treated as a unit of care and all the resources were focused on the combined unit, which is the epitome of health care. Fifth, its services were geared to intervention and prevention. Problem areas were identified early, whenever possible, and an emphasis was given to preventing problems rather than treating them after the fact.

With my time allocation dwindling rapidly, I will now highlight five major points in order to comment on problem areas that influenced the social work delivery in dealing with the problems experienced during Operation Homecoming. The first point is regarding <u>information</u>. Our role was one of information giving, but often the families were better informed about what to expect than the social work staff. The families had attended several briefings, and had the historical awareness of what to expect. On the other hand, social work staff was denied any advance information regarding families during the initial stage of Operation Homecoming or denied any contact with the FSAO or the family members until they arrived at the airport prior to the actual reunion with the returnee. Although this curtailment of any professional contact was based on the

assumption that a risk might be involved in contacting families when changes could be made in the routing of the patient or information wasn't clear on condition of the patient and many other concerns that were understandable, I feel that these concerns could have been handled, administratively and professionally, without denying the opportunity for building a social work relationship with the family and FSAO as early as possible. I believe this hesitancy stemmed from a lack of trust of social work skills and abilities, coupled with the fact that a considerable amount of pressure was generated from military intelligence, from the press, and from administrative policy-makers who were concerned over the high state of anxiety among the families.

The second point deals with the professional relationship. As no prior opportunity existed for the social worker to meet with the family members and have a chance to build a professional relationship until 24-hours before the actual reunion when the families arrived at the airport, spending a great deal of time with them prior to their actual reunion and in a crisis intervention type of relationship, having a total investment with the family at a time when they were most responsive to it. This professional availability and investment in all cases paid good dividends by building a very strong relationship very quickly.

Third point is to differentiate a social work role from other helping professions. Some difficulties arose in dealing with the families because so many other professional people were involved. The psychologists and psychiatrists dealt directly with the POW, the social worker worked with the family, the chaplains worked with both the POW and the family and then there were the escorts with the POWs and the FSAOs with the families. These role confusions were minimized by the early contact of the social worker with the family at the airport and by clarifying exactly what each person did. Thereafter, it seemed to clarify itself in practice from day to day.

The fourth point has to do with a sanction or authority to assume a professional role. Social work was charged with a high order of responsibility for the families of the POWs but were initially given, in my estimation, a very low level of sanction to use professional modalities to solve the problems. Again, it was helpful to understand the total picture in daily meetings with the Team Chief to know of the sensitivities for military intelligence and public affairs and other administrative requirements but ideally, responsibility and sanction need to be in close balance to permit effectiveness. This initial disparity changed rapidly and after some initial experiences, I feel, they were much closer together, which was probably an outcome of more trust and exposure to social workers and their manner of working at both a policy and operational level.

The last point relates to the tone of professional services. The manner in which social workers presented themselves to the families was extremely important. Our emphasis was simply that we acknowledged that their anxiety and stress at the time of reunion was at one of the highest points in their life experience. We attempted to cast the tone of normalcy

and professionalism by expecting that a high level of anxiety would create some stresses on the individual family members or units. These areas of individualized difficulty were openly discussed with the families and the alternatives of how to deal with these, or handle them, or minimize them. The families naturally maintained their option on which of the alternatives they preferred. Our main emphasis was to avoid any layering of problems but rather that we would attempt to help the families resolve them or in some cases isolate the problems at a time when it was not realistically desirable to attempt to solve them. Our main interest was one of support, reinforcement, and intervening with professional recommendations that included several options for the family in each situation. Generally speaking, the families were very receptive of these kinds of services.

As my time is up, I will close by summarizing that Operation Homecoming demonstrated an epitome of health care delivery. It was an optimum model in which social work functioned in a fully integrated position with the total health care team and at a level where it had the greatest impact. The reasons for success of social work's role in Operation Homecoming are based on the elements that have been listed. The major encouragement to me from my experience in Operation Homecoming was that the health care system appreciated social work involvement both at the policy level and operational level and that, had we been given more information and sanction at the earliest phase of Operation Homecoming, we could have done even a better job.

SOCIAL WORK AND "LESSONS LEARNED"

IN PHASE III OPERATION HOMECOMING

by

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My presentation this morning will hopefully augment the comments made by LTC Wanberg with reference to his experience at Fitzsimons Army Medical Center.

There were obviously many lessons learned during Operation Homecoming regarding the provision of social work services to the returnees and their family members. There were four major lessons learned which I feel contributed to a rather effective hospital-based program at LAMC for the returning POW's and their families.

First, we learned that strong group leadership was needed in the form of an individual who could address himself in general to all aspects of the process in which the returnee and family would be involved. This included the medical, psychological, and social evaluation, treatment and follow-up activities. LTC J. D. Lloyd was designated as Coordinator, Professional Services for Phase III of Operation Homecoming at LAMC. The hospital staff who participated in Operation Homecoming were allowed the flexibility to practice their expertise within a group atmosphere that both supported and questioned in a constructive way the professional service they were extending to the returnee and his family. In a word, the ward staff operated on a competency model, with a strong emphasis on real coordination of services.

Secondly, we learned that family cooperation during periodic crises while the medical processing occurred was enhanced by having had prior contact and relationship with the families. Social Work Service at LAMC initiated an outreach program to the primary and secondary next of kin who would seem to play a vital role in the returnee's re-integration process. The program took the form of social work officers visiting the homes of the next kin, including wives, children, extended family members, and in-laws. The fact that I had previously interviewed 9 POW/MIA wives for the Center, Prisoner of War Studies greatly influenced LAMC's validation of our outreach program. When home visits were not feasible,

extensive phone contacts were maintained with the next of kin and their Family Service and Assistance Officer. The family contacts were made prior to Phase III of Operation Homecoming whenever possible. For those families and the FSAO who were not contacted at their homes, the assigned social worker would interview them extensively upon their arrival at the hospital. The outreach program, in its many forms, was multipurpose in nature. Family interviews allowed the hospital representative to orient the family to the procedures for medical evaluation of the returnee, elicit and answer when possible questions relatives would have regarding the readjustment both the returnee and the family would encounter, and most importantly, to establish a relationship with family members to assist them in looking at the readjustment issues in relation to the returnee.

The third and fourth lessons learned took the form of actions initiated to cushion and diffuse an already pressured encounter between returnee and family members. At LAMC, it was decided that reunions would be held privately in the returnee's hospital room. Several returnees commented in subsequent family sessions that the private reunion was most appreciated because it eliminated the pressure of external expectations on how the returnee and his family responded to each other and had helped to avert potential panic situations. Another action taken was to interview children of returnees prior to reunion in order to elicit their expectations and fantasies regarding their father. For example, two children clarified for themselves in one of the sessions, the difference between their father as a prisoner of war and inmates that occupied the old prison on Alcatraz Island.

Finally I would want to make reference to the clinical objectives in counseling the returnee and his family. At LAMC, four out of the six married couples have decided on divorce as their way of readjustment. In order to arrive at a clear understanding of this high percentage of permanent separation, one must consider, among other things, the reported degree of marital satisfaction prior to capture. Another factor to be considered, is the manner in which the returnee's wife had attempted to resolve her "limbo status" during her husband's absence. Another ingredient impinged upon the marital relationship was either the confusion or direct conflict of views between returnee and wife regarding the political overtones of the Vietnam conflict. Further examination of the returnees themselves in terms of the military occupational specialty they had chosen also shed some light on the difficulty in re-integrating into their marital and family relationships. Therefore, much of the focus in the clinical sessions was on clarifying the real differences between the returnee and his spouse, which were non-negotiable and incompatible in some cases. The social worker involved in counseling the returnee and his family must view, in the end, the reintegration/readjustment process as one with potential for growth and new direction for all parties concerned and not limited to the notion of "coming together in reunion."

I hope my comments have reflected a useful description of actions during Operation Homecoming which can facilitate Social Work activity with families if faced with a similar situation in the future.

FAMILY STUDY

by
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For the last several months a small group of researchers at Walter Reed have spent their Thursday's planning and piloting an exploratory descriptive study of families of adolescents who seek professional help at the Child Guidance Clinic at Walter Reed General Hospital (WRGH).* The general goal of the study is to see if we can differentiate one family from another in terms of (1) the internal relationship connectedness of the family members, (2) the social networks outside the family and (3) to see if the presented problems generally can be given some kind of ad hoc classifications from a behaviorally descriptive framework; and finally, (4) to see if the nature of the adolescent problem is associated with any particular pattern of total family interrelationships.

Interest in the above areas of family groups was generated by clinical experiences in which it seemed that the kind of problem behavior presented by adolescents referred for Child Guidance Care was most often closely associated with the nature of the families relationship to the surrounding social environment, the internal family interrelationships and the interconnectedness of these two aspects of the family group. Families must relate to themselves and to the surrounding social environment in some way and it is the nature of those relationships to which this study is directed.

Rationale

The family as a social organization or system is an integrated but complex unit. Each family evolves and maintains a unique interpersonal system style which encourages or demands certain behaviors and/or prevents other behaviors by its members. Like all living systems, the family must change as it progresses through time. One change that usually occurs is the nature of the influence on the young members of the family unit as the young family offspring grow older and form close peer group ties outside the family. The social contacts with other than family members supplements the family socialization function. Of crucial importance is the family unit's response to extra-familial influences and the relationship between the family's particular internal social networks. Lidz, in reporting on troubled families, speaks of the adolescent being isolated from all but those interactions which take place in the family context. Wynne, also

*Donald R. Bardill, Linda Cunningham, Rosemary Diliberto, Eugene Grossman, John Newby, Jr., Joseph Rothberg, and Gloria Setti.

talking of troubled families, discusses family boundaries which create a barrier to the young person's extra-familial socialization. Wynne also discusses the possible negative effects of completely open boundaries where no solid family standards serve as a life reference framework. He says "disturbed families are differently integrated into the larger social system than better adapted 'normal systems'". He notes that in the disturbed families there is either defective boundaries or abnormally impermeable boundaries. Following this line of thinking, adolescent problems would likely develop in either tightly bounded, highly organized family systems or in loosely bounded aggregates of people type units which have a sense of complete disorganization. Thus, for family members the family experience is likely to be either extreme in its intrusive, engulfing nature or extreme in its remoteness, and non-involving characteristics.

The total way families interrelate internally and with others outside the system forms the framework for the family system. The time spent together as a family, topics discussed, particular family dyads, triads, alignments, and splits all form the internal aspect of the total family interrelatedness with others.

Given the importance of the family social network dimensions, family internal organization and the possible relationship of problems to these family characteristics the current family research project was launched.

Procedure

Selected for study will be at least twenty families of adolescents referred to the Child Guidance Clinic at WRGH. Families where the identified patient is an adolescent seemed to offer the best opportunity to examine the family in relation to its internal and external environment. Erikson (1950) points out that the central issue of the adolescent is the consolidation of a stabilized sense of personal identity, linked to, and differentiated within the psychosocial environment.

Thus, in families containing an adolescent, the issue of family connectedness within itself and with the social environment would be expected to be at a peak point for all family members.

Further criteria for families included in the study were that the family be intact, and the problem for which help is sought be non-psychotic in nature. There must also be a sibling above 10 years of age in the home. The sibling was expected to be able to provide additional information from a non-parental family locus. The families will be asked to come for an approximately 3½ hour interview at WRGH and to set a time for a 2 hour interview and questionnaire session in their home. The parents, the identified patient, and the closest sibling will comprise the family for study purposes.

The data collection procedures will include structured interviews, semi-structured interviews, and self-report questionnaires. The entire

family group will be interviewed for certain information while individual interviews will be conducted in order to gain other data. A family diary of one-week duration will be obtained from each family member, as well as individually administered self-report questionnaires and other psychometric instruments.

Study Areas

Classifying 'problem' is a tremendously complex task. Highly skilled therapists often disagree about what the problem is in a particular situation. For the purposes of this study 'problems' will be viewed from a descriptive frame of reference. Efforts to get a complete behavioral/descriptive picture will be exerted. While the exact aspects to be used in classifying the problems will emerge from the data, it is anticipated that 'manufactured problem groupings' will be developed according to such variables as the number of problems, the internal versus the external direction of the focal behavior and actual descriptions of behavior. Some general clinical suspicions suggest that problems differ in relation to the nature of the family system. A primary question relates to whether or not meaningful groupings can be made on a descriptive basis.

A psychometrically oriented research effort within the "Problems Section" is concerned with quantifying the behavioral stimulus value different family members present to each other during role enactments in a variety of family interaction settings. A semantic differential technique is being used wherein each family member is being requested to rate their past behavioral disposition and that of every other family member in a sample of common family settings. The ratings for each family member are obtained on a series of scales anchored by descriptive behavioral and cognitive antonyms (i.e., rewarding-punishing, sharing-withholding, etc.). The results will be factor analyzed to determine the evaluation commonalities employed by individual family members and, subsequently, the degree to which concurrent behavioral variability can be predicted given knowledge of both individual and situational stimulus contributions. Other instruments being employed in the individual psychometric evaluation include the Rotter Internal-External Locus of Control Scale, the Marlowe-Crown Social Desirability Scale, the Taylor Manifest Anxiety Scale, and a study-specific deviant behavior checklist (currently in preparation). Correlations between each of the psychometric instrument scores and behavioral emission frequencies, as determined by interview and checklist, will be obtained.

Internal

The internal atmosphere and transactional patterns influence and are influenced by the patterns of social networks of the family members. The internal family map refers to the total configuration of family activities together in the home. The amount of time spent in certain dyads, triads, and/or alone; the topics discussed; the activities shared, etc., represent the frame out of which a description of the internal family workings will be developed.

The Social Networks refer to the number of people family members spend the greatest amount of time with, by choice, and to the closeness of the network of people in terms of the number of reciprocal acquaintances. To aid in understanding the networks, information such as the felt closeness to persons, amount of time spent with the person, topics discussed, etc., will be obtained.

Summary

To repeat, the general goals of the study are to see if we can differentiate one family or set of families from another, in terms of (1) the internal family map (the internal relationship connectedness of the family members), (2) the social networks outside the family and to see, (3) if the presented problems can be given some kind of ad hoc classifications from a behaviorally descriptive framework and, (4) to see if the nature of the family problem is associated with any identifiable pattern of total family interrelationships. Other more specific findings should emerge from the study results. The study, at best, (or at the very least) will provide broad outlines of particular aspects of families. The hope is that the broad outlines will be a guide for more detailed inquiries into the family system as it relates to problem behavior.

MARRIAGE AND FAMILY COUNSELING STUDY

by

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The intent of this study was fourfold:

1. To explore the type of marriage and family counseling services other Army installations in CONUS, Hawaii, and Alaska are providing.

2. To extract from the data information and procedures which might be used to improve and enhance programs at Fort Leonard Wood (FLW).

3. To consider the establishment of a separate marriage and family counseling program which would combine the fragmented resources on post.

4. To disseminate the collected data to interested installations.

BACKGROUND

Other installations have recognized the same problem and have developed recourses to meet the needs of families living on their installations. A desire to search out the knowledge and experience collected by these forerunners prompted Social Work Service at FLW, MO, to organize a questionnaire. The task, therefore, was to locate and report on existing family and child counseling programs, with particular concern as to how they operate, and what military benefits are available because of their services.

It has long been recognized that all Army installations are faced with the same social problems which confront civilian communities of comparable size. The military has encouraged men with families to stay in the system; but, programs especially in regard to marriage and family counseling have not kept pace. Many facilities on post do some sort of marriage counseling but, in making contact with them, none are willing to really let it be known because of the numbers of people who are seeking such service. Services are fragmented due to the varying approaches taken by each discipline, i.e., Chaplains, Army Community Services, Neuro-Psychiatric Service, Hospital Social Work Service, etc., making it difficult for family or community resources to know where service can be found.

During the month of August 1973, the Hospital Social Work Service met with representatives from ACS, Post Chaplains and the NP Clinic to explore their family and child counseling facilities and presented the idea of

exploring other installations' programs with the purpose of incorporating some of their experience into our system. Everyone contacted was enthusiastic about the concept and participated in developing the questionnaire.

METHOD

The research data for this study was gathered from thirty-six installations whose ACS officers, Social Work Service and Post Chaplains responded to a questionnaire (See Appendix A) during the period 29 August to 30 September 1973. These services were chosen as respondents to the questionnaire on the basis of their expected sensitivity to the needs and the resources of the military community. In order to make this study as comprehensive as possible, the goal was to contact every Army installation in CONUS, Alaska and Hawaii with a population over 3000 active duty personnel.

In all, sixty-three installations were sent questionnaires and forty-seven of them responded. Five of the installations were closed, three questionnaires were answered by larger installations rather than the sub-posts to whom they were addressed, and eight of the total failed to respond the first time, so follow-ups were made with the installations in question.

The data was compiled in tabular form, separating those installations (11%) which presently have a separate marriage and family counseling program, opposed to the 89% of the installations which do not have or have some other form of marriage and family counseling service. Selected variables in the study were then compared and contrasted in order to emphasize some of the study's findings.

RESEARCH DESIGN

The research data scope was obtained through the use of a questionnaire sent to three services on each installation - Social Work Service, Post Chaplain and Army Community Services. The questionnaire was designed to explore several topics:

1. Does your installation have a separate marriage and family counseling program?

2. If the answer is "yes" =

    a. Who runs the service?

    b. What personnel are involved?

    c. Agency structure?

    d. Agency policies?

    e. Involvement with civilian agencies?

3. If a base had no marriage and family counseling clinic, we were still concerned about -

a. Where such services could be found at their installations.

b. Who is providing the services?

c. What are the plans for such a separate service, if any?

We also encouraged participants to send any information such as ideas, newspaper clippings, clinic SOP's or anything they felt might be useful in the development of a marriage and family counseling program.

RESULTS AND DISCUSSION

Tables I and II show the distribution of responses for those installations who returned a questionnaire. Questionnaires were sent to thirty-six Army, ten Air Force, five Navy and five Marine Corps installations. We received at least one response from 98% of the activated Army installations, 70% (7) from the Air Force, 0% from Navy and 33% (2) from the Marine Corps installations. The basic intention of this study was to obtain information which would aid FLW in the establishment of a Marriage and Family Counseling program and, since only Army installations responded as to having such a program, only Army installation responses were used in this study. There were no Marriage and Family Counseling (MFC) programs in any of the sister installations responding.

Of those installations surveyed, 48% reported that they had some type of MFC facility, however, only 14% (4) have a separate facility with a separate SOP to cover their operations. Those four installations were Fort Lewis, Fort Polk, Fort Shafter, and Fort Bragg.

TYPES OF MARRIAGE AND FAMILY COUNSELING PROGRAMS

Fort Lewis reported that its area of responsibility included approximately 145,000 active and retired Army personnel, and covered most of the Pacific Northwest. On-post marriage and family counseling services is a part of Army Community Services, however, the actual counseling is handled by various individuals and agencies on post. To eliminate duplication, fragmentation and gaps in services, a social work sub-committee was formed which includes a professional worker from ACS, Social Work Services, and an American Red Cross representative. Fort Lewis has access to several community agencies and makes referrals to them which, if need be, is covered by CHAMPUS.

Fort Lewis believes that family dysfunctioning requires other remedies than just marriage and family counseling and has begun a substantial community life program. The goal of this project is to provide better community life for the soldier and his family. A copy of their program can be obtained by writing the ACS director at Fort Lewis.

Womack Army Hospital located at Fort Bragg, NC, has developed a specific program aimed at delivering centralized services to families by focusing

TABLE I

DISTRIBUTION OF RESPONSES FOR INSTALLATIONS WHICH HAVE A SPECIFIC MARRIAGE & FAMILY COUNSELING CLINIC

Question Number	1		2		3					9										11	
Installations	Yes	No	Yes	No	NP	ACS	MHCS	SWS	OTHER	ACS	HOSP	SWS	NP	CHAPLAIN	ATC	DRUG C	SELF	MHCS	CIVILIAN	MILITARY	CIVILIAN
Aberdeen Proving Ground	X			X		X	X			X				X							X
Beaumont Army Med Ctr	X				X			X	X								X		X	X	
Ft Ben Harrison		X		X																	
Ft Benning	X							X			X						X			X	
Ft Bragg	X			X				X		X								X		X	
Ft Carson	X			X		X											X	X	X		X
D.P.A. Granite City		X		X		X															
Ft Eustis		X		X																	
Fitzsimons Army Hosp		X		X																	
Ft Gordon	X			X		X		X												X	
Ft Hamilton	X			X																	
Ft Huachuca		X	X					X													
Ft Jackson		X		X	X	X	X	X													
Ft Knox	X		X		X	X															
Ft Leavenworth	X		X						X				X				X	X		X	X
Ft Leonard Wood		X		X	X	X	X	X			X									X	
Ft Lewis	X		X			X		X		X		X								X	X
Ft MacArthur		X		X			X														
Madigan Gen Hosp	X		X					X				X								X	
McAfee Army Health Svc	X		X					X									X			X	
Ft McClellan		X		X																	
Ft McPherson		X	X																		
Ft Monmouth		X		X			X														
Ft Polk	X			X					X		X						X			X	X
Presidio of San Fran	X		X			X		X						X						X	
Walter Reed Army Hosp	X			X							X										
Ft Richardson					X		X	X													
Ft Riley	X			X			X	X									X			X	
Ft Rucker		X	X		X	X	X		X												
White Sands Missile Rng		X		X					X												
Schilling Manor	X			X		X				X				X			X			X	
Ft Shafter	X		X								X						X	X		X	X
Ft Sheridan	X		X			X	X						X				X		X	X	
Ft Stewart		X		X																	
Ft Story		X		X																	
Womack Army Hosp	X			X				X									X			X	
TOTAL	20	15	11	22	6	12	9	14	5	4	5	2	2	3	0	0	11	4	3	16	6

TABLE II

DISTRIBUTION OF RESPONSES FOR INSTALLATIONS WHICH HAVE A SPECIFIC MARRIAGE AND FAMILY COUNSELING CLINIC

Question Number:	12					13		17	19		19a		19c
Installations	Hosp.	AFS	AHS	Separate	Chapel	Yes	No	Number	From	To	Yes	No	Hrs per wk
Aberdeen Proving Ground				X			X	3	1930	2230	X		3
Beaumont Army Hosp.	X						X	4-6	0730	1830		X	2
Ft. Ben Harrison													
Ft Benning				X			X	10	0730	1630		X	
Ft Bragg	X						X	none	0730	1630		X	5
Ft Carson		X					X	?	0730	1630		X	
DFA Granite City													
Ft Eustis													
Fitzsimmons Army Hosp.													
Ft Gordon	X						X	?	0730	1600	X		1
Ft. Hamilton													
Ft Huachuca													
Ft Jackson													
Ft Knox													
Ft Leavenworth				X			X	10	0800	1700	X		5
Ft Leonard Wood	X						X	none	0730	1630		X	1
Ft Lewis		X					X		0730	1630			5
Ft MacArthur													
Madigan Gen Hosp	X					X		none	0800	1700	X		2
McAfee Army Health Svc	X						X	1-2	0730	1600	X		1
Ft McClellan													
Ft McPherson													
Ft Monmouth													
Ft Polk				X		X		1	0730	1630		X	
Presidio of San Fran.		X					X		0730	1615			1-2
Walter Reed Army Hosp.													
Ft Richardson													
Ft Riley			X				X	5	0730	1630		X	3
Ft Rucker													
White Sands Missile Range													
Schilling Manor		X					X		0730	1700		X	
Ft Shafter				X		X		1-2	1800	2100	X		4
Ft Sheridan		X	X				X	?	0730	1600		X	2
Ft Stewart													
Ft Story													
Womack Army Hosp	X					X		none	0730	1630		X	
Total	7	5	2	5	0	4	11				6	10	

on the family as a basic work unit. They identify and alleviate marital and family stress by utilizing counseling and crisis intervention techniques. A copy of the Womack Army Hospital Family Enhancement and Development SOP is found in Appendix B and C.

Fort Shafter, HI, has developed a family life program evolving from the Drug and Alcohol programs of 1970. The primary program was developed to meed the needs of drug abusers usually ranging in age 17-21 years old. It was discovered that many of these young soldiers were married. Often the wife was also abusing drugs as well, but inevitably tension and stress developed in the family in a number of ways, i.e., financial problems, malnutrition in children, psychiatric disorders and marital discord. Dependent children began to be found and to be introduced to the program which added another dimension. Cases were found where each member of a family was being treated by a different specialist, but no one was treating the family unit. Although there was a wealth of talent within the community, they found helping agencies must be coordinated to insure the most effective coverage while eliminating duplication. The Schofield Barracks Family Life Council came into being in June 1971, recognizing that a comprehensive mental health program was the only realistic approach in dealing with the diversity of problems common to the military community. A copy of the Schofield Barracks Family Life Center program may be obtained by writing Family Life Center, Fort Shafter, HI, APO SF 96558.

Fort Leavenworth, KS, developed a Human Resource Center supervised by the Army Community Service Center. Like Fort Shafter the Human Resource movement came about as a result of the president's declaration of war on drugs in 1971. They provide assistance for persons with both immediate and long-term problems such as marriage and family difficulties, alcohol or drug abuse.

At Fort Leavenworth the center utilizes, in a team approach, the Red Cross, USDB, TAG, Chaplains, Race Relations Officers, Social Work Officers, ACS and other parties in mutual planning and coordination of service to guard against duplication and gapping of efforts. A copy of The Human Resource Center Bulletin can be obtained by writing the Human Resources Center, Fort Leavenworth, KS 66027.

Table I, item three, demonstrates the various places marriage counseling can be found on many installations. A close look at these statistics reveals the need for organization and leadership. Thirty-one percent of those responding stated that they were aware of at least two places where marriage and family counseling could be obtained at their installations, while sixty-eight percent either know of none or only their agency was performing such counseling. The same figures as above applied to referrals, thirty-one percent of the respondents either gave or received referrals from at least one other agency while sixty-eight percent did not refer or receive referrals. Twenty-one percent of the total number reporting made referrals to civilian agencies.

Table II, item twelve, shows who is assuming leadership for marriage and family counseling services. Aberdeen Proving Grounds, Fort Benning, Fort Leavenworth, Fort Polk and Fort Shafter all have separate leadership not attached to the Hospital Social Work Service, ACS or Mental Hygiene. Of those reporting a marriage and family counseling program, 35% were affiliated with Hospital Social Work Service, 29% with Army Community Service, 11% with Mental Hygiene and 29% were separate.

HOURS OF OPERATION AND ATTIRE

Twelve of the thirty-five respondents or 34% are open during the evening hours at least one night a week.

Six of the seventeen installations reported that they have marriage and family counseling services and wear civilian attire (at least during a portion of their counseling time). Several of the programs stated that they wear civilian clothes during actual therapy sessions in order to help overcome rank barriers and make the service more meaningful.

CONCLUSIONS

The following conclusions were reached as a result of the study:

1. A higher percentage (48%) of Army installations than was originally foreseen have some type of marriage and family counseling program. Many others who do not currently have a program stated they were in the process of investigating or setting up such a service.

2. A family life education center is only found on 31% of the responding installations. These installations having such a program report that it is a valuable tool in preparing young people for marriage and as a focial point for helping families enrich their family life.

3. Social Work Service and Army Community Services are doing most of the marriage and family counseling, followed by Mental Hygiene, the NP Clinics, and "others" such as chaplains, ATC, etc.

4. A majority of referrals coming into installations who reported having a marriage and family counseling clinic were self referrals. Of the remaining, 649 came from the other services which came into contact with families.

5. Thirty-five percent of those having an MFC service reported that they wore civilian clothes during at least a portion of the work day.

6. MFC Service locations are usually found either in the Hospital, ACS or in a separate facility by itself.

7. Only 23% of those having an MFC Service reported having an SOP to cover their activities.

8. Civilian agencies were only used by 20% of the reporting installations to either supplement, or because of some other reason, to provide marriage and family counseling to military families.

9. Thirty-five percent of those installations who reported having an MFC service stayed open in the evening at least once a week.

RECOMMENDATIONS

1. Some type of direct or referral marriage and family counseling service should be established and publicized on each Army installation, regardless of size, where there are military families.

2. Family life education centers should be implemented on each Army installation with a population of 3000 or more. Those bases having such a program report it being a valuable tool in helping couples plan for marriage and as a screening and referral tool for counseling services found on the installation.

3. On many installations several different services are doing MFC; yet very often one service is completely unaware of what a sister agency may be providing. We have a multiplicity of talents, techniques and backgrounds all dealing with a common concern. It behooves these various services to be aware of how each is operating to avoid the waste of manpower which results from overlapping or gaps from separate programs. Such fragmented services are extremely confusing to families seeking help as they do not know where to go and few services are widely publicized. Close communication must be set up, not only to insure that each service is aware of the efforts another is making, but also to ensure that patients are referred to the type counseling which he will most quickly respond to, i.e., Social Work Service, ACS Volunteer program, chaplains or the NP Clinic.

4. In some cases civilian clothes are a positive factor in providing a professional service unbiased by the rank structure of the military. This should be determined by each facility and the type service it is attempting to provide.

5. Individual SOP's should be formulated to cover separate MFC Services to insure that workers are aware of their duties and responsibilities. This is also important in making sister agencies aware of what type of program is offered by a clinic or service.

6. Civilian agencies surrounding installations should be contacted to ensure that military families are afforded as many services as possible. Many civilian agencies offer specialized or long-range counseling which is beyond the scope of military facilities.

7. Hours should be regulated to ensure that a clinic or service is open when it is needed. Many families find it difficult to come during normal duty hours but would utilize an evening clinic.

APPENDIX A QUESTIONNAIRE

DEPARTMENT OF THE ARMY
Headquarters, US General Leonard Wood Army Hospital
Hospital Section, Social Work Service
Fort Leonard Wood, Missouri 65473

ATZT-GH-J 29 August 1973

SUBJECT: Questionnaire

Fort Leonard Wood is contemplating a family counseling service and we are writing for information you may have which would help in this endeavor. We have formulated a short questionnaire and would appreciate your time in contributing to our project. If you have additional responses to any question feel free to add comments or information you may have.

1. Does your installation have a specific clinic or service where marriage or family counseling can be obtained? yes____ no____
   A. If yes, what brought about the organization of such a program?

2. Does your installation have a family life education program? yes__no__
   A. If yes, why was such a program established?

3. With what department is your marital and family service connected? NP Clinic___, ACS___, Mental Hygiene___, Hospital section, Social Work Service___, other_____.
   Comments:

4. What type of personnel are involved?
   A. Is the chief an officer?_____ MOS_____
      enlisted man? _____ MOS_____
      or civilian? _____ GS#_____

   B. Number of officers_____ MOS_____

   C. Number of civilians_____ GS#_____

   D. Number of enlisted men_____ MOS_____

   E. Are chaplains used as counselors? yes____ no____
      full time____ part time_____

   Comments:

5. Are you satisfied with the clinic's objective?
What helps?
What gets in the way?
Comments:

6. Do you feel that your clinic is successfully meeting its mission?
What is its strength?
What is its weakness?
Comments:

7. How is it financed?
Do you have a fee system?
Comments:

8. If you could change anything about your clinic or method of operation
What would you change?
Why would you change?
What would you change it to?
Comments:

9. From where do the majority of referrals come? ACS___, Hospital Section, Social Work Service___, NP Clinic___, Chaplains___, ATC___, Drug Center___, Self___, Mental Hygiene___, Civillian agencies___.
Comments:

10. What is your installations' permanent party population?_____
Approximately how many marriage and/or family counseling cases per week does your service see?_____
Comments:

11. Do your counselors wear civilian or military attire? Civilian_____
Military_____
If your answer is civilian please explain what advantages or disadvantages you feel this makes in the delivery of services?
Comments:

12. Where is your marriage and family counseling service located?
hospital___, ACS___, Mental Hygiene___, Separate___, Chapel___
Comments:

13. Do you have a specific SOP which covers your family counseling service?
yes___ no___
If "yes" , may we have a copy?
Comments:

14. Do you engage the entire family in therapy? yes___ no___
Comments:

15. Do you make home visits? yes___ no___
Comments:

16. Do you have or are you connected with a 24 hour and/or weekend answering service and/or "on call service"? yes___ no___
Comments:

17. How many marriage or family counseling cases are referred to civilian agencies per month? _____
Comments:

18. What are the major reasons for referrals to civilian agencies?
Comments:

19 What hours does your clinic operate? _____to_____
A. Is your service open after duty hours? yes___ no___
B. Do you feel it should be open? yes___ no___
C. How many nights a week? _____
Comments:

APPENDIX B WOMACK ARMY HOSPITAL FAMILY ENHANCEMENT AND DEVELOPMENT SOP

WOMACK ARMY HOSPITAL
Social Work Service
Fort Bragg, North Carolina 28307
February 1973

STANDING OPERATING PROCEDURE

Family Enhancement and Development
Services Section, Social Work Service

1. PURPOSE: To outline the functions and responsibilities of the Family Enhancement and Development Services Section (FEDS).

2. APPLICABILITY: A professional family service program has been developed in Social Work Service to deliver centralized services to those families served by Womack Army Hospital. This program focuses on the family as a basic work unit and is designed to identify and alleviate marital and family stress utilizing counseling and crisis intervention techniques.

3. RESPONSIBILITIES:

a. The responsibilities for the organization and operation of FEDS is assigned to the Chief, FEDS, under the direction of the Chief, Social Work Service.

b. Although the Chief of FEDS is primarily responsible for organization and operation of the program, his tasks are shared by other Social Work Officers who work in the program on a part time basis.

4. FUNCTION: This program attempts to function at the highest possible level in quality and quantity of professional social work offered to families. All aspects of this program are administered or closely supervised by professionally qualified social workers. Social casework, group work, community organization, research, administration, and consultation are widely employed.

a. Professional Staff:

(1) Professional staff is defined as those persons having a Master of Social Work or higher degrees and shall include active duty and civilian personnel.

(2) Professional social work staff from Army Community Services, the 82nd Airborne Division, and the Air Force are encouraged to actively participate in this program.

(3) Volunteers: When possible, professionally qualified social work counselors or related fields shall have primary preference for inclusion in this program.

(4) Social Work Specialists (91G), with a special interest and under close supervision of a professional social worker, may participate as therapists.

b. Intake: The intake social history and as much as possible of the initial contact with the family will be the responsibility of a professionally qualified social worker.

(1) Intake card: FB Form 2149 will be completed by the patients prior to an intake history.

(a) Cards maintained by the secretary.

(b) A record and ready status (open, closed, times seen) report on the family.

(2) A social service record: The secretary will make up case record jacket on any new cases and maintain a record file. Old jackets will be maintained in a file and pulled should a family return for some reason after therapy or closure of the case.

(a) A social diagnostic study of the family is the responsibility of the intake social worker.

(b) Treatment plans: The intake social worker will make the treatment plans at the time of intake and present his findings to the professional staff.

(c) Follow-up reports: Reports to the staff and documentation in the family records is responsibility of the therapist assigned to the case.

(3) Patient medical records: It is the therapist's responsibility who is assigned a particular case to document medical records adequately pertaining to social services rendered.

(2) Professional social work staff from Army Community Services, the 82nd Airborne Division, and the Air Force are encouraged to actively participate in this program.

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(c) Follow-up reports: Reports to the staff and documentation in the family records is responsibility of the therapist assigned to the case.

(3) Patient medical records: It is the therapist's responsibility who is assigned a particular case to document medical records adequately pertaining to social services rendered.

(a) Treatment plan.

(b) Observation pertinent to medical care.

(c) Periodic entries on long term treatment.

c. Case Staffing:

(1) Weekly case staffing will be held to facilitate professional support of treatment and disposition of each case.

(2) Follow-up staffings on each case will be done periodically to keep abreast of the progress of treatment and to maintain quality of social work practice.

(3) Referrals: A case is referred to another agency if it has been inappropriately routed to this unit or if it can be handled more effectively by other agencies.

(a) Referral resources:

1. Alcohol and Drug Abuse Prevention Program.

2. Out-Patient Psychiatric Clinic.

3. Army Community Services.

4 Civilian agencies.

d. Treatment Modalities: In keeping with a comprehensive family treatment unit a multi-therapeutic approach is a must. The following are the modalities of therapy utilized.

(1) Individual casework.

(2) Group therapy (opened and closed groups).

(a) In cases where spouse will not come in, a women's group and a men's group.

(b) Adolescent group.

(c) Couple's group.

(3) Couple counseling.

(4) Total family counseling.

5. SUPERVISION: Weekly supervision has been built into FEDS by way of a case presentation and discussion. Supervisory time is usually in conjunction with the staffing of cases. Different techniques and approaches of the social work staff are explored for the benefit of each staff member.

a. Case discussions are encouraged at any time with member of FEDS staff.

b. In-service training and consultation should be utilized to the fullest.

c. Volunteers and 91Gs co-therapists need pre- and post-therapy supervisory time.

(1) Social workers should schedule times for supervision.

(2) Volunteers and 91Gs are responsible for their own training and self-development (i.e. reading).

6. REFERRAL: Requests for direct service or consultative service are made verbally or in writing to the Chief of the FEDS. A consultation sheet (Form 513) is preferred if the family (or case) is referred by a medical officer. All disciplines are encouraged to make referrals to FEDS.

Of course, self-referrals (telephone or welk-in) and referrals from other military and civilian agencies will be handled promptly.

APPENDIX C DEVELOPMENT OF WOMACK ARMY HOSPITAL, FAMILY ENHANCEMENT AND DEVELOPMENT SOP

About two years ago, it became necessary to request the support of interested volunteers to work with the social work officer at ACS. Due to the expanded services offered and the increased number of requests for assistance, the caseload became too much for one person to handle adequately. The Social Services Committee was formed to meet this need.

Since that time, volunteers have been trained as receptionists, typists, intake interviewers, case aides, and counselors. Presently, twelve volunteers donate an average of 80 hours per week. Their primary work areas include information and referral services as well as direct casework services and counseling. Routine CHAMPUS questions, problems with filing CHAMPUS claims, adoption information and referral, requests for emergency food and financial assistance, and the maintenance of a resource file on the various civilian social service agencies consume much of their volunteer time.

Several volunteers have been trained and utilized to work directly with families. The case work services which they provide are directly supervised by the social work officer. Important aspects of this casework service involve coordinating the many services available to individuals and families and the volunteer involvement with maintaining liasons with families through a homevisiting and homemaker program. Here, the volunteers are able to bring to the home environment the continuing support needed for effective problem solving. Home visits are an attempt to make the individual more at ease since the "counseling session" is conducted within familiar surroundings.

Specific areas in which the volunteers provide direct casework intervention include child neglect, financial referral, child abuse/neglect home and child management, hospital after-care, emergency transportation, school consultation, marriage and family counseling, family enrichment programs, and tentative groups on parent effectiveness training.

The utilization of volunteers to assist in the social work program has greatly enhanced ACS's ability to assist individuals and families requesting its services.

STANDARD OPERATING PRODEDURE

SOCIAL SERVICE COMMITTEE
ARMY COMMUNITY SERVICE

Fort Rucker June 1973

1. Objectives

a. To assist the Professional Services Officer in all areas of social work provided by the section.

b. To provide and support community service programs to meet both military and civilian community needs.

2. Training

a. The Social Service Committee will operate under the professional supervision of the ACS Social Work Section.

b. The volunteers are requested to attend bi-monthly in-service-training programs.

c. The volunteers of this committee will participate in the general training provided by ACS.

d. Volunteers will be provided with orientation materials covering resources, standard policies, programs, and services. Volunteers will be requested to familiarize themselves with this material.

e. The Professional Services Officer will provide consultation and direct supervision when needed.

3. Scope

The activities which are generally conducted involve general office work, interviewing, casework, and counseling services.

4. Accountability

Members of this committee are responsible to the chairman, and the chairman is responsible to the Professional Services Officer and the Volunteer Supervisor. All casework and counseling services come under the direct supervision of the professional staff.

5. Composition

Members of this committee will be ACS volunteers interested in the field of social work services. The committee will be headed by a chairman who will be responsible for all time records and other administrative duties.

Marital Counseling Precedures:

I. Initial call or contact

II. Marital inventories given (to be completed and returned before the first session.)

III. Analysis of inventories and possible approaches outlined.

IV. Session #1 Male and female counselors see each partner individually.

V. Counseling team refines problem areas and appropriate methods to be used.

VI. Sessions #2 thru ... Joint counseling sessions

Main techniques used:

Deep muscle relaxation -- to bring under control existing tensions
Contracting, behavioral techniques -- to modify some problems
Role playing, cognitive and affective sensitivity approaches -- to develope communication skills between partners

Realistic decision-making stressed

HUMAN RESOURCES

by

LTC James M. Timmons, MSC
Chief, Human Problems/ Comm Svcs Bn
U.S. Army Personnel and Administration
Combat Developments Activity
Fort Benjamin Harrison, Indiana

Last August when LTC Darnhauer called me to accept the challenge of a newly created position at Fort Benjamin Harrison, I responded favorably. I have not been disappointed; the position I currently occupy is indeed interesting, challenging, and I feel, contributes to the human resources development effort in the U. S. Army. During my limited contacts with my old friends and former colleagues, I'm met with the same question,"What do you do - what's that organization all about?" Today, I've been given the opportunity to share a few minutes with you in response to the questions you have been asking.

The Human Resources Development Division (HRD) was added to the Personnel and Administration, Combat Developments Activity (PACDA) as a result of a decision made at a General Officer's Conference held at Fort Harrison on 18 April 1973. The establishment of a Human Resources Development Division within the PACDA now enables the Administration Center to develop a broader basis in the functional concept of personnel management. This can perhaps best be seen by briefly examining the goals or objectives established for the Human Resources Development Division by the General Officer's Conference of 18 April. It was agreed by the conferees that Human Resources Development represented a new dimension of Army personnel management. They recognized the need to develop a reservoir of research data and experience dealing with leadership and personnel management and to translate that research experience into practical language and positive programs for implementation within the Army. Specifically, they suggested that the Human Resources Development Division be concerned with: (1) the development of HRD doctrine and associated training literature; (2) the introduction of such training literature into the Army's officer and non-commissioned officer educational systems; (3) the development of a capability to monitor research that is relevant.

Our mission is oriented towards the development of concept programs that will save us time, money, material and people. The establishment of a human resources capability within the PACDA provides the Army with a middle manager who can bridge the gap between research scientist and the soldier in the field. Our role as middle manager will also facilitate the exchange of information about Human Resources Development between the

various services, private industry, and the academic community. Thus, we hope to avoid duplication of effort and time wasted in pursuit of the unattainable.

To accomplish this, the Human Resources Development Division will:

1. Serve as a focal point for the development, review, and integration of new concepts and doctrine in the field of human resources development.

2. Monitor and evaluate behavioral and social science research for practical application to our problems.

3. Establish and maintain a Human Resources Information Center or Library. This center will provide the Army with a consolidated data base as well as resource material, thereby facilitating quick reference checks of the current state of the art, expedite conduct of studies, and enhance a more cost effective assessment of proposed Army funded research.

4. Review and evaluate on-going service school programs of instruction in HRD areas and make recommendations thru HQ, TRADOC, for modification, incorporation.

5. Monitor special studies in HRD areas as directed by ODCSPER DA and TRADOC.

6. Provide a responsive capability for conducting short-term, quick-fix, immediate need studies, surveys and evaluations as directed by ODCSPER DA and TRADOC.

7. Establish and maintain close professional coordination and liaison with private industry, universities, and the other services for exchange of information about human resources development areas.

Twenty-two of our 27 spaces are devoted to project personnel. There are 14 officers and 6 civilian professionals authorized. At the present time, we are at about 60% of our authorized strength. Of the 17 military positions, 10 require graduate or professional degrees, while of the civilian positions, 6 require professional degrees or equivalent experience.

In many respects, our role today is one of facilitator, monitor, or helper; as we get up to strength, a more comprehensive and sophisticated approach will be possible. HRD has been assigned a key role in helping the Army to rebuild a system of leader - follower relationships based, not upon fear or authoritarianism, but on mutual trust, respect and discipline. We are not trying to revolutionize the Army or it's traditional concepts of leadership, rather we are trying to enhance the capability of the commander to know his men, to take care of his men, and to accomplish the mission.

To gain the personal commitment of the American Soldier, we must make improvements that maximize concern for the individual. We must reaffirm the principles of the great leaders of the past. We must necessarily consider --

1. HIS PERSONAL DEVELOPMENT

2. HIS MOTIVATION

3. HIS ABILITIES

4. HIS JOB SATISFACTION

5. AND HIS OVERALL WELFARE

This ends the formal part of my presentation.

Now, a few disconnected but I feel, pertinent considerations. As one who has been involved in social research in some manner or another these past years, I pose some quick thoughts or comments. Each item could evoke an hour's discussion but in the interest of time, permit me to limit myself to a sentence or two.

1. Research Organization at the Right Level.
Do not plan for a research unit in the bureaucratic hierarchy to be objective and creditable if conducting research on activities for which their "boss" has operational responsibility. The name of the game here is "sanitize or whitewash."

2. The Public Information Role.
The research unit or evaluation, as well, can easily become an extension of the PIO, whose primary mission is to make something or someone look good. You don't need a professional behavioral science researcher to do PIO tasks.

3. The Discoverers of the Wheel.
Constantly, some obscure researcher emerges from his ivory tower to announce his new discovery - the wheel. The problem here is a lack of communication. A need for a clearinghouse - current info on the projects now underway. We all need to do our homework with respect to sharing information.

4. Next we want to do -
This you hear from the civilian contractors who play a game of continually feeding at the public trough. They propose more and more projects, building on the previous one and often using the same data. I'm not implying a general abuse, but it does occur. One way to avoid this game is to have competent professionals go over the design and the entire project carefully and have a clear understanding of what the end product is to be. Many projects are "fishing expeditions."

5. The Trivia Trip.

The independent researcher sometimes launches into a project, the subject of which may be close to his heart, but has very little significance to the potential user. The user may well ask, "So what??" Be prepared to answer that question as you formulate your design.

6. "I've Got A Secret."

We sometimes play this game and it doesn't enhance our professional image. Research contributes to knowledge, share it with others. Remember secrets are perishable.

7. Gimme What You Got.

An often heard "order" from the "boss" who is busily preparing his dog and pony show for the VIP; up the line. Your tentative, unrefined data or conclusions have a tendency to get set in concrete and become hard facts. Avoid the trap if you can, use benign material if you must and clearly define the unfinished state of the research project.

8. You Wouldn't Understand.

A statement at least felt, if unstated to the "boss" or other non-professionals. Our training in academia didn't tell us how to translate to the lay man, who is our boss or user. Make a special effort to communicate. It's really a necessity for survival.

There are many items that could be added to the list but time has imposed a restriction, so in closing I invite any of you to correspond or telephone and keep in touch.

COMPUTER SUPPORT IN MILITARY PSYCHIATRY (COMPSY)

by

CPT John Wells, MSC
COMPSY, WRAMC
Washington, D.C.

The subject of this presentation will be the Computer Support in Military Psychiatry (COMPSY) project. COMPSY is a research and development (R & D) project of The Surgeon General which is charged with developing a model for an integrated, Army-wide mental health information system. It has two developmental models: (1) an inpatient system and (2) an integrated community system.

The inpatient model attempts to apply computer technology to impact administrative tasks, medical records, and clinical care. Many tools, such as the automated Minnesota Multiphasic Personality Inventory (MMPI), mental status examination, etc., have been developed to take repetitive, fixed requirement tasks and automate them. The major contribution in the inpatient system by Social Work is the automated social history. This instrument is a 130-item questionnaire which is completed by the patient. It attempts to get a self-report of his life prior to admission. Currently, programs are being debugged to produce an output report for this instrument. The system will provide, when active, a copy of a summary history for the patient's chart and a detailed (i.e., every question answered) listing for the staff of the P & N department. Examples of the Mental Status and Social History are enclosed in Appendix A.

Many social workers have helped in developing this tool and their names need to be mentioned in acknowledgement of their service. Dough Nygaard, Jack Silver, Martha Dingey, Joe Bevilacqua, and Frank Montalvo worked over a three-year period in developing a questionnaire social history. Milton Grady, in his MSW thesis (1973), helped to check the reliability of the instrument. Finally, thanks go to Ben Arellano and his staff for implementing the social history system in 1974 for the Department of Psychiatry and Neurology.

The Community Model

One of the distinguishing features of the profession of Social Work is its recognition of the place of the community in the life of its members. Early in the COMPSY project the social workers began to explore the military community and its delivery of mental health care as an indication of how the community provides for its constituents. A COMPSY community model is the result of this explanation.

Joe Bevilacqua examined the MHCS as a caregiver. He visited ten MHCSs across the country in 1969 and subsequently published a comparison study. Joe assumed a large task by compiling an MHCS bibliography covering all the years that this organization had existed. At that point, Joe had decided to draft and complete a Monograph on the current state of affairs in the MHCS but he left the service just as the decision was made to apply the knowledge he had accumulated about a mental health information system to the MHCS at Ft. Benning.

Frank Montalvo and Greg Meyer stepped in at this point and started to develop a community mental health information system at Ft. Benning, Georgia. What they developed was to emerge as, not just an MHCS system, but a post-wide model. They discovered that an MHCS system is just too narrow and does not impact all the mental health caregivers on any given post. Only by a system that encompasses the many post agencies, such as ACS, Army Health Nurse, Chaplains, Army Drug Control Officer (ADCO), can a community model be fulfilled.

After several months of working, Greg Meyer had been able to join the MHCS, ACS, Army Health Nurse, and Benning House (ADCO) into the community mental health information system at Ft. Benning. The goals for Benning's system are embodied in the general goals of COMPSY. An attempt will be made to define the goals and to share the lessons learned as COMPSY has sought to implement its information system at Ft. Benning and, in 1973, at Ft. Meade, Maryland.

The first goal is to develop an information system. This global goal means that one has a need for knowing certain information. He can define the parameters around this need and can ask the questions that direct his search for knowledge. The information system would be responsive to this need and would provide what is required to satisfy that particular need. COMPSY has tried to be this kind of system by primarily meeting the standardized reporting requirements. Greg Meyer designed the initial data collection instruments at Ft. Benning to provide information for the Surgeon General MHCS Report. After much designing, refinement, and re-design of the collection output scheme, the Health Services Command came into being and streamlined the whole reporting requirements. We are now in the process of re-designing the whole system to meet the Headquarters' reporting requirements.

It is envisioned that the user agencies will develop their own standard reports in parallel to external reporting requirements. The agencies can use this information to make decisions and manage their services. COMPSY will be responsive to these individualized, particular needs.

A very important point should be highlighted. COMPSY has been placed in the position of developer and salesman of our abilities as a research and development project. This is not the strongest position one can take as it carries with it an "emotional commitment" by COMPSY for its products. A more desirable one would be as a "pure" consultant. How to get the clinician-administrators skilled at demanding certain services is a problem; hopefully, the clinicians will become more sophisticated in asking the questions. COMPSY is then in a better position to be responsive to the agency identified information needs. The overriding COMPSY goal is to have a user centered, user defined, information system.

The second goal is the continuity of care issue. The process of rapid collection, integration, and dissemination of information should enable one to provide well-planned care for a client from intake to disposition. Manual systems are barely able to provide for this continuity. The data is not uniformly collected, is not systematically stored, has no rapid collection capability, and is difficult to extract. Even if one can streamline his manual system, there is no way uniformity across post agencies or between different posts can be assured. Continuity of care gets lost somewhere in an in-basket or a filing cabinet.

An automated system can change that by providing data specification and categorization, as well as rapid data collection, processing, and retrieval. Recording systems are then able to trace the progress of clients within the clinic and across careproviding agencies. Client monitoring at any point in time is made possible in the COMPSY system. The utility of this system will be determined by the clinician-administrator as he has the ultimate responsibility for the continuity of care provided by his agency.

A concrete example of how the system has helped the continuity of care is the Walter Reed Army Medical Center (WRAMC) - Ft. Meade relationship. Patients are referred from Ft. Meade to WRAMC since Ft. Meade has no psychiatry bed space. Routinely, the referring person gets a report of the patient's status as an inpatient. With information, Ft. Meade can plan accordingly, i.e., expect him back for care, or know he'll be medically boarded from WRAMC. Example of the repont is attached in Appendix B.

This is helpful and we hope to make it more beneficial by providing a quick response terminal at Ft. Meade so the staff can gain access to the data on an as-needed basis. The equipment we have utilized in a test of rapid processing of the data just has not been successful. We are in the process of evaluating completely new equipment to provide the speed in processing needed for this continuity of care.

The third goal is the enhancement of the treatment process. This is to be done through the use of monitoring of patient care, creating and/or modifying diagnostic tools, and developing predictive models. COMPSY has not made a great break-through in these areas and that might be the appropriate thing.

One needs to examine the rationale for this conclusion. This is an area that clinicians, at the operational center of service delivery, will have to develop. COMPSY has no right to determine criteria for a specific agency's evaluation of its care; the agency must decide it will develop such guidelines. It if defaults on this, the agency that does decide the criteria may be more harsh than COMPSY. The point is that the front line clinician is going to have to become involved in monitoring patient care, creating tools, and explicating criteria for predictive models. The validity of measurement is a function of each agency's expertise about itself, flavored with true objectivity and not self-justification. Define the criteria and information from a COMPSY system can provide an ongoing evaluation of the agency's clinical activities.

The fourth goal is one that states a COMPSY system will reduce personnel time in the processing of routine, repetitive tasks. The great benefit of the computer is its ability to take the routine tasks and process them with ease, speed, and accuracy. Command reports, patient rosters, unit reports, and such lists which take a great deal of time for staff personnel can be accomplished by the computer easily and quickly. Analysis of what people do with their time freed up by automating routine tasks will have to be done to determine the utility of computer-assisted tasks and the realignment of the tasks in the agency.

A fifth goal is the addition which the system can make to scientific knowledge and its application to programs in human service delivery. The computer is a powerful instrument and if one can set criteria for determining effectiveness of care and the opidemiology of mental health problems, he could attempt mental health planning on an interagency or post-wide level. COMPSY has not impacted this area due to the constraints of the emerging criteria-setting ability of the clinicians and the absence of a post coordinating agency. This is the area in which COMPSY is seen as having a powerful effect interacting with the clinician-administrator as coordination becomes imperative.

The sixth goal is the enhancement of supervision and training. COMPSY has provided supervisors with lists of the activities of their supervisees. Supervision sessions have been a time for facts about names, numbers, etc.; the time now can be better spent on substantive tasks, i.e., clinical processes occurring in the supervisees' caseload. An MHCS roster is provided in Appendix C.

The seventh goal relates to applied clinical research. A data base is being built everyday about the service delivery agencies within the COMPSY system. Information from the data base may be utilized as a means of answering applied research questions that emerge within the agency. The research needs of each agency will probably be one of the driving forces for the clinicians to become acquainted with computers and the capability of computers, the design of data collection instruments, and the acceptance of research as a legitimate task of military mental health providers.

A newly-emerged goal for COMPSY is the need for systems research. This activity was suggested as COMPSY transferred the Ft. Benning system to Ft. Meade. Several assumptions were made, such as the MHCS is similar in nature, their information needs are the same, and similar suggestions of parallel service delivery systems at both posts. Verbal negotiations at Ft. Meade in 1972 did not reveal the dissimilar aspects of the two service delivery systems even though the dissimilar aspects of the two posts were known, i.e., training versus garrison status. After transferring the Benning-developed output scheme, it took only a few months for the Ft. Meade agencies to express their dissatisfaction. What went wrong? Our assumptions did not hold up on one hand, and on another, COMPSY did not take the opportunity to polish or streamline the Benning system at the time of transfer. We are working on the latter, however late, but only service delivery systems analysis could have prevented the operationalization of a system based on fallacious assumptions.

With such nicely-defined goals, one wonders why COMPSY is not further developed in the community model. COMPSY may well be ahead of itself in terms of theory development and a lack of implementation of the theoretical. Two aspects affect this observation, one technical and one organizational.

Toward the fulfillment of a test of technology to support posts through a regional center, Ft. Benning and Ft. Meade have taught COMPSY that on paper it is quite feasible. In other words, if one decides technical specifications for telecommunication and ADP systems, they can be met on paper quite easily. Translating the paper design to reality may not be very successful. Part of the problem lies in the nature of an R & D project; one often approaches a task with little or no application information on which to operate. The consequences of this is that the on-paper design and "hard" equipment may not meet the requirements of the project. There is only one way to counter this problem and that is through the axiom of R&D thinking: Try it!!

We tried it and we had some holes in our plans. The equipment which was to tie the remote site to the COMPSY computer just didn't function as we had planned. Ft. Benning was excited about what they had but the technical end of the automated system was just not responsive, as noted earlier in the continuity of care goal. After experiential knowledge, it was decided there are ways to correct for these holes. The main hope for revival is in the exploration of new and proven-capable equipment and acquiring the most suitable hardware to meet our needs. One of the characteristics of an R&D project is flexibility and constant reassessment of itself. Place an R&D project highly dependent on technical support in a rigid bureaucracy and costly delays could very well occur. COMPSY is appreciative of the support and resources of the R&D Command of The Surgeon General's office as new commitments are made to posts like Ft. Benning and Ft. Meade. They, in effect, are going to validate contracts COMPSY has made with these posts.

The organizational issue is also one of extreme importance. The problem has been that if COMPSY were able to develop an integrated information system, who would be the authority at each post to oversee the utility of the information and the security of the system? There exists no formal superstructure on which to frame the coordination of human service delivery. Many informal systems exist and they rest a great deal on the social relationships among the professional staff members. Few informal systems, however, have great clout in the bureaucratic structure in which we operate in the Army. What many among the professional groups have done is to build on their social and professional relationships and push for the fantastic idea of a human resources directorate (HRD). Some plans are in the staffing status at posts, while others have the plans turned into attempts at expanding the HRD to cover all human services (over and above Equal Opportunity, Race Relations, ADCO). LTC Timmens and others who are active in the research into this area are sure to impact this area for us all.

But, back to COMPSY. COMPSY is at the point of a chicken-egg, or is it the egg-chicken dilemma. COMPSY is at the point in which it could use the sanction and structure of a human resources directorate to manage its implementation and safeguard its function. At the same time, the COMPSY concept, in action, could provide the enabling resources that could make the HRD operable; with information, one can close gaps, eliminate duplications, and generally streamline the delivery of services. How this issue resolves itself is one that only the experience of the coming years can tell us and the present group of mental health professionals will have a determining role in the kind of answers one finds in the future.

The Thrust of COMPSY

The present concern in COMPSY is evaluating its impact on community mental health delivery. We have spent a lot of time in the development of the system and this will continue as we respond to changing needs or discovery of a better way of doing things. It is vital that COMPSY evaluate its impact on service delivery and this will be consuming a great deal of the COMPSY effort.

In evaluating its impact, a knowledge of "what goes on" in service delivery agencies is needed. From this "state of affairs" analysis, perhaps a monitoring of the change due to personnel changes (i.e., loss pf psychiatry, the "new" behavioral science specialists, etc.), realighment of functions on post, the establishment of HRDs, as well as COMPSY, will be a contribution to the knowledge of mental health services in the military community. This will, unfortunately, have to be restricted in the COMPSY task to a small number of posts. The methodology that we develop, however, will be available to all posts for someone at that post to utilize.

Again, hopefully, the system developed by COMPSY should be available to any post that has the desire and resources to implement a community mental health information system. Consultation about the system, a sharing of the knowledge achieved by a lot of "seat-of-the-pants" blisters, can save one a great deal of time, money, frustration, and even failure. COMPSY should have this available for anyone who wishes to explore the feasibility of a mental health information system. The implications of all this is that it is anticipated that Social Work will be the stable force in the delivery of human services. As we join, yes even lead, our friends in the other behavioral science fields, the goal of the most superior service delivered to the most people possible is paramount. This goal must have precedence over all professional jealousy and in-fighting.

Summary

COMPSY is a research and development project which is attempting to apply the power of scientific technology to enhance the delivery of mental health services. A new front in the military community is being investigated. The implications for Social Work is that here is a tool which can be utilized for clinical management, administration of services, and an evaluative function. A tool well developed and properly utilized could very well turn future problems in mental health delivery into an effective and efficient mental health delivery system. A more thorough knowledge about the changes that need to be made and which can be made in the administration and delivery (clinical issues) of service will hopefully be COMPSY's contribution to the Department of the Army, Department of Defense, and the civilian community.

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APPENDIX A

PATIENT DATA RECORD FOR ADMISSIONS TO PSYCHIATRY

FOR DATA PROCESSING ONLY

(1) *A1 (3)
(4) (5)

1. AUTHORITY FOR ADMISSION *(check one only)* WARD
   - ☐ 20-Active Duty ☐ 30-Spouse ☐ 50-Mother-in-law ☐ 01-Oldest Child
   - ☐ 25-Retired ☐ 40-Mother ☐ 55-Father-in-law ☐ 02-Other Child
   - ☐ 00-Emergency ☐ 45-Father ☐ 60-Other Dependents

(6) (7)

2. SOCIAL SECURITY ACCOUNT NUMBER *(Sponsor's SSAN if dependent)* ☐☐☐☐☐☐☐☐☐

(8) ← (16)

3.

4. PATIENT NAME _____ *(Last) (First) (MI)*

(26) ← (51)

5. SEX: ☐ Male ☐ Female

(52)

6. RACE: ☐ Caucasian ☐ Negro ☐ Other _____

(53)

7. SPECIAL CULTURAL BACKGROUND: ☐ Puerto Rican ☐ Mexican-American ☐ West Indies ☐ Other _____

(54)

8. MARITAL STATUS: ☐ Single *(never married)* ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Annulled ☐ Divorce Pending

(55)

9. RELIGION: _____

(56)

10. BIRTHDATE: _____ (Day) _____ (Month) _____ (Year)

(57) (62)

11. YEARS OF EDUCATION COMPLETED (not GED) _____

(63) (64)

If patient is a *dependent*, complete the following information on *military sponsor*; otherwise complete on the patient.

12. SERVICE: ☐ Army ☐ Navy ☐ Air Force ☐ Marine ☐ Other _____

(65) (66)

13. RANK _____

(67) (68)

14. LENGTH OF SERVICE _____ (years) _____ (months)

(69) (71)

15. DATE OF EXPIRATION OF TERM OF SERVICE (ETS): _____ / _____ / _____ *(Day, Mo, Year)*

(72) (77)
(78) =

16. MILITARY ADDRESS (duty station prior to hospitalization) _____

(1) (2)

HOME ADDRESS (Civilian or Retired ONLY) _____

(3) Address + = (50)

Admission form which opens computer record for the patient and provides the base data for computations (e.g. days stay, etc.), movement in treatment plan, and administrative accountability.

APPENDIX A (cont)

17. DATE OF WRGH ADMISSION: _____(Day)_____(Month)_____(Year) (1)_____(6)

18. IF READMISSION, GIVE DATE OF LAST WRGH ADMISSION: _____/_____/_____ *(Day, Month, Year)* (7)_____(12)

19. REFERRED FROM *(Specify medical installation)*: _____ (13)_____(14)

20. HOSPITALIZATION DATE AT REFERRAL SOURCE: _____(Day)_____(Month)_____(Year) (15)_____(20)

21. PATIENT'S ASSIGNED DOCTOR: _____ (21)_____(29)

22. PRIMARY ADMITTING PSYCHIATRIC DIAGNOSIS: _____ (30)_____(34)

23. DIFFERENTIAL PSYCHIATRIC (RULE OUT) DIAGNOSIS: _____ (35)_____
(36)_____(40)
(41)_____
(42)_____(46)

24. ASSOCIATED PSYCHIATRIC (WITH) DIAGNOSIS: _____ (47)_____
(48)_____(52)

25. ADMITTING MEDICAL DIAGNOSIS (if any): _____ (53)_____(56)

26. STATUS-PRECAUTIONS ON ADMISSION *(check all that apply)*
☐ Prisoner ☐ Special Watch ☐ Suicide ☐ Escape (57)_____(58)
☐ Homicide ☐ Other _____

WRAMC FORM 05 (TEST), 1 JAN 72

DO NOT WRITE IN THIS COLUMN

APPENDIX A (cont)

MILITARY HISTORY

1. On what basis did you enter active military service?

   1. I was drafted.
   2. Enlisted, but I felt forced to join.
   3. Enlisted because I wanted to join.
   4. Was activated from the Reserves.
   5. Received ROTC commission.
   6. Received direct commission.
   7. Graduated from Military Academy.
   8. If other than above, please specify _____

2. What is your present military service status?

   1. Drafted
   2. Regular
   3. Reserve

3. Please fill in the military post and year you completed the following military training and/or service schools:

Type	Post	Year
Basic (BCT)	_____	19 __
Advanced (AIT)	_____	19 __

Other Service Schools	Post	Year
_____	_____	19 __
_____	_____	19 __

4. What is your primary MOS (Military Occupational Specialty)?

   Number _____

   Title _____

5. Are you generally satisfied with your MOS?

   1. No
   2. Yes

6. Have you requested a change in your MOS?

   1. No
   2. Yes

7. Have you taken General Education Development (GED) courses while in the Army?

   1. No
   2. Yes

A page from the WRAMC Social History. This checklist will produce a narrative report similar to the Mental Status Exam noted earlier.

APPENDIX A
(cont)

NARRATIVE

0=none 1=minimal 2=moderate 3=severe
4=extreme

ATTITUDES DURING INTERVIEW

1.	Indifference	0	1	2	3	4
2.	Passive	0	1	2	3	4
3.	Dependent	0	1	2	3	4
4.	Aggressive	0	1	2	3	4

(PRINT NATURE OF AGGRESSIVENESS IN NARRATIVE)

5.	Hostile	0	1	2	3	4
6.	Suspicious	0	1	2	3	4
7.	Manipulative	0	1	2	3	4
8.	Anti-Authority	0	1	2	3	4
9.	Dramatic	0	1	2	3	4
10.	Change During Course of Interview	0	1	2	3	4

(PRINT TYPE OF CHANGE IN NARRATIVE)

11.	La Belle Indifference	0	1	2	3	4

DRESS AND PERSONAL HABITS

12.	Overly Neat	0	1	2	3	4
13.	Bizarre or Unusual Appearance	0	1	2	3	4
14.	Poor Personal Hygiene	0	1	2	3	4
15.	Use of Drugs	0	1	2	3	4
		D	W	M	Y	E

(PRINT DRUG OR DRUGS IN NARRATIVE)

Note Coding Scheme For Item 15

A page from the WRAMC Mental Status form. Information about the patient is checked as appropriate with space for elaboration about any item.

APPENDIX A (cont)

V P/SSAN:

BY DR 10 JAN 74

MENTAL STATUS: THE PATIENTS ATTITUDE DURING THE INTERVIEW WAS INDIFFERENT, PASSIVE, DEPENDENT, HOSTILE, SUSPICIOUS, MANIPULATIVE AND ANTI DRAMATIC. HE WAS CLEAN, NEAT AND APPROPRIATELY DRESSED. HE STATED THAT HE HAS EXPIMENTED WITH MARIJUANA. HE CLAIMED TO HAVE TEMPERATE USE OF ALCOHOL. MOTOR ACTIVITY WAS DECREASED IN AMOUNT. HE DISPLAYED NO UNUSUAL MOTOR BEHAVIOR. HIS VERBALIZATIONS WERE SLOW IN RATE. HIS VOICE WAS SOFT AND MONOTONE. HIS FACIAL EXPRESSION WAS SAD AND ANXIOUS. EYE CONTACT WAS DECREASED . AT TIMES HE STARED INTO SPACE. AFFECT WAS FEARFUL AND BLUNTED. AMBIVALENCE WAS NOTED . HE REPORTED HIS MOOD TO BE APATHETIC, ELEVATED, DEPRESSED, LABILE, ONE OF UNEASINESS AND FOREBODING AND NOSTALGIC. HIS THOUGHTS PROGRESSED LOGICALLY IN

A page from the computer generated Mental Status. These statements are produced in response to items checked in the WRAMC Mental Status checklist.

APPENDIX A (cont)

V P/SSAN:

MALE, CAUCASIAN, AGE 22, BORN 11 APR 51

DIVORCED, 11 YEARS OF EDUCATION, PROTESTANT

E4-ARMY, 2 YRS SERVICE, ETS: 2 JUN 74

ADMITTED TO PSY 10 JAN 74 FROM FORT MEADE

DISCHARGED ON 25 JAN 74

MIL ADDR: E BTRY 2ND BN

TRANSFER DX:
OBSERVATION, NEUROPSYCHIATRIC

15 PSY HOSP DAYS TO DISCHARGE

DISCHARGE DX:
OBSERVATION, NEUROPSYCHIATRIC

PHYSICIAN: DR L

COUNSELOR: C M F

DISPOSITION: RETURNED TO DUTY

Information which is available from remote terminals about the patient's entry into WRAMC Psychiatry Service and his current status.

APPENDIX B

PRIVILEGED INFORMATION - FOR MEDICAL USE ONLY - PLEASE DESTROY WHEN REPLACED. 05 JUN 74

WRAMC PSYCHIATRY PATIENT ROSTER BY SOURCE OF REFERRAL

*** FORT MYER REFERRALS ***

NAME	SOCIAL SECURITY NUMBER	SEX	MARK	DOB	ETS	DATE OF ADMISSION	TRANS DX	CURRENT DX	WARD	DOCTOR
[redacted]	[redacted]	M	D	63	18JAN44	31MAY76	12MAR74	ADJ/AL	S/PARA	MHC	SHEHI
561 MP CO FT MYER S VA											
[redacted]	[redacted]	M	M	54	11AUG52	04OCT74	01MAR74	NP-OBV	S/PARA	110	FERO,
USA> CAP FT MYER VA											
[redacted]	[redacted]	M	S	64	08OCT52	27OCT74	25JUL74		N/DEP	110	SHENT
MP CO FT MYER VA											
[redacted]	[redacted]	M	D	63	12SEP52	29JUN76	03AUG74	S/ACUT	NP-OBV	104	EDWA
ARLINGTON HALL STA VA											
[redacted]	[redacted]	M	M	65	01JAN45	17OCT77	10JUL74	NP-OBV	ACH/AD	106	MASSE
HHC TRP COM MON FT MYER VA											
[redacted]	[redacted]	M	S	64	27JUN46	18JUL74	24FEB74	P-AG/F	S/PARA	MHC	MASSE
DEF RM 3F 880 OFF SEC DEF WASHINGTON DC 30301											

REFERRAL SOURCE LISTING

Every post which has a patient at Walter Reed receives a listing detailing patient identifing information as well as status and dispositinn plan(not shown)

APPEXDIX C

INTERVIEWER ACTIVITY ROSTER AS OF 22 JUN 73 — FT. BENNING-361 — PAGE-

13016 CHILDS,J

SPONSORS SSAN	PRE	CLIENTS NAME	INTV STAT	CURR OPENED	DATE LATEST VISIT	TOT VST	MOS VST	SPONSORS RNK	UNIT	PURPOSE OF INTV	INTV IMPR	MOST RECENT DISPOSITION	DATE
[redacted]80[redacted]	01 A[redacted]	STEVEN	13016	OA 9MAR73	9MAR73	1		E-6			08	23	9MAR73
25[redacted]027	30 B[redacted]	ETHEL	13016	OA 10APR73	10APR73	1		E-6			05	23	10APR73
42[redacted]048	30 B[redacted]	BARBARA J	13016	OC 17NOV72	27MAR73	2		E-4	2062		08	C1	17NOV72
	20 B[redacted]	FAMILY	30999	OA 22NOV72	28FEB73	4							
			72044	OC 10NOV72	10NOV72	1							
			75999	OC 16MAY72	16MAY72	1							
				RC 6JUL72	6JUL72	1							
27[redacted]202	01 C[redacted]	PAMELA	13016	OC 17APR73	17APR73	1		E-7	3000		08	23,99	17A
	20 C[redacted]	JAMES H	10308	OA 11JUN73	11JUN73	1							
			75999	OC 8MAY72	8MAY72	1							
25[redacted]365	25 S[redacted]	WILLIAM	13016	OC 18MAY73	18MAY73	1		E-8	06		04	23	18M
			13015	OC 16APR73	30APR73	2							
			13999	OA 12APR73	12APR73	1							
52[redacted]329	31 U[redacted]	ELOISE J	13016	OC 28FEB73	27MAR73	2					05	01,23	28F
			31999	OA 28FEB73	28FEB73	1							
	30 D[redacted]	ELOISE	31999	OC 21MAR73	21MAR73	1							
39[redacted]262	30 D[redacted]	MONIKA	13016	OA 12MAR73	12MAR73	1		E-7	2020		08	23	12M
25[redacted]700	01 F[redacted]	RHONDA K	13016	OC 7AUG72	7AUG72	1			0000		01	91	7A
	31 F[redacted]	EFFIE L	13013	OA 11JUN73	11JUN73	1							
14[redacted]512	30 F[redacted]	LAURA	13016	OA 9MAY73	9MAY73	1		O-3		01	04	C1	9M
25[redacted]770	30 H[redacted]	VANESSA	13016	OA 21MAR73	21MAR73	1		E-5			05	01	21M
			13999	OA 9APR73	9APR73	1							
45[redacted]219	30 H[redacted]	HARRIETTE	13016	OA 1MAY73	15MAY73	3		O-3	1022	01,03	01	C1,23	8MAY73
25[redacted]961	25 H[redacted]	BERTHA	13016	OA 25APR73	25APR73	1		E-7			08	01	25APR73
	31 H[redacted]	BERTHA	13016	OC 9MAY73	9MAY73	1							
26[redacted]961	31 H[redacted]	BERTHA	13016	OC 9MAY73	9MAY73	1							
	25 H[redacted]	BERTHA	13016	OA 25APR73	25APR73	1					08	01	25APR73
26[redacted]312	25 J[redacted]	JOHN	13016	OA 28FEB73	6JUN73	8		E-7		01	08	01	6JUN73
			31999	OC 4FEB73	22FEB73	2							
24[redacted]969	25 L[redacted]	KNOX	13016	OA 9MAR73	9MAR73	1							
24[redacted]392	31 H[redacted]	EONA	13016	OA 31JAN73	31JAN73	1					05	01	31JAN73
46[redacted]523	30 H[redacted]	DEBORAH	13016	OA 12MAR73	12MAR73	1					08	01,23	12MAR73

A report produced for a clinician about his caseload. This report is also being revised for ease of reading and compactness of information.

HOSPITAL SOCIAL WORK SEMINAR
CURRENT TRENDS IN ARMY SOCIAL WORK CONFERENCE

by

LTC Fred E. Nelson, MSC
Chief, Social Work Service
Brooke Army Medical Center
Fort Sam Houston, Texas

1LT Joseph M. Gerard, MSC
Social Work Service
Raymond W. Bliss Army Hospital
Fort Huachuca, Arizona

The following areas were discussed and emphasized during the Hospital Social Work Specialty Seminar:

a. Importance of visibility and accessibility of Hospital Social Work personnel in the hospital.

b. Importance of giving professional social work support to Department of Psychiatry.

c. BAMC's Medical/Surgical Social Work Section has changed its name to Hospital and Ambulatory Care Section:

(1) To give truer picture of patient groups actually served.

(2) To latch on to HSC's number one priority, that being ambulatory patient care.

d. Regarding referral services:

(1) Importance of good psycho-social diagnosis before referral is made.

(2) Importance of professional follow-up on referrals.

(3) Are the social worker and the patient satisfied with what the patient is getting regarding the patient's health care where a referral is concerned?

e. Due to cuts in CHAMPUS funding, Hospital Social Work is going to have to do more within the Army hospital system. Example, more group work practice.

f. Regarding posts with very limited civilian resources: the Hospital Social Worker should take it upon himself to entice professionals to move into these small communities. Here the Hospital Social Workers' community organization skills should be highly utilized. It is the responsibility of the persons who work within the Army Health Center to help

develop community resources outside the Army hospital system.

g. Regarding skill levels: many times social workers will bite off more than they can chew in terms of promising to deliver services about which they have little knowledge base.

h. How to improve skill level:

(1) Importance of developing teaching skills.

(2) Need for self-awareness and self evaluation; know what you can and cannot do.

(3) Know the Army system.

i. Centralization versus Decentralization: there are arguments to support both centralization and decentralization of the Hospital Social Work Section depending on the size of your hospital, size of your staff, and general needs of the hospital. As your staff increases, the decentralization concepts may be better implemented.

j. Importance of both formal and informal inservice training.

k. Importance of almost all daily liaison and interaction with wards and specialty services, especially if your Hospital Social Work Section is a centralized one.

l. Boundaries for Hospital Social Work: according to AR's, Army Social Work has responsibility to both psychiatric and medical/surgical departments.

m. In several hospitals the hospital social worker is being utilized as the Patient Affairs, Patient Relations, or Patient Complaint Officer for the hospital.

n. The hospital social worker should be an interpreter to the patient regarding the meaning of his or her illness.

o. Importance of diversity of assignments for Social Work Officers: since the Army is a teaching organization, no one ever develops skills to adequately function at the particular job position to which he is assigned. You never get to be completely competent. You are moved to the next higher professional position before you are competent in your present position. Supposedly, the reasoning behind this concept is to get experience in many areas during peacetime to prepare you for crisis. These diversified experiences can be gotten at the same installation.

p. Utilize the Army Social Work community on an educational and consultative basis to assist in developing individual skills.

q. Develop seminars utilizing Army social workers rather than civilian social workers or other civilian professionals. The question is: "Why use people outside our own field to teach us what to do in a certain specialty area when we have Army social workers with expertise in many specialty areas?" We can utilize them to run workshops, seminars, and so forth.

r. Possible further formalization of specialization within Army social work with quality control parameters.

s. Importance of visibility at staff and council-committee meetings: maintain ongoing liaison and communication with Chief of Professional Services, hospital executive officer, and hospital commander.

t. Army social workers are encouraged to take advantage of possible summer institute training per fiscal year.

u. Importance of utilizing family systems frame of reference in social work intervention in the hospital setting. Short term intervention is usually indicated in the hospital social work setting. Short term goal should be to reestablish homeostatic balance; we would not expect to do too much long term treatment in the hospital setting although we should carry limited long term cases to develop expertise in that area of intervention.

v. Importance of institutionalizing the services you are providing via use of regulations, SOP's, brochures, etc.

Corrections Seminars

by

1LT James B. Rosenfield, MSC
U.S. Disciplinary Barracks
Fort Leavenworth, Kansas

An improved system for the dissemination of information on the Army's correctional system to mental health professionals in the field was the chief need pointed out by the correctional seminars. Under the Army's new installation confinement system, the correctional treatment mission at the installation confinement facility (ICF) or the larger area confinement facility (ACF) has been eliminated, speeding prisoners' post-trial shipment to either the United States Army Retraining Brigade (USARB) at Fort Riley, Kansas, or the United States Disciplinary Barracks (USDB) at Fort Leavenworth, Kansas. Both of these facilities, Army posts containing lesser level confinement facilities, and the staff of the Academy of Health Sciences were represented at each seminar. Among other issues raised during the discussion oriented seminars were: the role of the social work officer in military corrections; the role and training needs of behavioral science specialists assigned to, or coming into contact with, correctional programs; and the operation of the USARB and USDB. In addition to the discussion, the film, "The USDB Story: Our Mission - Your Future" was featured.

The Role of the Social Work Officer

The role of the social work officer operating within a military police environment is unique. The worker must define his role and demonstrate his usefulness in order to be utilized fully. It was the opinion of those social work officers currently involved in corrections that the optimal role for the social work officer is that of command consultant. The paradox of this role is that entry into the system must be made at a more fundamental level in order to obtain the working knowledge necessary to demonstrate usefulness as a consultant. The issue was raised that few social workers were entering local correctional systems and that few who did were able to become command consultants. The explanation was offered that, as has been seen at USARB, the consultant's role is a difficult one for the newly commissioned social worker to accept. Other roles currently assumed by social workers in corrections are: the teaching of inmate motivational courses, drug and alcohol counseling, discharge evaluations and counseling, assisting with difficulties in returning inmates successfully to duty or civilian life, staff assistance and in-service training, and the development or introduction of new programs.

Seminar co-leaders were CPT Ray V. Smith, CPT Robert Yaryan, CPT Joseph Giles, 1LT James Rosenfield, and SP5 William M. Barnwell.

Another problem which is drawing more social workers into the correctional arena is the decline in available psychiatrists at mental hygiene units. Some mental hygiene facilities have limited their correctional involvement to institutional referrals supplemented by an occasional 91G visit and contact by the psychiatrist while doing evaluations or serving as GMO. An increasing trend now is for psychiatrists to be relieved of GMO duties and psychiatric evaluations to give way to mental status evaluations conducted by social work officers at the local confinement facility.

The 91G, his Correctional Training and Role

Behavioral science specialists working in correctional settings or instructing in corrections at the Academy of Health Sciences were well represented at both seminar sessions. A number of specialists work in personnel control facilities (PCF), units to which those in legal difficulty but not requiring close confinement are often assigned. It is at the PCF, ICF, ACF, and USARB that the specialists must make discharge recommendations which may affect a man's entire future. Another important role for the 91G in a correctional assignment is contrasting or moderating the authoritarian outlook of his military police peers. He must serve as a supplement to the 95C MOS counselor who is given only a brief block of instruction in counseling techniques as a sideline to his custodial training. These pressures dictate that the 91G in a correctional assignment be a mature and highly competent individual. The opinion was expressed, however, that a local supervisor is not likely to send these higher quality specialists to facilities for which the supervisor is only indirectly responsible. The seminar participants felt that improved specialist staffing and supervision will result as ACF slots for social work officers are filled.

The behavioral science specialist training course provides for 10 hours of correctional instruction. The instructors for this block of instruction were in attendance at the seminars. They had admirable civilian preparation for their roles but were lacking in military correctional experience. None had been to either USARB or the USDB and had only been on brief TDY to the Fort Hood ACF. They are handicapped by the lack of any appreciable correctional facility at Fort Sam Houston, a lack of TDY funds, and the lack of military correctional exposure. It is felt that their efforts to establish a field placement at the ACF at Fort Hood is a much needed measure. Guest lecturers or instructor liaison from the local military police company was another suggested measure.

Programs at USARB

The United States Army Retraining Brigade is designed to receive all Army prisoners with sentences of less than six months and no (or a suspended) discharge. Some trainees arrive at USARB with completed hardship or administrative discharges which must be reprocessed. Others seek a discharge upon arrival or before completion of the program. Those awaiting discharge are placed into a separate barracks as they tend to be somewhat difficult to manage.

For those desiring to complete the USARB program and return to duty, a module system is available. This system uses a loose behavioral modification approach offering increased privileges as each module is completed. A draw-

back is the assumption that all trainees share the goal of returning to duty. In spite of Army regulations requiring receiving units to file follow-up reports, the current feedback level is only 23 per cent.

USARB has six social work officers and six 91G staff members. Their chief task are contributions to discharge evaluations and boards, command consultation, classroom training of trainees, and battalion and brigade duties. Minimal time is available for casework. A social work officer heads the USARB's research department.

The USDB and its Programs

The United States Disciplinary Barracks receives all prisoners (Army, Air Force, and Marines) sentenced to more than 30 days confinement with a punitive discharge or more than six months without a discharge. Like USARB its racial ratio is disproportionately black and racial tensions are present. Also like USARB, feedback to date has been minimal but a follow-up study is being developed. The USDB releases approximately 5 per cent of its inmates to USARB.

The USDB has a mental hygiene directorate with a staff of six social work officers, two psychiatrists, two psychologists, eleven 91G's and five civilian social workers. The directorate is headed by a social work officer. Chief duties of USDB social work staff include command consultations, duty on parole and clemency boards, advising the discipline board, obtaining and updating social histories on all inmates, group and individual counseling, and supervision of programs for which mental hygiene assumes responsibility (drug program, Alcoholics Anonymous, Sickle Cell, 7th Step, and Guides for Better Living, among others).

Conclusion

The point was made that the field of corrections can be a challenge to the social worker. Those engaged in it whether at the post level or at a confinement facility find it interesting, rewarding, and of value to the Army. However, as exhibited by the low level of interest manifested by disappointing seminar attendance, too few social workers are interested in accepting the gauntlet of this challenge.

SPECIALTY SEMINAR: MHCS AND COMMAND CONSULTATION PROGRAMS

Co-Leaders: LTC John G. Kisel, MSC and CPT Michael Doolittle, MSC

This seminar had two component parts. The first part provided participants an opportunity to examine policies, issues and problems in Mental Hygiene Consultation Service (MHCS) settings and is written in summary format. The second part focused on Command Consultation and for reader understanding is presented in a paper prepared by LTC Kisel.

Part I: MHCS Policies, Issues and Problems

Attendance at this seminar was very good suggesting a possible need for devoting more time to this area of practice at future Current Trends Courses. Approximately 30 persons attended the first seminar and 28 were in the second seminar. Over half the participants worked in MHCS settings. It is significant to note that many of the participants voiced concerns they regarded as unique, but in the ensuing discussions learned that others were also coping with similar problems.

Due to the decreasing availability of Army psychiatrists in MHCS, many social workers described situations in which they were writing prescriptions and admitting patients to the hospital since they were on Psychiatric On-Call Rosters. The appropriateness and legality of these duties were questioned, particularly the dispensing of medication which is not in the realm of social work expertise. No participant saw this as a legitimate social work function. As for serving on Psychiatric On-Call Rosters and admitting patients to the hospital, a number of divergent views were expressed. The majority felt social workers had sufficient expertise to provide on-call services, but questioned the advisability of signing the hospital admission form, especially since this function has medical and legal implications. It was recommended that in these situations legitimate sanction be obtained from the Commander to ensure his knowledge and support in the event difficulties occur. This point was emphasized since a number of the participants states they were conducting "psychiatric on-call" and admitting patients to the hospital based upon informal verbal agreements between psychiatrists and social workers.

Three MHCS settings were identified as having a social worker or psychologists filling the position of Chief. This was viewed as an appropriate responsibility and in accord with mental health trends in the civilian community where the person most qualified assumes the position of leadership regardless of his academic discipline.

Mixed feelings were expressed about other disciplines such as the Psychiatric Nurse Clinician and Chaplain Counselor serving as members of the MHCS team. Those who did have other disciplines working at their MHCS reported harmonious work relationships ensued. The need for increased cooperation and dialogue among all professionals of the behavioral sciences was emphasized, particularly since most participants complained of chronic staff shortages.

Some participants stated that at their MHCSs the 91Gs were permitted to wear civilian clothing instead of the Army uniform. Reportedly this was done to have command be more accepting of the 91G as competent counselors and consultants. Those having the 91Gs wear civilian clothing reported glowing results, but none had subjected this practice to empirical testing to determine its actual effectiveness. This is an area which possibly needs to be critically and hopefully scientifically evaluated.

The idea of MHCS being seen or used as a Rubber Stamp by Command was entered as an issue for discussion. Many MHCSs are doing psychiatric clearance statements for administrative discharges (AR 635-200, Chapter 13 and 179-day discharge) when the same activity could be legitimately performed by a dispensary physician while he was doing the physical examination. Often times Command sees this activity as the primary function of the MHCS and overlooks or resists using the consultative and counseling capacity of MHCS. Social Work has taken on the role of writing clearance statements in many MHCSs in lieu of the psychiatrist when one is not assigned or when he is absent. This problem areas points up the need for a more efficacious and active consultation program.

Only a few participants reported having well organized, effective Command Consultation programs at their MHCSs. The what, why and how of Command Consultation was examined in detail to give it conceptual and practice clarity. Part II of this report focuses on both conceptual and practical consideration in the practice of Command Consultation.

Part II: Command Consultation*

In Command Consultation a mental health worker seeks to assist command (command and cadre) cope with a work problem. The nature of the work problem serves as a basis for breaking down Command Consultation into two types.

First type of Command Consultation is called Case Consultation. It can be simply defined as consultation with command regarding a unit soldier having adjustment or emotional difficulties. In practice there

*This material on Command Consideration was prepared by LTC John G. Kisel and is used in teaching Command Consultation to Behavioral Science Specialist (91G) students at the US Army Academy of Health Sciences.

are a number of variations of Case Consultation. The most common variation is consulting with command about the soldier and direct involvement with the soldier for evaluation and/or counseling. Other variations are consulting only with command or the consultant, command and soldier getting together as a group.

The second type of Command Consultation is Unit Consultation. It can be simply defined as consultation with command regarding a unit problem which has an adverse effect on the mental health of unit members. Examples of unit problems are high AWOLs and low morale. Such problems as these generally have multiple causes and solutions can be complex. Normally such problems would be dealt with by MHCS consultive team. There are also less complex unit problems which you may learn to deal with, such as exploring with command a common problem expressed by their unit soldiers. As you may suspect, you will probably be doing less Unit Consultation than Case Consultation. Mental health workers, be they officer or enlisted, are more case oriented. Further, a few requests are made for Unit Consultation since most unit problems are in commanders' area of expertise, namely the leadership area.

In Command Consultation practice, be it Case Consultation or Unit Consultation, you want your consultive efforts to achieve positive results. Your chances of attaining positive results are enhanced if you take into consideration four basic principles of Command Consultation practice.

The first basic principle states you should know the problem and the unit. You need to develop knowledge and skills to cope with the problem. In most situations for you this problem will be a soldier having some sort of adjustment difficulty. You need to develop the ability to properly assess or diagnose his condition and examine alternative courses of action to resolve his difficulty. In Command Consultation you involve command in the problem solving process. So that you effectively involve command you need some knowledge of the command unit. Seek to identify the unique characteristics of the unit. These characteristics are such things as the leadership exercised by those in the unit chain of command, policies governing unit functioning and adherence to the policies, and any special constraints imposed upon sections or individuals which may have relevance to the identified problem. When you consult with command try to relate your observations and recommendations in realistic action terms.

The second basic principle emphasizes you should respect command authority. Never forget that the commander is responsible for everything that occurs in his unit. At the outset of any consultive venture you should have the commander's sanction and approval for consultive involvement. This does not mean that you must always have direct contact with the commander. The unit First Sergeant may have the authority to authorize your involvement. However, when possible, seek to make your presence known to the unit commander. When you consult about a problem, be it with the commander or other person in the unit chain of

command, such as the First Sergeant, seek to clarify mutual expectations. These expectations include such things as the amount of freedom you have to consult with unit personnel and how much information you will have to share with him about his subordinates who are not adhering to established unit policies or practices. If you tell the commander all the so-called "bad things" you find his subordinates doing, you may find yourself classified as the commander's spy and may lose the trust of subordinates. The commander also has to have your trust. Not all consultive ventures have happy endings. Your recommendations to resolve the problem may be rejected. Remember, actions and decisions as a result of consultation reside in the commander. You as a consultant can only recommend. Threats to turn him in to higher authority for not following your guidance may not only bring out his anger, but destroy any chances you have of future consultive involvements with the unit.

The third basic principle of Command Consultation practice stresses that you should educate command. This education is not only in relation to the immediate problem but also preventive in nature to preclude a reoccurrence of a similar problem in the future. In dealing with the immediate problem you assist command to identify the nature of the problem and to initiate courses of action to bring about problem resolution. By doing this you are imparting knowledge and skills to command, that is educating command. Is this sufficient? No. You as mental health workers need to constantly seek to prevent or minimize the occurence of situations which impair the functioning of individuals and/or units. In the practice of Command Consultation you should seek to not only resolve the immediate problem, but also, when possible, educate command on measures they can take to prevent or minimize the chances of a similar reoccurence.

The fourth and last basic principle indicates you should maintain consultant-command liaison. All too often mental health workers end consultation when command and consultant agree on courses of action and decisions to be made by command. When this occurs the consultant may be satisfied that he had a successful consultive outcome. But was it successful? The consultant will not know unless he gets feedback from command as to what subsequently occurred. Thus, it would seem important that the consultant make provisions with command to check with them on what actually occurred and if necessary provide additional consultation. An equally important reason for maintaining consultant-command liason has to do with the basic philosophy underlying mental health practice which encouraged mental health workers to reach out and offer their services to those in need. Military mental health workers, in such settings as MHCSs, are obligated to educate command on how we can assist them through Command Consultation. This means that between consultive ventures we do a public relations job of selling our services. A secondary benefit of this interaction is that we get to know the unit and develop interpersonal work ties with the unit command (commander and cadre). How might this help when a unit has a problem? A research study I did several years ago produced a finding that chances of successful consultive outcomes are greater when a close work relationship exists between consultant and command at the outset of a consultive venture.

During this period we named and discussed two types of Command Consultation, these being Case Consultation and Unit Consultation. We also identified and examined four basic principles of practice. They are now the problem and the unit, respect command authority, educate command, and maintain consultant-command liaison. Adherence to these principles increase your chances of attaining successful consultive outcomes.

THE FAMILY ORIENTATION and TREATMENT CONSIDERATIONS

by

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While the family orientation to people problems uses the family unit or group as an entry point in many problem situations, it is realized that the family is only one of a number of life systems which influence human behavior. For instance, much of our behavior is influenced by the cultural expectations of our living situation. The very fact that we eat three meals a day, usually at generally predetermined time periods, is culturally determined. The cultural norms in varying degrees influence every area of our life.

Our immediate social context in terms of peers or social networks influence parts of our behavior. Our actions here in this town with other social workers will be partially determined by peer influences. We are also influenced by our own unique self-personality. In the words of the psychoanalytic therapist, we are influenced by the unique balance of the id, ego, and superego. Finally, we are influenced in our behavior by the family of which we now are a part and the family of the past -- family of orientation and family of procreation. Many actions we take each day reflect the "basic training" for life received in our family of orientation. Culture, peers, family, and/or individual personality are frequently looked to for explanations of behavior. In fact, we have "therapies" for each level respectively, social action groups, group therapy, family therapy, and individual therapy.

Thus, for family oriented therapy the family level is used to gain some look at the troubled situation. Using the family as the entry point makes sense in view of its place in total society. The family stands as a go-between for the individual and the other life system. Especially when we are young, the norms and values of the family greatly influence all that we do. As we grow older and/or become an adult member of our own family these family influences may be diminished, but they still exert influence on our behavior. In order to get an initial view of troubled situations, the family is the logical place to begin. A word of caution is in order here. Simply because we first use the family as the entry

point does not mean family directed treatment will be the primary treatment method. The answer to the question, "When is family treatment best?" must relate to the particular problem situation. If the family unit is the unit whose alteration would most likely result in problem resolution, then the treatment should be directed to the family unit. At times, the troubled behavior may be most directly related to any one of the other levels, i.e., individuals, peers, culture, but the family level may be in such an influential position that supportive treatment of the family unit would be useful. At times, interventive efforts may be directed to more than one life system resulting in various combinations of family, individual, group, and/or community action programs. Determining which life system in which to direct our interventive efforts is one of the primary goals of the assessment process. Some of the findings of the pilot phase of our family research at Walter Reed has directed our attention to the issue of determining just what the problem is for the family. It appears that, in one sense, it is incorrect to talk about "the problem" in planning interventive efforts. Families bring to a service giving agency a problem cluster.

The problem cluster refers to the interconnectedness of people who are part of a troubled group. When problem behavior is exhibited by one member of the group, the other members become involved in different ways and in varying degrees. In one family, the focal behavior was academic failure by the oldest son with some accompanying disruptive behavior at school. When the problem cluster was examined, it was found that each family member owned a different part of the problem. The mother was concerned about the resulting disrupted relationship with her "oldest son." The father was concerned about the marital troubles resulting from the wife's concern about the son. The sibling was not concerned at all and, in fact, was enjoying her relative freedom which she felt was associated with the parents' over concern with her brother. The identified-client was upset because he was trying to maintain a set of peer relationships where the prerequisite for membership was poor school performance. Each family member owned a different part of the problem and the totality of the situation represented a problem cluster.

In order to account for the clustering effect, some of the members of our family treatment seminar experimented with the use of a particular procedure in evaluating family problems. The reported results were very encouraging and has resulted in a closer examination of the clustering effect of any focal problem.

Cluster Analysis

In cluster analysis the change agent, in addition to whatever else is obtained during the evaluation stage, gets the answer to the following four questions from first each family member individually and second the total family unit.The first question relates to a descriptive analysis of the problem or focal behavior. The family members are asked to use descriptive words to tell about the focal behavior. In this approach, describing the identified-client as passive would have to be further examined on a descriptive basis. Questions relating to what does he do

that makes you see him as passive would be asked. The family members would be asked to draw a mental picture or scene of his activities which depict passivity.

Using Haley's ideas, the problem behavior may be explored in terms of too much of some behavior--"compulsive hand washing" or too little of some behavior--refusal to go into a small room--phobia. This approach is useful in getting to descriptions of the problem.

The objective is to get a clearer idea about the behavior that is referred to as the problem. From another perspective, the question is what would be changed if the problem did not exist? This set of questions gets to the first view of the crucial question "what is the problem?"

The second question to be answered clarifies when, where, how often, and with whom the problem behavior occurs. The answers to the above questions get to some of the social and situational issues involved in the problem behavior. It is often an interesting and informative exercise to plot the people, time, and place where problem behavior takes place.

The third question aims to identify who first mentioned the problem. It makes a big difference if a family member mentioned the problem first, or if someone in another system first identified the problem. For instance, one only has to consider the implications of a problem first identified by the police and one identified by a parent. There are motivational issues as well as issues relating to the complications of multiple system ownership of parts of the problem. For instance, a school referral may reflect as much about a teacher or school system as the client or family on which the referral is made.

The final question gets to who owns what part of the problem? In this area, the goal is to get the individual responses to the problem. An example of the kinds of questions whould be "What are you doing that you would not be doing if the problem did not exist?" "How are you being affected by the problem?"

In any situation, our behavior is influenced by the behavior of those around us. The problem behavior may be diminished or enhanced by the responses of significant others. The purpose here is to get to the interconnectedness of the family members in general and around the problem behavior specifically.

Cluster Interviewing

Cluster interviewing refers to the direction of the interviewers questioning more than a specific procedure. While the following procedure has been found to be useful in determining the nature of the problem cluster, any procedure which is directed to the same goal may be useful.

A procedure which seems productive is to have the family members come together for the first interview. The change agent first sees each member in a family-oriented individual interview for the purpose of getting the answers to the cluster questions. Following the individual interviews, the entire family is seen for a family interview and the questions are again examined.

For some families the total situation may be clarified only after interviews, which include other involved such as the school, neighborhood representatives, etc. In this approach, the significant systems become involved in identifying the problem and possible resolutions.

In the approach described above, several important concerns are addressed in specific ways. There is primary attention to the definition of the problem. Almost any problem-solving technique known recognizes the importance of clearly defining the problem. In the evaluation, or assessment stage of service delivery, many decisions are made with minimum information. The nature of the information obtained is most important. The nature of the questions identify the interconnectedness of the family members. This point is important if family group treatment is determined to be the intervention of choice. Finally, the circumstances surrounding the problems are given attention. No problem exists in a vacuum and to know the life circumstances is important information in problem solving. Finally, in any goal directed, interventive effort, understanding the problem clarifies the tasks to be accomplished.

A brief word about the process of family treatment: Once it is determined that the family is the relevant unit for treatment, the process of setting goals and tasks begins. Goals are established in terms of where one will be and how we will know we are there at a certain point in the future. Generally, in the initial phases of treatment, families cannot accomplish their tasks, and the new treatment goal becomes that of examining the barriers to task accomplishment. Often in this phase, new goals and tasks are set and if not attained the barriers are again examined. As the family begins to reach the goals they themselves set, the growth process usually takes hold. In an ideal situation, the termination process begins with increased ability to accomplish tasks and reach the goals established by the family themselves.

In closing, it might be useful to mention the importance of working under explicit contracts with families. It is not a question of a contract existing or not, but a question of whether the contract will be explicit. Contracts give an operational frame of reference from which to work. The process of setting the contract may be therapeutic in itself.

The processes of problem definition and contract setting, if given full consideration, many times provide the family with the needed intervention to get unstuck and begin to grow. Other families require more intensive efforts, but the success of the more intensive efforts are enhanced by full attention to problem definition and contract setting.

SOCIAL STRESS AND THE MILITARY FAMILY

by

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Our goal today is to develop a conceptual framework and some design specifications for an Army Family Therapy Clinical and Training Programs.

We define Family Therapy for the purposes of our get together today, as encompassing aspects that go beyond just family group treatment -- that is, aspects that also include the family systems interface with the community, i.e., a family orientation.

The means we plan to use involves you. We are asking your help in developing this family therapy framework, and hope we can involve you in the dialogue.

We will, however, kick things off by providing some framework for dialogue--a framework that is based on our individual perspectives regarding family intervention.

To give you some idea of where we're coming from and what our individual perspectives might be, let me introduce the panel. First of all, Ray Bardill, probably needs no introduction. He comes to us from the Walter Reed Institute of Research where he has had continuing and extensive involvement in the family therapy training and research in the Walter Reed area.

John Shalett is with me at Madigan, where we have operationalized a Family Therapy Training Program. John carried to that program much of Ray's work at Walter Reed, which we have used as a basis for our "Family Therapy Training Institute."

I come to you from primarily a clinical and program development base, backed by some family research, and have had the opportunity to set up and operate some community-wide family oriented programs.

Now, I want to develop with you, in the next few minutes, a conceptual framework for viewing family stress that has been helpful in designing clinical, community organizational, and training programs.

If we were to run through a few vignettes that typify the ordinary fare of the social worker going about his family business, they would probably fall naturally into three streams of theory and research that have been running parallel for some time.

First, there is the research on crisis proneness in families carried out by family sociologists and culminating with the work of social work researchers on the properties of the "multi-problem family."

Second, clinical literature has increasingly tended to regard and conceptualize the family as a social system, having defines structures, goals, reciprocal roles, status and values, boundaries and attributes of equilibrium.

Finally, the family as a system has been researched in its relationship with other systems--with particular emphasis on the dilemmas and binds occasioned by these relationships.

CONCEPTUAL FRAMEWORK FOR VIEWING FAMILY STRESS

The conceptual scaffolding on which the family stress research has been built makes frequent use, or frequently involved, four variables: family systems, community systems, crisis provoking event, and the meaning attached to the event.

I will not attempt to summarize the specific research 1, 2, 3, 4, 5 underlying these variables, but merely identify their major conceptual properties. First, the family and its interface with the community.

The Family as an Interacting and Transacting Group. Family behavioral scientists have come to view the family as a small group, intricately organized internally into paired positions of husband-father, wife-mother, etc. Norms prescribing the appropriate role behavior for each of these positions specify how reciprocal relations are to be maintained and changed.

The family members play many roles--with each other and with society. Sometimes these roles are contradictory, particularly regarding their interface with a contemporarily, rapidly changing society. The family tends to be a focal point of frustration and tensions and a focal point of resolutions of these tensions.

Viewed from the outside, the family often appears to be a "closed corporation" presenting a solid front, handling internal differences, protecting members and keeping secrets. Nevertheless, the closed nature of the family is selectively (depending on family, kin, community and societal rules) opened for transacting business with other agencies, including kin and professionals. These agencies can be ranked on their accessibility to the interior of the family, ranging, for example, from kin through neighbors and friends to professionals.

Viewed historically, the family is more dependent today than it was formerly on other agencies in society for fulfilling its purposes. Once a self-contained economic and social unit supported by kin and neighbors, the family now has many inter-dependent relationships with other associations that play both a role in occasioning and resolving problems.

Most families have a long history of trouble and have worked out procedures, for good or ill, for meeting problematic situations. These are the family's repertoire of resources for dealing with crisis.

The Crisis Precipitating Event. The second major aspect of our conceptual framework is the stressor, or crisis provoking event. The stressor is often viewed as a situation for which the family had had inadequate preparation.

It is often difficult, empirically, to disentangle the stress of the event from the meaning the event has for the family. Therefore, no crisis occasioning event is the same for any given family. Its impact ranges according to the several hardships that may accompany it, and the meaning these hardships have for the family.

In any case, hardship may be defined as those complications in a crisis precipitating event which demand competencies from the family which the event itself may have paralyzed.

Definition of the Event. It has always puzzled observers that some families ride out disasters without apparent disorganization, while others are paralyzed or decimated. The key, in many people's eyes, appears to be the meaning of the event. To transform a stressor into a crisis requires this intervening variable.

Placing this final variable into an equation with the other elements of the coneptual framework, we get the following simple minded formula:

A. (The Event) interacting with

B. (The family's crisis meeting resources, internal and external) interacting with

C. (The definition the family makes of the event) produces X (the crisis, manifested variously in terms of intra and inter-personal problems).

This three-fold framework enables us to ask the proper questions in accounting for, resolving and preventing crises in families. Studies designed to specify factors conducive to good adjustment to stress, utilizing the above formula, have arrived at certain characteristics which can be broadly stated as follows: Family adaptability, family integration, affectional relations among family members, generally agreed to means of decision making, social participating, and previous successful experience with stress and crises.

Specific to family organizational needs and to social participation, research and empirical observation have found that if the family is closed, that is, if the individual family members are isolated from one another, or if the family system itself is closed in its relationship and interface with the surrounding community, then the family is increasingly vulnerable to stress. Hill, in his studies of war separation, for example, found that families who adjusted least well were solitary families, void of the support of kin, friends and neighbors. Left to their own devices, these crisis stricken families withdraw and fester internally, or act out inappropriately.

This brings us to the point of recognizing the importance of comprehensive family therapy clinical and training programs that address both the family system and its interface with the community system.

Now, for a few specifics from John Shalett on the family orientation and its interface with the community.

THE FAMILY ORIENTATION AND ITS INTERFACE WITH THE COMMUNITY

For those of us who have selected to focus our attention on the family as an orientation, we must be well aware of the community in which the families we deal with are living. To work with families in a vacuum and not pay attention to their interchanges (positive/negative) we are only completing half the task.

Therefore, we must be well aware of the community of which we are a member and further identify the component parts of that system. In looking at the component parts we must be ready to identify those sub-systems which are either working against or for the psycho-social needs of its individual members. All too often we overlook this aspect when we are dealing with the family system.

As in family systems which undergo the process of change and growth, so must the community begin to adapt to change and growth in order for that system to remain in equilibrium. Thus, a major task presents itself to us. We must be readily available to deal with the larger system of community and serve as either consultants or advocates in (1) helping the community to remain in homeostasis; or (2) serve as effective change agents to help the community explore some side-step functions which might permit them to return to a state of equilibrium.

If we are to assume that this is in the best interest of the sub-systems (individual and families) and of the larger sub-systems (community) then we must be ready to explore another component of the family as an orientation. The constant pressures for growth and change, reshaping and adaptation come from within and without the family unit and the community. We must be ready to grasp both the internal (deviations and disturbances within the sub-system) and the external (community pressure, public opinion, etc.) pressures.

The above information leads us to our next phase of developing a sound and working knowledge of the family orientation. Initially we must assume that the system (community) is headed somewhere. Our task in this phase is two-fold. First, we must determine the direction of the community--where it has been and where it is headed. Second, we should analyze the direction in terms of (1) is the system functional and meeting the physical and psychological needs of its members; and (2) the degree of achievement of the system to remain in equilibrium. In order to effectively meet this requirement we must recognize the need to understand the community in terms of (1) its influence upon its individual members (sub-systems) and (2) the influence of community members upon the community--relationship of sub-systems to the next larger sub-system.

If we are able to effectively incorporate these kinds of issues into our frame of reference in working with families, then we are able to better understand what the general management issues for progressive change may be in our own communities. As a further outgrowth of this kind of appraisal, we can better understand some of the broader implications of a family in disequilibrium and its interface with its respective community. Finally, we begin to appreciate the impact and the pivotal force that a community may indeed place on its individual members.

In shifting our focus from the individual to the family orientation, there was a definite need to develop new conceptual tools and observation methods. In order to be effective we must (1) familiarize ourselves with the structures and functions of the family (2) the family must be studied in terms of its range of collateral values (laterally) and the range of family generations (vertically) and (3) the interface of the family and broader community.

FOOTNOTES

A sample of the theory and research referred to can be found in the following references:

1. Rubin Hill, "Generic Features of Families Under Stress," Social Casework XXXIX (Feb - Mar 1958) 139-158.

2. Frank Flores Montaluo, "Family Separation in the Army" A Study of the Problems Encountered and the Caretaking Resources Used by Career Army Families Undergoing Military Separation" (Unpublished Doctoral Dissertation, University of Southern California, 1968).

3. Jerry Lavin McKain, "Alienation, Geographical Mobility and Army Family Problems: An Extension of Theory, (Unpublished Doctor Dissertation, The Catholic University of America, 1969).

4. Joan W. Stein, The Family as a Unit of Study and Treatment (Seattle, University of Washington, Region IX Rehabilitation Research Institute, 1969).

5. Frank A. Pedersen and Eugene J. Sullivan, "Effects of Geographical Mobility and Parent Personality Factors on Emotional Disorders in Children," American Journal of Orthopsychiatry, XXXIV (April, 1964) 575-580.

SMALL GROUP TECHNIQUES SEMINAR

by

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This seminar provided participants an opportunity to share and consider the various kinds of small groups currently being used in a variety of Army social work settings.

From the participants in the seminar it appeared that there was much creativity being exercised in the use of groups but most of this was not shared or made available to the field in general. Examples of this creativity were an adaptation of encounter groups to drug and alcohol settings, use of Sensitivity or "T" groups, groups to assist smokers to stop smoking and the like.

On the less positive side there also appeared to be a tendency (not unique among those doing groups) to minimize the importance of tailoring specific group experiences for particular purposes with individual clusters of clients. For example, the common phenomena of a "neurotic women's group" in Mental Hygiene Clinics or Social Work Services tended to be only minimally defined by group leaders as a place where lonely women could meet together.

In this seminar the following were considered: various approaches to designing groups; the differences and impact of what the change process is called, e.g., therapy, counseling or learning; the value of systems theory as a means of clarifying the systemic focus of a group's purpose; the range of choice in group leader behavior; and how to tailor groups to individual clusters of clients. A partial bibliography is included for the reader interested in learning about small groups.

Small Group Techniques Seminar

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CURRENT TRENDS IN ARMY SOCIAL WORK, 1974

"Issues in Training and Utilization of the 91G"

by

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This seminar was designed for participants who were interested in systematic planning for the future of the 91G MOS. Utilizing a group discussion format, the participants met with the following specific goals: First, to discuss the present 91G20 course, its potentials and its problems. Second, to consider several projects currently being carried out in the 91G training program, and third, to elicit feedback from the field regarding the training and utilization of 91G's on the job.

The following points were made by the participants and seemed to draw general group consensus. (1) There was general approval by the participants as to the quality of recent 91G course graduates, given the 10-week training limitation. The group also endorsed the current course content, but wondered how it was possible to adequately cover as much material as the POI indicated in ten weeks. (2) The group gave unanimous support to the idea of lengthening the course so as to be able to train 91G's for tasks they are now assigned to perform, but have not received training. (3) The group felt that an advanced level course was essential for 91G professional and career development. (4) Group members were briefed on three projects which are currently being carried on at AHS, i.e., the publishing of a 91G student handbook, the two volume Special Text being developed to replace TM 8-246, and the Systems Analysis questionnaire which is being readied to collect job data from the field.

Finally, feedback was elicited from the participants regarding utilization and expectations of the 91G. It was agreed that the two universal skills that the 91G needed to have when reporting for his first duty assignment are the ability to interview and to do an accurate write-up of that interview. It was also noted that Social Work Officers had the dual responsibilities of supervising and providing on-going training for 91Gs. The group also noted that because of many different factors, all 91G's do not always receive adequate supervision or in-service training, and that Social Work Officers need to become aware of, and remedy this situation if it exists at their facilities.

Other points made in the small group discussions included: (1) the need for channels of communication between the school and field personnel on matters relating to 91G training; (2) the suggestion that a process be set up so that "retreads" can be screened by a Social Work Officer before being sent to the 91G course; (3) that the staff of the 91G course should have input into decisions on where to assign the new 91G; (4) that consideration be given for a way of enabling the staff of the 91G course to communicate with the field on current developments at the school; (5) that field personnel let the 91G staff know of actions being taken to remove the MOS from school trained 91G's who do not function adequately on the job.

CONCLUSIONS: Many issues were raised regarding the training and utilization of the 91G. Discussion among the participants was free flowing and creative. There existed a feeling that progress was made in the specialty seminar. It was the group consensus that the format of the specialty seminar was worthwhile and productive.

LEADER'S REPORT ON CHILD PROTECTIVE SERVICE SEMINAR "CURRENT TRENDS" COURSE, MARCH 1974

by

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Both the Tuesday and Thursday sessions were well attended with about 25 people per session. The meetings were generally lively with good participation from the group.

Tuesday's seminar was predominately composed of people with work experience in the Army child protection field. Thursday's seminar had more who were interested in learning about, establishing, and operating new programs. The two meetings were thus differently focused.

In beginning each seminar, the participants were asked to estimate the number of child maltreatment referrals they were receiving annually. This included all referrals from "false alarms" to confirmed abuse. The Tuesday siminar reported nearly 500 referrals for 1973 (out of eight posts). There were about 12 children killed in this population. This "straw count" was informal, but reflects the extent of the program Army-wide.

Both seminars unequivocally endorsed the need for a Child Protective Regulation. There was some concern that the recent request for comments from the field on the proposed Army regulation might not receive as strong endorsement as the social workers thought necessary. This was because the lower echelon elements asked to comment were not always those working in the child protective services field (i.e., Drug Abuse or Personnel Directorate Officers). Three-fourths of seminar participants had never seen the regulation at the local level.

The major concern of the attendees regarding the regulation was the appointment of a senior personnel officer as chairman of the committee. There was strong opinion that a MEDDAC person should chair the committee, but that the program should be a command, as opposed to strictly medical, effort. This may seem inconsistent, but what is needed is a command program with support and community involvement, but also professional case management and skill. A public health model seems most appropriate, rather than either a strictly medical or "command" model. Education and broad social planning is done by the community with technical assistance from experts, but diagnosis and treatment is done under professional direction of the medics.

Those experienced in child abuse in the Army expressed concerns that the proposed regulations does not go far enough in addressing some of the legal questions which need to be answered pertaining to federal jurisdiction. These included:

1. Right to hold a child in a hospital until a court order can be obtained.

2. Waiver of privileged communications and protection for reporting without malice. Also in this area, can a chaplain sit on the Protective Committee and be required to testify in court?

3. Competent investigative authority on exclusive jurisdiction posts. The MP's are not alone best qualified, the Welfare Department can't investigate, and the medics really lack authority.

The consensus was some regulation is needed even if it is not ideal in every respect.

Thursday's seminar was addressed more toward management of cases, and program effectiveness.

The uniqueness of child protective work was covered. For example, the child protective worker has to go to the client, who is seldom openly receptive, as opposed to waiting for the client to request help. These cases involve court testimony, a matter in which most social workers are not well trained. The cases must be carried regardless of clients' insight or motivation. Strong pressures are placed on staff managing cases. Some of these are external -- physicians, commanders, family members, etc. Others are internal -- worker's own feelings about child abuse, desire to get out of the case, to close precipitously, the desire to "hope" that everything is okay, the sweat that a child may be injured or killed.

Management techniques were discussed. Fort Carson has had good success with parent aides (volunteers). Others had found it difficult to get volunteers to work such cases. Generally, interdisciplinary teams seem to be the most effective medium for management, but caution was expressed that families can feel overwhelmed with "teams" and "too many cooks in the kitchen." Need for effective communication was expressed between team members as well as between posts. One of the major problems in child abuse is that of "entry" into the case. To our knowledge, very little has been documented on this subject, but is the crucial area that sets the course for the rest of the case. Most commands are getting 75-90% of their cases through hospital channels. Entry in these cases may not be as difficult, but those coming in from schools, neighbors, et cetera are another matter. One approach used by some with considerable effectiveness is a dual staff interview with the parents in which one staff member confronts while the other supports.

The broader area of child welfare services was briefly covered. Three specific problems were uncovered.

1. We still need to convert day nurseries on posts from warehouses to growth experiences for children.

2. A greater thrust in preventing child maltreatment needs to be made.

3. The Army really lacks clear-cut policy on relinquishment, adoption, and management of unwed mothers. A paper written by CPT Martin last year revealed many smaller hospitals really lacked a viable medical social work program. If this be the case, who is handling relinquishments and unmarried mothers? Are babies going out for adoption through inappropriate channels? While no hard data was available, it seems that the pill and liberalized abortion laws have not markedly reduced the "unmarried mother" population in the Army. What may have had greater impact is the emerging social acceptance of one-parent families. Single women are carrying children through to term and keeping the child. This may have the potential for more child neglect and abuse in the future, especially among younger, poorly prepared women.

In summary, there is a strong interest in child protective work within Army social work. While programs still range from nonexistent (three posts in the seminars) to comprehensive; overall there is a quality and competence of practice in which we can begin to take some pride. Strides really have been made. Expertise has been developed. These influences may not yet have visibility in the larger Army community, but child abuse is probably not missed in Army hospitals like it was in the past, and consistent management techniques are beginning to be practiced.

Typical of this progress is the undramatic, barely noticed emergence of a child abuse team network throughout the Army. Referrals and follow-ups between CA/N teams at different posts have become almost routine, similar to the communication between Army Community Service agencies.

AN EDITORIAL COMMENT:

Those of us working in the child protection field in the Army can take some satisfaction in seeing an Army Regulation on Child Advocacy being considered for adoption. At the same time, it would be less than honest not to admit some disappointment at the way it will come out (if it comes out at all) unless higher level staff make changes in it.

The revisions in this regulation, between what was originally proposed and what is now under consideration, are significant. Revision is to be expected, but these reflect a lack of knowledge about the problem, an ambivalence about whether to deal with it, and an uncertainty as to how to deal with it. The disappointing part comes from the fact that, for once, pretty good input was originally provided for higher staff consideration. The evidence of ambivalence is apparent in the cover letter to the field asking them to determine if the regulation is needed. It cites the interest of congress and civilian groups as the thrust for this regulation, not the Army. It appears that the medics wanted command to assume overall responsibility (which is desirable) but assumed a personnel officer could chair a committee deciding complex questions of medical and behavioral consequence that may be irreversible for children and families (which is naive).

Legal sanction and protection common to all 50 states' laws were deleted and thus denied (or left open to question) for many "on post" families. What happened to waivers of privileged communication and protection for those reporting without malice?

In spite of early denial, when the Army decided it had a drug abuse or race relations problem, it wrote a program, funded it, and ordered it implemented. Why does it ask the field whether there is a child abuse problem? The answer is clear that there is, not because it is an indictment of the Army, but because it is a problem everywhere in the country. For the record, there were not 60 cases in the Army last year, there were probably 60 cases at every post of significant size. The AMA has said child abuse may be a major cause of traumatic death, second only to automobile accidents in young children.

What is most encouraging is the growing body of professionals in the Army who really are child protection experts. They are largely made up of pediatricians, health nurses, and social workers (but not personnel officers). There are many national civilian leaders available and willing to assist us. The uniformed services can have the edge on civilian life because they have a single health care system and a comparatively higher degree of community organization. They could create programs of significance for effective child advocacy. What they need is genuine and clear commitment without dramatic wars on child abuse, effective regulations and legislation, some (but not a lot) better staffing, and a good training program for those working in the field. Let us hope that if a regulation is adopted, there would be at least one annual training seminar similar to those for Drugs, Race, and ACS.