The Orthopsychiatric Approach

to mental health

CONFERENCE REPORT

At the 35th annual meeting of the American Orthopsychiatric Association, held in New York City on March 6–8, 1958, 70-some papers were presented on various problems of human behavior.

The Association, formed in 1924, is primarily concerned with the development of an integrated approach to the understanding and treatment of human beings as physical, mental, and social entities. It seeks to promote "straight-mindedness" (which the term "orthopsychiatry" connotes), essentially in preventive, therapeutic activities. The annual meeting serves as a forum and a unifying force for psychiatrists, clinical psychologists, psychiatric social workers, and allied specialists concerned with emotional and mental illness.

Eleven papers from the meeting, summarized on the following pages, present several facets of the orthopsychiatric activities.

Need Cited for Attention To Basic Sciences

Unless orthopsychiatry takes cognizance of the work being done in the basic sciences, it may well be a horse-and-buggy discipline in a world of motor cars, warned Dr. Reginald S. Lourie, president of the American Orthopsychiatric Association, and director, department of psychiatry, Children's Hospital, Washington, D. C.

Lourie stressed the basic work of neurophysiology and neurochemistry as having "profound implications for our patterns of professional work in the future."

Some of the factors that threaten to mire down the horse and buggy, he said, are the advent of new drugs, the future of psychoanalysis in light of the advances in biochemistry, and management of brain-damaged children. The development of tranquilizers, the salvaging of babies, many of whom have brain injuries, and discoveries in cytological life functioning are part of the new, "motorized" age, he said.

The main thing, Lourie urged, is to see that these sciences cooperate in interdisciplinary roles. He suggested five ways in which the orthopsychiatric profession can prepare itself to advance its interdisciplinary status:

- Communication patterns need to be clarified. Nomenclature common to different disciplines has different meanings ("energy" and "activity," for example). Semantic differences can be overcome if modifications can be accepted as natural, useful, and foreseen eventualities. "Freud himself," Lourie commented, "felt that his ways of describing the phenomena he found were modifiable. He changed his concept, for example, of psychologically based drives to one of forces, somatically based, underlying the drives." The days of usefulness of Freud's terminology will be numbered when we can pinpoint the origin of the forces and control them, he said.
- To prevent compartmentalization of knowledge, all members of the orthopsychiatric team should be acquainted with the structure, physiology, and chemistry of the brain. The extent of training would vary with an individual's specialty and need to know.
- Basic scientists should work as part of the orthopsychiatric team, at least for brief periods of time. All would learn from each other and true interdisciplinary research would be effected.
- Contributions by specialists in orthopsychiatric fields should continue at a high level, avoiding a low common denominator and guarding the interdisciplinary functioning.
- New explorations and speculations must be encouraged. Observational abilities should be cultivated to evaluate new directions, choosing those with promise and putting aside those that appear fruitless.

Finds Therapeutic Milieu A Complex of Variables

Dr. Fritz Redl, National Institute of Mental Health, Public Health Service, reviewed the concept of the patient's milieu as a factor in psychotherapy.

Confusion in the early concepts has led many people into the trap of seeking "the" therapeutic milieu, he said. It is not possible to determine whether a milieu is in itself good or bad or truly therapeutic on the basis of our philosophical, ethical, or political convictions, or our "taste buds." Those who adhere to the concept of total milieu therapy also need to remain cognizant of the fact that elements of the milieu are not equally important or constantly relevant in all situations. In some situations, for instance, the "pecking order," which determines the position of power, is operable; in other situations, it is not. "The thing that counts," Redl asserted, "is not only the description of a variable, but the assessment of the potential impact on the treatment process of a given group of patients."

It is naive, he went on to say, to think that the discovery of a needed milieu "would automatically make it easy to produce that style of milieu in a given place."

The adjective "therapeutic" he mentioned as another trap, and listed seven common meanings of therapeutic to be found in scientific writings. Therapeutic might mean, for example, "don't put poison in their soup," a translation of "the demand for absence of crude forms of punishment in a place that calls itself a residential treatment center." It might also mean, "you still have to feed them," the implication of the belief that children must have an activity program even though the plan of therapy is not concerned with play or diet.

"Milieu" is also a difficult word to define, Redl pointed out. He briefly outlined some of the factors that would be clinically relevant to therapeutic goals, choices in techniques, and assets or liabilities in various phases of therapy. Among these factors would be:

1. Social structure, comprising the type of hospital ward; the distribution of adult roles, in order that patients may be clear about who may make what decisions; the pecking order among the patients; and the communication network that enables the patient to know who can be approached to listen to certain problems.
2. "The value system that oozes out of our pores," for patients can "smell" what a staff feels, regardless of what it says.
3. The routines, rituals, and other behavioral regulations that have an impact upon the ability of the individual to maintain self-control.
4. Group relationships with respect to scapegoats, mascots, cliques, role playing, mob psychology, leadership tensions, and other such forces that demand more concern than "the curious stares of an anthropological slumming party."
5. Personality peculiarities that a patient "swings around his body like a wet towel hitting whoever gets in its path, innocent or not." Personality traits are "real things that hit and scratch if you get in their way."
6. The staff's attitudes and feelings that actually have an impact on the clinic situation.
7. The behavioral output by others to which a patient is exposed, and

which is distinct from the underlying feelings out of which people act.

8. Activities patients are requested to perform and the performance required of them ("constituent performances").

9. Space, equipment, time, and props: the space the patients work in, the time permitted for various activities, the medical and other equipment, and other "properties" of a clinical setup.

10. "The seepage from the world outside": the impact of visitors, the "sociological body odor" of the old neighborhood the patient may see in being transported from one place to another, excursions, movies, television shows, all the things that impinge upon and break open the institutional setting.

11. The "traffic" regulations of social interactions that normal life leaves to a person's own resources, and the "umpiring" services that may or may not be provided to protect a patient from specific experiences or to interpret certain experiences for him.

12. The "thermostat" for regulating the behavior of patients according to their needs during different phases of treatment. (Behavorial ceilings must be lowered when impulse-panic looms and raised when self-imposed internal pressures mount.)

In the face of so many complex variables, Redl proposed that the clinician isolate ingredients in the milieu as they affect patients in a specific setting during a specific activity. If the clinician knows the actual experience that a concrete situation has produced in a patient as well as what the patient did with the experience, then "milieu" will make more sense, Redl said.

Drift Theory Inadequate, Investigation Reveals

Investigation of the hypothesis that schizophrenics tend to drift into socioeconomically lower sections of a city was reported by Dr. Robert Plank of the Veterans Administration in Cleveland, Ohio.

Four major hypotheses have been offered in the past to explain why schizophrenics are consistently admitted into hospitals in larger numbers from socioeconomically low central districts:

- Statistical artifacts may have clouded the true proportion.
- In certain neighborhoods, schizophrenics are more likely to get into difficulties and therefore to be noticed. This is called the visibility hypothesis.
- The drift hypothesis.
- The breeder hypothesis, which assumes that the type of neighborhood is causally related to schizophrenia, so that by living in certain neighborhoods some people are more apt to develop schizophrenia.

Plank observed that the last two hypotheses are now receiving the most attention.

For his study, Plank selected active cases of schizophrenia at a Veterans Administration mental hygiene clinic. They were white, male, and veterans of World War II. The reasons he gave for selecting this group were: (*a*) whites have more freedom of residential mobility than nonwhites; (*b*) men have different residential patterns from women and also there were fewer women; and (*c*) veterans of World War II provide men of similar ages for experimental and control groups.

The number of veterans in both groups was 32, for a total of 64 in the study. Their present place of residence was compared with their residence at the time of induction into military service. Plank concluded that there was no evidence that these schizophrenics had tended to drift into lower neighborhoods, "but it is shown that they tend to stand still on the residential level on which they are while other people move upward."

The effect of marriage status was next examined, and Plank found that those who were single at induction but were now married had tended to move upward. For the others, there was a balanced upward and downward movement.

When living arrangements were compared, results were similar to those on marital status. Men living with parents or someone in place of parents at the time of induction, but were no longer, showed an upward tendency. The others were about balanced.

"In considering these figures in conjunction with individual case histories," Plank stated, "we find several patterns clearly emerging. The prevailing pattern is marked by two concerted steps in young adulthood: marriage and emancipation from parental figures. This involves a change in living arrangements which in our culture often opens the way to a residential upward movement. The typical schizophrenic patterns are characterized by the absence of these elements. . . . The new element that recent ecologic research has introduced is that we now have evidence that these patterns account for the relative drift."

We have to consider, Plank concluded, that while studies such as these help us understand the rationale of the drift hypothesis, a similar job is also being done for the breeder hypothesis. Understanding and, eventually, better control of schizophrenia through ecology would be forthcoming "if we were in a better position to see the dynamics by which a type of neighborhood can foster the development of schizophrenia in individuals who live there," he said.

Recovery Ratio Is High For Untreated Applicants

What do families do when they apply to a child guidance clinic for help but cannot be accepted? This question was posed by Sylvia Fowler, chief psychiatric social worker, Reiss-Davis Clinic for Child Guidance, Los Angeles, Calif., and Mary B. Novick, lecturer, School of Social Welfare, University of California, Los Angeles.

At the Reiss-Davis Clinic, where this study was conducted, less than a third of the applicants for treatment could be accommodated. In a 6-month period, 383 applicants were referred elsewhere. Of these, 145 were selected for followup, with 107

persons reached by questionnaires or by telephone and personal interviews.

Answers revealed that 46 percent had obtained treatment and 54 percent had not. Of those treated, 75 percent obtained treatment from one of the community's resources suggested by Reiss-Davis. The other 25 percent obtained treatment on their own initiative from other resources. Of those who had not obtained treatment, approximately 25 percent each made no further attempt to find help, contacted suggested sources but abandoned all efforts when refused further, did not try these sources but tried others before giving up, and last, tried many sources, those suggested as well as others, but failed to obtain treatment.

"The reason most frequently given for the inability to obtain treatment by those who made further effort," Fowler and Novick commented, "was that the other community resources also could not provide service within a relatively short time."

One important finding, the authors stated, was that almost 45 percent of those who had not obtained treatment felt that the problem was either solved or conditions had improved to the point where professional help was unnecessary. The authors speculated on the reason for this, but observed that their study could not prove, for example, that the mere interest in treatment the parents had shown resulted in some improvement, or that the conditions had changed.

"If further studies could establish that improvement without treatment could be predicted in certain delineated situations or at specific maturational phases, what a boon this would be for all who work with troubled people," they said. Criteria would then exist to permit the selection of those "who must be treated and those who could be kept off waiting lists."

Recognition of parental frustration in these matters led Fowler and Novick to a thoughtful consideration of a clinic's relationship to those who, for the first time, seek help. The authors recommend the following:

"Procedures in clinics for telephone interviewing should be developed so that everyone engaged in this important public relations function will act with sensitivity and thoughtfulness when talking to a troubled parent who may be faced with a discouraging number of rejections from other community facilities.

"It is important to realize that a parent's application to a clinic may be his first step toward achieving a better adjustment, whether treatment does or does not ensue. If an agency mishandles this first contact, the parent may become immobilized or even regressed, thereby impairing his ability to deal with his problem. If, on the other hand, every member of the clinic staff is aware of the therapeutic value of every contact, then these contacts can be made constructive experiences for the parent, mobilizing his strength to obtain treatment or to handle his situation better.

"Some parents cannot afford to take time off from work to accept treatment offered during regular hours. Clinics should consider the feasibility of adding Saturday or evening hours for marginal income families whose financial stability would be jeopardized if the parent must have weekly sessions during the working day."

Treatment Not Significant In Child Adjustment

An evaluative followup study, conducted by Dr. Eugene E. Levitt, Indiana University Medical Center, and Dr. Helen R. Beiser and Dr. Raymond E. Robertson, Illinois Institute for Juvenile Research, revealed no significant differences in adjustment between psychotherapeutically treated and untreated child patients.

The purpose of the study was to evaluate the effect of psychotherapy at the Institute for Juvenile Research, an agency of the Illinois State Department of Welfare.

For their study, adjustment was defined on the basis of 26 variables; followup meant 5 to 6 years on the average after the case was closed; and a treated case was one in which at least one member of a family had a minimum of ten 1-hour therapeutic interviews.

Four methods of obtaining a control group were examined and rejected by the authors:

1. Use of patients discharged from State hospitals, because persons in hospitals are usually more disturbed than those in clinic or outpatient groups, and the criteria for discharge are not well defined.

2. Correlational analyses based on certain hypotheses, such as improvement as a function of the number of treatment interviews instead of an actual control group, because results may be equivocal.

3. Use of cases diagnostically eliminated from treatment, because the groups would differ importantly with regard to prognosis.

4. Use of alternate cases in the same group for treatment and control, because the clinic cannot ask the control group to wait too long for treatment. Some will seek therapy elsewhere, and evaluation could only be made at close of treatment and not at followup.

A fifth procedure, and the one accepted for this study, is to use "defectors" for the control group. Defectors are persons accepted for treatment but who fail to undergo treatment.

A sample of 1,006 cases was randomly selected from among treated (experimental) and untreated (control) cases. A total of 327 experimental and 142 control cases actually participated in the first stages of the study. The experimental group number was further reduced to 192 cases, when the qualification of at least ten 1-hour treatment interviews was introduced as a factor in selection.

A study of the experimental and control groups revealed no significant differences in adjustment between the two groups, the authors stated, but mentioned a few conditions upon which this estimate was based.

First of all, the conditions under which the study was made refer specifically to those prevalent at the Illinois Institute for Juvenile Re-

search. Second, almost half of the individuals treated were in the hands of relatively inexperienced personnel (students or those with less than 1 year of experience). Third, 34 percent of the patients were treated by more than one therapist, and 90 percent had been seen only once a week.

The authors concluded that the results of the study are due in some part to less than optimal conditions of therapy. "However," they added, "the data themselves do not bear directly on this hypothesis."

Behavior a Function Of Person and Setting

Contributions to mental health and psychological therapy would be more significant if the psychological aspects of environmental factors were classified and quantified along with the "internal" variables of personality, suggested Dr. Harold Raush, Child Research Branch, National Institute of Mental Health, Public Health Service.

Although the investigator is faced with difficulty in defining situations, it can be shown that the particular setting affects the kind of behavior that one sees, Raush said. He indicated that such considerations have implications for problems of diagnosis and psychotherapy. One simple illustration, Raush observed, was that two members of a staff might disagree about the improvement of a patient depending upon where they observed his behavior.

"People exist, behave, fantasy, and think in specific environments, and conversely, for psychology at least, situations exist only in the sense that they impinge on specific organisms," he said. We can predict something about behavior when we know the person involved, and we can predict something about behavior when we know the kind of situation, but, he added, there remains the issue of interconnections between persons and situations. Persons and situations do not work additively in their contribution to behavior, Raush noted. Thus, the ability to gauge the direction of behavior is enhanced far beyond an additive function when one's focus is on the interaction between person and situation.

Raush raised the point that two patients could react to the same psychological features of a situation in different ways or "scan the same situation for different features." This obviously implies that variables of personality cannot be played down while one is considering the variables of a situation. "It is at the juncture of these two classes of variables that we meet behavior," he concluded, "and it is the study of this juncture that I should like to emphasize."

Public Health Nurses Promote Mental Health

Public health nurses are a potent resource in the promotion of mental health, commented Dr. Hildegard E. Peplau, associate professor of nursing and director of the program in advanced psychiatric nursing at the Newark College of Nursing of Rutgers University.

Informing the lay public and obtaining its moral and financial support are activities in which the public health nurse has proved herself particularly able, Peplau said. The capabilities of the public health nurse along these lines, she added, are in direct proportion to the confidence and respect she has won through her constant endeavors in the public's interest.

Of particular importance to the promotion of mental health, she said, is the public health nurse's skill and understanding. In times of family crises as well as at those times when a sustained, sympathetic relationship is called for, the public health nurse is prepared to provide support, information, and counsel for the anxious people she may serve.

The public health nurse is also in a strategic position to offset the consequences or to prevent the occurrence of mental illness.

Peplau pointed out that case finding, prompt referral for early treatment, and therapy are routine activities for the nurse and can be easily extended into the field of mental health. In addition, the nurse can bring to the attention of those in need new treatment facilities. She can inform families about the nature and extent of illness in a member of the family, and prepare them for responsible attitudes toward such members when they are returned from hospital care. Lastly, mental health education can be inculcated without difficulty into the public health nurse's normal activities, Peplau said.

Dying Patients Prefer Talking About Death

Two dominant attitudes toward death were discussed by Dr. Herman Feifel of the Veterans Administration Mental Hygiene Clinic, Los Angeles, Calif. One views death in a philosophic vein as the natural end process of life. The other, the religious perception, is that death is really the beginning of a new life and a termination only of physical existence. From these attitudes two contrasting ethics may be derived: a stoic acceptance, or an idealistic glorification of death (or the "afterlife") that gives meaning to the biological cycle.

Feifel offered an interim report of the results of questions about death he asked 85 mental patients with a mean age of 36; 40 aged persons with a mean age of 67; 50 young people, mean age 26; and 35 professionals, mean age 40.

Patients were asked what disease they expected to die from. The majority were unable to associate their prospect of death with a specific disease, but a high proportion of mental patients visualized themselves as dying in a violent accident. Most patients hoped to die quickly and with little suffering.

In response to the question, "If you could do only one more thing before dying, what would you choose?" the mental patients voiced religious or social interests. "Give my belongings to charity . . . stop war if possible . . . know more of God," they said. The young persons and professionals, in contrast, expressed

more personal desires: they wished to travel, live in a new home, and so on.

The religious persons had more personal fear of death than the nonreligious. They expressed concern with purgatory or hell and with their failure to expiate sins, in contrast with the nonreligious who more frequently wished to continue their work in life, provide for their families, finish undertakings, or enjoy their experiences. Even those religious ones who expected to go to heaven were not all free from the fear of death.

Feifel suggested that the fear of death could well be one of the reasons connected with society's rejection of the aged. He also felt that it would be interesting to examine the attitudes toward death of those working in the "life saving" professions.

To deny or ignore death, Feifel said, is to distort life's pattern. Human maturity, he said, entails a recognition of limit. "We are not altogether free in any deed as long as we are commanded by an inescapable will to live. . . . Not until man overcame the fear of death could he permit himself to be bitten voluntarily by a [yellow fever] mosquito, sail to the seven seas, or master the art of flying."

Feifel found that dying patients wished to talk about their feelings and thoughts about death but felt that they were denied the opportunity by those who look after them.

He said a large number of terminal patients prefer honest and plain talk about the seriousness of their illness. "They have a sense of being understood and helped . . . when they can talk about their feelings concerning death. There is truth in the idea that the unknown can be feared more than the most dreaded reality. . . . Patients can accept and integrate information that they are to die in the near future but want a gradual leading-up to this rather than a 'cold shower' technique, as one patient put it."

Feifel said the reaction of the patient to such information depends on his character more than on the event itself. He adds, "The crisis is often not the fact of oncoming death per se . . . but rather the waste of limited years, the unassayed tasks, the locked opportunities, the talents withering in disuse, the avoidable evils which have been done. The tragedy which is underlined is that man dies prematurely and without dignity, that death has not become really 'his own.'"

Consistent Help Needed For Problem Families

Chronic problem families functioning at primitive and regressed levels can be helped if social agency workers maintain consistent relationships with the family over a long period of time rather than at sporadic intervals. Moreover, services provided for the family must be flexible to meet its needs and must be immediately available. Initial emphasis must be on material support.

These were the conclusions presented by Dr. Joan J. Zilbach of the Judge Baker Guidance Center and United Community Services in Boston, Mass., Lester G. Houston, Greater Boston Council for Youth, and Emily C. Faucett, Smith College School for Social Work, reporting on their study of selected families in Roxbury, Boston.

Seven public and private social agencies pooled their resources "to develop more effective methods for reaching and serving chronic problem families," the authors stated.

Criteria for inclusion in the study were: (*a*) repeated contacts with social or law enforcement agencies over a minimum of 3 years, with requests for assistance; (*b*) at least one child in the family under 13 years old; and (*c*) at least one child in the family who had experienced social difficulties.

Eighteen families were selected for study. These families live in urban areas with high rates of social disorganization and delinquency. All had had at least 15 years contact with 10 or more agencies. With so many agencies trying to help them, duplication and ineffectiveness of services and lack of coordination between the agencies were discovered by the researchers.

Children in these families presented numerous problems, running the gamut from physical handicaps to sexual delinquency. Many had been in courts and State institutions of correction. Surprisingly, the authors commented, "only one family had been known to a child guidance clinic."

In many of the families, fathers were elusive or nonexistent. Fathers and mothers came from homes marked by physical handicaps, psychosis, alcoholism, illegitimacy, prostitution, or imprisonment of one or both of the parents.

According to the type of relationship the mothers had with their families and other persons in the community, the families fell into two broad classifications. Mothers in the first group showed strong attachments to their children, often having many. And they resented any efforts of the social worker except the offering of material assistance. Mothers in this group, however, were able to request medical care for their children even when they were unable to do this for themselves.

Mothers in the second group were characterized by apathy and impersonal relations with those around them. Whereas mothers in the first group exacted from their children fulfillment for the deprivations they had suffered themselves in childhood, maintaining ties with their children when they moved away, those in the second group neglected and ignored their children.

These emotionally deprived people, it was observed, "have learned to function in a fragmented way without the ability to move forward from a primitive level." Their needs are difficult to understand, and agencies that merely supply their requests for concrete assistance do not help them towards individuation, independence, and self-support, the authors pointed out.

Social workers must involve themselves in the routine and repetitious crises of chronic problem families, however difficult such a relationship may be—and chronic problem families are "notable for their ability to rout and defeat the hardiest worker." By meeting emotional as well as

material needs, "work with families has become not only more understandable but more fruitful," they observed.

Antisocial Behavior in Boys Traced to Their Mothers

In a study of 20 aggressive, antagonistic, and antisocial boys without fathers, the relationship between mother and son was revealed to be intense, highly sexualized, and full of hostility and guilt.

Reporting on this study were Dr. Howard L. Wylie, assistant director, and Dr. Rafael A. Delgado, psychiatrist, of the Worcester Youth Guidance Center in Massachusetts.

The mothers came to the center under external pressure, usually from school authorities, with the chief complaint that their sons could not be controlled or disciplined. The mothers, it turned out, treated their sons in much the same way they had treated their husbands, and, in most cases, that relationship had been a stormy one, Wylie and Delgado said.

The particular forms of behavior the mothers imposed upon their sons were seductive and punitive, the authors said. In many instances, mothers shared their beds with their sons, bathed them at an age when the boys were quite capable of bathing themselves, wrestled with them, and engaged in other sexually charged, symbolic activities.

Punitive measures, apparently arising from hatred for the former mate, self-derogation, or guilt over the sexual substitution of son for father, were inflicted by many mothers on their sons. "We often have the feeling," the authors said, "that the mothers were driven by an intense need to see their sons behind bars." For some mothers, this seemed to be a protective measure: they feared hereditary incompetence and a consequent emulation of the scorned father by the son. For other mothers, an imprisoned son would be means to a symbolic revenge upon the father.

The boys, reacting to this love-hatred complex, took their revenge through a variety of antisocial activities. Aggressiveness and belligerence were accompanied by enuresis and soiling, and, occasionally, delinquent acts. Several had appeared in courts and three were in corrective institutions, the authors found.

The mothers could not all be delineated in precisely the same terms. Some had found replacements for their husbands and, on the one hand, were adjusting to their situation better, and, on the other, were replacing their sons with psychologically more valid objects for their love. Other mothers were persistent in their substitution of son for father, and still others were "dominated by a vengeful, competitive attitude toward males, and by a strong wish to be a man. These women looked upon their sons as the fulfillment of this wish," the authors averred.

Therapeutically, the situation was not enviable, and the authors said that their attempts to help these people had not been very successful. Most of the mothers rejected the offer of treatment outright or withdrew after a few visits. Most of those who came showed a blatant resistance to treatment. The boys were also seen for only brief periods of time. Those that showed some improvement rapidly relapsed into their former behavior when they returned to their unchanged environment.

Recognizing that the significance of their findings is open to some question, the authors described several limitations that restrict their conclusions and require further investigation: (*a*) some boys with fathers behave similarly to these boys; (*b*) not all boys without fathers behave this way; (*c*) siblings of these antisocial boys may or may not conform to the same behavioral patterns in the same circumstances; and (*d*) the socially antagonistic behavior of the child, so far as it is an extension of the mother's maladjustment, may be transitory if the mother is capable of forming a valid relationship with another man and is in the process of doing so.

Atomic Radiation Poses Mental Health Hazards

Atomic radiation "is surrounded with an aura of mystery and must be expected to evoke strong emotional reactions," according to Dr. Frank Fremont-Smith, member of the executive board of the World Federation for Mental Health.

Citing an atomic radiation incident in Windscale, England, another in Holland, and a third in Houston, Tex., Fremont-Smith pointed out that each gave rise to anxieties and fears disproportionate to what the factual situation called for. The problem, he said, was primarily a failure in proper communication, both in official and public domains, so that there was a loss of confidence in the responsible authorities.

He referred to present anxieties about X-rays as an analogous situation. With a great deal of publicity directed toward the dangers of X-rays and faulty equipment, a number of people have refused to permit roentgenograms to be taken, even when urgently required for proper diagnosis.

"The mental health problems of the peaceful use of atomic energy are the mental health problems of preventing war," he concluded, "and with the advent of nuclear weapons the problem of preventing war has become the human problem of human survival. The real issue is not the peaceful use of atomic power but the peaceful use of human power."