THE CONSULTANT PSYCHIATRIST IN A
FAMILY SERVICE AGENCY

Formulated by the
Committee on Psychiatry and Social Work**

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INTRODUCTION
In two previous reports* the Group for the Advance-
ment of Psychiatry Committee on Psychiatry and Social Work** explored the relationship between
psychiatry and social work as they coordinate their
contributions in the functioning of the clinical team.
For many years the clinical team in the psychiatric
hospital or clinic provided almost the sole opportunity
for collaboration between the two disciplines. In the
last two decades, however, family service and other
social agencies have increasingly applied the develop-
ing knowledge of the psychodynamics of human behavior
to their appraisal and treatment of disturbances in
interpersonal relationships within the family. As a
result an additional area of contact between psychiatry
and social work has developed and many psychiatrists
have become consultants to social agencies that are
not a part of a hospital or clinic organization.

This committee has devoted its current efforts
towards clarification of the present status of this
relatively new role of the psychiatrist. The report is
directed primarily to psychiatrists and family agencies
who are interested in the development of psychiatric
consultation. In addition to our own experiences as
family agency consultants we have drawn on several
sources outside of the committee, one of which was a
questionnaire returned from several Family Service
Association of America agencies.***

The concept of psychiatric consultation and its
adequate use, as described in our report, is predicated
upon the assumption that the agency has attained and
maintained certain professional standards as outlined
by the Family Service Association of America. Some
of the material in our report is applicable to programs
in which the agency goals are defined differently, while
other points will require modification. In those agen-
cies as yet unable to provide the personnel and the
resources that are necessary to carry out a program
optimally, the consultant may make a contribution as
long as he recognizes that the limitations of the agency
necessitate a modified approach to consultation.

The psychiatrist customarily participates in col-
aborative efforts with caseworkers in the setting
of hospital or clinic. Before accepting the role of
consultant to a family agency, therefore, he should
have defined in his own mind certain similarities and
differences that exist between casework in a psychi-
atrict clinic or hospital and casework in a family
agency. For example, the casework services of a
family agency are under social work leadership in
contrast to the organization of the clinic in which the
psychiatrist carries ultimate responsibility. The
psychiatrist’s role as a consultant thus differs from
that which he fulfills in the clinic. In order to formu-
late his function as consultant he should clearly under-
stand the structure of family service agencies, and
his place in its organization.

THE FAMILY SERVICE AGENCY
Social workers are responsible for the formulat-
tion of social casework theory and practice.
Revision of their theory and methods can be
anticipated as practice and research studies in
human behavior, in social work, and in related
fields continue. As background material we have
used the 1953 publication of The Family Service
Organization of America, “Scope and Methods
of The Family Service Agency.”

This report merits careful study, and the follow-
ing excerpts from it illustrate the fundamental
principles which guide practice in Family Serv-
ice Agencies. The purpose of the family service
agency is stated as follows: “...to contribute
to harmonious family interrelationships, to
strengthen the positive values in family life,
and to promote healthy personality development
and satisfactory social functioning of various
family members.” “The focus of casework in
the family agency is on the family as a unit. The
family’s values, its patterns of behavior, the
interplay of social, economic and cultural forces,
and the role each member plays within the
family and in the outside world are major con-
siderations in family casework”...“Casework
treatment by a family agency may be described
as ‘composite’ or ‘family oriented’; it takes into
account family interrelationships as well as the
needs of individual members of the family.”

* GAP Report No. 2, Jan. 1948. The Psychiatric
Social Worker in the Psychiatric Hospital and GAP
Report No. 16, Aug. 1950. The Psychiatric Social
Worker in the Psychiatric Clinic.

** Previously named The Committee of Psychiatric
Social Work.

*** Mrs. Elmor Zaki, Assistant Director of Publica-
tions Service, Family Service Association of America;
Miss Jeanette Regensburg, Casework Associate, Com-
Community Service Society of New York and the Family
Service Association of America assisted in develop-
ing and organizing material around the question-
aire.
The following standards for a Family Service Agency are drawn from the same source and represent some of the criteria used to evaluate an effective Family Service Agency program:

(1) Principles of Organization. The agency has a structure and plan of organization clearly within the framework of social work leadership and responsibility so that it functions as an integrated whole. It is rooted in a supporting community. It is composed of the board of directors, and an administrative and practicing staff.

(2) Board. The board of the agency has ultimate responsibility for all parts of the agency program and for the kind and quality of its practice. It is important that the members of the board (through the administrative staff) know about psychiatric consultation and have confidence that it contributes to improved service to the agency's clients.

(3) The Executive. The executive of the agency is selected by and is accountable to the board. He offers leadership in directing and coordinating the agency program. He administers the program in accordance with policies approved by the board. The executive in consultation with the casework staff develops a plan for the use of psychiatric consultation and for integrating the consultant's contribution into the agency program. The executive selects and employs the consultant, who is administratively responsible to the executive. A consultant within the family service agency is in a staff service position. He does not carry administrative responsibility and is not accountable for agency services.

(4) Casework Staff. The casework staff (case supervisors, supervisors and caseworkers) is selected by and accountable to the executive. It has primary responsibility for the casework service of the agency. Thus, the caseworker is responsible for the case management of the treatment of each individual, family or family member assigned to him for service. He is accountable to his immediate supervisor, and together with the latter, to the administration for the soundness of his casework diagnosis and appropriateness and competence of the casework service he renders agency clients. Effective utilization of psychiatric consultation depends on qualified professional staff of appropriate size including caseworkers, supervisors and casework supervisors.[1] Ideally the staff should be well balanced in terms of levels of experience or professional development. There should be a sound ratio of case-load to caseworkers and of caseworkers to casework supervisors. There should be a casework supervisor responsible for the casework services who gives leadership to the program and integrates the contribution of the psychiatric consultation into the total program.

(5) Casework Services. The Family Service Agency is primarily concerned with a program of Casework Service, which then permeates and extends into the administration of tangible complementary services. The latter may include foster homes, homemaker service, camps, etc. The quality of casework service also determines the quality and effectiveness of the agency's program related to such other functions as participation in community planning, group educational activities, and contributions to professional education and research. The level of casework services will affect an agency's program of interpretation of its work, of fund raising and of public relations. A psychiatrist who serves as a consultant should be aware of the significance of the casework service in a family service agency. Proper emphasis on casework service as the pivotal or core service enables the agency to keep the program closely related to the needs of families and individuals, to the needs of the community and of the profession. It enables the agency to determine appropriate expansion or curtailment of the program. Furthermore, it assures competent practice and an appropriate use of the contributions of the psychiatric consultant.

The family agency defines casework practice as a service which focuses "on the family as a unit." The goal of social casework treatment . . . is to improve the social functioning of the individual and of the family unit of which he is a member."[2] An agency with this focus and goal views the social caseworker's techniques as a method of treatment, "a professional method of helping people," which is valid within its own framework, its purpose, methods and goal.

(6) Staff Development. A family agency should have a program of staff development. In some agencies this will consist of supervision in its teaching aspects, special staff meetings related to casework practice, group discussion and

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[1] A consultant psychiatrist, if he has some question as to case-load size and staff structure, can obtain information concerning this by reading the Family Service Association of America report in regard to Job Classifications and size of case-load in

selected opportunities to attend conferences or institutes. In another instance, the program may be more formal and extensive and include, in addition to the above, agency seminars, special lectures and more extensive provision for attending conferences and seminars. Psychiatric consultation on individual cases contributes to the program of staff development. An appropriate emphasis on continuing professional development indicates the agency's readiness to use psychiatric consultation effectively.

"Scope and Methods" identifies and describes two casework treatment aims:

1. Treatment directed toward maintaining adaptive patterns.

   "The aim of this type of treatment is to help the client, within the framework of his pattern of functioning, to find solutions to his problems and to improve his social reality. Treatment is directed toward supporting the existing strengths and toward increasing the ego's integrative capacity."

2. Treatment directed toward a modification of adaptive patterns.

   "The aim of this type of treatment is to help the client handle specific aspects of his psychosocial situation with patterns of functioning different from those used in the past. Its goal is to improve the client's ability to master reality situations by increasing his understanding of himself, of his problems, and of his own part in creating them. He is helped to gain awareness of his habitual patterns of behavior, including his relationships to other persons and his reactions to specific aspects of his life situation. This treatment, by helping the client to differentiate between subjective and objective factors in his life experience, leads to modifications in his attitudes and behavior. It strengthens the ego's ability to assess reality, thereby reducing anxiety and the use of destructive defenses. It deals with conscious and pre-conscious material; it does not attempt to reorganize the basic personality structure."

Thus casework methods are primarily directed toward the utilization of the adaptive potential of the individual as defined by his character structure. As a rule, caseworkers deal with conscious and pre-conscious material and focus on the client's reality situation. They expect the client to exercise judgment, to make conscious choices, and to enter into realistic planning. While caseworkers should be alert to the emergence of unconscious material, they do not perceive their role as one that encourages the mobilization of unconscious material.[3]

Certain situations at times arise that cause technical problems. For example the relationship between the caseworker and client is utilized to strengthen the latter's positive steps toward improved functioning and to provide realistically defined corrective experiences in interpersonal relations when possible. An intense transference response, in which the client relates to the caseworker as if the caseworker were undifferentiated from some meaningful person of the past, creates difficulties in social casework; when it does occur it should be utilized only to define and correct a faulty evaluation of reality. Another example of a similar problem occurs when a client spontaneously offers dream material in interviews. Any discussion of the dream is again limited to defining the fears and wishes of the client as related to his current life situation. Also clients do not always confine the material they offer to the present, but rather bring up past feelings and events. A client, for example, may repeatedly bring up her guilt that became conscious at the time of her mother's death. It is the conscious, not the unconscious, roots of this guilt that are dealt with primarily in direct work with the client. In this it differs from those techniques in psychotherapy which attempt to remove the defenses against unconscious conflicts in order to reveal the dynamic forces behind the pathology.

THE CONSULTANT PSYCHIATRIST

When a psychiatrist wishes to serve as a consultant, he should not only understand the structure and functioning of a family service agency, but he also should carefully evaluate the agency's need for consultation, its readiness for it and his potential contribution to the agency. It is equally essential that early in his contact the consultant become acquainted with the functions, goals and interests of the specific agency he serves. He should also familiarize himself with the educational background and experience of the individual members of the staff and their position of responsibility in the agency.

Qualifications of the Consultant Psychiatrist

The consultant psychiatrist should be qualified to make a real contribution to the field of family casework. As a specialist, he should have completed the requirements for certification by the Board of Neurology and Psychiatry. Training and experience in child psychiatry is desirable. He should have a clear understanding of the concepts of dynamic psychiatry. While

psychoanalytic training provides a rich background for consultation work, he has to transmit his knowledge of dynamic forces rather than his techniques of treatment. The consultant should not only understand the dynamics of human behavior but he should be able to communicate this knowledge to members of other disciplines in understandable terms. He needs to be alert to the existence of and effect upon the individual of the subcultures of which the client may be a member. He should recognize the part the family and society plays in defining the function of a social agency. His training should enable him to evaluate his professional relationship with staff members and to recognize his own skills and limitations as well as those of the individual staff members.

Ideally, psychiatrists who show interest and qualifications for consultation work should have opportunities for direct experience with social agencies, with formal seminars in which the purpose, techniques and procedures of consultation are discussed and with individual supervision by experienced consultants before undertaking independent consultation. At the present time, however, this type of training is not sufficiently available. From a more practical standpoint it would seem important that both the agency and the consultant see the consultant's initial period with the agency as a mutual learning experience.

Functions of the Consultant Psychiatrist

In his role as consultant in a family agency, the psychiatrist applies his specialized background in medicine, psychiatry and psychodynamics, as well as his clinical experience and skill. As a physician he is particularly alert to evidence of organic disease, possible psychosis, or other conditions requiring referral for medical evaluation or for direct psychiatric treatment. For example, the client's history and current behavior may indicate to the psychiatrist the possibility of an organic neurological lesion. Referral for a physical and neurological examination is then indicated. As another example, the psychiatrist's understanding of psychosis may make it possible for a family service agency to facilitate the patient's return to society and the family following hospitalization.

The consultant contributes to the family casework agency primarily through consultation on specific cases. This type of consultation may involve a conference between the caseworker, supervisor and the psychiatrist. When cases are, however, particularly appropriate as teaching material, other members of the staff may attend the conference. Some agencies thus utilize group consultation as an integral part of their over-all staff development program. In the consultation, the specialized contribution of the consultant psychiatrist is combined with the knowledge and skill of the casework staff, as the participants focus upon the needs of a specific family, the goal to produce a more definitive psychosocial diagnosis and treatment plan.

Since the consultant's responsibility in reference to a psychosocial diagnosis is to contribute from his own discipline, he may assist in the further clarification or understanding of the personality structure and dynamics of current behavior and relationships, or he may corroborate the caseworker's diagnosis, impressions or treatment plan. The diagnostic formulation should include genetic, clinical and psychodynamic factors with emphasis on the client's integrative capacity as shown in his current social functioning, as well as in his way of relating to the caseworker. The formulation should also include an appraisal of family interrelationships and equilibrium. Although the psychiatrist may express a diagnostic impression the clinical diagnosis must inevitably be a tentative one. Only when the psychiatrist has had a diagnostic interview with the client can a definite clinical diagnosis be added to a psychosocial diagnosis. With the integration of the various contributions of the caseworker, the supervisor, and the psychiatrist, a more precise psychosocial diagnosis is reached.

When the psychosocial diagnosis has been formulated, treatment goals can then be identified. These are based on an understanding of the needs, conflicts and capacities of the client. In most situations the treatment of choice will be casework treatment, aimed at maintaining or modifying adaptive patterns. The psychiatrist contributes towards treatment planning in terms of assessing the adaptive potential of the client. Through his more precise understanding of the defense mechanisms and the purposes served by them he appraises those that can be wisely strengthened and those that are destructive. As a result of this discussion it may become apparent that changes can be effected that will alleviate the necessity for unsatisfactory patterns of behavior, or if this is impossible, to minimize their effect on the client and on the family.

In some situations the treatment goal may be to evolve a plan that minimizes the destructive effect the client has on his family. For example, a case was brought to consultation in which a mother was forcing her adolescent children to succeed in areas in which they had no interest, but in which she had vital concern. Consultation revealed that the mother was defending herself against deep anxieties by a strong drive for success. Unable to express this drive effectively, because of family responsibilities, she sought vicarious gratification through her children. She apparently could not permit the children to seek their own outlets unless she could find direct gratification for her own desires. An opportunity to find other satisfactions led not only to a happier pattern of life for her, but more importantly, to the release of her children from the strain of satisfying her. The clarification of the above problem suggested that work opportunities rather than a direct attempt to modify the mother's attitude toward the children was indicated. In this way psychiatric consultation led to a modification of casework goals.

At times hospitalization or direct psychiatric treatment for the client is indicated. When this occurs, the consultant can be of assistance not only in evaluating
the available psychiatric facilities, but also in planning with the worker the wisest approach in interpreting the need both to the client and to the client's family. When adequate psychiatric resources are not available the treatment plan will require re-evaluation to determine if casework can make a positive and appropriate contribution. However, when the case does not come within the scope of the agency's function, the consultant should support the agency in its refusal to offer the agency's services, and not advise the caseworker to attempt to carry out psychiatric therapy. The fact that a Family Service Agency has a consultant psychiatrist on its staff does not justify any expectation upon the part of the community that the agency will accept added medical responsibility.

Once the treatment goals have been defined, it is the responsibility of the casework staff to develop the casework treatment plans. The casework staff structures and implements the plan according to the agency's policy and the agency's resources, the latter based in part upon the time and skill of the professional casework staff available. The psychiatrist however often discusses his evaluation of the specific plan suggested by the caseworker. Just as the psychiatrist contributes his knowledge of the meaning of behavior, he also contributes the dynamic meaning of any plan. An additional function of the consultant is to predict when possible the immediate and long time effects of the selected plan. To illustrate, although a particular plan could ultimately lead to achievement of a desired goal, it may initially cause increased difficulties or occurrence of an undesirable side-effect. If these possibilities are anticipated, they may be more constructively handled.

Mechanics of Consultation

A consultation session should be flexible in form in order to be adaptable to the circumstances particular to the given situation. Although the agency decides where the consultation will take place, the psychiatrist has a better opportunity to become oriented to the agency's total program and staff, whenever it takes place in the agency. The requirements of the agency, the consultant, and the case will determine the form of the consultation, its participants and the type of preliminary preparation. Generally the caseworker writes a case summary after he has determined with his supervisor the suitability and need for the consultation. The content of the summary will vary according to the working policy developed by the agency staff and the consultant. Usually this material contains the reason for consultation, historical data, the caseworker's psychosocial formulation, the treatment plan and questions. The summary, with names disguised to insure due protection for the client, may be circulated for advance study to those who will attend the consultation. The complete case record may be utilized, wholly or in part, to supplement the summary prior to or during the consultation. There are advantages in providing the psychiatrist in advance with this material. As the psychiatrist studies the summary he has an opportunity to clarify the material in its genetic and dynamic aspects. He also can make some assessment of the client's adaptive patterns and the nature of the relationship between the worker and the client.

How the consultation hour begins is unimportant as long as it leads to mutual discussion. Such interchange enables the participants to study the total case, rather than a psychological economic or social fragment of the whole. As each participant responds to the ideas of the others a clearer conceptualization evolves. The responsibility for stimulating this free interchange is that of the supervisor and the consultant.

Often during the consultation session, there are additions made to the material previously received. Not infrequently after the summary has been sent to the psychiatrist and perhaps as a result of the more sharply defined thinking of the caseworker, a subsequent contact with the client may contribute important material. Also the written word as often lacks the emotional tone of an oral presentation so that the case becomes real or alive only as the worker adds verbally to the material. Oral presentation permits the consultant further to recognize and evaluate inappropriate reaction to the client or the material presented. When it becomes apparent that the worker's subjective reactions to the client will interfere materially with treatment, the psychiatrist should discuss these reactions either in the consultation or later.

While the consultant does not need to translate his contributions into social casework terms, it is important that his contribution is not misunderstood. For this reason at the end of all psychiatric consultations, the discussion should be summarized, differentiating clearly between what was speculative and what was established. In current practice a summary usually is written by the caseworker, approved by the supervisor, and submitted to the psychiatrist as soon as possible after the consultation. If the psychiatrist discovers any confusion or misconceptions in the summary, he should arrange further discussion with the caseworker and supervisor. If the summary reflects an understanding and use of the material discussed in the consultation period, the consultant approves it and returns it.

Cases are often brought back to psychiatric consultation after a further period of casework treatment. This may be by plan when a treatment trial is used purposely for further diagnostic understanding. It may be that new material which suggests the need for diagnostic re-formulation, has emerged. If the consultation brings out an indication for more exploration, the psychiatric consultant points out additional material that is required for more adequate diagnostic evaluation. The case is then brought back later with the additional material. Another case may be brought back to psychiatric consultation because the expected developments did not occur. In this instance the difficulty may be due to limitations in the previous formulation and therefore in the treatment plan itself or
it may be the result of the worker’s subjective reactions. On the other hand the difficulty may clarify the limitations in the adaptive potential of the client. Occasionally an agency may bring a case for a second consultation in order to evaluate why the plan was more successful than had been anticipated. This sometimes offers an unexpected learning experience. The success may be due not to the worker’s use of the formulation developed during consultation but rather to a change in the external situation of the client.

Additional Roles of the Consultant Psychiatrist

In addition to the psychiatrist’s primary contribution through consultation on individual cases, he may function in a variety of other roles in the family service agency. As indicated above, the case consultation conference may be structured to create a learning experience for the total staff as well as for the particular workers on the case. Consultation has a further value in addition to the primary benefit it offers to the client. The staff present gains knowledge from the particular case that has application to other cases. Because of this, the consultant is a teacher whether or not he sees himself in a teaching role. Since the formulation given on a particular case may be applied to others with some common components, it is often important to point out the atypical aspects of a case, so that an erroneous general concept will not be drawn from a specific situation.

Some agencies wish the consultant to use a particular case as a focal point for a discussion of a general topic. When this takes place, the consultant should be alert to certain dangers in the situation. In his enthusiasm for teaching he may lose sight of the particular case under discussion and present his material in a way that implies an applicability to the particular case where actually the contrary may be true. In such instances the consultant should define clearly wherein the theoretical material has direct bearing on the particular case under discussion, where it does not apply, and where the application is tentative and subject to further exploration.

In addition to the teaching material available on a particular case family service agencies often ask the consultant psychiatrist to conduct more formal seminars on some particular aspect of the dynamic concepts of behavior. The staff may express a desire for a presentation of material related to normal growth and behavior and concerning deviations in behavior. Then the consultant becomes an integral part of the staff development program of the agency, contributing his specific knowledge to the over-all development.

Very occasionally the consultant may see a client for diagnostic evaluation or to facilitate commitment. In this role however he is not a consultant, in the context of this report. The term “consultant” is used in family agencies to refer to the practice in which someone outside of the agency -- psychiatrist, attorney, home economist, etc. -- consults with the caseworkers on the basis of the caseworker’s material without seeing the client. This does not imply that the psychiatrist should not see the client for diagnostic or treatment. When he does so, however, he is not functioning as a consultant but rather as a clinical psychiatrist.

Because of his medical training the consultant may act as a liaison person with other medical facilities. He also interprets the significance of medical material to the caseworkers.

The executive may wish to discuss with the consultant some of the implications of the present and future policies of the agency as determined by the board. Again his contributions should be limited to offering opinions within the area of his experience. He must be aware that as a consultant he neither determines the agency program nor has the responsibility or privilege of executing it.

Don’ts of Consultation

There is a wide range of variation in structure and function of agencies in different communities, and the consultant psychiatrist should be adaptable and aware of the specific requirements and opportunities of the particular agency. The committee believes, however, that there are a few activities he should avoid in any case.

1. The consultant should not make agency decisions. As consultant he communicates material to others for their use. Whenever he takes on the additional responsibility of making a decision he steps out of his role as consultant. He may recommend a treatment plan but he does not share in its execution.

2. The consultant should not supervise casework. In developing his contributions to agency planning for the client, he may be tempted by his own enthusiasm or encouraged by the agency staff to usurp or to accept the task of casework supervision. If he permits this to happen, he will find himself involved in an activity for which he has neither responsibility nor training.

3. The consultant should not teach casework methods. When the psychiatrist uses individual cases for general discussion he should not teach casework goals and techniques. If he does, he assumes a responsibility he cannot carry out since his experience does not prepare him to understand fully the techniques of the casework field.

4. The consultant should not teach psychiatric techniques as such to caseworkers, who are not trained in psychiatry.

5. The consultant should avoid over-generalization. As in any case-focused teaching, he should take precautions against the formulation, either by himself or by others, of broad generalizations from a dynamic evaluation peculiar to the individual situation. The danger of this can be avoided if any general discussion of a problem is terminated by a re-focusing upon the particular case that has been brought in for consultation.

6. Whenever other facilities are available in the community, the consultant psychiatrist should avoid
treated a member of the staff of the agency for which he is consultant. Serving both as consultant on a case and as therapist for the caseworker usually creates an untenable situation from which neither the caseworker's client, the agency nor the caseworker as a patient can profit. In an emergency the consultant may be asked to give a diagnostic impression of a serious disturbance in a member of the professional staff, but this should be considered a carefully evaluated exception rather than an accepted responsibility of the consultant.

Summary

The consultant psychiatrist has a valid function in contributing his knowledge of his discipline to social workers in family agencies. This contribution will be most constructive if all participants keep in mind the differences as well as the similarities of the two disciplines, and if all participants recognize that the treatment goals, plans and implementation are the responsibility of the caseworker and his agency to be achieved through casework techniques.

To insure this contribution both the consultant psychiatrist and the family agency should have several basic qualifications. In this report we discuss these qualifications, and the framework in which they are, in our opinion, currently used to best advantage.

This report should be viewed as a statement of progress in a developing area of communication between the fields of psychiatry and social work. As new concepts and techniques in this area are developed and refined, we can anticipate a progressively broader understanding of the problems of the family, the individual, and the social structure.

The committee wishes to express its appreciation for the contribution made by the social caseworkers from family agencies who worked with the committee on this study.

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