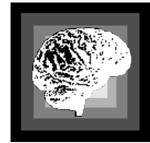

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World citizenship and the emergence of the social psychiatry project of the World Health Organization, 1948–c.1965

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Abstract

This paper examines the relationship between 'world citizenship' and the new psychiatric research paradigm established by the World Health Organization in the early post-World War II period. Endorsing the humanitarian ideological concept of 'world citizenship', health professionals called for global rehabilitation initiatives to address the devastation after the war. The charm of world citizenship had not only provided theoretical grounds of international collaborative research into the psychopathology of psychiatric diseases, but also gave birth to the international psychiatric epidemiologic studies conducted by the World Health Organization. Themes explored in this paper include the global awareness of mental rehabilitation, the application of public health methods in psychiatry to improve mental health globally, the attempt by the WHO to conduct large-scale, cross-cultural studies relevant to mental health and the initial problems it faced.

Keywords

Psychiatric epidemiology, social psychiatry, transcultural psychiatry, world citizenship, World Health Organization

Attempts to globalize mental health studies were based on the idea of 'world citizenship', a term coined by the first Director-General of the World Health Organization (WHO), Brock Chisholm. This idea hoped to achieve a universality of human minds and the hidden aspiration of promoting peace; this ethos helped to shape scientific practices associated with WHO. In this paper, I first describe the efforts of psychiatric professionals to deal with war trauma among soldiers before and during World War II, and then to extend their care to civilians. Then I examine the World Congress on Mental Health in 1948 in London as the turning point for international mental health. After this event, psychiatry began to transform itself from a science regulating social deviants into a discipline concerned about the wider community, including civilians, with a greater range in the age

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distribution of recipient populations. I also demonstrate the attempt to combine psychiatry with public health, which gave birth to a new paradigm of research into global mental health, namely psychiatric epidemiology. Finally, I describe the early projects carried out by the Mental Health Section of the WHO, examining the meanings and functions of the awareness of mental health as these have grown in non-Western developing countries.

The transformation of the discipline of psychiatry arose as a collective response among psychiatric professionals to the traumatic period following the war and to the need for rehabilitation. Individuals as well as organizations were involved in transnational activities that facilitated the globalization of mental health research. As described by Sturdy, Freeman and Smith-Merry (2013), from 1970 onwards, the method employed by the WHO to enable the manufacture of international mental health policy-making had shifted away from its technocratic approach of standard making and enforcement of universal norms to an empirical, knowledge-based and context-sensitive methodology. In this paper, I attempt to explore the knowledge and logical foundation of the WHO's early mental health research before its technocratic work started. I argue that the WHO's enthusiasm to apply public health methods in psychiatry, in order to improve mental health globally, to establish universal profiles of mental disorders and to classify them were catalysed by the ethos of internationalism among scientists and their collaborators, particularly in WHO, encouraging them to develop new terminologies and instruments of research. The ultimate aim was to establish a new paradigm for understanding the landscape of mental disorders on a transnational basis.

Lessons of war

Warfare has had an immense impact on the development of modern psychiatry. Historians have written a broad range of theoretical accounts regarding the origination and transformation of traumatic psychologies. Historians have also discussed at length the alteration of disease terminology in the wake of battles and the influence of warfare *per se* on the psychiatric disciplines (Jones and Wessely, 2006; Micale and Lerner, 2001; Scull, 2011; Shephard, 2000). With various opinions on the treatment of war traumas, prevention of mental impact on those who are sent to the front line became central to the discussion. During peacetime, a number of individuals continued to examine the lessons of World War I. During World War II there seemed to be a tacit agreement between British and American psychiatrists, with both camps embracing preventive psychiatry in the form of screening soldiers' intelligence and personality. The screening ensured that only soldiers who were both physically strong and mentally robust were sent to the front line. These preventive methods emphasized personnel selection, through which weaker individuals were spared front-line duty, rather than establishing ways of protecting healthy minds from mental breakdowns.

The preventive work on mental disorders had also spilled over to civilians. Medical men began to draw their own conclusions about the human condition resulting from post-war devastation, and it was hoped that psychiatry would provide the solution. For example, Head of the Medical Sciences Division of Rockefeller Foundation, Alan Gregg (1948), considered '[t]he greatest unpleasant surprise of the war for medical men [was] the importance of psychiatry and psychology'. In addition, during World War II, as head of the Canadian Army Medical Services, Brock Chisholm expressed his views on the negative psychological impacts of war (Farley, 2008: 41). After the war, he considered the post-war human condition to constitute 'a valid anxiety'; by this he meant a 'free-floating' anxiety that was part of everyone's life, which was 'not necessarily seen to belong to its real source, but maybe just felt as a discomfort and unhappiness, a fear that "something is wrong"' (Chisholm, 1957: 92).

However, psychiatrists had not yet found feasible methods of inquiry, apart from stressing the importance of mental health research. For example, Karl Bowman (1946), the President of the

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American Psychiatric Association (APA), said in his inaugural speech: 'We believe that there is a science of human behavior; that it is possible to understand the causes of good and bad adjustment.' However, practical research was difficult because of the disruption in the scientific community as a result of the war. Another APA president, Ewen Cameron (1953), for example, mentioned that, '[w]e live in a world where massive displacement and sudden death are strangers to no one, a world in which the continuous safety of the whole depends upon the goodwill of every part, but a world still tragically far from unity.'

Mental health as an issue of public health

Mental health professionals expressed specific concerns during the post-war period, but not before or during the actual war. The concept of world citizenship provided the core philosophy for all health initiatives. With regard to mental health, psychiatry no longer served as an instrument to control the social order. Rather, it viewed mental illness as a heavy burden on human beings in post-war society and attempted to understand why certain people were particularly at risk for mental symptoms. Psychiatric research attempted to identify the stressors and risk factors and whether other psycho-social factors played a role in mental illness.

A great number of international health initiatives of were set up by clinicians previously employed by the military (Amrith, 2006). Mental health was no exception. The impetus to study the causes of mental illness from an international perspective was also derived from the concept of world citizenship coined by Brock Chisholm. He was a Canadian psychiatrist, who was renowned for his pioneering ideas about preventive medicine and children's education, and was also known for his controversial endorsement of birth control, sterilization, eugenics and euthanasia in the 1930s. Before his epoch-making contribution to scientific practice, Chisholm's central concern was human conflict. He pondered why human conflicts occurred, how they affected people, and what psychiatrists could do to help people avoid further devastation. In 1946 he commented on the effect of the war on returning soldiers in the journal *Psychiatry* (Chisholm, 1946).[1]

In the same year, Harry Stack Sullivan invited Chisholm to lecture on 'The psychiatry of enduring peace and social progress' at the William Alanson White Institute in New York. The lecture was later published by Sullivan, who was the editor of *Psychiatry*, and it attracted feedback from numerous individuals and societies (Brody, 2004; Chisholm, 1946). Realizing his own popularity, Chisholm extended his focus from the military to the wider population. Some readers even sent their own proposals to him in response to his appeal. Thereafter, either by invitation or spontaneously, Chisholm contributed a number of articles, not only to academic journals but also to popular magazines. His prescription for the world community drew both appreciation and controversy among his readers. His concept of human beings sharing a common destiny became a magnet for like minds. In contrast, his views criticizing superstition and traditional morality irritated a number of religious groups. However, the world-peace proposal buried deep in Chisholm's heart did not surface in practical terms until he stepped down as the Director-General of the WHO in 1953. During his tenure, he had managed several epidemics successfully, such as outbreaks of cholera in Egypt and malaria in Greece and Sardinia. Regarding psychiatry, however, he had remained relatively quiet.

The project that made 'world citizenship' a feasible psychiatric premise began in 1953. At the end of that year, at the Seminar on the Mental Health of the Eastern Mediterranean Region, Ronald Hargreaves, then Chief of the Mental Health Section of WHO, delivered a paper on 'Mental hygiene and the epidemiology of psychiatric disorders' at a seminar. This emphasized the need to develop psychiatric care outside asylums, and the need for cooperation between public health and psychiatry personnel. Regarding preventive work, and recognizing that psychiatric disorders might include genetic factors, he posited that full-blown disorder might only develop in the presence of

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various stressors. Thus Hargreaves was referring not to the devastation caused by human atrocities and natural disasters, but to everyday stresses such as work, parenting, schooling, and even the weaning of infants.[2] His words acknowledged the universality of all human beings and the need for mental health professionals to probe the causality of mental health issues.

After the 1953 seminar, the core spirit of psychiatry shifted, and new research methods began to take shape. While in Buenos Aires in 1953, Hargreaves wrote another paper entitled 'Preliminary statement on a research project dealing with mental health and disease from a comparative point of view'. In this, he stated:

> Kraepelin's paper on comparative psychiatry formulated the problem at the beginning of the century, and the Milbank Memorial Fund's Symposium on the Epidemiology of Mental Disorder gives us an example of the current application of the method. It must be said, however, that the subject has so far not been dealt with in a truly systematic way, the reason for this being in all likelihood that it was until now practically impossible to carry it out in sufficient scope.[3]

Hargreaves referred to the 'urgency' of pursuing this project 'in the near future'; he further proposed '[the] initial task of assembling the available evidence, collecting such additional facts as seem necessary for securing the over-all usefulness of the existing material and of organizing the sum of our present knowledge with a view towards making truly systematic research possible'.[4] According to Hargreaves a 'manageable project' was necessary, such as Kraepelin's research in comparative psychiatry, through which he determined the environmental, social, cultural and ethnic factors that influence the types, prevalence and expression of mental illness (Pols, 2011). Hargreaves' words implied that a manageable project, based on the universality of human beings, would be an international effort and would lend itself to epidemiology and would benefit future research. The essence of his project can be found in his book published in 1958, in which he saw psychiatric illnesses as actual diseases, like cholera (Hargreaves, 1958). This became a cornerstone of public health. Nevertheless, Hargreaves had to wait a long time before his visionary project was carried out.

The WHO model, and early efforts in the mental health field

The globalization of modern psychiatry in the post-war period occurred in tandem with the development of international organizations, of which the WHO was a main player. In contrast to its predecessors, such as L'Office International d'Hygiène Publique before World War I and the Health Organization of the League of Nations during the inter-war period, the WHO did not limit its scope to Europe but covered six regions of the world. The WHO and other UN special agencies were based on the 'spill-over' theory endorsed by functionalist economists (Siddiqi, 1995). Spill-over theorists believed that alleviating health challenges in less-developed countries would decrease the conflict between states due to unequal resource distribution, thereby fostering stability at the economic level and facilitating world peace. The WHO was inaugurated on 7 April 1948. At the subsequent first World Health Assembly, held in Geneva in the summer of the same year, health issues requiring urgent post-war rehabilitative work were identified by health professionals.

The WHO has a unique structure and *modus operandi*. One aspect of its design was the decentralization of power to six regional offices; another was ensuring that recommendations made by headquarters were distributed effectively. The decentralized design was intended to keep the WHO from becoming a 'supranational organization' and to remain an instrument only, which would 'take its instructions from the governments of the world, and for its personnel to do exactly as they were told to do by the peoples of the world through their governments' (Chisholm, 1957: 92). To enable this huge organization to function well, the WHO used to employ thematic projects or programs of advisory

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services, with expert advisory panels and committees to facilitate the projects. The operational style of the advisory services has never been simple. To meet a request from a country, the regional director consults with national authorities to determine the type of international assistance needed. A suitable expert or team is then recruited by the WHO and briefed on the purpose of the project, the conditions in the region and country, and the general administrative and technical procedures that the organization has found useful in similar circumstances. The regional office assists with the necessary liaison and co-ordination with national counterparts and local services appointed to work with the expert or team (WHO, 1958). Although declaring itself to be decentralized, the operation of the WHO relies on a vertical model (Siddiqi, 1995: 24). In addition, it could not detach itself from the politics in the United Nations (UN) during the Cold War period (Farley, 2008: 58–61).

The 1948 International Congress on Mental Health

In addition to the above activities, the WHO provides a hub for health professionals worldwide to meet, exchange ideas, and promulgate their proposals. Its *zeitgeist*, however, dwindled within two years of the signing of its constitution. The organization could neither encompass the participation of all nations, nor prioritize mental health work. In 1948 the topic of mental health gained international attention in its own right. The International Congress on Mental Health played a pivotal role in corroborating international mental health research as an instrument for the post-war project of global rehabilitation. This led to the establishment of the Expert Committee of the Mental Health Unit, which later grew into a Section in the WHO, and the birth of another organization, the World Federation for Mental Health. These new organizations helped to promote the work of individual mental health professionals to the level of international collaboration.

The International Congress on Mental Health was organized by Michael Harvard of the National Association of Mental Health in the UK and was chaired by Dr John (Jack) Rees, who had been the head of psychiatric services in the British Army. The Congress was held in London, 16–21 August 1948. By the time the WHO was officially established in Geneva in 1948, its membership policy allowed only those countries that were members of the UN to join the organization – a point which contradicted the idealism of the WHO constitution. Britain discouraged its own delegates from attending international conferences organized by bodies other than the WHO.[5] Nonetheless, Michael Harvard strategically attempted to gather delegates by issuing invitations to the Congress through the Foreign Office, and by accepting personal applications. His intention was to create a genuine assembly of world citizens that was not hampered by the membership policy of the WHO or hindered by world politics during the Cold War. For example, Germany, Japan and Spain were initially banned by British national law from attending the Congress, as the gathering was regarded as a British diplomatic mission.[6] These nations were eventually allowed to attend after making individual applications. The Soviet Union, however, could not send a representative according to its own national laws.

During the week of the Congress, psychiatrists, anthropologists and sociologists gathered to search for ‘a basis for common human aspiration’ regarding human mental health. The statement of the Congress provides a rare example of international organizations reflecting on the wrongdoing of modern science after World War II (Flugel et al., 1948: 285–6). It asserted: ‘Few societies of which we have knowledge are wholly free from distortion of human impulse, sometimes on a large scale, such as racial oppression, or industrial conflict’. Due to the ‘profound disquiet following two world wars, and the fear of a third catastrophe’, scientists were compelled to face the dreadful ‘possibilities of biological and atomic warfare’. Instead of initiating social reforms, the Congress was determined to ‘infuse a scientific spirit into the movements of reform and reconstruction’ in those countries that

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had suffered in the most recent war. The Congress concluded with three main objectives, related to recruiting specialists and making suggestions to the newly founded UN specialized agencies.

Two new organizations related to mental health, namely the Mental Health Expert Committee at the WHO and the World Federation for Mental Health (WFMH), were founded in line with proposals from the Congress. The former was regarded as a centre to foster international mental health, and the latter replaced the International Committee for Mental Hygiene. Specifically, the WHO Mental Health Expert Committee was expected to handle forthcoming international surveys and develop international standards regarding research methodology. The WFMH would assess the universality of the Congress's statement from the standpoints of various nations and cultures, and suggest modifications for its improvement. The WFMH records, however, indicate that the various experts maintained close correspondence with one another and were actively involved in meetings and study groups organized by either official body.

Although the practical considerations of these new international organizations were complex, the core agenda of the 1948 International Congress was simple. It sought to treat the damaged minds of people devastated by the war and to find methods of peacemaking by enhancing mental health. At the beginning of the summary of *Mental Health and World Citizenship*, the statement prepared for the International Congress published later by WFMH, several questions were asked: 'Can the catastrophe of the third war be averted? Can the peoples of the world learn to co-operate for the good of all? On what basis is there hope for enduring peace?' (World Federation for Mental Health, 1948: 47). One might say that the development of world psychiatry in the post-war period was based on these bold and rather naive questions.

From the 'collection of hunches' to the practice of collaboration

Individuals involved in international activities around 1948 tended to have a fairly consistent level of awareness regarding mental health issues. In contrast, consensus was never reached about development priorities and know-how during the first 10 years of the WHO. Thus, before the large-scale systematic approach was fully formulated, the concerns of early visionaries regarding mental health were akin and yet diverse. Nevertheless, theories and protocols were proposed to deal with the question of the aetiology of mental illnesses. The experts attempted to answer questions such as 'Why do human beings develop psychiatric symptoms?' This general concern shifted the direction of mental health beyond the desire to prevent individuals from deteriorating mentally under exposure to extreme experiences, to exploring the stressors that human beings encounter during their development. In addition, the focus shifted from removing mentally ill people from society towards a community-oriented preventive psychiatry.

Mental health professionals realized that before they could initiate preventive work they needed to understand the mental health problems among different nations, and this became their first concern. Despite their similar attitudes towards international collaboration, they lacked a useful methodology. Brock Chisholm, disillusioned by the activities of nation states, turned to humanism and world government, believing that the only real hope lay with the people of the world: if individuals could come to their senses and learn to think and act globally, they would form a single human race, embodying his concept of 'world citizenship'. As the Director-General of the WHO, Chisolm promoted collaborative works among nations, regarding these as 'essential for the very survival of the race'. However, although he recognized the importance of 'learning from each other', Chisholm did not propose substantial practical methods to facilitate the international work on mental health. His contributions were limited to random observations of selected populations and the identification of characteristics of human emotions, such as anxiety and aggression (Chisholm, 1958).

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Among the priorities identified by the WHO after World War II, mental health was listed as the fifth most important. Several factors accounted for the delayed programming of mental health issues. First, the more urgent categories were attended to first, namely malaria, other endemo-epidemic diseases, and public health administration (WHO, 1962: 48). Another reason was that Chisholm, himself a psychiatrist, had to distance himself from privileging mental health issues so that he would be perceived as neutral (Lin, 1994: 96–7). Although sluggish in its actions, the Mental Health Expert Committee never stopped looking for urgent issues and assessing the immediate needs of society.

The Mental Health Expert Committee of the WHO was drawn from an advisory panel of nearly 100 members in 38 countries. It met for the first time in 1949 and carefully considered the principles that should govern the WHO's future activities in mental health. The principles laid down by these experts clearly reflected the new imperatives of mental health in the post-war era. First, by encouraging training and specialization in mental hygiene, the advisory experts hoped to build up the preventive aspects of mental health work. Second, they were concerned about developing psychiatric services for children, both therapeutic and preventive. Finally, they saw the need to integrate mental health with other activities being conducted by the WHO, such as public health administration, maternal and child health, and nursing. In the first decade of its existence, the WHO had assisted in the development of psychiatric services, notably by making available the services of qualified short-term consultants to help member states regarding law, hospital treatment, personnel training and other issues. Apart from its own areas of focus, the Expert Committee also worked extensively with other international organizations such as the UN Educational, Scientific and Cultural Organization (UNESCO) and the International Labour Organization.

New issues in mental health after World War II

Issues thrashed out by the Mental Health Expert Committee of the WHO covered a wide range of topics, which reflected the emergent psychological needs of people overwhelmed by World War II. Not all issues were persistent or far-reaching enough to gain the attention of all member states. The various issues raised not only reflected the early visions of the experts themselves but also passively echoed the work of the WHO or the UN to some degree. Most of the agenda items were discussed in study groups; some items did not exist for long, and others became important projects. These matters could not be detached from the turmoil of international politics in the post-war world, and in all cases the altruistic philosophy of the WHO was evident.

For example, children became a main focus in mental health. In the devastation of war, children were left uncared for, and the social environment became a huge threat to human development. Consequently the mental health problems of childhood and youth immediately gained concern. One of the Expert Committee members, John Bowlby, popularized the view that mental health problems among children were caused by prolonged deprivation. His concern with aetiology was congruent with the project of maternal care developed by WHO, which in turn contrasted somewhat with views expressed by the Social Commission of the UN in 1948. The Social Commission had identified the need to study 'children who are orphaned or separated from their families for other reasons and need care in foster homes, institutions or other types of group care'.[7] By including refugees from wars and other disasters, Bowlby's approach responded to the Social Commission's report, which was confined to children who were homeless in their native countries (Bowlby, 1951). Bowlby's theory also corresponded with Chisholm's emphasis on the value and purpose of the family, and fitted with other projects related to maternal care carried out by WHO. Based on the verdict of the UN Social Council report, the Mental Health Expert Committee was advised to participate in the study of juvenile delinquency, including important medical and

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psychiatric problems (Bovet, 1951: 90). Experts' opinions on juvenile delinquency varied, and many were voiced to correspond with the UN's programme for the prevention of crime and treatment of offenders.

The main discussion concerning adults was about the effect of technological change and 'automation', and the increasing mechanization of 'work' in post-war society. As noted by a study group member, Charles Walker, 'Automation [...] sometimes appears as a savior, sometimes as a devil or menace to the modern world. And both kinds of phantasy, the phantasy of irrational hope, and the phantasy of irrational fear, have created urgent problems in the mental health field'.[8] This comment opened the debate for psychiatrists to talk about 'stresses among ordinary people rather than front-line soldiers. The conditions of workers in weaving factories and coal mines were brought up in these discussions. Opinions from India, USSR and China were also heard and considered. To an extent, the discussion fulfilled Hargreaves' appeal to study stressful experiences among ordinary individuals.

All these projects, carried out in the first decade of the existence of WHO, reflected the concerns of mental health professionals about the devastation of war and post-war society. Despite the consensus among experts, these projects had not been able to take full advantage of the wisdom of WHO, which sought the cooperation or coordination of national bodies. Thus a *bona fide* international project had not yet emerged. At the end of the first decade of WHO, Ronald Hargreaves wrote that 'systematic research' was 'only accessible to the long-term study of carefully selected research teams'. He added that such teams should be 'facilitated by a critical collection of the available evidence' and that data collection should be carried out by 'one individual who has the benefit of a sufficient amount of technical and clerical help'. In Hargreaves' view, not only psychiatrists but also public health workers, psychologists, anthropologists, and other social scientists had made 'pertinent observations'. However, they had done so while remaining uninformed about each other's work. He acknowledged the strength of a variety of viewpoints which together formed a 'critical unification', but maintained that a 'single objective investigator' was an 'absolute necessity'.[9]

The emergence of the 'manageable project' and four-man meetings

Hargreaves' 'manageable project', described in his epidemiological proposal, contained four basic requirements: place, people, money and method. Hargreaves understood, but did not publicize, the need to resume the work of comparative psychiatry initiated by German psychiatrist Emil Kraepelin at the beginning of the twentieth century. However, Hargreaves had a far larger project in mind. He had been trained in Germany, Switzerland and France, had worked as an expert consultant in the Philippines dealing with the problems of immigrants, and was himself a multilingual speaker. Hargreaves was thus convinced that the best approach to research would be a comparative one. Interestingly, many of his colleagues at the WHO shared similar cross-cultural and migrant backgrounds. From a practical perspective, Hargreaves thought that the project should be carried out from a 'centrally situated country, like Switzerland'. Without doubt the headquarters of WHO provided the perfect hub for scholarly exchange and logistics. Yet, by the time Hargreaves drafted his proposal, the choice of the place was the only one of the three critical conditions which had been addressed.

The recruitment of personnel was never easy. To facilitate the project, Hargreaves sought out advocates among individuals with similar aspirations, who were more concerned about data obtained from 'community studies' than hospital settings. In 1956 Hargreaves planned a study group on the epidemiology of psychiatric disorders, and proposed a series of meetings that began in September 1956.[10] The gatherings stimulated scholarly exchange among specialists, and it was hoped that they would become the core personnel of WHO's psychiatric epidemiology project. In the early 1950s, epidemiological surveys were particularly prominent in Scandinavian countries and Germany. Paul Lemkau, then consultant of mental health to the WHO, 'daydreamed' to

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Hargreaves that the committee might recruit people from 'Norway, Demark, and perhaps in the U.K.' for information exchange. French scholars were considered 'not good enough' for research of this kind.[11]

From October 1954 onwards, in his position as Chief of the Mental Health Section at WHO, Hargreaves widely circulated an invitation to psychiatrists around the world and waited for their responses. Thereafter, the correspondence between the WHO headquarters and its potential collaborators snowballed. Hargreaves first wrote to Eduardo Krapf, the German-educated Argentinian psychiatrist (who later succeeded Hargreaves as Chief of MH Section) for advice. Krapf forwarded Hargreaves' idea to the National Institute of Mental Health (NIMH) in the USA. Moreover, in response to his proposal, Hargreaves obtained access to several papers written by seemingly visionary individuals, such as Carney Landis, Professor of Psychology at Columbia University. Landis had published a book entitled *Modern Society and Mental Disease* in 1938; this was essentially an epidemiological survey of mental disease in America and in Europe. In a letter Hargreaves on 15 April 1953, Landis considered 'the possibility of re-doing [the] book' and emphasized 'the changes which have taken place in mental disease statistics since 1935'.[12] During two months of correspondence, Hargreaves became deeply intrigued by Landis's research. Yet he voiced his concern about the shortage of funding and suggested that Landis's data, derived from hospital admissions, were too dependent on factors other than natural variations in the prevalence of psychiatric disorders.[13] Hargreaves' concern reflects a widespread apprehension among specialists, which could have obstructed the project.

One of the strengths of the WHO was the participation of scholars from North America. Given this support from other strands of academia (e.g. members of Pan-America Health Organization), the WHO acquired a privilege not enjoyed by its previous incarnations as the League of Nations Health Organization (between the two World Wars) and the UN Relief and Rehabilitation Administration (UNRRA, during World War II). A number of psychiatrists from the USA showed their interest in Hargreaves' project. They, however, were different from the main players of USA's post-war mental health research, mostly linked with NIMH, who were themselves believers in biological psychiatry and beneficiaries of pharmaceutical industries. For example, F.C. Redlich at the Yale University School of Medicine communicated his interest to individuals who he knew were conducting projects similar to the WHO's initiative, such as Ernest Gruenberg, Erich Lindermann and Paul Lemkau. Many of these individuals later became core personnel in the international field of psychiatry.[14]

Feedback gradually emerged about the pragmatic aspects of the project. For example, Paul Lemkau, as a consultant to both the National Institutes of Mental Health and the WHO, offered his opinion as a pioneer in preventive psychiatry (Lemkau, 1955).[15] He mentioned the difficulty of having to travel to collect data from all over the world. He also discussed some dubious or inadequate statistical techniques. Lastly, he was concerned that not enough people would be willing to carry out the task. He mentioned a few potential candidates for the data collection work, including Ernest Gruenberg (New York, Mental Hygiene Commission) and Morton Kramer (United States Public Health Service). Despite Lemkau's doubts, Hargreaves still intended to invite him to act on behalf of the WHO and to commit to its project in 1954.[16] In fact, earlier while Lemkau was writing his book, *Mental Hygiene in Public Health* (1956), the work had failed to help him crystallize methods for conducting the epidemiology study.[17]

As for the financial aid, philanthropic organizations who shared the same vision of social medicine had naturally been asked for help. When Hargreaves was seeking backup and comments for his proposal, he mentioned the Milbank Memorial Fund in a number of letters, including those written to Redlich and Lemkau.[18] The Milbank Memorial Fund had been interested in population studies since the 1920s, and played a critical role in scientific research related to human

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populations, such as family planning, fertility and eugenics (Kiser, 1981; Porter, 2011). However, it had not encompassed psychiatric science until Hargreaves' invitation. Seeing an opportunity for financial support, Hargreaves wrote to Gruenberg, then technical board member of the Fund, suggesting a joint project between the Milbank Fund and the WHO, and hoping that Gruenberg would direct the project.[19] However, the Milbank Memorial Fund had already committed itself to a local mental health project evaluating selected services. Although Gruenberg shared a similar perspective with Hargreaves, he felt he could not take on the role and turned it down – as many others had done, including Lemkau and Krapf.[20] Nevertheless, Milbank became the main funding body for the mental health project.

As for the methodology, while epidemiology was gaining its role in understanding the clinical picture and natural history of chronic diseases in the mid-1950s (Porter, 2011: 161–6), statistical experts of the WHO's Expert Committee of Health Statistics were invited to help; Donald Reid at the London School of Tropical Hygiene and Medicine was one of the first statisticians contributing to the mental health project. Together with Bradford Hill, the leading figure in medical statistics at the same school, Reid was renowned for his capacity to identify factors causing non-communicable, especially cardiovascular, diseases. While Hill's criteria heavily influenced Richard Doll's search for the cause of lung cancer, Reid himself plunged into cardiovascular disease research. Believing that the search for clues about causation had become more systematic, Reid thought that his methods of vital statistics could be applied to mental health research. A number of his studies had found mental status to be one of the variables that influenced the course of cardiovascular or other diseases. For example, mental tension and/or overwork were among the aetio-pathogenic factors of atherosclerosis.[21] Reid wrote that 'the evidence accruing from field observation is circumstantial in that it may be enough to suggest a causal relationship but it cannot give final proof of it'.[22] This situation provided the rationale for mental health experts to endorse practical interventions for mental health issues before the aetiology of psychiatric disease had been confirmed.

In addition to Krapf, Gruenberg and Reid, the Swedish psychiatrist Jan Arvid Böök was asked to join the WHO group because of his expertise in empirical research in social psychiatry. These four individuals were 'temporary advisors' and comprised the core personnel of the project's study group.[23] The four-man meeting described below enabled the escalation of their projects. Frank Boudreau (President of the Milbank Memorial Fund) wrote in a letter to Jerome Peterson (Director of WHO Public Health Division) that the psychiatric epidemiology project 'promises to be as thrilling and probably just as difficult as the pioneering explorations into cholera, typhoid fever, and malaria. If nothing interferes with your plans, all the "old hands" in public health will envy you and Dr. Krapf, and the excitement of the chase and WHO itself will grow in the opinion of the profession'.[24]

The Exploratory Meeting on the Epidemiology of Mental Disorders took place in Geneva from 16 to 20 September 1957. As stated in a note about the meeting, the four participants had agreed that epidemiology might usefully be studied as a route to understanding the aetiology of mental illness. But how exactly should such a study be carried out? The four consultants agreed on the urgent need to establish 'special surveys of baseline incidence rates' for congenital mental abnormalities. In addition, they noted that an 'adequate long term follow-up investigation is needed'. Regarding the scale of the project, they felt it was premature to attempt a diffuse 'global epidemiology' study. However, the WHO could play the role of an 'intellectual catalyst' to stimulate workers in the field to travel and meet together, and to support the training of specialists in the appropriate epidemiological techniques.[25] The meeting also clarified several practical steps, the first being a critical rather than comprehensive literature review of epidemiological works on mental disorders. In addition, 'comparisons between the larger or more competent may be invalidated by differing standards of diagnostic precision'.[26] Based on this proposal, the attempt to develop standardized classifications and diagnostic criteria for psychiatric diseases gradually intensified. However, having formed a

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well-balanced core group (or ‘four-man meeting’), none of the experts wanted to direct the long-term project. Applying the snowballing method of recruitment once again, it took another few years for them to implement the project in any systematic manner.

Impeding forces: ethnographic approaches

While the large-scale international study on mental health was being incubated at the WHO headquarters, comments were sent to Geneva from the various geographical regions. Most of these were ethnological accounts drafted by researchers informed by cultural relativism, questioning the feasibility of the ambitious WHO project.[27] Clearly, as the capital of international medical studies, Geneva was not the only place in the world to be concerned about cross-cultural issues. In 1955, Eric Wittkower and Jack Fried set up a section of Transcultural Psychiatric Studies as a joint venture between the departments of Psychiatry and Anthropology at McGill University in Montreal. Its first achievement was to develop a newsletter and network of psychiatrists who could exchange information about the effects of culture on psychiatric disorders, a topic that was poorly understood at the time. The first issue contained a description of the first survey study. Wittkower and Fried had managed to circulate a questionnaire among specialists in 18 countries (Wittkower, Jacob and Pande, 1956).[28] Wittkower concluded his concise report on this transcultural project with the somewhat sceptical comment that ‘it is obviously impossible to draw any definite conclusions from the heterogeneous material which has arrived from psychiatrists of 18 different countries’.[29] He noted several findings, including: the ‘prevalence of mental disorders treated by psychiatrists in various countries varies considerably’, ‘transcultural comparison of the prevalence or of marked disorders is almost impossible’ and ‘there are differences in the relative frequency of illness, of severity of illness, and of symptomatology and of content in relation to cultural background’. However, he also concluded that ‘[t]he major psychoses are ubiquitous’.[30]

Among the specialists in social psychiatry who shared perspectives similar to those of WHO, Wittkower was probably the most critically minded. Yet he noted exceptions among the seemingly impossible comparative studies, such as those of some Scandinavian and Asian countries.[31] From the mid-1950s onwards, the school of transcultural psychiatry as a discipline developed from the approach of Wittkower and his colleagues (Bains, 2005). With doubts on the feasibility of Hargreaves’ proposal, the WHO was still able to proceed with its initiative. The middle ground sought between universal humanity and the Boasian model of cultural relativism provided the theoretical basis for the WHO to go ahead. Margaret Mead, who served as the President of the World Federation for Mental Health between 1956 and 1957, was a classic example. Directly trained as an anthropologist under Franz Boas and then later becoming an internationalist, she was torn between the two extreme approaches. Yet she was also ardent in applying anthropology to international relations and public services (Mandler, 2009). Her concept of ‘one world, many cultures’ set the basis for neo-Freudian psychiatrists who no longer attributed the causation of mental illnesses to the varied individual achievement of mental capacity in different ethnical groups but to the social and cultural factors that determine one’s mental integrity. In other words, there were no longer superior or inferior ethnic groups with regard to their intelligence and mental functioning. Culture itself became a neutral geographic concept rather than a determinant to study the development of mental disorders in different countries. It was under such momentum that survey studies similar to Hargreaves’ initiative gained their worldwide acceptability.

Running in parallel in the early 1950s, the WFMH project ‘Cultural Patterns and Technical Change’, led by Margaret Mead, was commissioned by UNESCO to study possible methods of relieving tensions caused by industrialization in various countries. This project was one of the main anthropological inputs to international mental health. Unlike the vertical model of the WHO, it

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aimed to collect and disseminate existing knowledge of various cultures 'with respect for their cultural values so as to ensure the social progress of the peoples' (World Federation for Mental Health, 1953: 348). Sociologists and anthropologists comprised a relatively high proportion of WFMH participants. Mead, however, left the WFMH in 1957 due to her disillusion with the role of anthropology being gradually taken over by psychiatric specialists (Mandler, 2013). Over time, in the second half of the twentieth century, the work of the WFMH became less and less important.

The pilgrimage of developing countries

As mentioned earlier, although Hargreaves acknowledged the need for interdisciplinary cooperation, he emphasized the importance of 'critical unification' and the 'absolute necessity' of a 'single objective investigator'. While the 'manageable project' was being developed, several ethnographic approaches became opponents of the project.[32] Fortunately they were never allowed to derail the ongoing work of the WHO, but instead became valuable balances to the absolute idealism of the WHO. Despite some eye-catching epidemiological research, such as the Stirling County Study in Scotland (Murphy and Leighton, 1989) and the Midtown Manhattan study in the USA (Srole et al., 1962), Hargreaves favoured the local studies conducted in then developing countries, not only because of his intention to outsource, but also because individuals from these countries were keen to participate in the work of the WHO. A typical example was Tsung-Yi Lin, a lesser-known psychiatrist,[33] who conducted an unprecedented – and never repeated – door-to-door survey of mental disorders in Taiwan (then regarded as Free China and referred to as Formosa in the WHO official document); he later become the Medical Officer of WHO's Mental Health Section.[34]

Prior to the research done by Tsung-Yi Lin and his students, Pao-Meng Yap (a Cambridge-educated anthropologist and psychiatrist from Malaysia) had put forward his version of comparative studies on mental illnesses. Viewing the causation of mental illnesses as somewhere between biological and psychogenic, Yap stressed the necessity of a quantitative approach. He attempted to treat mental health disorders as real illnesses, working 'towards an illness model for comparative research'. In the Foreword to his book he suggested that the model should be biographical and in principle convertible into other kinds of models. This flexibility would allow for a continuous transition from health to illness and reflect the complexities of multifactorial causation, with a necessarily quantitative dimension. Yap insisted that a unitary framework for all types of psychiatric illness was necessary to '[give] due weight to the biopsychological substrate which alone makes cross-cultural comparisons meaningful' (Yap, 1974: 1–3).[35] Yap's approach was pioneering in the field of comparative psychiatry at that time. As a member of the Expert Committee, he continually contributed innovative input to the WHO project. However, he did not join as a core member of the large project because of a previous commitment to work in Toronto. Early work done by Tsung-Yi Lin, Pow-Meng Yap and other individuals were central to the field later called 'transcultural psychiatry' or 'cultural psychiatry'. For Wittkower, transcultural psychiatry was a newly created scholarly field. However, attempts to explore mental health issues cross-culturally had already been evident during Kraepelin's era, although they were limited in scale and incomplete in their methods.

To understand the causation of mental illnesses internationally, individuals and institutions approached the research question from a variety of angles. Lin's epidemiological survey (1953) was rewritten and later printed as a pamphlet with the title *The Scope of Epidemiology in Psychiatry*, co-edited by Lin's assistant, C.C. Standley, and was widely cited by early WHO specialists (Lin and Stanley, 1962). According to Lin's memoir (1994), the motivation for him to conduct such a survey was to study how Chinese mental health profiles were different from those of patients he saw while being educated in Japan during the war. Such an impetus was completely different from that of Chisholm or Hargreaves appealing for research based on world citizenship.

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After Hargreaves' 'manageable project' was proposed, the work actually conducted by the WHO did not unfold completely in accordance with the original intention. Participants involved at Headquarters invested the project with their own interests and with an awareness of their own country's niche. Before the project had been proposed, experts involved in the snowballing network agreed that studying mental health issues among various cultures was necessary and urgent. However, the first large-scale cross-national study of the Mental Health Section was not realized until 1965: the Ten-Year Plan in Psychiatric Epidemiology and Social Psychiatry was proposed by Tsung-Yi Lin, who profited from the WHO's outsourcing mechanism. This proposal became the start of the Section's work on international disease classification and the epidemiology of schizophrenia (De Girolamo and Sartorius, 1999; Lin, 1994). Most scholars who participated in the programme agreed that this project was not the achievement of a single visionary individual. In fact, many mental health projects could not have been carried out by bold, charismatic leaders who went beyond the *realpolitik* atmosphere with their progressive attitude (Sartorius and Talbott, 2011). Lin's role as a slick and managerial leader in the WHO was a good remedy for its bureaucratic defects.

Conclusion

In this paper, I have outlined the precursors of a new paradigm in psychiatric research during the early post-war period. I first argued that World War II affected psychiatric sciences by shifting the concern about war trauma to concern for the general public. At that critical juncture, preventive psychiatry was born of the effort to lessen the human burden caused by war and its aftermath. The focus also shifted from treating mentally ill patients in hospitals to prevention in communities. Regarding the method of prevention, mental health workers no longer selected fit and suitable military personnel and put them on the battlefields. They began to concentrate on everyday stresses associated with industrialization and urbanization, rather than on extreme experiences.

Second, I have described the verdict of the World Congress on Mental Health held in 1948 as the key event that transformed the pragmatic aspects of mental health care. This Congress resulted in a shift from individual and sporadic research attempts to transnational collaboration. The Mental Health Expert Committee in the WHO and the WFMH was created thanks to the post-war design of the UN special agencies and Brock Chisholm's vision of 'world citizenship'. The UN special agencies were designed to fulfil functionalist economists' notions of the spill-over theory, thereby promoting international cooperation on specific issues and boosting economic growth in developing countries, with the ultimate aim of world peace. Most concerns raised by the Mental Health Expert Committee were directly associated with psychiatric professionals' views on post-war human conditions, such as the mental health problems of children and young people, and the safe use of atomic energy. The issues overlapped considerably with those being discussed in other UN projects. Mental health professionals apparently formulated these concerns as a collective response to post-war devastation.

Third, I have illustrated the slow emergence of the Expert Committee's cross-cultural project. Apart from the advantageous location of the WHO headquarters in Geneva, problems existed with personnel and finance, as well as research methods. The first Chief of the Mental Health Section, Ronald Hargreaves, managed to recruit his colleagues to the leadership group, formed in the late 1950s. The Milbank Memorial Fund, one of the main advocates of population studies in the 1950s, supported the project. Techniques borrowed from the fields of public health, epidemiology and statistics contributed to the methodology. Finally, there were challenges by people who favoured an ethnographic approach and questioned the feasibility of the project. I see this as an influence which did not merely obstruct but also stimulated the scope of the WHO project, while the middle

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ground of diverse approaches was sought in the atmosphere of scientific internationalism. This long preparation process provided the foundation for the actual 10-year project to begin in 1965.

To summarize, the transformation of psychiatric disciplines in the early post-war period can be seen as a collective response among mental health professionals to war and its aftermath. World War II, like World War I, stimulated psychiatric thought. The effects of environmental stress aroused much interest, as did social psychiatry in general, and a new kind of psychiatrist emerged who engaged largely in preventive work away from the institutional sphere. Apart from mutual recognition regarding the need to study mental health issues cross-culturally, the realization of these professionals' visions was facilitated by the birth of new international health organizations. These organizations tended to be based on the idea of world citizenship and spill-over theories. Professionals involved in the process of knowledge-making included an esoteric circle of experts, the exoteric circle of wider society, and marginal individuals who created new issues out of the conflicts.

The newly envisioned public health approach to mental health research and epidemiology was carefully planned by visionary thinkers. The research projects coincided with other projects being developed in UN specialized agencies, and provided fresh ways of looking at mental health issues in different parts of the world. Through complex processes of scientific practice, Chisholm and Hargreaves' individual viewpoints were transformed into thought collectives and the objective reality of international collaboration. Peripheral inputs that could untie the bureaucracy and immobility of the Headquarters were also critical to its future projects that were expected to function in the post-war world order. Although the WHO tried hard to fulfil its philosophy of decentralization, these inputs did not necessarily share the WHO's original objectives. The slow incubation of the 'manageable project' marks the best example of such *problematik* in the WHO's Mental Health Section. The development and the consequent glitches faced by its common language and disease profile projects in 1960s and 1970s require a separate account for further analysis.

Notes

(Many notes cite M4/445/2 which is in the WHO Archive in Geneva.)

1. WHO Archive, WHO 4. Director General's Office: Brock Chisholm.
2. M4/445/2 J1.
3. M4/445/2 J1, p. 1.
4. M4/445/2 J1, p. 2.
5. UK National Archives FO 370/1411. Representation of His Majesty's Government at the International Congress on Mental Health to be held in London in 1948. Code 403 file 5577 J. Lindsey to Miss Murray, 17 Dec. 1947.
6. UK National Archives FO 370/1525 International Congress on Mental Health, London, Aug. 1948. Code 403 file 310.
7. See United Nations Economic and Social Council, 'Economics and Social Council. Official Records: Third Year, Seventh Session. Supplement No. 8. Report of the Social Commission', (New York: United Nations Economic and Social Council, 1948), 28–29.
8. WHO Archive, WHO/MHA/1, p. 2.
9. M4/445/2 J1, p. 3.
10. Hargreaves to Lemkau, 8 Sep. 1954, M4/445/2/J2.
11. Lemkao to Hargreaves, 30 May 1954, M4/445/2 J2.
12. Landis to Hargreaves 15 Apr., 1953, M4/445/2 J1.
13. Hargreaves to Landis, 17 June, 1953, M4/445/2 J1.
14. M4/445/2 J1.
15. In the book he offered two types of preparatory work in preventive psychiatry: (1) being prepared to meet generalized and non-predictable stresses, and (2) being prepared to meet expected stresses.
16. Hargreaves to Lemkau, 7 Oct. 1953, M4/445/2/ J1.

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17. Lemkau to Hargreaves, 12 May 1954, M4/445/2 J2.
18. M4/445/2 J1.
19. Hargreaves to Gruemberg, 22 July 1955, M4/445/2 J2.
20. Hargreaves to Krapf, 23 May 1956, M4/445/2 J2.
21. Donald Reid Papers. London School of Tropical Hygiene and Medicine archives ACC/OS.
22. WHO Archive WHO/MENT/178.
23. M4/445/2 J4.
24. Boudreau to Peterson, 10 Oct. 1957, M4/445/2 J5.
25. M4/445/2 J5.
26. M4/445/2 J5.
27. For example, Opler (1956) also gave some insights into the emerging project.
28. Wittkower to Candau, 8 July 1956, M4/445/2 J3.
29. M4/445/2 J3
30. M4/445/2 J3.
31. M4/445/2 J3.
32. M4/445/2 J1, p. 3.
33. According to Brock Chisholm, Taiwan representing the seat of China was 'an absurdity which is outstanding even in this era of absurdities'; see Farley, 2008: 90.
34. Lin's research, however, was later criticized for its lack of standardized techniques for the clinical examination and diagnosis of patients, rendering comparisons with other studies dubious; see Leff, 1988: 92–100.
35. Noted by I.C. Jarvie, who wrote in the Preface for Yap's essay collection, 'The work that Dr. Yap began and can now, alas, no longer pursue'; see Yap, 1974: 3.

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