The Military Psychiatrist as Social Engineer

BY JOSEPH DUBEY, M.D.

The social roles of the military psychiatrist are examined with special attention to the uses and misuses of power. The ethical dilemma of loyalty divided between the individual patient and the community at large is complicated by the social impact of psychiatric diagnosis. Diagnosis may be considered a seemingly harmless choice of medical language describing social behavior, but the choice of the medical model has profound social consequences.

MANY psychiatrists, upon entering the service, find themselves called upon to perform functions quite different from those familiar to their civilian practice. This paper deals with some of the problems inherent in the role of the military psychiatrist and shows how such problems may be analogous to those seen outside the military.

Many of the concepts outlined here apply as well to all behavioral scientists in a culture which has become increasingly psychological-minded and which has turned to science for its salvation much as the culture of medieval Europe turned to religion. Today, when men have created a formidable technology with cataclysmic potentialities, the threat to our existence appears more clearly than ever to be not from nature but from human nature. The behavioral scientist is sought out as the seer who should have all the answers and is thrust into positions of power for which he may be ill prepared by training as theoretician or as observer. He thereby takes his place in what Wolpert calls the "New Republic in which Scientists would play the role reserved by Plato for the philosopher kings"(8).

Examination of the psychiatrist's role in any context is liable to be confusing, for there are many diverse activities which fall under the rubric of "psychiatry" by virtue of their exercise by psychiatrists. The psychiatrist may be physician, teacher, theoretical scientist, social engineer, advisor, judge and jury, and thought policeman. He may seek to alleviate discomfort, provide information, manipulate people and events, protect or coerce individuals and communities, or analyze events. He may try to help people to assume responsibilities or he may try to protect them from responsibilities. We will be most concerned with the function of the psychiatrist as physician and social engineer and with its implication for the military.

The traditional task of the physician has been the healing of diseases and the alleviation of pain, although the actual infliction of pain through noxious procedures and medicines, in the interest of eventual cure, is still found to be necessary. The same model applies to certain phases of psychiatry in that the process of learning to deal with stressful or painful situations entails enduring discomfort. At this point the model breaks down, for the doctor of the physicochemical machine may be expected to intervene directly in the workings of the machine(4), since he is an expert in the laws governing physiology, biochemistry, anatomy, and so forth.

The laws governing human social behavior, however, are not those of nature(3) but of men. Men live by an assortment of rules, some actually codified into "laws," but most being simply "what is expected" and existing under the titles of culture, language, ethics, morals, and so forth. Direct intervention and

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At the time this paper was prepared, Dr. Dubey was a Captain, MC, USAF. His present address is 25 Sintsink Drive West, Port Washington, N. Y. 11050.

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regulation in such human affairs has usually been the task of politics and law rather than medicine.

How, then, has medicine gotten into the act? Certainly not through the enlightenment of analytic psychiatry. The role of the psychoanalyst has been more analogous to that of the theoretical scientist who observes, formulates theories, and tests his theories with observed data. Although Freud was a physician and neurophysiologist and tried until his death to correlate his observations of behavior with physical laws, his enduring successes were in formulating theories about human nature using the methods of the theoretical scientist. The job of the psychoanalyst has since been that of helping his client to analyze the data of his life so that the patient can take more effective action according to increased knowledge about himself and about what he is doing. This is far removed from medicine as we know it.

Historically, of course, the psychiatrist was primarily the asylum keeper, a kind of jailer, concerned simply with limiting behavior (9). But there is something that psychiatrists do today in regard to human social laws or rules. The medical doctor seeks to alter a physicochemical machine in order to restore a biological norm; the psychiatrist, however, may be said to be concerned with behavioral norms(4), which are defined according to social rules.

Mental illness, then, might be regarded as a kind of rule-breaking(5), with the psychiatrist as an analyst or interpreter of rules and "games" (human behavior) on the one hand, and rule maker or enforcer on the other. (For instance: "It is forbidden to be psychotic, punishable by confinement, shock treatment, etc." or even "It is not healthy to be anxious; these pills will keep you from being so.")

Both approaches have been criticized, the analytic for being idealistic and impractical, the directive (controlling) for being coercive. Certainly the analytic position is more difficult to maintain in the face of demands for control and enforcement by the patient himself. However, the control model is much more likely to be misused, considering the unwieldiness of the power involved. In any case, the psychiatrist's choice depends on several factors in the patient, himself, and the circumstances that bring them together.

The Patient

Under this metaphor it is important to distinguish between those who break their own rules and those whose personal codes of conduct are in conflict with the social expectations of others. The proverbial "onion" and "garlic" neuroses come to mind here. The former apply to those who appear as voluntary psychiatric patients suffering from their own conflicts of values, needs, and meanings and from their failure to come up to the standards they set for themselves.

Consider the chronically hypochondriacal frequenter of the doctor's office who seems to make a life's game of being "sick." One of her rules requires that she be well and be a wife and mother to perhaps too many children; another, perhaps a holdover from childhood, demands that she herself be taken care of. To follow one rule means rejection of the other. She cannot win. What is more, she is to a degree unaware of the rules by which she lives and suffers, as it were, from the consequences of her ignorance.

Her psychiatrist may act as a traditional doctor, administering psychic analgesia in one form or another, or he may attempt to engage in a kind of educative process directed towards the behavioral changes which result from increased awareness of choices to be made. In any case, the patient defines her part in the relationship and, so to speak, writes some of the rules about what the doctor does. As an educator, he will be more the interpreter-analyst.

"Garlic neurosis" applies more often to the involuntary patient who has disturbed others so that he is brought to the psychiatrist or coaxed, bribed, or coerced to him by spouse, parent, court, or commanding officer. The "patient" feels only the discomfort of the displeasure of others; his own integrity is maintained. The real patient here is the community which asks the doctor to perform some social surgery; remove the offending member, change him, or put him in deep-freeze where he won't hurt so much.

To this individual, the doctor is an enforcer. The same individual may, of course, become a voluntary seeker of help when or if shown that he is acting against his best

interests. In more conventional psychiatric language, this is called converting a character disorder into a neurosis.

The Psychiatrist

The psychiatrist as physician, then, may serve two vastly different causes: that of his patient and that of his community(1). Relief of distress for one may or may not entail the same result for the other. Whose interests are put first depends, naturally, upon whom the physician works for, but also upon whether he defines mental health in terms of what is best for the individual's self-adjustment or what is best for his environmental adjustment.

In other words, the psychiatrist chooses an individualist or a collectivist ethic according to his own humanitarian instincts about what best fits the circumstances. His ethics, in turn, will be colored by the values inherited from his training.

The Social Situation

The commonly shared ethic, I hope, is one of basic humanitarianism—a desire to help people as social beings. In this, choice of method must be consistent with social context. Analysis and closed systems are not compatible: in an open society the physician does not have the power to intervene beyond offering advice. But within the closed organization, power is placed according to the needs of the institution, and when these needs include control of human behavior, it may be placed with the behavioral scientist.

We see this not only in the military but also in the community mental health centers of many states. Yet few enjoy such environmental engineering power as does the military psychiatrist, who is in a unique position for attacking and removing the actual etiology of so much human misery—other miserable humans. However, he may thus fall into the trap of helping people to remain helpless.

By "social engineering" we mean that psychiatric operation which consists of direct social intervention, analogous to the physician's biological intervention and which, following the analogy, treats people as essentially mindless parts of a social body. One cannot control a person as one would a streptococcus, tubercle bacillus, or thyroid gland nor can one treat what a person *does* ("mental" illness) in the same way as what he *has* (physical illness).

A counterargument is that while the analytic psychiatrist observes, formulates patterns and theories, and passes this information along for his client's use, the engineering psychiatrist performs a kind of decision-making, based upon skills in interpreting certain data and in formulating solutions to problems. Rather than providing information, he provides instructions and recommendations.

Unfortunately, there is some confusion and deception on this point, for the recommendations are often couched in the language of nonpromotive information. That is, the manifest content of the psychiatric evaluation is supposedly descriptive, but the latent content or implication of the report demands specific action. For instance the term "schizophrenia" is vague, descriptively, but highly definitive, promotively, demanding separation from the service and instant social ostracism.

The request for social engineering rather than for psychotherapy comes from both the individual and the organization. The individual may well know what is making him "nervous." He wants help in manipulating his situation. Likewise, the organization may want to change a man's position or else remove him from it. For instance, a commander may know that an individual is not well suited to his job, but does not feel that he has the authority to make an administrative decision without a higher priority. For him, as for others, the most convenient and unimpeachable priority is medical. In other words, medical needs are taken seriously and the organization binds itself to acknowledging and fulfilling them, thereby acting in the interests of the individual.

In this way, physicians provide the ponderous military machine with a necessary counterbalance, offsetting the dehumanizing effect of the massive institution. Like any large organized corporation, the military, in pursuing its own interests, must of necessity upon occasion ignore the needs and interests of the individuals who serve it. Such people suffer from the deprivation of certain human needs, and their suffering comes to a medical channel for relief.

Thus the military psychiatrist comes to be a kind of bootlegger of humanitarian considerations for those whose personal needs conflict with those of the institution(6). All sorts of humanitarian transfers, permissive or emergency leaves, and discharges are accomplished largely through the use of the power of medical sanction, if only in the form of a letter from a doctor (as well as others) attesting to the existence of a "medical" condition rather than conditions of loneliness, demoralization, and marital disintegration. It is as if the latter are considered to be necessary agonies of living, whereas medical distress need not be endured.

Power of the Organization Psychiatrist

As the patient may expect his physician to use some magical or scientific power to alter an unwanted somatic process, so the psychiatrist is often expected to use his power over social processes. No magic could match the real power of the organization psychiatrist. The military accords decisive power to psychiatric evaluations and decisions where subjective opinions about moral character are labeled as objective scientific medical reports.

This is perhaps best illustrated by the policies concerning the so-called character disorder. Such a label properly can be affixed only by a psychiatrist and becomes part of the medical record, but disposition is specifically through nonmedical channels. Paradoxically, the psychiatrist does not have as good an opportunity to observe the pattern of character behavior problems as does the squadron commander and supervisor. He often ends up rubber-stamping a report of the individual's misbehavior, backing it up with some damning evidence of earlier deprivations and making the diagnosis which provides at once for the most expedient disposition while hurting the individual least.

The diagnosis may be affected by the psychiatrist's attitude towards the organization as well as by the patient. For instance, if he feels sorry for the patient and/or carries animosity towards the organization which is keeping him from a lucrative practice, he might make a diagnosis of "personality pattern disorder," "immature," or "unstable personality." But if he dislikes the patient, agrees that he is a "bad guy," or feels that he needs a disciplinary experience to put him straight, he might apply more ominous labels: "passive-aggressive," "sociopathic," "paranoid," "antisocial," etc.

The commander's choice between general discharges "with honor" and "without honor" hinges upon the semantic connotations of those labels. What this accomplishes is a kind of face-saving all around, particularly in that the squadron or commander is relieved of a burden of guilt over forcibly separating someone who has not really committed any major offense; more often, both the organization and the individual are allowed to take leave of one another, to their mutual satisfaction, with a minimum of confrontation about their mutual failure as regards one another.

In short, it might be argued that the cause for the diagnosis of character disorder is the necessity to separate the individual from the service. Once this necessity is established, an appropriate label is applied to promote separation. This argument could be countered with the fact that the need for separation is based upon intolerable social behavior, but why should not this be a matter of military law and discipline rather than medicine?

The answer is perhaps that the military penal system shares with its civilian American counterpart a harshness and inhumanity, in some areas, which is no longer in tempo with modern times and character. In other words, the system has been slow to reform as public attitudes towards the criminal have softened. The result is that the executors of such penal systems sometimes find themselves bound by regulations to inflict unduly severe or inappropriate punishment. A convenient way to avoid this embarrassment is to settle out of court, so to speak, by translating the problem into a nonlegal framework, such as the medical.

To illustrate this, consider the real case of a 21-year-old Airman First Class who was referred to the psychiatrist by the Office of Special Investigations after being found to be a "user of narcotics." The situation was this: The airman, who was considered one of the best men in his squadron, with flawless record, well liked, discovered over a period of time that his wife was conducting

a very degrading affair with a slovenly derelict. In order to control his rage, the patient fell back upon something he had discovered in his teens when ill with bronchitis: the tranquilizing effect of a cough syrup which is classified as a tax-exempt, nonprescription narcotic containing codeine.

For a period of time he took to buying several small bottles daily, signing different names in different stores in the area. He was caught accidentally, as it were, in a major OSI investigation of a marihuana and heroin ring that had been operating for some time on the base, but with which the patient had had no contact.

It rapidly became apparent that the man was not dependent upon the drug in the addictive sense. He knew he was violating some federal regulations in obtaining the medicine as he did, but did not feel that this was too serious. In this way he was able to keep his feelings in check and at the same time maintain secrecy about his problem, of which he was extremely ashamed. What is worse, he was afraid to seek help, for reasons which we will take up later.

The squadron presented their problem to the psychiatrist: According to regulations, this man required a 39-17 discharge, without honor, for the use of narcotics. However, everyone was very sympathetic towards him; no one wanted him separated under such conditions. Therefore could some character disorder be diagnosed so as to allow for a 39-16 disposition, with honor?

Here the psychiatrist's ethical dilemma is in full focus. The humanitarian thing to do, the kind thing to do (and the physician's admonition "Do no harm" comes to mind) is obviously to be professionally dishonest. Many psychiatrists consider an ordinary part of their job to be the affixing of promotive labels in order to protect individuals from the inexorable gears of the military machine just as the forensic psychiatrist diagnoses mental illness to protect his client from legal or penal processes(7). Others do the same thing in the name of protecting the organization from individuals whom they feel pose a threat to its welfare.

The dilemma is complicated by the fact that such labels can backfire on the recipient and damage his reputation and self-esteem far more than any criminal record, despite our nationwide pretense of being modern and open-minded about "mental illness"(2).

The problem is not one so simple as a matter of honesty in the face of pressure to be dishonest. Such pressures can be dealt with, as will be illustrated shortly. The problem is that a statement about behavior can with complete honesty be made in either medical or nonmedical language, the mere choice of semantics having profound social consequences. For instance: "Patient is having anxiety reaction under stress" vs. "Individual is extremely worried and distraught under major threat to career." Logically, "situational reaction" becomes "anxiety reaction" whenever the observer is uninformed as to the full circumstances.

The decision to make a "medical" diagnosis, then, rests not in evaluation of degree or type of symptomatology, but upon a judgment, based on one's personal moral definition of what is appropriate behavior. ("It is symptomatic of *x* pathology to react so strongly [weakly] to so minor [major] a stimulus.") Unfortunately, the moral characteristics of psychiatric diagnosis go largely unrecognized, especially outside the profession.

Conclusion

It seems to me that the best way to handle this problem would be to limit medical language diagnoses to communications between *treating* personnel and to refrain from the use of such language in dealing with administrative, legal, managerial, and academic power structures and personnel. This was done in the case of the airman: No medical (or "character") diagnosis was made. He was brought before a legal hearing, and psychiatric testimony reviewed only the known events: occasional use of a drug under stress. The airman was found "not guilty" of "addiction" (a disease) and returned to duty, where he continued an exemplary career.

The impact of the psychiatric diagnosis is even greater in the military where high anxiety over security and nuclear safety must exist. The concomitant lowered tolerance for ambiguity is manifested by intolerance for behavioral deviations when such behavior is not clearly understood. In this respect, the criminal is more easily accepted than is one

whose deviations are "mental." We can understand criminal, but not crazy, behavior.

This is why so much that we have come to think of as associated with craziness—emotional illness, nervousness, even "problems in living"—in short, the bailiwick of the psychiatrist, falls under a pall of suspicion and vague anxiety. In addition, although the psychiatrist in the military is often called upon to act in a capacity similar to that of the industrial psychologist, as a kind of personnel screen, he is also expected to treat individuals as patients, but neither he nor the patient knows when a request will come for an evaluation which both know will be decisive in determining the future course of the patient's life. This is common knowledge among military personnel. The outcome is often that the individual, fearing that any kind of psychiatric record in his file might damage his career (and the organization maintains a watchfulness that supports this fear), hesitates to seek psychiatric help from military physicians and, in the case of noncommissioned career personnel, cannot afford to go outside.

Emotional problems thus take on the status of venereal disease during World War II. Although not liable for court martial, such an individual stands to lose his job via "Human Reliability for Nuclear Access" regulations or, more likely, simply be passed up at promotion time or when other opportunities for advancement and cross training into skilled areas come up. Medical records of sensitive personnel are repeatedly screened for evidence of "instability" by the flight surgeons and psychiatrist.

Although we may know that the utmost of professional discretion is used, career personnel do not, and they are hesitant to incur a black mark or even a question mark until their situation becomes so threatening as to overwhelm their concern for job security. This is essentially why the airman of our case did not seek help through available channels.

In such a role, the psychiatrist can be like the proverbial china shop bull; any professional contact is liable to shatter the patient's military career. I must make it clear that this problem is not fostered by an official military or institutional attitude, but rather by diverse attitudes of individuals within the institution who are in power positions over the prospective patient.

An airman in group therapy meeting one hour per week, although he had recently been cited as Airman of the Month, was forced to withdraw from the group because of undercurrents of resentment from his immediate office supervisors at his taking the hour off for group therapy. In his subordinate position, he perceived his career to be in jeopardy due to squadron pressures, which are like any influence on the part of family members who support a person's resistance to psychotherapy.

As a family may oppose a member's psychotherapy, they may also wish to promote it. The patient referred for treatment by his superiors is not unlike a juvenile brought to a psychiatrist by parents who have a vested interest in him and who may desire merely to have him controlled rather than changed. At such times, the psychiatrist walks a delicate wire, attempting to treat both patient and family in such a way as to promote understanding between all concerned about how they are treating one another.

The most useful service that the psychiatrist can provide to the military, consistent with his training in the techniques of understanding and analyzing human behavior, is clarification of the confusion generated around the prospective patient. In this, he is more the social consultant than engineer, which has the advantage of placing administrative responsibility in the hands of administrators.

There is already a precedent for this in industry, where psychologists are employed not as power tools but as modified group therapists and consultants, analyzing and interpreting interpersonal activities and promoting communications between organizational levels and between individuals. A move in this direction might counter the covert slippage of administrative responsibility into psychiatric-medical channels.

If psychiatrists have oversold their product, I hope it has been because of their humanitarianism. But, in doing so, they run the risk of fostering unnecessary dependency upon them on the part of their military client, who should move otherwise in the direction of greater autonomy and responsibility like any patient.

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Fortune does not change men, it unmasks them.
—MADAME NECKER