

Treatment Contributions of VA Psychologists After WWII¹

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The role of VA psychology in addressing the treatment needs of veterans after WWII are characterized by three major contributions--helping increase mental health services for veterans, especially group therapy programs; helping shift mental health care from inpatient to outpatient care; and contributions in developing specialized mental health care programs.

In his 1948 article on priorities for psychiatric treatment of veterans, Daniel Blain, M.D., Chief of the newly formed Neuropsychiatric Division in the VA, outlined the problems that psychiatry, neurology, and clinical psychology faced in treating veterans seeking mental health care in the VA after WWII. Heading the list were problems presented by the long-term hospitalization of veterans, especially the chronically mentally ill patient.

Blain estimated that 134,000 beds would be needed for neuropsychiatry patients, reaching this peak in 1965. This estimate more than doubled the 55,000 psychiatric beds in the VA in 1947. Blain clearly noted in his article that the VA would not be able to staff the projected bed increases as this would exhaust most mental health manpower in the country. Even in 1947, for example, 3,000 psychiatric beds in the VA were closed due to shortages of personnel.

Although 50-60% of VA beds were occupied by neuropsychiatric patients, the number of admissions for these patients represented only 12% of all hospital admissions, but with not much change in the average length of stay from the 519 days reported in 1940. Patients with chronic mental illness were historically given only custodial care and, Blain noted, that the prevailing medical opinion was that there was not much a doctor could do for an old mental case so that little money and staff were assigned for their care.

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MENTAL HYGIENE CLINICS AND GROUP THERAPY

The most important impact on reducing hospitalization of psychiatric patients came from the development of Mental Hygiene Clinics (MHCs) in the VA, the first established at the VA Regional Office in Los Angeles in 1945. These outpatient mental health clinics were initially placed only in the VA's Regional Offices which served as business offices for helping veterans apply for disability compensation, educational programs, and other benefits authorized by law. It was believed that this first point of contact for many veterans would also be an ideal site to provide veterans with outpatient care for minor readjustment problems which might interfere with their ability to take advantage of the training offered veterans under the G. I. Bill.

The strategy of placing MHCs only in Regional Offices was changed after a 1947 pilot study showed the benefits of placing MHCs in the hospital setting. By late 1954 the VA was operating 62 MHCs with staffing of 165 psychiatrists, 151 clinical psychologists, and 162 social workers. Also included were 45 psychiatry residents, 160 psychology trainees, and 42 social work students. The median number of staff in these clinics was three psychiatrists, three psychologists, and three social workers. Typical activities in a MHC included screening and intake, therapy, teaching, and research. Of particular note was the fact that 25% of the patient load included work with psychotic patients kept functioning in the community without hospitalization.

Two special contributions of psychologists in MHCs included their roles in developing group therapy programs and in conducting research and program evaluation that helped develop specific therapeutic or rehabilitation programs. I will leave to Dr. Penk the task of describing the research contributions of psychologists from that early date.

The early therapy groups started by psychologists were not given much value. Group therapy benefits were considered primarily limited to reducing isolation and the stigma of mental

illness so that the patient became more accessible for treatment. An early 1947 VA technical bulletin noted that the indications and advantages of the many group techniques had not yet been worked out, but it seemed that any form of group therapy was better than none at all.

Part of the problem with the perceived limited value of group therapy was that group therapy did not fit well with psychoanalysis and the psychodynamically-oriented individual therapy modalities that were the treatments of choice for VA psychiatry at the time. To assist the VA psychologist interested in developing group therapy skills, the VA published the *Manual of Group Therapy* in 1960. The book was co-authored by psychologist Hal Dickman, then at the VA in Roseburg, OR, and two psychology consultants. This manual not only reviewed the theoretical bases for group therapy but was one of the first “how to” books giving the beginning group therapist practical guidance in conducting effective group therapy. Its chapters discussed such topics as different kinds of groups and desired outcomes, where to conduct groups, the time and frequency of group meetings, the optimal number of members in a group, preparing the patient for group therapy, and how to handle hostile, dependent, silent, and talkative patients. The manual became popular with psychologists and their students and helped establish a sound theoretical and therapeutic basis for group therapy in the VA.

In addition to the significant impact of MHCs and group therapy in keeping the patient functioning in the community in work and family activities, the reduction in days of care and costs for hospitalization were significant. The average length of stay for all psychiatric patients had been substantially reduced from the 519 days of care reported in 1940 to 226 days of care in fiscal year 1953. Fifty percent of patients admitted for psychiatric care were being discharged within 30 days, and an additional 25% of admitted patients were being discharged within three months. However, the days of care for chronic psychiatric patients, especially for the WWI patient, was still high.

VA COUNSELING PSYCHOLOGY AND WORK THERAPY PROGRAMS

Although counseling psychology did not get officially established as a service in the VA until 1952, the early activities and contributions of counseling psychologists in Regional Offices and in the field were substantial, including activity in what were called work therapy programs which produced some early successes in breaking the dependency of the chronic psychiatric patient on the hospital. Work therapy programs essentially employed patients to work in the hospital as part of their rehabilitation goals. This treatment program concept had existed in the VA domiciliary program in the Veterans Bureau as early as 1868. In the late 1940s, these work rehabilitation programs, called member-employee programs and, later, called Compensated Work Therapy, were used to help discharge many of the long-term hospitalized patients in the VA.

The first member-employee program for psychiatric patients was established at the VA in Roseburg, OR in 1949. By 1954, there were 19 VA hospitals with established member-employee programs. In his survey of member-employee programs, Peffer reported that 61% of the patients had a diagnosis of schizophrenic reaction of various types. Of those discharged to community employment, only 3% were readmitted to the hospital.

SPECIALIZED HOSPITAL TREATMENT PROGRAMS

By the mid-sixties, psychologists had also helped pioneer a number of specialized treatment programs for veterans in the VA. In 1965, the VA sponsored a psychology conference in Chicago to focus on the programs being developed to meet the challenging treatment objectives of the VA. The emphasis was on non-traditional treatment approaches. The papers presented represented some of the early work of VA psychologists like Earl Taulbee at the VA in Tuscaloosa on attitude therapy, Joseph McDonough's work at Palo Alto on systematic reinforcement (token economy), Julian Meltzoff and Richard Blumental at the VA outpatient clinic in Brooklyn on day treatment centers,

and Fred Spaner at the VA in Downey on the unit system. Other papers like that of Philip M. Carman at the VA in Wadsworth (Los Angeles) described activities of VA psychologists in renal dialysis, open heart surgery, automated retraining of aphasics, and other medical programs. Harold Dickman at the VA in Roseburg described unit therapeutic milieu programs, and Roy Brenner at the VA in Hines (Chicago) reviewed the work of psychologists in domiciliary restoration centers.

A clear consensus emerged from that conference that the traditional one-on-one psychodynamic therapies were not adequate to meet the treatment needs of veterans. In his presentation of the attitude therapy program at Tuscaloosa, Taulbee expressed the concern of other presenters that there would never be enough therapists for the one-on-one therapies. He also made the observation that understaffed hospitals, clinics, and domiciliaries were crowded with what psychodynamic therapists considered poor diagnostic risks for their treatment techniques.

Taulbee argued that the total hospital environment must become the therapist, including all personnel who came in contact with the patient. He proposed five attitudes, one of which was to be selected and used by all staff to guide them in interacting with the patient: (a) active friendliness, (b) passive friendliness, (c) kind firmness, (d) matter-of-fact, and (e) no demand.

In a three-year review of the attitude therapy program, Taulbee noted that the custodian reputation of the Tuscaloosa VA had been converted to that of an active treatment program reputation with the highest turn-over of all VA hospitals. Their turn-over rate of 16% was, in fact, among the highest for all psychiatric hospitals in the country at that time. The use of attitude therapy with the confused, elderly patient was also reported as helping discharge some of these patients after 20 years of hospitalization.

VA psychologists were also taking advantage of the behavior therapies gaining popularity in the 1960s. John M. Atthowe developed a research project at the Palo Alto VA in

1963 to look at the use of a token economy program on a chronic psychiatric treatment ward. During the conference, McDonough described how he had adopted Atthowe's token economy program for use on an acute psychiatric treatment ward at Palo Alto. McDonough was finding some of the same results as Atthowe that systematic reinforcement with the use of tokens to reward desired behaviors was helping patients acquire new behaviors and habits that made it appropriate for them to be placed in foster homes or for return to their family. In addition to helping patients leave the hospital earlier and for longer periods of time, the token economy program also helped patients who could not be realistically discharged by providing a better hospital adjustment with a reduction in patient management problems.

Another issue that the VA had begun to address in the 1950s was the problem that many chronic, ambulatory schizophrenic patients did not need the 24 hour medical and nursing care of the hospital but could not function independently in the community with only the intermittent outpatient care provided by MHCs. Day Treatment Centers were established in the VA to provide long-term care to these patients by utilizing what was called a partial hospitalization treatment model. Patients would attend a four to six hour day of treatment activities up to five days a week but would return to their homes in the evening. Psychologists were also helping to develop Day Hospitals, another partial hospitalization program in the VA that was designed to use the same daily treatment structure of Day Treatment Centers, with patients living at home, to provide short-term, intensive outpatient treatment for a non-chronic patient population to help reduce the need for hospitalization.

The conference clearly illustrated that the 1960s were a period of program experimentation for psychologists in the VA. This experimentation and examination paralleled what was happening outside of the VA, and is worthy of brief comment.

VA PSYCHOLOGY IN CONTEXT: 1946-1965

In their history of the profession of psychology in America, Benjamin and Baker (2004) noted that the military had opened the doors for psychologists as therapists during WWII. The emerging role of clinical psychologists as therapists in the VA was following a national trend. Psychology was additionally helping shift the focus in therapy from the intrapsychic conflict of psychoanalysis to interpersonal conflict and from a psychosexual emphasis to an emphasis on psychosocial processes.

About the same time as VA psychologists were meeting to discuss how they were dealing with treatment issues in the VA, the NIMH was sponsoring its third national conference on psychotherapy research. In characterizing that 1966 conference, Rosner cites an unpublished report indicating that there was a proliferation of therapy forms, techniques, and applications when compared with the 1958 and 1961 conferences. Psychoanalysis research was found to be receiving fewer NIMH grants, a direction reflecting the disillusionment of VA psychologists about the use of these techniques in their 1965 conference. Research on behavior therapy was receiving more NIMH grant funding as was research on therapist-patient interactions and psychopharmacology and psychotherapy issues.

The parallel growth directions of VA and non-VA psychology in the sixties in part reflected the fact that some of the key leaders in developing American psychology in the academic community were also involved in helping guide VA psychology. Those that Donald B. Lindsley invited to the first conference on graduate training in clinical psychology in 1941 included Donald Marquis, David Shakow, Henry Murray, Chauncey M. Louttit, and James Quinter Holsopple. Marquis and Shakow were on the first VA psychology subcommittee formed to advise the new VA Neuropsychiatric Division. Murray and Louttit were early consultants

working with James Miller to design the new VA psychology program, and Holsopple joined the VA Central Office in 1949 serving as the Assistant Chief of Clinical Psychology. Other noted consultants to either VA Central Office or the Branch Offices in 1947 included Carl Rogers, Gordon Allport, J. McV. Hunt, George Kelly, Rensis Likert, Laurence Shaffer, Leona Tyler, Ernest Hilgard, and Edward Tolman—all of whom were to become future APA presidents..

MENTAL HEALTH TREATMENT PROGRAMMING

IN THE 1970S AND 1980S

From 1970 to 1981, the number of Mental Hygiene Clinics and Day Treatment Centers doubled, and the number of Day Hospitals quadrupled. Several factors led to a significant growth of psychology's involvement in other specialized mental health treatment programs in the 1970s. These factors included an influx of Vietnam veterans seeking treatment in the VA for post-traumatic stress disorder or PTSD, and special Congressional funding for treatment of substance abuse and PTSD.

During the 1970s, Congress passed special legislation to fund increases in treatment of substance abuse, one of the most frequently encountered diagnoses in the VA, either as a primary or secondary treating condition. Inpatient alcohol treatment units grew from 30 units in 1970 to 113 units in 1981. In 1981 the VA was also operating 110 outpatient alcohol treatment programs with a staff psychologist assigned to most of these programs.

The drug dependency treatment programs in the VA could and did draw on the treatment experience of non-VA psychologists and mental health professionals in the development of these programs. The increasing number of Vietnam-era veterans coming to the VA seeking treatment for PTSD, however, presented a unique problem for the VA. Other than in the Department of Defense, the PTSD treatment experience in the non-VA sector was primarily limited to non-

combat trauma experiences in such areas as sexual assault and trauma produced by natural disasters. VA psychologists had little to draw upon from the non-VA sector in building programs to meet the needs of veterans with combat-related PTSD.

The pressures for change in the VA due to the special treatment needs of Vietnam veterans resulted in a series of five conferences held around the country in May and April of 1971. The conferences were organized and moderated by Charles A. Stenger, one of our symposium presenters, in his role as Chair of the VA's Vietnam Veterans Committee and in his leadership role in psychology in VA Central Office. I will let Charlie tell you more about these conferences and his role.

The conferences were used to propose initiatives and programs to address the needs of Vietnam veterans. By 1988, the VA was operating 31 inpatient PTSD programs, 65 general outpatient PTSD programs, and an additional 30 special funded PTSD clinical team programs. Each of these programs again almost universally included a staff psychologist position on the team and, together with the increase in psychology staffing for the drug dependence treatment programs, resulted in a significant increase in psychology positions in the VA during the 1970s and 1980s.

Legislation in 1979 also created the Vietnam Veteran Readjustment Counseling Program that established new community-based VA treatment teams operating outside of the VA hospital grounds in what were called Vet Centers. The Readjustment Counseling Program was initially assigned to the Mental Health and Behavioral Sciences Service and headed by psychologist Donald Crawford. By 1985 there were 189 Vet Centers treating 371,000 Vietnam-era veterans and 80,000 family members.

By the time of the VA's survey of mental health treatment programs in June 1988, the VA was employing over 1400 doctoral psychologists in these and other treatment programs.

SUMMARY

The significant numbers of psychologists employed by the VA and their contributions to treatment programming summarized in this presentation provide support for Wolman's 1965 observation that the VA provided a significant impetus to the emergence of psychologists as health-care practitioners in the country. This presentation, however, illustrates only part of the story of the role of psychology and the VA in mental health treatment of veterans. The topics chosen are meant to characterize rather than fully describe these contributions. Time limitations have required difficult decisions about what to include and in what depth. Omissions include the role of VA psychologists in the 1940s in the treatment of tuberculosis, the role of psychologists in the treatment of spinal cord injury and other medical conditions, the work of VA psychologists in developing neuropsychological assessment techniques and other diagnostic instruments, the treatment of former prisoners of war, and the contributions of VA psychologists in the treatment of the elderly.

In many ways, the values of psychology and the skills of VA psychologists promoted a greater sensitivity of VA health care programs to the human needs of veterans served and psychologists helped transform the VA into a major mental health care program in this country, a role continued to this day.