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Rehabilitation

Volume XV | Friday, April 14, 1944 | Number 21

STAFF MEETING BULLETIN
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UNIVERSITY OF MINNESOTA

Volume XV | Friday, April 14, 1944 | Number 21

INDEX

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UNIVERSITY OF MINNESOTA MEDICAL SCHOOL
CALENDAR OF EVENTS
April 17 - April 22

Visitors Welcome

Monday, April 17

9:00 - 10:00 Roentgenology-Medicine Conference; L. G. Rigler, C. J. Watson and Staff, Todd Amphitheater, U. H.

9:00 - 11:00 Obstetrics and Gynecology Conference; J. L. McKelvey and Staff, Interns Quarters, U. H.

12:30 - 1:30 Pediatrics Seminar: The Anatomic Basis of Emotions; R. A. Jensen, W-205 U. H.

12:30 - 1:30 Pathology Seminar; The Effect of Maternal Diabetes on the Infant; S. V. Lofsness, 104 I. A.

4:00 - Preventive Medicine and Public Health Seminar; Mental Hygiene, Definition and Scope; Burtrum Schiele, 6th Floor, H. S. Lounge.

Tuesday, April 18

8:00 - 9:00 Surgery Journal Club; O. H. Wangensteen and Staff, Main 515, U. H.

9:00 - 10:00 Roentgenology-Pediatrics Conference; L. G. Rigler, I. McQuarrie and staff, Eustis Amphitheater, U. H.

11:00 - 12:00 Urology Conference; C. D. Creevy and Staff, Main 515, U. H.

12:30 - 1:30 Pathology Conference; Autopsies. Pathology Staff, 104 I. A.

12:30 - 1:30 Physiology-Pharmacology Seminar; Phosphates of Muscle During Rest, Exercise, Crush Injuries, and Shock; J. L. Bollman, 214 M. H.

4:30 - 5:30 Obstetrics and Gynecology Conference; J. L. McKelvey and Staff, Station 54, U. H.

4:00 - 5:00 Pediatric Grand Rounds; I. McQuarrie and Staff, W-205 U. H.

5:00 - 6:00 Roentgen Diagnosis Conference; A. T. Stenstrom; M-515 U. H.

8:00 - Minnesota Pathological Society Meeting; Regeneration of Bone in the Cranium Following Fractures and Osteomyelitis; W. T. Peyton, Me.S. Amphitheater.

Wednesday, April 19

9:00 - 11:00 Neuropsychiatry Seminar; J. C. McKinley and Staff, Station 60, Lounge, U. H.

10:30 - 12:00 Otolaryngology Case Studies; Out-Patient Ear, Nose and Throat Department; L. R. Boies and Staff.

11:00 - 12:00 Pathology-Medicine-Surgery Conference; Duodenal Ulcer with Massive Hemorrhage; E. T. Bell, C. J. Watson, O. H. Wangensteen and Staff, Todd Amphitheater, U. H.

12:30 - 1:30 Pharmacology Seminar; Detoxification of Organic Arsenic Compounds; L. Fink, 105 M. H.

4:30 - 5:30 Neurophysiology Seminar; The Electroencephalogram Anoxia; F. Kottke, 113 M. S.

Thursday, April 20

9:00 - 10:00 Medicine Case Presentation; C. J. Watson and Staff, Todd Amphitheater, U. H.

10:00 - 12:00 Medicine Rounds; C. J. Watson and Staff, East 214 U. H.

12:30 - 1:30 Physiology Chemistry Seminar; Oral and Dental Biochemistry; W. D. Armstrong, 116 M. H.

4:30 - 5:30 Bacteriology Seminar; Actinomycetin A and B; Miss Bohland, 113 M. S.

5:00 - 6:00 Roentgenology Seminar; Reviews of Recent Radiological Literature; Staff, M-515 U. H.

Friday, April 21

9:00 - 10:00 Medicine Grand Rounds; C. J. Watson and Staff; Todd Amphitheater, U.H.

8:30 - 10:00 Pediatrics Grand Rounds; I. McQuarrie and Staff.

10:00 - 12:00 Medicine Ward Rounds; C. J. Watson and Staff; East 214 U. H.

11:45 - 1:15 University of Minnesota Hospital General Staff Meeting; Surgery of Forearm and Wrist; A. Schwyzer, Powell Hall Recreation Room.

1:30 - 2:30 Medicine Case Presentation; C. J. Watson and Staff, Eustis Amphitheate

1:00 - 2:30 Dermatology and Syphilology; Presentation of selected cases of the week; Henry E. Michelson and Staff; W-306 U. H.

1:30 - 3:00 Roentgenology-Neurosurgery Conference; H. O. Peterson, W. T. Peyton and Staff, Todd Amphitheater, U. H.

Saturday, April 22

9:00 - 10:00 Medicine Case Presentation, C. J. Watson and Staff, Main 515 U. H.

9:15 - 11:30 Surgery-Roentgenology Conference; O. H. Wangensteen, L. G. Rigler and Staff, Todd Amphitheater, U. H.

10:00 - 12:00 Medicine Ward Rounds; C. J. Watson and Staff, E-214 U. H.

11:30 - 12:30 Anatomy Seminar; The Initial Emptying Time of Stomach in Pregnancy; E. A. Boyden and L. G. Rigler, The Formation of Antibodies in Lymph Nodes; Dorothy S. Reiff, 226 I. A.

WAR AND POST-WAR REHABILITATION OF HANDICAPPED PERSONS

Federal Security Agency
Office of Vocational Rehabilitation.

The Vocational Rehabilitation Amendments of 1943, approved by the President on July 6, 1943, provide the necessary framework within which a peacetime as well as a wartime program of rehabilitation will be administered. The scope of services available to disabled persons now and after the war has been broadened to include any services necessary to render them capable of engaging in remunerative employment or to render them more advantageously employable. These include surgical and medical care, hospitalization, therapeutic treatment, artificial appliances, vocational guidance and training, maintenance during training, and placement in employment. In contrast, the Vocational Rehabilitation Act of 1920, under which authorization the rehabilitation program has operated during the last 23 years, limited the use of Federal funds to training and furnishing of prosthetic appliances.

Other changes made by the new amendments concern the groups of disabled individuals to be served and the methods of financing this Federal-State program. Mentally as well as physically disabled individuals are now eligible for rehabilitation. Specific provision has been made for the rehabilitation of the blind and war-disabled civilians, the latter of whom are defined to include members of the citizens' defense corps, aircraft warning service, civil air patrol, and the merchant marine.

The fiscal provisions have been liberalized, with the old limitation of $3\frac{1}{2}$ million dollars appropriated annually by the Federal Government for matching purposes having been removed. Grants to the States may now be based on actual requirements and the amount of State funds available for matching, rather than on the basis of population as provided by the Act of 1920.

Under the amendments of 1943, the Federal Government will assume the entire cost of administration of State programs in contrast to the previous requirement of matching on a 50-50 basis. It will assume half of the cost of medical examinations, surgical and therapeutic treatment, hospitalization, prosthetic appliances, transportation, occupational tools and licenses, rehabilitation training, and maintenance. The entire cost of these services will be assumed by the Federal Government in the case of war-disabled civilians.

Sole responsibility for the administration, supervision, and control of this program rests with the State Boards for Vocational Education. Where there is a State commission or other agency authorized to provide rehabilitation services to the blind, that commission or agency will administer the part of the rehabilitation program pertaining to this group.

Responsibility for certification of Federal funds and establishing standards rests with the Federal Security Agency. Within this Agency an Office of Vocational Rehabilitation has been created to discharge these Federal responsibilities. The basic condition to the certification of Federal funds is a State plan of vocational rehabilitation approved as meeting Federal requirements under the Act.

A complete State plan of vocational rehabilitation for a disabled individual is composed of nine integral factors, all of which operate to restore the individual's working and earning capacities. To meet the total needs of handicapped persons, a well-rounded program is being established to include the following services. Except where indicated, Federal reimbursement is not conditioned on the establishment of financial need.

1. Location of Persons in Need of Rehabilitation.

It is important to locate such cases as early as possible in order to

minimize the disorganizing effects resulting from mental and emotional conflicts. Having some assurance that a life of dependency may not be theirs, such individuals can look to the future with hope. The cooperation of all private and public health, welfare, and other agencies and of individuals is necessary in locating disabled persons and in carrying out the steps involved in the successful completion of their rehabilitation.

2. Physical and Vocational Diagnoses.

As a basis for determining the individual's total rehabilitation needs, a medical diagnosis is required to establish the general health and medical history of the individual, including organic and functional conditions. The medical diagnosis and prognosis indicate the type and extent of medical or surgical care needed, and must be taken into consideration together with the vocational diagnosis. The latter consists of an analysis of the individual's intelligence, education, experience, interests, and aptitudes, as well as environmental and personality factors. In each case a complete rehabilitation plan must be made with the disabled individual, based on the results of these diagnoses.

3. Vocational Guidance.

Most handicapped individuals are in need of guidance in selecting suitable fields of work. Guidance must be provided to relate the occupational capacities of the individual to the occupational opportunities of the community.

4. Medical, Surgical, and Prosthetic Services.

Medical and surgical services must be closely coordinated with vocational guidance, training, and other services required in the individual case. Type of training and work tolerance must be determined jointly by the physician or surgeon and the guidance and training specialist. Many individuals may need only a prosthetic appliance and guidance before they can return to their previous employment; such appliances must be adapted to the occupational needs of the individual. With the exception of war-disabled civilians and civil employees of the United States disabled in the performance of their duties, the inability of the individual to pay for the needed medical services must be established before Federal reimbursement for the cost of these services is made.

5. Physical and Occupational Therapy and Psychiatric Services.

In some cases the functions of impaired limbs must be restored before the individual can undertake vocational training or employment. Therapeutic services must be closely integrated with other preparatory services. Physically handicapped individuals whose minds have been distorted by the effects of their wounds or other cause, and those with mental and neurological disturbances, require psychiatric care in addition to other services. Where such therapeutic and psychiatric services are parts of the medical or surgical treatments being rendered, inability to pay for these services must be established before Federal reimbursement can be made.

6. Vocational Training.

Those disabled persons whose impairments have incapacitated them for their normal occupations, or who have never had vocational experience, or whose skills have become obsolete due to changing industrial needs resulting from technological developments, require vocational training. The success of this phase of the rehabilitation process depends in large part on the degree to which the other services are closely coordinated with it. Specific training programs will have to be geated to the needs of disabled individuals as well as to the labor needs of the community.

7. Financial Assistance.

Because of the fact that disablement comes more frequently to persons in the lower-income groups, many handicapped persons will be in need of finan-

cial assistance to support themselves while they are undergoing training. Lack of such aid may jeopardize an otherwise promising rehabilitation plan, especially where the individual program may extend over a period of months. However, Federal reimbursement for the cost of maintenance during training is conditional on the establishment of need in all cases.

8. Placement in Employment.

Upon completion of preparation, the individual must be assisted in securing employment in accordance with his physical condition, qualifications, and temperament. Such placements are effected to safeguard handicapped workers and to assure proper utilization of their abilities and skills.

9. Follow-Up on Performance in Employment.

Follow-up is needed to determine whether the handicapped worker was properly placed. Adjustments may be found necessary; medical follow-up may be needed; a prosthetic appliance may require adjustment; the individual may need supplementary training; or he may need some special assistance in adjusting himself to working with others.

Two objectives stand out in the implementation of this program. First, we must, in the present emergency, salvage disabled manpower to relieve the growing labor shortage. Second, with thousands of disabled individuals seeking employment in the post-war period, we must assure them proper facilities with which to secure employment. We must also prepare for the readjustment of handicapped workers who may be displaced by industry at the end of the war.

In the accomplishment of these objectives, full use will be made of existing voluntary and governmental agencies of the community.

Disabled persons coming to the attention of an agency or individual and who appear to be in need of rehabilitation should be referred to the Vocational Rehabilitation Division of the State Board for Vocational Education, which in most instances is located in the capital city of the State.

REMARKS

by Richard M. Elliott, University of Minnesota, from The Psychological Bulletin, Vol. 41, No. 1, January, 1944.

Total war has resulted in the occupational dislocation of many millions of persons. Before the fruits of returning peace can become real, vast readjustments in the life of the nation and in countless individual lives must be effected. Labor has to find its way out of war jobs into normal employment. Military personnel must return to peacetime jobs. Disabled soldiers must be helped to become self-supporting and socially useful persons. An orderly, and in some respects a new, peacetime economy must be built. In this tremendous task alert psychologists can foresee that their profession will be called on to play many substantial roles. Not the least important of these - it may turn out to be the most important - is to provide more and better occupational diagnosis and guidance. The demand for it exists. Unprecedented expansion in the use of the sound and useful methods which have already been developed is a real possibility. Ideally diagnosis and counseling should be provided wherever there is a soldier or a civilian who needs it.

How completely inadequate the nation's present facilities are is shown by recently published figures, obtained through the U. S. Public Health Service, estimating the number of physically impaired men, only, between the ages of 15 and 64, who need selective placement at over six and one-half million, the number who need rehabilitation before employment at over one million, and those who need "extensive rehabilitation and sheltered employment" at an additional three hundred fifty thousand. These figures include both men who are in and those who are not in our labor forces, but it excludes men who are essentially invalids or who are in institutions. By far the largest group of those who need selective place-

ment are the males with some chronic disease, while nearly one-half of those needing rehabilitation, mild or extensive, before employment suffer from orthopedic impairment.[1]

Congress, recognizing that in two areas the need is urgent, has this year passed two laws, similar in many respects, one expanding the program for the vocational rehabilitation of physically handicapped civilians, and the other providing for the vocational rehabilitation of veterans of World War II whose employability has been destroyed or threatened by a disability incurred in service.[4] Under the 1943 law providing aid for civilians (Public Law 113) the program is to be administered on the federal level through the Office of Vocational Rehabilitation of the Federal Security Agency. Federal funds are to be made available to pay the entire administrative costs of approved State programs but the states are expected to pay one-half the cost of the services extended to disabled persons, who must be 16 years of age or over and re-employable. A valuable feature is that the Federal Security Administration is authorized to conduct or to pay for courses of instruction, not to exceed six weeks in length, for the professional personnel of the rehabilitation staff. Costs assumed by the government include tuition, books, subsistence, and traveling expenses. While psychologists will regret the imposed limit of six weeks, they should note two things: first, that a most important principle has been accepted and, second, that we are starting almost from scratch. If anyone has supposed that a six weeks course can adequately train specialists in vocational guidance he has not yet grasped the professional nature of the work. Recently we have seen the Army, in wartime, providing a course 24 weeks in length for men who will do certain kinds of personnel work requiring psychological training. The men who complete the course cannot be commissioned without receiving further professional training.

As an interesting indication of future opportunities in the rehabilitation field it may be worth while recording that at a recent conference of State Directors of Vocational Rehabilitation held under the auspices of the Federal Administration a scale of salaries was proposed which, if adopted, would compare favorably with the salaries prevailing in other fields of applied psychology and would be rather higher than academic salaries, at least in the low and middle academic ranks. The normal scale for Rehabilitation case workers, as propsed, runs from $2800-$3400, with a minimum in any state of $2400. Senior rehabilitation workers would receive $3400-$4000; an Assistant State Director, from $4000-$4600; and a State Director from $4600-$5200.

What can a properly organized rehabilitation program do? We all know in a general way that its fundamental purpose is the conservation of human resources and that it aims to assist persons who have suffered from accident, disease, or congenital disability to establish themselves in full-time employment. Services which may be rendered include individual diagnosis, counseling or vocational guidance, medical and psychiatric examination, training, and - when necessary and where financial need can be established - surgery and therapeutic treatment, hospitalization, prosthetic appliances, occupational tools, equipment and licenses, and transportation and maintenance during training.

The duties and responsibilities of a rehabilitation worker are fundamentally like those of a worker in the general occupational adjustment field, though in at least two respects his task is more difficult. First, his responsibility extends continuously from the time of referral of a case throughout a long series of contacts which culminate in adjusted employment. Second, he must draw on a wide background of professional knowledge and experience, since the disabled group with which he works is a typical cross-section of the general population in respect to age (above 16), educational background, social and cultural environment, previous employment, and job capacity. He is equipped with an asset of great value if he has derived some of his knowledge of various types of jobs from industrial experience.

He should be a mature person and one sharing the interests which characterize successful adult workers in the general personnel group of occupations.

To indicate in what respects rehabilitation work is psychological in nature, and to give some idea of the sort of training which is, or should be, required of a personnel staff, rehabilitation services may be divided under four heads: Selection and Diagnosis of the Case, Counseling, Rehabilitation Procedures, and Placement.

Selection and Diagnosis of the Case

Basic data to determine eligibility for rehabilitation and to estimate the chances of success include an appraisal of the residual physical abilities of the client, his mental ability, his personal and social adjustments, his special aptitudes, interests and personality traits - all to be weighted in relation to what will be required for successful preparation, adjustment, and performance in an appropriate job. Formal testing procedures and interviews with the client are supplemented by school records, reports from friends, parents, teachers and others who may have observed significant emotions, attitudes, interests and aptitudes, reports from social and welfare agencies covering family and social relationships, and employment records. The diagnostic techniques are identical with those applied in any clinical guidance program. The worker must know the uses and the limitations of psychological and clinical data, and he must be able to sift dependable from undependable evidence and to distinguish between relevant and unessential data. The more thorough and objective his analysis of a case the greater will be his tendency to emphasize general and specific potentialities for job adjustment rather than physical disabilities.

Counseling

The future welfare of the disabled person and his dependents is contingent upon the quality of the counseling he receives. Consultation begins with explaining to the client the foundations on which every sound and wise vocational choice rests. Emphasis is laid on the desirability of cultivating self-understanding of one's assets and liabilities without allowing recognition that the liabilities exist to divert one's primary and positive concern from the assets. The techniques are the same as those used in counseling persons who are not disabled. They include providing the client with plain facts as to the demands upon abilities, physical strength, and skills made by various jobs, and the opportunities for employment in them (2,6). The client must be supplied with information and must cooperate actively in working out his own occupational goals. The plan of preparation for employment must be feasible and congruent with the individual's potentialities and physical condition, and he must know that this is so, and know why it is so. Since the over-all purpose is to alleviate maladjustment the goal must be acceptable, intellectually and emotionally, to the client. He must see it as his own responsibility to make whatever effort will be required to attain the goal.

Rehabilitation Procedures

The restoration of the disabled person to employment is a cooperative task which may involve a wide variety of community and state resources. A rehabilitation counselor must know exactly what resources may be drawn upon and secure whichever services may be needed to prepare his client for employment. These services include medical care, surgery, hospitalization, fitting out with artificial limbs or other prosthetic appliances, supplying occupational tools and equipment, licenses, and, most frequently of all, training.

Since the rehabilitation service does not maintain its own training facilities, it must contract with established agencies for the particular training required in each case. Knowledge of a great variety of training resources, and knowing just where each is located geographically to determine whether its use is feasible, and judgment as to its appropriateness in all other respects for a particular client, are all absolute

essentials for the rehabilitation worker. In many instances it becomes necessary to arrange suitable modifications in existing training, and even to stimulate the setting-up of a wholly new training opportunity, in order to secure just what is needed for a particular client or to prepare a group of clients for a relatively new vocational outlet.

The rehabilitation worker needs to understand the principles of learning, and how they apply in a wide variety of situations. If his psychological background is deficient in this respect - if, for example, he does not grasp the differences between typical learning in school and "learning by doing" - he may try to hold the client to a regime of retraining under which he will become discouraged, decide to discontinue training, or even slide into an attitude of general defeatism. On the other hand, skilfully directed vocational training may be a tremendous morale builder, by giving a disabled person a method of compensating constructively for unalterable handicaps, and at its best restoring the long withheld right of a person who has "felt different" to hold his head as high as anyone else in the self-sustaining community of workers.

The rehabilitation worker cannot relinquish either advisory contacts with the client, or supervisory contact with the agency or agencies supplying service, until the restoration is complete. He is responsible for the expenditure of public funds, and he must assure himself that all is going well, or if not, after restudying the case, promptly introduce the called-for changes.

Placement

The test of rehabilitation is permanent and appropriate employment of the client, in the regular business and industrial world, at a job consistent with his ability and preparation, and at a wage commensurate with that paid other workers in a similar occupation. This is often a formidable assignment and the counselor must surmount many difficulties which block its realization at the beginning, or which threaten its continuance once a placement is made. The rehabilitation worker has to be well posted on employment trends and opportunities. He must be thoroughly familiar with the placement techniques used with the able-bodied by such agencies as the U.S. Employment offices. He must have a good knowledge of the psychology of accident proneness and prevention, and of workmen's compensation laws and a disabled person's rights under these laws. He must apply with skill and tact the most effective methods of surmounting employers' prejudices against hiring handicapped persons.[3] Following placement the rehabilitation worker cannot safely lose touch with his case until he is certain that the client has acquired the skills needed to hold his job and to escape exploitation or discrimination based on his disability. It is clear that in all this the worker will need knowledge, technical sckill, patient, imagination, understanding, and persuasiveness. He should inspire confidence through his pleasant and effective way of meeting people, either individually or in groups, and through his maturity of judgment and good common sense.

The Need for Psychologically Trained Personnel

From the above summary description of vocational rehabilitation work it can immediately be seen that many of the technical methods employed are those of psychological testing and measurement, psychological personnel work (especially individual diagnosis and job analysis), and clinical psychology.[5] Yet the plain fact is that in 23 years since passage of the original Federal Vocational Rehabilitation Act and appropriation of funds for state use, only a few stated have employed psychologists as rehabilitation workers. They constitute but a microscopic percentage of the total group of 314 persons employed in this field by all states together in 1942 - a number soon to be increased, it is hoped, to double its pre-war size. This situation should be corrected, and it will be if the psychological profession is quick and realistic in following through its recent gains and if our profession can persuade administrators that rehabilita-

tion work must be put on a professional basis. Psychology has won prestige by notable technical contributions to the sweeping educational trend toward the use of individual guidance at all school levels, by its role in helping to set up sound public and private employment procedures, and by its conspicuous accomplishments in the personnel systems of the armed forces.

Stepwise with measures to bring more psychologists into rehabilitation work, there must come a recognition that a more specialized division of labor in this field is is inevitable. The specifications laid down above for the rehabilitation worker do indeed represent him as the very model and paragon of versatility. He is pictured as capable of being all things to all men - and is correspondingly hard to find in flesh and blood. So here, as elsewhere in the development of an expanding profession, specialization of function must come. The time is ripe for it, and the means to pay for it have already been appropriated in part, and more will be forthcoming.

To be sure, this specialization can in some respects be accounted a loss. In the above picture the typical rehabilitation worker has been represented as a single case-selecting, case-diagnosing agent who thereafter assumes complete, continuous and sole responsibility for counseling the client through whatever successes and vicissitudes of training and employment may befall him. Under many circumstances this has been the most feasible arrangement. Perhaps for a long time, especially in isolated geographic regions, it will continue to be standard procedure. But many facts suggest that in increasing measure past practices may tend to be superseded by at least some greater degree of differentiation in the contacts between the client and the rehabilitation staff. The partially distinct roles of the occupational specialist, the psychometrician, the clinical psychologist, and the case or field worker who serves as the training and follow-up supervisor, can and should be distinguished. The clinic type of organization, with its advantage of more refined diagnostic methods and staff conferences and therefore pooled judgments in the diagnosis of a single case, can be used wherever transportation of the client to the guidance center is feasible.[5] This will usually not be difficult in the large centers of population, or when it is practicable to take advan0 tage of the provisions of the new Federal Law authorizing payments for the transportation and maintenance of clients in order that they may receive necessary services, including training. Remote areas can perhaps be served by a mobile diagnostic clinic comprised of specialists who will move on when the preliminary study of a group of cases is completed, leaving a field worker in charge.

An additional and compelling reason for raising the issue of specialization of function among the rehabilitation staff lies in a new provision of the 1943 Federal law providing rehabilitation services for civilians. The possession of so-called "functional" disabilities now qualifies a person for aid, if the other conditions such as re-employability, etc., are met. What this comes down to, stripped of technical distinctions, is that for the first time persons suffering from psychoneuroses and the social maladjustments which arise from personality disorders are eligible for vocational rehabilitation. It will be seen at once that the importance of the clinical psychologist (and of the psychiatrist, as well as the occupational therapist) on the rehabilitation staff has been increased many times over. Now the case picture as only the well-trained and psychiatrically-oriented clinical psychologist can grasp it will more often be the central factor in diagnosing a case than it has been with clients who were physically disabled. The person, in all his clinical complexity, will need really to be studied first and studied thoroughly. Only afterward will the prospects of initiating rehabilitation and the finding of suitable jobs come into relation with the diagnosis. More often than with a physically disabled case, the insights which spring out of the clinical psychologist's professional training and experience might be altogether lost on an admirably competent vocational specialist. The latter, incidentally, may well be a quite differ-

ent sort of person temperamentally from the "intraceptive" clinician.

Clinical and vocational psychologists, and even psychologists as a total professional body many of whose members will be seeking civilian re-employment in the post-war years, should study the implications and opportunities in this fast developing situation.

Veterans' Rehabilitation and Vocational Training

Under a law passed by Congress on March 25, 1943, the Veterans' Administration is intrusted with the program for the rehabilitation and training of soldiers with service-incurred disabilities by virtue of which they have become unemployable.[4] Vocational Advisement and Training are included up to a maximum length of four years of training, during which the disabled veteran receives a pension, adjusted to the number of dependents. It is unnecessary to make any long statement here describing the projected procedures for carrying out the provisions of this law. Detailed plans are still being worked out.

Actually the principles of case diagnosis and rehabilitation are the same wherever they are to be applied. Many additional opportunities for counseling and training will be open to ex-soldiers, some of which may be non-governmentally sponsored, as by the Red Cross and the American Legion. The Vocational Advisement Division of the Veterans' Administration is at work now on its plans to provide its own diagnostic counseling facilities working with and through a staff of rehabilitation field workers. In at least one instance (Minnesota) the State Director has already set up a diagnostic and counseling clinic headed by a vocational and clinical psychologist with a wide background of previous experience in guidance and rehabilitation and with Ph.D. training in psychology.

The facilities of the Veterans' Administration will of course be supplemented by the use of existing non-governmental agencies of every kind and description which can furnish guidance, training, placement, and follow-up - much as the civilian rehabilitation program now does. Only so could there by any hope of supplying the requisite services. Meantime, it is to be hoped that steps may be taken to increase at the earliest possible date, through professional training, the available rehabilitation personnel.

Well-conceived and reasonably liberal plans are also under way to provide vocational guidance and education for veterans who have not incurred disability at the time of discharge from the Army. Up to the present time Congress has not been asked to consider the legislation necessary to put such a sweeping plan into effect. It appears to be not unlikely, however, that eligible veterans, after adequate individual diagnosis and recommendation, will be offered free tuition and maintenance while enrolled in an approved curriculum of general, vocational or professional education, ordinarily for a period not to exceed one year. No soldier may receive training for any occupation unless it is believed that the existing supply of trained personnel in that occupation, or profession, is likely to be insufficient to meet the expected demand. An extension of this educational plan permitting longer training periods in selected fields, either for picked students whose professional education was interrupted by entrance into service, or for other veterans with special abilities, is also under consideration, with favorable action by Congress extremely probable.

The response from the psychological profession to the immediate and prospective opportunities in the fields of occupational and vocational rehabilitation should be enterprising and prompt. First attention might well be given to an overhauling and expansion of the existing training opportunities in the fields of vocational psychology and clinical psychology. In the past there has been in sufficient stress in these areas, and throughout applied psychology, on in-service apprenticeships. The use of these, perhaps under the designation internships, might well become almost universal for

graduate students, on both the M.A. and Ph.D. degree levels, who entertain doubt (or should be doubting!) that their professional lives will lie exclusively in the classroom or research laboratory. Curricula so theoretical that they seem to be planned almost solely to produce research specialists have their place, but not to the exclusion of curricula designed to turn out psychological "practitioners" and technologists.

It requires no gift of prophecy to foresee the demand for all sorts of psychotechnology in the post-war world. Now is a fitting time to get rid of a "cultural lag" in the educational processes by which we make psychologists. Let us be sure that we are realistically prepared for our bright future. The love of scientific discovery will still continue to be our strongest historical tradition, as it should be in every science, and especially in a young science. We need not fear that pure research will be neglected or that we shall fail to press on - on all fronts - to the devising of ever more refined methods of analysis and measurement.

References

1. Anon., Editorial, Manpower Rev., 1943, 10,4.

2. Gleason, Clyde W. The use of job families for the physically handicapped. Psychol. Bull., 1943, 40, 714-718.

3. Lavos, George. Unfounded objections to hiring the handicapped. Jr. Consult. Psychol., 7, 191-197, 1943.

4. Marquis, Donald G. Agencies for rehabilitation and vocational adjustment. Psychol. Bull., 40, 687-691, 1943.

5. Marquis, Dorothy P., Novis, Frederick W., and Welsey, S. Medford. The role of psychology in a rehabilitation program. Psychol. Bull., 40, 692-700, 1943.

6. Shartle, Carroll L., Dvorak, Beatrice J. and Associates. Occupational analysis activities in the War Manpower Commission. Psychol. Bull., 40, 701-713, 1943.

Note:

Rehabilitation of the war injured must start as soon as the injury occurs. It is impossible to eliminate medical care from the program and emphasize testing and counseling as the most important phase. Medical care must include psychiatric management even though no psychiatrist is in charge. The move placing the staffs of the Veterans' Bureau in the army will mean continuity of service between field, hospital and post-service care.

Everyone should keep abreast of the literature in this field. It can be found in the Medical Research Council Bulletin of War Medicine, which contains abstracts of psychological medicine. This is a monthly publication printed by the Bureau of Hygiene and Tropical Diseases, London. The American Journal of Psychiatry, published bi-monthly, is full of articles of interest. The Symposium on Military Psychiatry was printed in Vol. 100, No. 1, July 1943. This contains Bart Hogan's famous article on the sinking of the Wasp, and the description of the Marines who had given up hope. War Medicine for February 1944, Vol. 5, No. 2, has a good article on Occupational Therapy. You are also urged to read two books, The Neuroses in War, edited by Emanuel Miller, The Macmillan Company, 1940; Psychological Effects of War on Citizen and Soldier, by R. D. Gillespie, published by W. W. Norton & Co., Inc., New York, 1942. The was has demonstrated a great need for more psychiatrists, psychiatric social workers, and occupational therapists. We should be training more workers in these fields.

III. GOSSIP

Senior class in Military Medicine meets Monday, Wednesday and Friday, 8:00 to 8:50 A.M. To date they have heard about the defects uncovered at the induction centers, reasons for separation from the service, social implications of diseases and defects, and the story of the Veterans' Bureau. They have also seen the movie, "Psychiatry in Action" which is being shown at Staff Meeting today. The story of disease and injury to date is largely one of nervous and mental disease. They have learned that this condition is the commonest cause for rejection at induction. The commonest cause of separation from the service, and the commonest cause for hospital care by the Veterans' Administration (over half the beds). Tuberculosis is another problem for the Veterans' Administration, and although the program of perpetual care of this disease will be modified by present day x-raying of the chest at induction centers, it will not be eliminated as we learn that new cases are developing and review of their films does not reveal that mistakes were made. In the field of nervous and mental diseases it appears that society must make a great effort to control the problem, greater than it has made to date. As I watch this film made by the British I wonder if similar centers for civilian neurotics will be established in the post-war world. At the present time most neurotics receive various types of treatments and undoubtedly contribute much to the coffers of those who sell vitamin mixtures. One of our University high school students has been checking radio copy in broadcasts and learned that identical statements are made for stomach powders and vitamin pills. Physicians in the service are thoroughly indoctrinated with the proper attitude toward the neurotics and the psychotics but I am wondering how many of these same physicians will recognize these patients in civilian life before they give them something or recommend an operation. One is impressed with the lack of adequate health program in the schools. It is an old story to say that physical defects at induction centers are identical with physical defects uncovered in school examinations. The Common wealth Fund made a study of school examinations in Tennessee and recommended that these surveys should not be made more often than once every three years. A physical examination every year which reveals the same uncorrected defects doesn't do much for the cause. Examinations of the special senses are inadequate in most schools (eye and ears). Hearing loss and defective vision retard many youngsters. Recent studies indicating the extent of reading disability are striking. A handy rule for classification of students who do not get along well in school is as follows: 1) too smart or too dull, 2) reading disability, 3) poor home conditions (mental hygiene). Neurotics apparently marry neurotics and raise children who become neurotics. The same is apparently true of juvenile delinquents for many juvenile delinquents marry and eventually raise delinquent children. Richard M. Elliot of the department of Psychology deplores the lack of adequate counseling for disabled persons. Techniques are same as those used in counciling persons not disabled. The psychologists believe individual guidance at all school levels is necessary but the number of persons trained for this work is inadequate. There is apparent need for psychiatrically-orientated clinical psychologists. Perhaps hospitals will have a department of psychology which will function in several fields (employment of personnel, classification of hursing students, and personality measurements of the sick). Many of the labor problems in hospitals are due to haphazard employment methods. Some hospitals apparently feature opportunities for nurses whose intelligence quotients are below average. In view of the large number of clinical observations which must be made by the modern nurse it would seem ideal to train superior women for nursing supervisors, and less intellectually endowed individuals for aides. As constituted today many hospitals care for emergency illness (obstetrics, infectious diseases, and surgical problems). The patients whose problems are of long standing either come through the diagnostic machine with negative results or receive treatment for conditions which are not the cause of the patient's illness even though they may represent organic deviation....