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Psychiatry and International Affairs

Psychiatric approaches to analysis of international transactions will require professional innovation.

Bryant Wedge

Albert Einstein wrote to Sigmund Freud in 1932 that "It would be of the greatest service to us all were you to present the problem of world peace in the light of your most recent discoveries, for such a presentation might blaze the trail for new and fruitful modes of action." Freud answered that he saw " . . . no likelihood of our being able to suppress humanity's aggressive tendencies" (*1*). This reply failed to undermine Einstein's hope that psychiatry, the profession most practically concerned with disorder and conflict within and between human individuals, might help in the management of relations among nations. That hope is still with us but continues to be disappointed. Psychiatry has failed to provide practical assistance in the management of international conflict, though such conflict has become vastly more dangerous to mankind since the time of Einstein's appeal.

The idea that "wars begin in the minds of men" and that "it is in the minds of men that the defenses of peace must be constructed" is as old as the history of relations between organized societies. It has been restated most recently and authoritatively in the constitution of UNESCO. Why has the scientific profession most concerned with helping the individual with the troubles of his mind failed to contribute to solving the most significant problem in all human behavior? What could psychiatry contribute? How should the profession make the contribution to better management of international affairs which it is theoretically capable of making?

Albert Einstein was certainly correct when he observed that "Peace cannot be kept by force. It can only be achieved by understanding." A psychiatry of international affairs can, I think, contribute to such understanding.

Demands of and Responses by Psychiatry

Einstein was neither the first nor the last to call on psychiatry to contribute its services to the solution of problems in international affairs, nor was Freud unusual in his willingness to respond and to assert that the discipline has something useful to say on the subject. A number of substantial reviews have documented these claims (*2*).

Most psychiatric statements on international affairs can be classified as diagnostic, prescriptive, or inspirational; few have addressed themselves to problem-solving at the international level, either in theory or in practice.

When William Alanson White, for example, suggested that "War removes cultural repressions and allows the instincts to come to expression in full force," he was making a dynamic-diagnostic statement which is somewhat more sophisticated than the frequent statements describing national behavior as "collective psychosis" or nations as "paranoid" (*3*). When Harry Stack Sullivan, one of the few psychiatrists who attempted to cope with the realities of international life on an operational level, called for a "cultural revolution to end war," he spoke more thoughtfully than the recommendation that "universal love must be encouraged from childhood" (*4*).

Inspirational statements have come in waves: after World War I, in the years before and after World War II, and again in the early 1960's. The last wave was apparently released by the thaw in the Cold War and growing awareness of the risk of nuclear annihilation. In 1935, 339 psychiatrists from 30 nations signed a manifesto on war prevention, declaring that "we psychiatrists declare that our science is sufficiently advanced for us to distinguish between real, pretended, and unconscious motives, even in statesmen." In 1941 George H. Stevenson's presidential address to the American Psychiatric Association claimed that "we as psychiatrists are able to evaluate [psychopathological factors constantly determining toward war] more adequately than other groups" (*5*). Repeated calls to the psychiatric profession from

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its leaders have inspired individual psychiatrists to apply their talents to the problem and have resulted in establishing various committees and associations concerned with the issues, but in no case, to the present time, has any psychiatrist been able to sustain a professional role in the field.

The year 1963 was a vintage year; over a hundred psychiatrists gave papers, and many more participated in symposia, at the American Psychiatric Association, the American Orthopsychiatric Association, the American Psychological Association, and the American Association for the Advancement of Science. Many of these were thoughtful indeed; a number were based on substantive study of actual problems; some came to the attention of distinguished statesmen such as Senator Fulbright and Vice President Humphrey. But almost none of the participants has continued this interest in any professional way; one by one each has reverted to more ordinary professional work; except for brief periods such as a summer working group, none has been able, despite many attempts, to gain financial or institutional support for his efforts.

The story is the same on the organizational level. The Committee on International Relations of the American Psychiatric Association has yielded to the Committee on Transcultural Psychiatry; the brave beginnings of the World Federation for Mental Health in 1948 have been reduced to exchanges of psychiatric experience; the Committee on International Relations of the Group for Advancement of Psychiatry has not been able to realize the vision of its own 1950 report (*6*). Even the much broader UNESCO "Tensions Project" quietly folded.

This plausible idea, now over 50 years old, is actually in decline. There have been virtually no identifiable contributions to definitive policy problems; there is no institutionalized course of training or professional position in which to "practice." Perhaps it is time to examine some of the problems and some of the requirements which would be necessary for its realization (*7*).

Problems of a Psychiatry of International Affairs

The principals in the international system are the national states, and a true psychiatry of international affairs would be concerned with the transactions among these. This discussion will be confined to that level. Meanwhile, it is useful to note certain contributions of psychiatry which have some indirect bearing on international relations. Conventional psychiatry does provide professional services in a number of national and international organizations —services in the selection, training, and treatment of national and international public servants. Conventional psychiatric consultation is sometimes provided to national agencies in the assessment of personalities of leaders and the consequences for national policy processes. Some research and consultation has been held concerning group processes in international conferences and negotiation.

International psychiatry is even more narrowly restricted with respect to the problems of international affairs. In general, the international applications of psychiatry involve the communication of theory and techniques from one society to another with due attention to cultural differences. In short, international psychiatry represents a technical and scientific monoculture adapted to mental health problems in differing national settings. There is no doubt that the building of international intellectual and technical ties contributes to the moderation of national behavior but in this respect psychiatry acts no differently than, say, international chemistry.

The indirect contributions of psychiatry are more significant than the direct work of psychiatrists. Social psychologists, political scientists, and development economists have drawn on psychiatric ideas in developing and testing hypotheses (*8*). Furthermore, it is possible that some of the larger generalizations of psychiatric theorists—for example, that dehumanization of the "enemy" may have profound consequences for self-image and for making behavioral judgments—have had some effect on the attitudes with which foreign relationships are approached in the policy community.

These represent the contributions of psychiatry to date; they can hardly be characterized as inputs to a "policy science" which Harold Lasswell believes possible (*8*, p. 337). Before considering what these contributions might be, let us examine why psychiatry has contributed so little of consequence to problems of international affairs.

Level-of-analysis problem. Scholars of international affairs agree that the areas relevant to their subject are those of the international system itself, with the national states as participants (*9*). It is clear that no simple model, whether based on considerations of power, personality, economic factors, or ideological preferences can describe the transactions within the international system. The political systems of national states determine their responses to changing circumstances in the international system.

When I speak of the political systems of nations, I mean a system of assumptions concerning the domestic and international exercise of the authority process (*10*). Such a system is the product of the unique history and circumstances of the people and of the nation as an entity and includes the whole range of belief, value, habits of communication, economic activity, government forms and practices, and customary expectations which bind a people together into a nation (*11*). This is not to deny the significance of individual leaders, of the international environment, of culture diffusion, or of systemic revolution as factors in the behavior of states in the international system; it is only to assert that all these elements interact with the purposeful behavior of the separate political systems.

Psychiatry is primarily concerned with individual human beings. Only recently has the revolutionary concept of social interdependence led psychiatry to broader concerns, those of the community and the nation as these bear on the history of individuals. The orthodox limits of psychiatry do little to prepare the profession for the scientific consideration of international affairs.

Psychiatrists who become concerned with the international world quite correctly perceive that dynamic psychological factors are somehow operative in it. Here, however, the scale of the problem is baffling and most contributors on these matters have deserted their profession's own standards of evidence and resorted to analogical thinking, often quite crude in quality; they equate the behavior of states with that of the persons or groups with which they are familiar. Here, psychiatrists often make fools of themselves from the standpoint of the decision-makers who deal with different kinds of reality. It is only the rare psychiatrist who persists in the face of these difficulties and becomes empirically sophisticated in dealing with the realities of political systems.

Cultural problem. Psychiatry, which has grown out of medical and biological science, is only gradually outgrow-

ing its own history. It has been forced to do so by its own mission of meliorating the life-difficulties of its primary object, the human individual. Gradually, we have come to learn that man is an exquisitely social being as well as an intelligent animal. We are learning how very deeply the social history of an individual enters into his psychological fabric and how intimately his social circumstances affect his well-being. We are learning that, to realize our mission, we must sometimes intervene at the social level (*12*).

Meanwhile, to a certain extent, psychiatry has avoided acknowledging the fact that people of different cultures may be "just as different on the inside." So long as patients are approached one at a time it is possible to maintain the view that persons are sufficiently alike in basic psychological quality to make unnecessary a close consideration of the culture which the individual has assimilated and in which he transacts his living.

Since a fundamental requirement for the analysis of national behavior in the international system requires a deep appreciation of culture differences and techniques for their identification, psychiatry is in this respect ill-equipped to deal with problems in the field of international affairs.

Operant factor problem. The realities which affect national and international decision-making include a host of issues peculiar to the political systems. These include strategic balances, economic resource-allocation, treaty obligations, international legal considerations and domestic political questions. And the decision processes are quite different at these levels than they are on the level of individuals or small groups. For example, appreciation of fundamental differences between national and household economic planning is important to an understanding of economic stabilization.

Always, history is of profound significance, a point which I emphasize because psychiatrists, who would not think of diagnosing an individual without his history, have frequently neglected the historic realities of and between nations in their diagnostic and prescriptive essays in the field of international affairs.

The dynamics of physiology and of the flow and channeling of affect and action within the individual human mind are quite different from those which motivate the political-economic-social systems of nations. *Within* a social system the latter can be taken for granted or ignored for the purposes of treatment; *between* national systems they are critical. Unless these factors are taken into account, there is little chance of contributing to realistic assessments of international relations.

Through all these systems, of course, flow unique patterns of the perception of reality and action tendency which characterize any given culture (*13*). No one, except extreme advocates of power-political or economic determinism theories, seriously questions that national decisions are always and above all psychological. All of the decision-making roles in national and international political structures are filled by individuals who must rationalize and communicate their policies to constituents and counterparts in other countries. However massive and impersonal are the systems within which man lives, the human voice and human transactions play very substantial parts which must be analyzed and taken into account if their behavior is to be understood.

Problem of disciplinary orthodoxy. All true professions define their boundaries and discipline members who seek to transcend these. This is quite necessary to the maintenance of professional order and standards. The psychiatric profession has been savage in its treatment of members who show serious interest in international affairs. Such psychiatrists are often accused of grandiosity or immaturity. It appears that international affairs seem both abstract and oversize from the profession's usual vantage point.

Other scholarly disciplines also resist the entry of psychiatry into their fields of competence. This may be due to the psychiatrist's limited background in another field such as political science. When he recognizes these limitations and seeks guidance in other fields, he is often warmly received and eventually consulted by scholars in contiguous fields.

In the realm of policy consideration and execution the reception is somewhat different. Only one question is really asked, "Does this man have the goods?" In no case that I know of has any psychiatrist or other scholar lacked a hearing if he brought well-based considerations to bear on a problem of concern to the policy community, especially when the evidence is couched in language that makes sense. Statesmen constantly seek to enlarge their understanding of policy-relevant factors but have no time to waste with what they regard as pretentious intellectual exercises. Having worked with a number of statesmen and bureaucrats on questions of substance, I have come to appreciate the dim view they take of a number of prescriptions thrust at them from our profession. If these prescriptions are operationally meaningless they get no attention.

Here, I must mention some of the practical problems of professional psychiatric approaches to international affairs. There is no institutional base that encourages, or even allows, serious professional work. There are as yet no university chairs in the field. The best bet for a psychiatrist seriously interested in these matters is to attach himself to some other department in a university or institute. The economic circumstances of the profession are also nearly prohibitive; it is nearly impossible to earn income close to normal professional expectations, especially at the beginning. Yet serious work in the field demands full professional attention. We are priced out of the market.

Finally, the *role* of the psychiatrist in his normal professional life has ill-prepared him for his role as consultant or investigator in international affairs. The psychiatrist is used to having the ultimate findings and final decision left to his judgment, even when he works with a team. Nothing like this pertains in his work on international affairs; here his findings and recommendations are certain to be marginal at best; if he contributes 5 percent of the rationale for any substantial decision he will be doing well and must rest content. The psychiatrist who wants to be a decision-maker in these matters is simply in the wrong profession.

The Argument for a Psychiatry of International Affairs

Despite all these problems, there is a substantial case for applying psychiatric methods to international affairs. Clinical psychiatry involves the professional application of complex multivariate analysis and decision-making in areas of profound human relationships and in terms of incomplete and inexact information. This represents an approach more akin to the actual problems of international affairs than almost any other profession. We have learned to approach such decisions systematically and realistically; we have learned to exercise objectivity and com-

passion with respect to human actions, and these qualities are desirable in the analysis of international problems. At our best, we tolerate considerable ambiguity but try to reduce it to the minimum.

Psychiatry characteristically relies on many other professions for measurements, from biochemistry to sociology, and such collaboration is very useful in international affairs analysis which must also deal with many special factors from economics to weapons technology. Orderly habits and procedures for diagnosis, prescription, and correction of analysis are apt to the policy process.

More specifically, psychiatry works with behavioral propositions which are highly relevant to international affairs; we even possess some experience with explanations for behavior which might provide models sharper than those now being used as a basis for decisions. Our work with genetic-historic hypotheses, especially, might be useful in predicting behavior if we should develop them as required.

At its best, psychiatry possesses a specific set of skills and attitudes which are professionally highly developed and which are directly applicable to behavior problems in international relations. These are the skills needed to understand other persons, especially those who are alienated from our society, in their own terms. It is not a source of confusion among psychiatrists that there are many worlds, not merely one, to paraphrase Walter Lippmann. It is not surprising to psychiatrists that differences in outlook divide the human race, a circumstance which George Kennan has characterized as the source of tragedy in international life. It is just because of this skill and this experience, polished over generations, that psychiatry may have something of real value to offer in the field of international affairs because this specific competence is often lacking in the training and experience of statesmen. Indeed, in this respect no other profession or discipline is so well prepared by everyday practice.

Training Requirements

For psychiatry to live up to its claims it would be necessary to support at least a few of its members in training for quite specialized purposes, to provide and support recognized positions and, above all, to approach the complex issues of international policy with humility. I have suggested that international affairs involve levels of system-analysis, factors of history and culture, and structural and dynamic factors with which psychiatry is relatively unfamiliar and which the psychiatrist of international affairs must learn to take into account, even if he confines himself to questions of social and psychological dynamics. Consequently, the training would require education substantially beyond the normal limits of psychiatry.

Such training should include gaining a reasonable level of theoretical and practical knowledge of international affairs, both as an intellectual discipline and in terms of practical operations. In addition to psychiatric training, there should be study of government politics, economic and cultural structures, national growth patterns, linguistics, and the analysis of social-psychological phenomena.

I am aware that I have outlined a curriculum which would require 3 to 5 years of study to acquire minimal competence and which goes far beyond the field of psychiatry (*14*). Indeed the only possible places to gain sophistication in these subjects are the universities and international affairs schools where study can be undertaken with appropriate departments—those of anthropology, history, political sociology, economics, and international relations. How could a psychiatrist, already extensively trained and economically privileged, be expected to undertake such a course of training? It is clear that he must if he is to be competent in matters of international affairs.

Five years of post-residency training, when coupled with research and the development of specialized capabilities, is not unusual for the psychiatric specialist, whether he works in psychoanalysis or community organization. I suggest that federal and other special grants might be obtained to subsidize such training. If we were to assume that this had been accomplished, let me visualize the course of career development.

Ideally, the psychiatrist should be experienced and mature as a professional in his field before entering such a specialty; in short, he should have had 4 or 5 years of psychotherapeutic and community practice. At this point he might enter a department of psychiatry or an institute for specialized training and experience. He would then pursue study outlined above, perhaps contributing something from his own professional background to the teaching program —I have indicated that several of these fields have some interest in psychiatric theory although they lack professional competence; my personal experience has been that substantial consultation is sought by scholars in relevant fields.

Meanwhile, it would be possible to supplement theoretical training by practical field experience; 2 or 3 months of case study each year, whether in the field or from documents, could be devoted to analysis of appropriate problems. Such case studies could provide the student with practical experience in dealing with the policy community. From such study and such experience, it is certain that—*if* the claims of psychiatry have been correct and it does have something to offer—specialized professional roles would develop.

I will not be too specific in outlining the precise roles which could be developed for a psychiatry of international affairs; this question is open to experimentation. But it is clear that these would involve analyses and predictions of behavioral response in international transactions. In matters of communication, the analysis would include questions of "What does the other fellow really mean to convey?" or "How can I make him understand me?" and "How can I keep my role defined while I communicate with him?" These are questions which are obviously involved in any psychiatric dialogue and they are critical to the conduct of international affairs (*15*).

Some psychiatrists would certainly conduct their work as teachers and researchers in universities; some would go into government service where there is a serious shortage of specialists in the behavioral sciences; others would become consultants in diplomatic problem-solving. The role would be technical, one of providing analysis of problems and of carrying out such studies and making recommendations. Never, in my view, could a psychiatrist enter into the decision process in any direct way without abandoning his proper professional role.

While the kind of program outlined here may sound visionary and almost impossibly extended in time and resource, the outcome might provide sufficient justification. By the age of 35, the psychiatric specialist in this field could be fully trained, experienced, and

prepared to contribute to a most critical enterprise, that of building a viable international order.

Potential Contributions of a Psychiatry of International Affairs

It is as yet impossible to visualize all of the possibilities for a psychiatry of international affairs. They range over the whole spectrum of human communication and social behavior. At a practical level, psychiatry could contribute to more accurate conduct of international affairs. My own work has involved studies of the personality characteristics of foreign leaders, of psychopolitical factors in specific international conflicts, of interpretation of negotiating behavior, of improving effectiveness of communication among nations, of analyzing psychological aspects of policy—as these might modify cost-effectiveness or strategic decisions—and of working out means to establish human contact with groups isolated from and essentially wrong-headed about the United States. I am satisfied that in each of these case studies something unique has been systematically derived from the psychiatric discipline—concepts, attitudes, and modes of analysis which are peculiar to our profession and nowhere else so well developed (*12, 16*).

The ultimate contribution of a psychiatry of international affairs could well be conceptual and theoretical. Working by the case method and basing generalizations on hard evidence, we may be able to construct a new and deeper understanding of the political processes within which we all live.

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NEWS AND COMMENT

AMA: Some Doctors Are in Revolt, but Revolution Is Not in Sight

From an intellectual point of view, criticizing the American Medical Association may be like beating a dead horse. All the criticisms have been made, and made well, and the points raised about the organization a decade or a year ago are equally valid now. Politically, however, the beast is alive and kicking, or at least it is alive enough so that when its new president suggests in his inaugural address that health care in America is not a right but a privilege, those who have come to take the opposite principle for granted feel stirred to make a loud response. In taking his stand at the AMA convention late last month, Milford O. Rouse, the conservative Texan who is the organization's incoming chief, did for the dissenters in American medicine approximately what Pearl Harbor did for FDR.

Rouse spoke in a context of rising anxiety throughout medical circles about cracks in America's system of delivering medical care. The main thrust of concern varies with the perspective of the observer, but it derives essentially from three considerations: cost, quality, and equality. Costs are soaring: hospital rates went up 16.5 percent last year, the highest increase in 18 years, and doctors' fees rose by 8 percent, the highest annual increase since 1927. The distribution of resources, one measure of the potential for quality, is notably uneven: New York State has 211 doctors per 100,000 population; Mississippi has 74. Massachusetts has 502 professional nurses per 100,000 population; Arkansas has 120. U.S. infant mortality rates are now 15th lowest in the world. Equality is a goal not even shared in principle by a large proportion of the providers of medical service: the maternal mortality rate for Mississippi Negroes is 15.3 per 10,000 live births, more than six times the national average for whites, which is 2.5. Differential service based on class as well as race is well documented in Northern hospitals, as well as in facilities in the South.

The context of AMA President Rouse has little to do with these social realities. Rouse entered the debate with a speech in which he made at least four points with an oddly anachronistic ring. First, he made his much quoted pronouncement: "We are faced with the concept of health care as a right rather than a privilege." Second, he asserted the frequently stated but objectively discredited homily: "The United States [has] a quality of health care unsurpassed anywhere." Third, he stated that, faced with increasing government programs which "provide health and medical care for large segments of the population, including many who have no need for government help," the job