

Aging, Illness, and Addiction

Illness raises the specter of unpredictable choice and action. Leaders who are impaired by physical or psychological illness, or unduly affected by drugs and medication rarely remain as stable or predictable as those who are not. The prospect of disabled leaders arouses fear, anger and anxiety in many observers and constituents as they contemplate the loss of stability, security or predictability in their nation's future. This public discomfort can produce different outcomes. On the one hand, voters often appear loath to vote for candidates who had past serious illnesses, even if they appear to be "cured" at the time of the campaign. This clearly occurred with the revelation of vice presidential candidate Tom Eagleton's past bouts with depression in 1972, and his treatment with electro-shock therapy (ECT). McGovern was forced to pull Eagleton off the ticket in the wake of the public furor, thus leading to accusations of lack of judgment on McGovern's part for selecting Eagleton at all. Politically and perhaps medically, McGovern may have been justified in his choice; but the public wanted chief executives that they believed could stand up to the inherent stresses of the job without undue vulnerability. And indeed, despite the fact that Eagleton had experienced his depression many years prior with no subsequent recurrences, about 30% of people who suffer major depression do not always respond well to medication.¹ Clearly this outcome was also fueled by high levels of public stigma, as well as ignorance, surrounding mental illness, along with a deep-seated and wide-spread belief that people who suffer from mental illness in whatever form do not really ever get better. In fact, Eagleton was reelected to the Senate by those constituents who knew and trusted him most, and he continued to have a successful political career without subsequent psychological impairment. Of course this also highlights the difference in public perception based on an official's position.

While the public may be happy to vest confidence in a legislator with a history of serious mental illness, they may remain understandably reluctant to give ultimate control of the nuclear football over to such a man. This episode highlights the enormous, and often unfounded, public fear that psychological illness in particular precipitates. Possibly, as education increases, public attitudes can begin to change slowly. By 1990, for example, the fact that Florida Senator Lawton Chiles had taken prozac did not prevent him from being elected governor despite his opponent's attempt to use this information against him.²

On the one hand, serious consequences can result from a mentally ill leader, and the public should be concerned about such impairments. On the other hand, many psychological illnesses remain highly treatable, with success rates, depending on the condition, of upwards of 90%. But treatment requires the person being able to acknowledge and seek help without fear of political suicide. As long as mental illness continues to be devastatingly stigmatized, leaders who suffer from serious depression and other mental illness will be driven to hide their conditions, remain untreated, and thus ironically become much more likely to exert a negative impact on their decision making without others necessarily being aware of this dynamic. Note that Eagleton, who received treatment, did not commit suicide although both British Lord Castlereagh, foreign secretary and leader of the House of Commons in the government of Lord Liverpool in the post-Napoleonic era, and James Forrestal, Secretary of the Navy during the Second World War, and America's first Secretary of Defense, did.

Another example of public reaction to ostensibly "cured" illness occurred in the case of Paul Tsongas' 1992 bid for the Presidency. Despite claims that his lymphoma was cured, the public did not seem to trust that he would not fall ill again. As it turned out, he and his doctors

did hide a recurrence of his cancer from the public during the campaign. In this case, the public proved right, Tsongas was forced to pull out of the race when he lost a string of Super-Tuesday primaries to Clinton, and was forced out of the race for financial reasons. In fact, Tsongas began chemotherapy on the day that he would have been inaugurated and later died of his pre-existing condition during the time he would have been in power had he been elected.

The second way in which the public may react to anxiety about the health of its leaders involves denial. Especially if a leader's illness is insidious in onset, intermittent in occurrence, and not mentally debilitating, such as congestive heart disease, a leader with loyal staffers may be able to hide the severity of a leader's impairment from outsiders. When this occurs, the public, including the press, may not pursue the case as aggressively as they might follow a case of sexual indiscretion, for example. Certainly the era affects the extent to which these cover-ups are possible. Roosevelt's impairments, for example, were hidden from the press and the public quite successfully; even the press was complicit in hiding his paralysis from public view in a way unimaginable today. Even relatively recently, Reagan's aides were able to hide the severity of his mental compromise. For example, in a 1982 visit, Reagan toasted the people of Bolivia while he was in Brazil and he appeared constantly confused about who was fighting whom in Latin America. He was even known to call his dog by the wrong name.³ And even today, Cheney and his doctors successfully refuse to release important information about his health, including the list of his medications. Not to put too fine a partisan point on the matter, John Kerry was not fully disclosing about his prostate surgery during the 2004 Presidential election either. In this case, while such surgery would not impair his leadership abilities, many people may feel reluctant to vote a possibly sexually compromised man into a powerful office.

So what impairments and disabilities produce the most anxiety in the general population? Are they the illnesses that should raise such concerns? Would a more educated public react differently, appropriately demanding more information in cases where such concern merits attention, while also accepting some other illnesses that currently remain more frightening to the public than incapacitating to the leader?

This chapter seeks to outline some of the ways in which leaders can become incapacitated while in office. One of the central tasks involved in assessing disability revolves around establishing a baseline for relative impairment. Obviously, there can be many reasons and causes for sub-optimal decision making, including bad luck, bad timing, bad political skill, or plain stupidity. How and when can impairment be distinguished from these other alternative explanations for decisions, behaviors, and outcomes? Luckily, previous unrelated medical and psychological research has already helped establish some well respected parameters for normal physical and psychological functioning. If previous medical or psychological literature has suggested that certain cognitive or behavioral sequelae result from particular illnesses or medications, and the leader is known to suffer from a particular precipitating condition or manifests expected symptomatology, we can gain confidence in arguing that the leader's impairments followed from the particular condition or treatment, just as it would in any other person.

The payoff of a comparison between established baselines and leader decisions and actions lies in the development of a richer understanding of historical cases where aging, illness, or addiction have critically affected a leader. Such a tracing of four presidents' impairments, treatments and consequences for specific foreign policy decisions follows in the next few

chapters. The effect of one foreign leader, the Shah of Iran's, medical illness on U.S. foreign policy follows in the appendix. Hopefully, this investigation can help contribute to a clearer sense of the most appropriate decision rules and procedures for handling cases of a leader's illness or impairment in the future. Impaired leadership is a dynamic, multi-faceted and complex issue. Knowing more is not always enough; greater sophistication in interpreting what to do with medical and psychological information and knowing what information matters is the key to greater understanding and more responsible solutions. To be clear, all three types of problems, aging, illness and addiction entrain all give of the evolutionary heuristic effects mentioned in the previous chapter.

The first section of this chapter briefly addresses the issue of self-selection in leadership. The next three parts deal sequentially with the symptoms and impact of processes of aging, illness and addiction on human leadership and performance.

Self-Selection

One of the first things to note about leaders is that they often seek their fate, as do their followers. Especially in a democratic system, individuals often put themselves forward for election. They run for a variety of reasons, but it seems obvious that at least some of those who seek political power do so because they are especially interested in power for its own sake. In and of itself, this particular incentive structure predisposes certain types of people to seek positions of political leadership. For example, shy and retiring types who do not want private aspects of their lives investigated and judged may choose not to run, even though they may be immensely qualified for the actual tasks of office. Narcissists, on the other hand, only too eager to obtain evidence of their superiority, might seek out elected office at a disproportionate rate,

regardless of substantive qualifications. Yet voters can only choose among existing options; they cannot support candidates who refuse to run for office.

Robins raises some very interesting and important issues in his work on the relationship between psychopathology and political leadership.⁴ His discussion remains limited to cases of psychological deviancy, not physical impairment. While much of his discussion on the origins of madness lies beyond the scope of this work, Robins raises some very insightful issues about the relationship between larger societal forces and psychopathology in leadership, as well as the relationship between mental illness and political power more broadly. Drawing heavily on work in anthropology, Robins argues that times of great societal upheavals produce a disproportionate number of deviant people, including more pathological leaders. An obvious example of this occurrence lies in Adolf Hitler's rise to power. While many authors have pointed to various psychological problems which appear to have plagued Hitler, few argue that his pathologies were severe enough to compromise his leadership abilities, at least until the very end of the war. Hitler may have demonstrated paranoid and narcissistic tendencies, and these personality problems were likely exacerbated by substance abuse of various kinds, but the paranoid elements of his world-view clearly found ardent admirers among many ordinary Germans, who were angry and frustrated by the devastation wrecked on Germany by the First World War and the harsh terms of the peace Treaty of Versailles.⁵ As Post so eloquently writes in his review of Redlich's book, Hitler's political paranoia represented "the fit between a malignant leader and wounded followers."⁶ A particular mix between leader and followers establishes and maintains pathological leaders in positions of power. In other words, part of the success of deviant leaders lies in the transferenceal lock they create with their followers, who seek the biased view of the

world they present.

Indeed, a similar argument can be made with regard to regime types, such that certain types of regimes, especially those that rely on repression and other means of violence to maintain societal control, enhance the likelihood that certain types of psychopathology emerge in leadership circles. Paranoid leaders may garner the support of a populace that feels vulnerable and threatened. Totalitarian regimes can succeed when the public finds the economic and social costs of freedom too high to bear, such as in ethnically fractionated societies like Yugoslavia and Iraq.. Democratic systems, while they may weed out some of the intellectually and politically weaker candidates, certainly do not prevent powerful narcissists from obtaining office; the reverse seems the case because it often takes someone with a grandiose self-image to make it through the brutal campaign process.

Robins makes a compelling case that, “it may be that certain forms of madness, like other traits, are most likely to be seen where they help their holder to achieve power than where they do not.”⁷ Indeed, he argues that in some cases it can prove difficult, especially at the outset, to distinguish between an extreme charisma and various forms of mental illness. Again, a political leader like Hitler comes to mind; recall, of course, that Hitler was democratically elected. In retrospect his psychological problems may seem clear, if not specific, and yet he was enormously successful in gaining the trust and support of the German population prior to the Second World War. Everyone who knew him commented on his tremendous charisma; clearly the line between his appeal and his pathology remained very fine, at least in the early days of his power. Other instances which prove difficult to distinguish exist as well. For example, manics in an expansive phase can often exert very strong persuasive powers through their charm, wit and optimistic

visions for the future.* They can also be quite charismatic and effective at getting people to do what they want them to do for them.

Robins concentrates his analysis on three facets of the relationship between pathology and leadership. These included recruitment, retention and removal. Obviously, many types of mental illness prevent people from attaining political power; serious illness can often prevent individuals from being organized enough, or functional enough, to effectively run for office. However, Robins argues that certain types of mental illness benefit particular people who are trying to attain power. Paranoid and hallucinatory behavior, in particular, seems to help leaders achieve power because leaders seized by such visions and beliefs can appear particularly compelling and persuasive. Paranoia can energize a movement, and provide clear guidelines for action, especially under obvious external instances of threat, such as an attack. In this case, a leader can direct his paranoia toward a vulnerable group whose existence may appear to pose some kind of economic or social threat. Hitler's scape-goating of the Jews, for instance, allowed ordinary Germans to blame the Jews for all their economic and social ills, while benefitting from the wealth that could be forcefully extracted from them. Hallucinatory behavior can also, in certain circumstances, offer a blueprint for action. The classic positive case of an effective leader aided by visions remains Joan of Arc.

Once in office, a pathological leader, like any other, needs to maintain his power. In this

*I am reminded here of a former patient at a Veteran's administration hospital who during a two-hour leave once convinced the local Winnebago dealership to deliver 24 Winnebagos COD to the VA the following Monday. The salesman remained convinced that the RVs were going to a rich, athletic doctor despite being told the buyer was a patient on the locked ward.

situation, a deviant leader may remain in power if his followers share his particular pathology for their own various reasons. Again Hitler's followers shared in his anti-Semitism to a greater or lesser degree, and therefore could share in his paranoia about them without questioning his overall judgment. Pathological leaders may also stay in power if their odd behavior remains limited in time or place, so that it is not evident to most people most of the time, or remains encapsulated to a particular topic, event or group. Particularly in times of great social upheaval or stress, deviant behavior can prove useful in helping to structure new types of social exchange or interactions. And sometimes eccentric behavior can serve a leader well, especially if it conforms with general societal biases, and proves useful against an external enemy, as sometimes a ruthless or aberrant style might. Thomas Schelling's notion of the "rationality of irrationality" whereby a leader might force opponents into concessions by making them believe he is crazy, and thus capable of taking inordinate risks, falls under this category.

A pathological leader can sometimes remain in office by asserting repressive control. When others challenge his leadership, he can jail or kill them and remain in power through fear and domination. Stalin provides an excellent example of just such a leader. In addition, a deviant leader can stay in power if those surrounding him manage to take control and serve in his stead. They might do this to retain their own political power, prevent a political rival from coming to power, or for reasons of personal loyalty to, or fear of, the stricken leader. Sometimes pathological leaders are removed from office, either through established procedures, or through violence and overthrow.

Yet sometimes it can also prove quite difficult to distinguish the effects of mental illness from the effects of ordinary stress, such as that which might easily accompany a job of

international pressure and importance. Mental illness remains a severe stigma in society. And certainly some forms of mental illness present more of an impediment to successful leadership than others; severe depression, such as that experienced by Calvin Coolidge upon the death of his son, can render a leader essentially unresponsive.⁸ Responding to, and coping with, the effects of mental illness in a leader can prove extremely challenging. Often insidious in onset and intermittent or cyclical in manifestation, various forms of mental illness can prove difficult to distinguish from the transitory effects of severe stress, which can easily be brought on by the importance and time pressures of national decision making itself.

Yet mental illness represents only one of several forms of potential leadership impairment. At least three types of conditions can partially or severely affect a leader's performance and effectiveness in office. The impact of aging and its consequences on judgment and decision making creates one identifiable set of limitations on leadership performance. Illness presents another, whether it appears in physical or psychological form. Finally, the effect of medications, whether prescription or illicit, can result in systematic impairments in thought processes as well, depending on the particular drug. Each of these restrictions will be addressed in turn.

Aging⁹

Aging presents a particular challenge for stable, healthy leadership because most world leaders are in late middle or old age by the time they ascend to power, or remain in power until older ages. It typically requires decades to rise in political rank and achieve the kind of experience and support necessary to make a bid for power. Advanced age is by no means a disability in and of itself. However, increasing age is associated with an increased incidence of

such ailments as arteriosclerosis, cancer, stroke, and end stage alcoholism.¹⁰ In addition, the treatments for such ailments, including various pharmaceutical regimens, carry their own supplemental risks to the elderly with regard to distorted judgments in particular as well.

Thus, aging really presents a double-edged sword in leadership. On the one hand, older leaders often prove unusually effective and insightful, bringing a unique and extensive history of experience and understanding to their job. On the other hand, older people tend to suffer disproportionately from certain particularly debilitating types of diseases. The naturally occurring and unavoidable consequences of age therefore threatens powerful leaders in particular, because they tend to be disproportionately drawn from the more experienced, and thus older, ranks of leadership. While older leaders may lack the energy and vitality of younger ones, they often more than compensate for this deficit of stamina with increased experience, wisdom, and perspective. The problem arises when aging leaders begin to fade, through some combination of stress, illness, or medication.

There are several important facets of the aging process that deserve consideration. One aspect of aging that appears to be universal in manifestation is decreasing energy and stamina. This factor, more than illness, may prove decisive in choosing a leader. In the last election of a new Pope, for instance, cardinals over the age of 80 remained ineligible to vote or run for the office. While this age related restriction may result partly from the desire of church leaders to not have to pick a new leader too often, it also clearly reflects some concern that men over 80 may not have the endurance of a younger man in responding to the demands of office. Interestingly, the cardinals elected the 78 year old Cardinal Ratzinger as Pope. Perhaps the church elders did not want another long papacy following the extended reign of John Paul II

which could occur with the election of a younger pope, but perhaps too they valued the extensive experience and wisdom that comes with age. Or perhaps they simply wanted someone with assured conservative credentials, more likely to be found in the ranks of the older clergy. And Ratzinger had clearly demonstrated his conservative proclivities as head of the Congregation for the Doctrine of the Faith, a post which he held under Pope John XXIII.

Second, age exerts a differential impact of stress on older people. Third, common illnesses in the elderly can precipitate early complications of brain aging; in particular, such conditions can exacerbate the cognitive sequelae of cardiovascular disease. However, it should be noted that some leaders, regardless of age, thrive on stress, and indeed go out of their way to seek out the stimulation inherent in stressful situations.¹¹

Stress produces an enhanced effect on older people, although obviously individual differences provide a continuum of effects across the aging spectrum; everyone knows someone who remains sharp as a tack well past 90, while others seem unable to function well beginning in their early 60s..** Robert Sapolsky, a biologist at Stanford, has studied the effects of stress on baboons in the Serengeti. He argues that aging itself can be understood as the progressive inability to deal effectively with stress.¹² Chronic stress can affect anyone negatively regardless of age. It can predispose people to cancer, lead to heart disease, and cause suppression of the

** Aging used to refer to people starting in their mid-60's. Current gerontology refers to "old" as someone in their late 70's and beyond. Even then people are divided into groups of the "young old" between say 75 and 85 and "old old" after 85 or so, even though many people function very well into their 90's.

immune system. At any age, heightened stress can impact peoples' performance in negative ways; but this decline occurs much more rapidly with age. In other words, in many ways older people function as well as younger people, unless additional stress comes into play, whether in the form of even minor illness, time pressure, a novel or rapidly shifting environment, or even physical exercise. When such stress occurs, older people do not function as well as they once did, or as well as their younger counterparts might.

Counter-intuitively, older people tend to exhibit too much, not too little, of a physiological response when confronted with stressful situations. In other words, they secrete more stress hormones even when they are not stressed. They have a hard time turning off the relevant stress related hormones after the stress is no longer present. These stress related hormones include epinephrine, norephenephrine, and glucosteroids. When these hormones exist in the absence of a stressor, as appears more commonly in the elderly, they can compromise the immune system and make the person more vulnerable to various secondary illnesses, just as people who take steroids to control asthma may suffer from cataracts and other side effects of the medication. For example, Sapolsky demonstrated that higher levels of glucosteroids, found in elderly rats, made tumors grow almost twice as fast as in young rats, who have a lower baseline levels of such hormones. Such elevated hormones also tend to elevate blood pressure, a coronary risk factor found much more commonly in older individuals.

To make the effect of stress on age even more complex, recent research indicates that not all kinds of stress exerts the same kind of impact on human biology. Some kinds of stress, such as sleep deprivations, loud noise, bright light, and heavy workloads, produce catecholamines, including adrenaline, to help the person respond quickly and cope effectively with the increased

pressures. But stress associated with uncertainty and a lack of predictability in the environment releases an altogether different set of hormones, corticosteroids, such as cortisol. And elevated cortisol levels, regardless of age, impair learning and memory, and weight gain, among other things.¹³

The second major concern related to aging derives from the impact of age alone on certain cognitive processes.¹⁴ As noted above, the problem, of course, lies partly in deciding what exactly constitutes “aging.” Some younger people in their 50s or even 40s can start to suffer from the effects of cerebral degeneration brought about by arteriosclerosis, while other people operate with great mental clarity well into their 90s or even beyond. However, once arteriosclerosis begins to denigrate cognitive functioning, the pattern of progress typically becomes increasingly severe over time.

Bert Park has laid out the following criteria for the impact of aging on the brain, in increasing order of impairment:

(1) Loss of recall and recent memory; (2) the inability to make up one’s mind while delegating decision making to others; (3) the proclivity to become set in one’s ways—to become, if you will, a caricature of oneself; and (4) a restricted ability to abstract, thereby returning to well-remembered themes or anecdotes when faced with unfamiliar material or circumstances. As the process accelerates, the individual begins to perceive gray issues in black and white terms. Even then, intellectual deterioration does not necessarily follow a steadily progressive course. Good days alternate with the bad, reflected in the universal observation that the elderly perform better in structured situations.¹⁵

Clearly, the fourth criteria poses special problems for an aging leader. The ability to think abstractly, to quickly assimilate and interpret new data or novel situations, to draw creative conclusions, and the skill to seek innovative solutions to a crisis form the foundation of effective leadership. As this skill diminishes, a leader’s ability to perform effectively and efficiently can

become compromised.

These effects become even more pronounced in the elderly following anesthesia, as would be required in the event of any necessary surgical procedure. Anesthesia represents a special case because its effects can produce profound and persistent deficits in cognitive abilities. The medical term for this impairment is Post-Operative Cognitive Dementia (POCD). Many factors appear to contribute to the occurrence of POCD in elderly patients following surgery. Age remains a major exacerbating condition. Other factors include decreased preoperative cognitive functioning, overall general level of health, and intra-operative events.¹⁶

In earlier studies, researchers discovered that elderly people suffer profound mental impairments, including memory loss, cognitive impairment and word finding difficulty for up to six weeks following surgery.¹⁷ As a result elderly patients undergoing anesthesia are routinely instructed to refrain from any important decision making for at least a week following the administration of anesthesia.¹⁸ Thus, Reagan making important decisions concerning the Iran-Contra scandal from his hospital bed may have been pure folly; on the other hand, it simply may have been politics that were too clever by half since such decision making could always be plausibly denied if it did not work out as planned, as in fact occurred when Attorney General Edwin Meese claimed during the Irangate hearings that Reagan may have approved the illegal shipments of arms to Iran when his judgment was compromised as a result of his surgery and post-operative medications. Reagan gave three different answers to the Tower Commission inquires about his role in Iran-Contra. In his first two answers, he indicated that he had approved what was done. Only in his third answer did Reagan admit that he did not remember making this decision, and it was indeed both reasonable to assume that his memory may have been

compromised by anesthesia and medication, and politically expedient to excuse his participation in such illicit activity.¹⁹

More recent studies have expanded medical understanding of the impact of anesthesia on the elderly in particular. Cognitive side effects of anesthesia include a delayed recovery of cognitive functioning following surgery.²⁰ In patients over 60, 19.7% manifest symptoms of cognitive dysfunction 7 days after surgery; 14.3% remain impaired after three months.²¹ Further studies conducted specifically with cardiac surgery patients produce similar results. In one study, patients were assessed using a wide battery of common neuropsychological tests between 3 and 10 days after surgery. They found a significant decline in six specific areas of functioning in over 66% of patients. These limitations encompassed concentration of attention, immediate verbal memory, psychomotor speed, visual construction tasks, and verbal skill deficits.²² An additional study reported that over 40% of spouses still notice some sort of cognitive deficit in their mates twelve months after coronary bypass surgery, especially in the realm of short term memory. These problems were serious enough to lead to altered interpersonal relationships between spouses.

Age produces an impact on the brain independent of any effects of anesthesia. Park's categorization of the effects of aging on the brain dovetail nicely with the features which Post describes as the psychological manifestation of hardening of the arteries, or arteriosclerosis, a common characteristic of coronary artery disease especially prevalent in the elderly.²³ These factors include rigidity of thought, especially the increasing inability of a person to think abstractly. Such individuals come to rely more and more on concrete, rigid, structured, familiar patterns or thinking and response. Impairment of intellect and judgment can affect

concentration, memory and decision-making. Emotional lability increases as people become less able to control their emotions; emotions often become more mixed as well, such as when crying and laughter become not far removed in time or stimulus, often co-occurring, as when elderly people may smile through their tears when recalling a fond memory from the past; this tendency can be witnessed in small children whose brains have not fully developed yet as well.

Further, as Park noted in his description of the more general effects of aging on the brain, a person's earlier personality characteristics become exaggerated. If a person was a little angry, they may now become belligerent and even aggressive, if they were suspicious, they are now paranoid, if they were good and loving and kind, they become saintly. However, good days alternate with bad. Sometimes decline can precipitate quickly, other times more slowly. For purposes of assessment when arteriosclerosis is suspected, medical personnel prefer to observe a person over several days at different times of the day to get a clear picture of the level of cognitive decline. Differential diagnosis can prove difficult because senility and depression often present in remarkably similar ways in the elderly in particular. One of the typical diagnostic differences relates to circadian rhythms; dementia often produces a "sundowner" syndrome where the person gets worse as the day wears on, while anyone who has ever been seriously depressed knows that the worst time of the day occurs upon arising, first thing in the morning. As Post writes, "If one can with some certainty diagnose cerebral arteriosclerosis, even though an individual apparently may be alert on a specific occasion, the other features already enumerated—in particular, decline in intellectual abilities and problems of judgment—are, nevertheless, operating."²⁴ Typically denial on the part of the patient accompanies the presence of disability. Apparent disregard for the loss of previous abilities sometimes goes by the French

name *la belle indifférence*, literally translated as “the beautiful indifference,” suggesting that those afflicted remain untroubled by their limitations.

Recent research indicates that the impact of aging on the brain produces effects which mimic those that result from damage to the hippocampus, the portion of the amygdala, where emotional processing often occurs, which appears responsible for transferring information into memory. Specifically, both conditions cause impairments in learning. Reductions in the number and regulation of various synaptic structures which connect neural cells in the hippocampus, resulting from age or injury, can impair the encoding of memory and enhance the erasure of memories, which in turn lead to various kinds of larger cognitive problems and deficits. In addition, deficits in the storage and retrieval of information, especially concerning the spatial organization of the environment, can also produce difficulties with learning and memory. At an extreme, such deficits help explain the common problem with wandering seen in patients with Alzheimer’s disease, who often fail to find their way home even after living in the same place for years, but this problem can become evident even when a healthy older person moves to a new environment, or demonstrates difficulty in finding objects like keys and locating new places. In a more abstract sense, difficulty in learning may help explain why leaders oftentimes overly rely on the historical analogies of their youth, which are overlearned and readily available for retrieval; such scenarios are familiar and accessible to them, and do not require new learning to recognize or implement.

As noted, age can exert an independent effect on leadership performance, particularly through its effect on energy and stamina. But increasing age also predisposes individuals to increasing susceptibility to a whole range of illnesses, such as heart disease, that can impair

attention, memory and judgment in additional ways as well. The next section specifically addresses the influence of both physical and psychological illness independent of age.

Illness

In addition to aging, physical and psychological illness can have a tremendous impact on leaders as well. And illness can take either a physical or psychological form, although often these categorizations meld in the presentation of any given disease. For example, one of the common symptoms of Grave's Disease, a disease of the thyroid gland that President George Herbert Walker Bush was diagnosed with in March, 1991, is depression.²⁵ While most people think of depression as a primarily psychological illness, in many cases it can be brought on, maintained, or follow as sequelae to various medical conditions. For example, anyone who has experienced chronic or prolonged pain knows that depression can often accompany the physical experience as pain wears down energy, hope, and resilience over time.

Physical and psychological illnesses are not unusual among leaders, whose abilities are seriously impaired by them more often than the public may realize. As noted above, such problems are partly a function of age, partly a function of stress, and partly a function of being human. While in office, for example, several American Presidents suffered from physical or psychological ailments: George Washington had an abscess on his thigh; Chester Arthur suffered from Bright's disease, a kidney ailment; Andrew Jackson had a bullet removed from his shoulder; and Grover Cleveland has two secret surgeries for cancer of the jaw in 1893. Woodrow Wilson, who will be discussed in much greater detail in the following chapter, had an incapacitating stroke in 1919, and his condition was kept secret throughout the rest of his term in office by his wife Edith, and his physician, Admiral Cary T. Grayson. Franklin Roosevelt's

heart disease was so serious that he died less than five months after his fourth election. Roosevelt's health will be the topic of chapter four. Eisenhower suffered a heart attack, underwent surgery for ileitis (Crohn's disease), and had a stroke while in office. Kennedy suffered from Addison's disease and back pain which required constant treatment with medication which presents independent serious cognitive side effects. In addition, he appears to have partaken of amphetamine injections. His disabilities will be analyzed in chapter five. In addition to his incipient Alzheimer's disease, Reagan was shot and had colon and prostate cancer surgery while in office.

While in office, George Herbert Walker President Bush's Graves disease presented as atrial fibrillation. Once properly diagnosed, he was treated, as is standard, with radioactive iodine, a treatment where the person is required to avoid close contact with others for several days in order to prevent them from being exposed to radiation. And who can forget this President Bush's bout with the flu which led him to faint and vomit in the arms of then Japanese Prime Minister in January of 1992? At the time, the oft-replayed picture of Bush slumping into the arms of Prime Minister Miyazawa was presented as a symbolic exposition of American dependence on the Japanese economy. President Clinton, while largely overtly robust during office, had to undergo surgery for a torn thigh muscle after a bad fall following a game of golf in March of 1997.

A wide variety of illness, both physical and psychological, can affect leaders while in power. In examining this issue, Hugh L'Etang conducted the first and most important work on the subject of impaired leadership.²⁶ In his book, L'Etang categorized the different types of illnesses and conditions that might impair a leader's ability to render effective judgments and

decisions. These included problems associated with workaholics, mental illness, alcoholism and other forms of drug abuse, age, illness including diabetes, and what he termed “self-destructive aggression”, which he saw as the way in which anger can negatively impact the functioning of a leader’s heart and lungs. Most presciently, L’Etang wrote about the expense account meal. Although his take then was slightly different than it might be interpreted on face value today, the notion of the impact of diet and exercise on physical functioning has certainly increased in importance over the last quarter-century. Certainly, dining out frequently makes it harder to avoid the high-salt, high-fat diet which exacerbates heart conditions.

L’Etang was cautious in warning that the mere presence of these illnesses and conditions should not immediately lead to the conclusion that those afflicted are not fit for office. The existence of some kind of impairment does not automatically mean that the particular condition inevitably exerts a negative impact on judgment and decision making. Depending on the condition, the person, and the political context, illness may precipitate a debilitating effect on the leader. But there are other situations where a particular compromise may not prove deleterious at all to the leader’s ability to render and execute careful and effective judgments and actions, as might be the case with many sexually transmitted diseases, for example.

L’Etang builds on previous work by psychiatrist Dr. Mottram Torre to argue that the best way to assess and evaluate the extent to which illness impacts leadership performance is to evaluate four essential leadership qualities, including vitality, mood, rationality, and intellectual capacity. If the illness impacts any one of these qualities severely, or if limitations in several areas add up to serious restrictions overall, then an impairment may indeed limit the quality of leadership performance. If such occupational detriments do not occur in the wake of illness, then

disability need not be diagnosed. In other words, particular illnesses may not necessarily impede a leader's ability to run a nation successfully if they do not exert a negative influence on the person's energy, stamina, mood or cognitive abilities. Well-controlled diabetes, for example, might fall into this category of illness. Other conditions, while seemingly minor, may exert a more decisive impact on a leader's ability to render effective judgments and decisions; a hit on the head might cause such a problem, at least for a short period of time.

Physical Illness

Issues of physical health can present in a wide variety of forms and duration. Accidents can occur, as with Clinton's fall. Temporary ailments can produce dramatic events, as was the case with President Bush's flu incident in Japan. Sudden incapacitation can occur any time an assassin makes an attempt on a leader's life. As Abrams details in his book on the assassination attempt on Reagan, sudden incapacitation as a result of trauma can produce a whole series of psychological and physical consequences.²⁷ Trauma, such as that which a shooting would no doubt provoke, can cause depression, withdrawal, agitation, perplexity, emotional instability and paranoia. Blood loss, which can be severe following an assassination attempt, as it was in Reagan's case, can add fuel to the fire by producing agitation and mental confusion. Further, Abrams argues that surgery alone creates post operative depression and anxiety in nearly 100% of patients, at least for a time.²⁸ Post-operative recovery can include periods of mental and perceptual disorientation. In addition, pain following surgery, or as a result of injury alone, can produce anxiety and irritability.

In Reagan's case, the anesthesia he was administered during surgery was thiopental, which can cause profound hangover effects, and also lead to overconfidence and slowed reaction

time. Add to this the various medication that Reagan took for pain following surgery, including morphine, codeine, demerol and valium, and mental compromise becomes readily assured.

Morphine alone produces mental clouding and detachment, while valium has been shown to lead to impaired learning up to 50 hours following administration.²⁹

Post argues that the illnesses which pose the greatest danger to public welfare are those which can go unrecognized for long periods of time before detection or obvious incapacitation occur.³⁰ Such diseases are typically categorized by their insidious, slow onset, their subtle effects, at least early, and their fluctuating course, so that some days the affected leader appears much better and stronger than on others. Alert advisors can schedule public appearances for an impaired leader on just those days and at those times when the leader appears to be at his best and strongest. Illnesses such as cancer, diabetes, heart disease, or Alzheimer's disease and other incapacitating dementias fall into this class, and can slowly distort a leader's capacity without others being necessarily aware of a specific date of onset, or a clear pattern of impairment. The form and onset of illness can impact not only the extent to which it might impair judgment and decision making, but also whether it can be hidden from the public, but also how the leader's physician might be involved in diagnosis, treatment, and even cover-up. Much of the potential for success in undertaking a medical cover-up depends on how many people know about the problem from the outset. If awareness remains limited to the inner circle, a cover-up is more likely to succeed. In some sense, the more overtly serious or traumatic the illness, injury or disability, the most likely it is to be discovered, and thus the less likely it is to have an impact on public policy, because appropriate procedures can be put into place to treat the condition and make sure that responsible others can assume the mantle of command either temporarily or

permanently if such action becomes necessary. Not so with the more subtle illnesses. As Post notes:

But it is the insidious illness, the subtle disability, not readily obvious, which in many ways is the most problematic for the political system. When the onset is gradual and the symptoms are fluctuant, the leader is unlikely to present an obvious or consistent public image of medical impairment even though the disability is evident to the inner circle. In such a circumstance, if the leader and his inner circle ignore how much the illness is compromising his decision making and effectiveness and carefully orchestrate his public appearances, the presence or degree of the disability can be significantly obscured. Such a situation can present a conscientious leadership circle with a choice between being loyal to the leader who may be temporarily ill and deceiving the public.³¹

Psychological Illness

Psychological illnesses may present even more catastrophic consequences for the ability of a leader to make reasonable judgments, and for a leader's nation to be well-served. It is noteworthy, at the outset, to recognize that many primarily physical ailments create psychological and cognitive side effects independent of their other physical effects. These effects can produce a wide variety of independent problems and symptoms. For example, patients who suffer a heart attack often display symptoms of depression, anxiety and insomnia in the wake of the attack. Further, over half continue to manifest depression and other psychological problems four months after the attack. A third of patients report problems of fatigue, memory, concentration, emotional stability and irritability for over two years following their attack. In fact, heart disease alone appears to predict decline in intellectual ability and functioning.

Strokes can cause similar cognitive impairments, including depression, anxiety, emotional instability and memory loss. Between 40-60% of patients remain cognitively or emotionally impaired following a stroke, while over 25% suffer memory problems. Individuals

with hypertension experience similar effects as well, including depression, anxiety, irritability, emotional instability, and shortened attention span. Oftentimes, these restrictions are accompanied by deficits in judgment, reduced speed in comprehension, thinking and mental processing, and memory impairments as well.

Cancer can also produce cognitive sequelae. Depression, anxiety and anger are common responses to cancer, and certain kind of chemotherapy can lead to serious cognitive problems as well.³² Medications can also induce or exacerbate these symptoms in people suffering primarily from physical ailments.

Yet mental illness can manifest all on its own as well, independent of any physical precipitant. Under the category of mental illness can fall transitory illnesses like depression, which, if properly treated, can remit within a reasonable period of time in the majority of cases, as well as more persistent and severe disorders such as schizophrenia. But even in circumstances of transitory illness, clear cognitive impairments follow. Serious depression, for example, can induce a tendency to focus on more bottom-up information processing styles, a greater propensity to focus on detail to the exclusion of larger issue concerns, preoccupation with fear and anxiety, and a literal, if temporary, lowering of IQ. And the difficulty with such illnesses, of course, is that they can neither be predicted nor prevented. Calvin Coolidge was a vibrant and active politician prior to the death of his favorite son, sixteen year old Calvin, Jr. in 1924; after the loss of his son, Coolidge fell into a serious and unremitting clinical depression which resulted in his complete disengagement from politics and political life.³³

Most commonly, depression is characterized by at least five of the following symptoms: depressed mood; anhedonia, where the person feels nothing and does not care about anything;

weight disturbances; sleep disturbances; psychomotor disturbances; fatigue; feelings of worthlessness or guilt; “diminished ability to think or concentrate, or indecisiveness, nearly every day”; and obsessions with death and suicide. The Diagnostic and Statistical Manual of Mental disorders IV, describes the cognitive difficulties associated with depression as follows: “many individuals report impaired ability to think, concentrate or make decisions. They may appear easily distracted or complain of memory difficulties. Those in intellectually demanding academic or occupational pursuits are often unable to function adequately even when they have mild concentration problems.”³⁴

Obviously, these kind of impairments can present severe, unmanageable constraints on a powerful political leader. In addition, psychological problems appear the least likely to become exposed to the public eye, especially because individuals make extreme attempts to hide these kind of symptoms because of the social stigma associated with them and can do so with effort for short periods of time. As discussed earlier, Tom Eagleton was removed from McGovern’s Democratic ticket for President in the 1972 election campaign because of revelations that he had suffered from depression, been hospitalized, and received electroshock treatment for this illness.

In addition, there are other pervasive and insidious psychological illnesses that may not be as transitory in nature. Robins and Post argue that the political world presents the ideal screen upon which certain affected men and women can project their personality disorders. They argue that paranoia is the most common of the personality disorders to manifest in the political world, although it may appear to the casual observer at least that narcissism exists quite commonly as well. Post and Robins write particularly about the place of paranoid disorders in the political world.³⁵ They use paranoia to refer to a broad set of personality traits that are “characterized by

guardedness, suspiciousness, hypersensitivity and isolation.”³⁶ From a psychodynamic perspective, the grandiosity of paranoia represents an inadequate attempt to overcome deep-seated feelings of inadequacy which often begin in childhood as a result of parental neglect or abuse. No amount of external validation or success can serve to adequately fill the deep psychic void that such individuals experience at the center of their being.

At the extreme, paranoia represents a kind of pathological narcissism. Indeed, elements of both paranoid and narcissistic personality characteristics can go hand in hand and feed off each other in the same person. After all, being surrounded by enemies, becoming the object of conspiracies, and the obsession of adversaries places the paranoid person in the center of everyone’s universe; persecution remains infinitely preferable to indifference. Self-absorption demands attention regardless of form or kind. And indeed a person can suffer from both a narcissistic and a paranoid personality disorder simultaneously. In fact, Post discusses a type of narcissism which combines both elements together. Labeled “malignant narcissism,” this syndrome combines ambition and aggression with an absence of conscience and paranoia. Such a personality disorder becomes particularly dangerous, according to Post, because it can combine with, or produce, a destructive charismatic leadership style. Such leaders not only believe that the rules which apply to everyone else don’t apply to them because they are so special, but also will go to extreme lengths to accomplish their goals because they cannot live with the possibility or consequences of failure. Post characterizes Saddam Hussein of Iraq, Kim Jong Il of North Korea, and Fidel Castro of Cuba as examples of such a personality structure.³⁷

People afflicted with paranoid personality disorders tend to manifest at least four of the following characteristics: suspect without foundation that others are exploiting, harming or

deceiving them; remain preoccupied with doubts about the loyalty of others; appear reluctant to confide in others for fear of information being used against them; read demeaning or threatening messages into benign remarks and events; bear grudges or remain unforgiving; perceive attacks on their character and react with anger where others see no such attacks; and retain recurrent suspicions about a partner's fidelity. This disorder is more common in men than women.

Post and Robins find evidence for the pervasive presence of paranoia in a wide variety of world leaders, including Pol Pot, Idi Amin, Joseph Stalin and Adolf Hitler.³⁸ As evidence for the manifestation of paranoia on the political stage, for example, they note that Stalin killed between 20 to 40 million of his own people and officers in various purges throughout his reign. In Uganda, Idi Amin was responsible for the deaths of over 375, 000 out of the 11.5 million inhabitants of his nation. Between 1971 and 1979, he consistently blamed others for the political troubles in his country and demonstrated incredible grandiosity. In Cambodia, Pol Pot was responsible for the deaths of over 15% of the population between 1975 and 1979. His behavior resulted from his xenophobic hatred of everyone who was not Khmer Rouge, a predilection which existed simultaneously with his pathological idealization of all things Khmer.

C. Owen, a physician and prominent former politician in the British government has also written about the relationship between political regime types and the development of paranoia in leaders. While it may be the case, as Robins suggested, that paranoid leaders are disproportionately attracted to, and often surprisingly effective in, positions of political power, it may also be the case that certain political environments or situations evoke, or even create, paranoia in otherwise normal leaders.³⁹ Owen eloquently describes how this process might take place:

One of the questions most commonly asked by a concerned public about leaders committed to brutal politics is: are they mad? Hitler, Stalin, and more recently, Saddam Hussein, Milosevic, and Mugabe have often been described as being mad in popular newspapers, when in fact they were far from being certifiable. In part the very question reflects a wish of those who live within democracies to underplay the latent evil within society, and to forget or ignore the brutalizing effect on personality that stems from living within, let alone presiding over, a Communist or Fascist dictatorship, or an ethnically divided country such as Rhodesia or the former Yugoslavia. The longer a leader lasts in office in these regimes, the more their power stems not from popular consent but from imposition. National minorities within a divided country can give their leaders ethnic electoral support, but such leaders are vulnerable to coups or assassination. They tend to lead evermore secret lives, become out of touch with the people they lead and the reality of the world around them, and develop paranoid tendencies. In addition, such leaders almost always become corrupt.⁴⁰

Such commentary not only points to the difficulty of distinguishing illness from evil, but to the way in which the power of the situation can corrupt individuals over time as well; the torture of Iraqi prisoners by formerly ordinary American soldiers at Abu Ghraib prison provides a clear illustration of this phenomenon. A reciprocal relationship exists between a leader and his followers, and between a leader's style and his regime type. Certain regime types, such as those totalitarian or authoritarian structures which rely on repression for control, may indeed unduly exacerbate particular personality characteristics, including paranoia, in their leaders. And, in turn, certain personalities may find it easier to successfully rule such regimes than their more institutionally constrained democratic counterparts.

But paranoia does not represent the only psychological condition which can pose severe consequences for world politics when leaders become afflicted. Narcissistic personality disorders appear commonly on the world stage as well. This disorder afflicts about 1% of the population and, like paranoia, is found more commonly in men, who constitute up to three-quarters of those affected. Clearly, people suffering from a narcissist disorder might disproportionately self-

select into positions of political power because of their need to believe that they are special and deserving of only the best and most of everything.

Narcissistic personality disorder is defined as a pattern of grandiosity, need for admiration and lack of empathy. It manifests in at least five of the following ways: grandiose sense of self-importance; preoccupation with fantasies of unlimited power, success, brilliance, or beauty; belief that the person is special and can only be understood by or associate with other high status people; desire for excessive admiration; a sense of entitlement; interpersonal exploitativeness; complete lack of empathy; enviousness; and arrogance. As noted above, Post has argued, for example, that Saddam Hussein represents a prime example of this disorder on the world stage.⁴¹ Post saw Hussein's disorder manifested in his destructive messianic ambition for unlimited power, and in his absence of conscience, uncontrolled aggression and paranoid outlook. Thus, analysis of leader's personalities from a distance represents more than a mere academic enterprise. Implications drawn from such interpretations can suggest different, and often non-overlapping, intervention strategies and policy responses.

Addiction

Addiction can take many forms in political leadership. The most common addiction, certainly, is alcohol abuse. This occurs, at least in many, as the consequence of years of social drinking in political situations that becomes more severe in some over time. False allegations of alcoholism in Tom Eagleton, along with true reports of electro-shock treatment for depression, contributed to his removal from the Democratic ticket in McGovern's 1972 Presidential Campaign. Senator John Tower lost his nomination for Secretary of Defense in the Bush, Sr. cabinet over concerns surrounding his alcoholism.⁴² Senator Key Pittman, chair of the Senate

Foreign Relations committee during Franklin Roosevelt's presidency provides perhaps the most dramatic example of the serious effects of alcoholism on performance in powerful office. Escalating alcoholism cycled with destructive behavior to bring about Pittman's ultimate downfall. He battled for his 6th term in 1940, becoming ill from alcohol 6 days before the election; despite his victory, he died 5 days later of alcohol abuse.⁴³ Congressman Wilbur Mills, Democrat of Arkansas from the late 1950's until the 1970's also suffered from alcoholism; his career was cut off after he was found drunk early one morning, swimming in the reflecting pool on the Washington Mall with prominent stripper Fanny Fox.⁴⁴ Estes Kefauver, Democratic Senator from Tennessee, was an early favorite for the 1956 Presidential nomination, earning a Vice-Presidential slot on the Adlai Stevenson ticket, but undermined his own effectiveness with his heavy drinking. He was driven by his parents, who expected him to make up for an older brother who died tragically before his time, just like the young Senator from Massachusetts, John Kennedy, who wrested the 1960 nomination from him.⁴⁵

Alcohol is a central nervous system depressant, and induces sleep. At low doses, imbibers often experience a lack of inhibition and gregariousness, but in larger doses, it can produce sleepiness, depression and anger. Alcohol systematically impairs performance in a number of realms. It causes negative effects on vision, slows reaction time, and decreases performance on a wide variety of judgment and motor tasks. In general, the more complex the task, the less alcohol it takes to begin to notice impairments in performance. Alcohol has a detrimental effect on memory, affecting both storage and retrieval, but exerting a stronger influence on storage.⁴⁶ Older studies have reported a relationship between alcohol intake and increased levels of risk-taking, recklessness, and aggression.⁴⁷

An additional problem with alcohol arises when an alcoholic tries to quit. Alcohol is one of the few drugs that can kill an addicted person who attempts to quit suddenly, and without medical support. While most people only manifest weaker signs of withdrawal, which nonetheless include nasty symptoms such as agitation, tremors, vomiting, nausea, sweating and rapid heartbeat, some experience the more severe symptoms, including delirium tremens. Serious withdrawal symptoms can include confusion, disorientation, hallucinations, seizures, and death. Before modern treatment strategies were developed, about 37% of people experiencing alcohol withdrawal died. Current detoxification takes a person off alcohol through the use of cross-tolerant tranquilizers, such as Valium, whose dosage is then lowered slowly. The current rate of death resulting from withdrawal holds at about 2%.⁴⁸

Other central nervous system depressants that can be abused include tranquilizers, such as barbiturates and benzodiazepines, opiates, and pain killers. The effects of barbiturates and benzodiazepines are similar, although barbiturates remain much more lethal at lower dosages. Barbiturates lower respiration and blood pressure; like alcohol, their rapid withdrawal has the capacity to kill. Benzodiazepines, such as Valium, on the other hand, typically do not have effects outside the central nervous system, although they do appear to have some muscle relaxant properties that operate through the brain. They rarely kill except in large doses and in combination with other drugs, such as alcohol. Reagan's national security advisor Robert "Bud" McFarlane discovered this when he tried to kill himself on February 9, 1987, following the Iran-Contra scandal, by swallowing numerous Valium; he was admitted to Bethesda Naval Hospital to sleep it off and emerged none the worse for wear, with the possible exception of the assault on his pride. Valium is typically prescribed for anxiety and sometimes for insomnia. Interestingly,

their anxiolytic effects do not seem to occur in people without anxiety. Low doses of benzodiazepines appear to exert little influence on motor performance. However, they do appear to reduce the ability to learn new information, both visual and verbal, by as much as 66%. Duration of impairment depends on the particular drug taken; barbiturates have a shorter impact than benzodiazepines because of their briefer half-life in the body. The duration of learning effects from benzodiazepines can be 24 hours or more. Significantly, the user typically will not recognize any drug induced learning impairment that might occur.⁴⁹

Withdrawal from benzodiazepines produces similar, though less severe, effects to that of alcohol withdrawal, depending on dosage and length of use: it can produce agitation, depression, insomnia, stomach pain and seizures. Even with a tapered withdrawal, symptoms usually last about two weeks, and include such ailments as anxiety, sleep problems, difficulty with loud noises and bright lights, weight loss, and numbness or tingling.

There appear to be two types of withdrawal processes from benzodiazepines. The first type of benzodiazepines, called sedative-hypnotics, cause tremors, delirium, cramps and possible convulsions in those using high dosages for at least a month. These drugs, including Halcyon, are typically prescribed as sleeping pills. The second kind, low-dose withdrawal, happens in those who have been taking low doses for over six months. Symptoms here can include anxiety, panic, irregular heartbeat and high blood pressure, problems with memory, concentration, perception, loud noises and bright lights, and a sense of derealization. These symptoms appear to come in 10 day cycles and can last as long as a year. People addicted to high doses for longer than six months may experience both types of withdrawal. About 15-44% of people who withdraw from recommended doses may experience some withdrawal symptoms.⁵⁰

The final class of sedative drugs that might easily be abused include opiates like heroin, morphine, and the new drug of choice, oxycontin. Opiates are typically used in medicine for the relief of pain. People abuse opiates to relieve depression, anxiety and induce euphoria. People can even become addicted after a single session. When first used, their most typical side effects include nausea and vomiting, resulting from stimulation of the brain's chemoreceptor trigger zone. The body usually becomes tolerant to these effects after a single dose. Performance slows a bit, but this occurs more in the psychomotor than in the cognitive realm. Characteristic later side effects of opiates include tiny pupils, constipation and immensely lowered sex drive. Although heroin can cause a prototypical nod, or sleepiness, shortly after ingestion, heroin actually induces insomnia and other sleeping problems over the long term.

While the pleasant effects of the drug may last only 30-60 minutes, the letdown can prove quite agitating. Over time, the addiction causes activity and social interaction to decrease, and aggressiveness and isolation to increase. More importantly, addicts quickly develop a tolerance to the positive effects of the drug, so that they maintain their use merely to hold off the withdrawal effects more than to induce any euphoria. Opiate withdrawal, while certainly incredibly painful and difficult, is almost never lethal in the way that alcohol or barbiturate withdrawal can be.

Heroin withdrawal, for example, progresses along an extremely predictable path, starting 6-12 hours after the last use, and ending by 72 hours post-use. The user begins withdrawal with restlessness, agitation, yawning, chills, goose bumps and nausea. After a second phase involving 8-12 hours of a form of deep sleep called yin sleep, the addict awakens to cramps, vomiting, diarrhea, twitching and sweating.⁵¹ Severity of withdrawal symptoms depends on how much of

what drug an addict was abusing. Less potent drugs taken at lower levels produce less severe withdrawal symptoms. Withdrawal can be stopped almost instantly by injection or consumption of any opiate, including methadone.

Significantly, people who are in pain, or other chronic users of opiates, appear not to manifest many of the cognitive impairments typically associated with opiate use. Opiates in the body really look like “smart drugs” in action. If there is pain, the pain is typically reduced, though not necessarily eliminated, with little or no side effects, even at reasonably high doses. Most difficulties with opiate abuse derive either from the legal and financial problems resulting from addiction, or the medical problems which result from unclean methods of injection, as when dirty needles infect addicts with HIV, hepatitis or other illnesses. If there is no pain, the typical effects of addiction and withdrawal are easy to witness.

Amphetamines are central nervous system stimulants. They cause an increase in heart rate and blood pressure. They also cause a dilation of the blood vessels and airways in the lungs. In fact, amphetamines were developed as a treatment for asthma, since they proved so quick and effective at opening constricted air pathways to the lungs. Use of amphetamines can produce several unpleasant results, including headache, dry mouth, stomach problems and extreme weight loss. Heavy use or overdose of amphetamines can cause dizziness, confusion, tremors, hallucinations, problems with heart rhythm and panic. Convulsions and coma occur in overdose conditions as well.

But the main effect of using amphetamines is that they tend to make people feel good, at least initially. The effects of amphetamines and cocaine are extremely similar, and in the case of intravenous use, identical. Amphetamine use at high doses, or with intravenous or intranasal

induction, produces strong positive rushes. High dose users almost always characterize these feelings in strongly sexual terms. Even with lower doses of amphetamine usage, mood improves, energy increases, and, in many cases, the person feels like they have a clear mind and a strong motivation to get things done. Depression often occurs when the user comes down off the drug, and tolerance to its positive effects occurs extremely rapidly, often after even a single use.

At first blush, amphetamines do appear to improve performance on certain tasks. They increase visual skill and endurance, and diminish the effects of fatigue on performance, especially in tasks that require prolonged or diligent attention. Many of the studies demonstrating some of the positive effects of amphetamine use on performance were conducted by various militaries during the Second World War. Positive effects were especially noted for pilots, who did not show any diminution in performance over time as a result of fatigue with the help of relatively low doses (5 mg) of amphetamines. Some researchers have argued, however, that these effects appear limited to overlearned tasks, while they may actually impair performance under conditions requiring flexible and creative thinking.⁵² For competitive athletes, amphetamines do appear to improve the performance time over their best non-drug event times by about 1%, a difference that can prove critical, even definitive, at world class levels of running, biking, or other physical sports.

However, amphetamines can cause some serious side effects over time. The person tends to have an increased sense of well-being, alertness and energy. But tolerance quickly develops and then more and more of the drug is needed to achieve the same effect. The risk of toxic responses at these higher doses becomes very real. When this occurs, addicts demonstrate

impaired judgment, becoming increasingly grandiose and euphoric, overoptimistic, and most importantly, less cautious and more impulsive in their actions. Impairments which appear characteristics in stimulant addicts include deficits in cognition, motivation, insight, and attention. Addicts show emotional instability, impulsivity, aggressiveness and depression.⁵³ Those who have used large amounts for long periods develop stereotyped behaviors, referred to as punding, where they repetitively perform some ritual, meaningless task, like washing their hands, or crossing and uncrossing their legs, for long periods of time.⁵⁴ Such behavior might appear evident, for example, in someone who can't stop rearranging items on the top of his desk. In high dosages, amphetamines can induce a form of psychosis—amphetamine psychosis that is indistinguishable from any other form of psychosis in presentation. The symptoms include hallucinations, delusions, hostility and violence. Oftentimes, paranoia is present as well. Users who develop psychotic episodes often report feeling the experience of bugs crawling under their skin. A cocaine user might call these cocaine bugs; an amphetamine user typically refers to these as crank bugs.⁵⁵

Amphetamine withdrawal often potentiates depression and fatigue. This can occur as soon as a half hour following administration of the drug. Addicts who have used a high dosage of the drug for a long time can precipitate severe depression from drug withdrawal, including suicidal ideation or attempts.

Clear evidence of amphetamines abuse by British Prime Minister Anthony Eden during the Suez crisis in 1956 explains a lot of his seemingly bizarre behavior at the time.⁵⁶ Close advisors and observers noted his frenzied, panicked style, as well as his isolation, paranoia, and inability to sleep. He became irritable and argumentative. More severe reactions to high doses

of amphetamines include talking too much or too fast, lack of emotional control, hyperactivity, hypervigilance, suspiciousness, aggressiveness and hostility, which remains consistent with the reports of Eden's behavior by his friends. High doses of amphetamines over time can provoke confusion, delusions, hallucinations, and paranoia. When Eden's doctor cut him off for fear of an overdose, Eden collapsed in the middle of the crisis and had to be sent to the Caribbean with the public excuse that he was suffering from a fever related to the re-emergence of a bout of malaria. Fever, in fact, is a classic symptom of abrupt withdrawal from amphetamine abuse.

One of the notable things about the use of these illegal substances by leaders is that most often their doctor is their supplier.⁵⁷ The doctor, over a long period of personal and intimate contact, often develops a personal loyalty to the leader. Indeed, in some countries a doctor who does not offer what is demanded may be killed. But at least in the American cases, problems occur more often when the doctor is not well trained in substance abuse or not properly supervised by others. While personal physicians remain crucial for the timely care for a sick or impaired leader, such doctors can easily err on the side of personal loyalty, perhaps even unknowingly facilitating their patient's addiction, thus compromising the care of their patient and possibly betraying the national welfare in the process. This happened, for example, when the Capital doctor, Freeman Cary, prescribed inappropriate medications to at least two powerful U.S. leaders. In one case, Cary misdiagnosed Senator John East of North Carolina's symptoms of depression, anxiety and insomnia. Cary prescribed sleeping pills and tranquilizers to which East became addicted. East later used these prescription drugs to commit suicide in June of 1986. In reality, East suffered from hypothyroidism.⁵⁸

This same physician was responsible for over-prescribing Placidyl, a sleeping pill, to

Supreme Court Justice William Rehnquist before he ascended to the Court. Sleeping pills are rarely recommended for more than two weeks of regular use because of the high potential for addiction. Indeed, only recently has one sleep drug, Lunesta, been approved for long term use. Rehnquist took this drug in excess of recommended dosage under this doctor's care for over nine years. In fact, Rehnquist had to go through treatment for withdrawal in 1981. Later, his addiction became an issue in the Senate hearing on his Supreme Court confirmation.⁵⁹

Indeed, Presidents and other leaders can be affected by prescription medications that are given in service of other medical conditions, but which may have powerful cognitive side effects as well. Steroids present particular problems because they are commonly used to treat so many ailments, from asthma to pain resulting from inflammation, and yet can produce such extreme mood effects. To some extent, as Post & Robins note, every drug also creates its own disease.⁶⁰

Some leaders manage to be aware of, and eschew, such drugs and their effects. In the most heroic, or perhaps extreme, example, John Foster Dulles, who was dying of extremely painful stomach cancer, refused any pain medication because he was concerned that it would interfere unduly with his job as Secretary of State under Eisenhower. In another example, Lady Bird Johnson admitted that one of the reasons she did not want her husband Lyndon Johnson to run for President in 1968 following one heart attack was because she was afraid that his tendency to refuse medication that might affect him mentally would harm his health and cause another heart attack.⁶¹ Less extreme measures than those taken by John Foster Dulles have also been taken by others in an attempt to prevent cognitive deficits as a result of medication. Clinton, for example, underwent only local anesthesia during the surgery to repair his injured thigh in 1997, and was given only anti-inflammatories for pain, in order to stay conscious and avoid a transfer

of power to Vice President Gore during his ordeal. Yet, extreme chronic pain can produce its own mental limitations and effects as well, so a balance must be achieved between illness and treatment effects. One recent study, for example, showed that people suffering from a physical illness showed a deficit in verbal IQ. This effect was not otherwise explained by the presence of depression, cognitive load, or medication.⁶²

Conclusion

Clearly, aging, illness, and addiction can affect a given leader's judgment and decision making abilities. How these conditions affected particular leaders within the context of specific foreign policy contexts will be the subject of the remainder of this book. Leaders will be presented in chronological order. In each case, a leader and his relevant illness will be discussed, followed by an examination of a particular foreign policy decision which was assumed or appeared to have been at least partially affected by that leader's impairments. These leaders are not intended to represent the entire universe of affliction in high office. Rather, they present a sample of the kind of medical and psychological conditions that can affect leaders in systematic and predictable ways which significantly impair their ability to make optimal judgments, at least in the foreign policy arena.

1. On Eagleton, see Post & Robins (1993), pg. 33. On refractory nature of severe depression, see H. H. Goldman, *Review of General Psychiatry, 2nd Ed.* (San Mateo, CA: Appleton & Lange, 1988, p. 344). In fact, electroshock therapy appears successful in about 70% of those treated, who are in fact the most severely depressed. The main side effect is anterograde amnesia. *Ibid.*, pg. 504. It remains the treatment of choice for refractory depression, or patients who need rapid improvement because of anorexia or other complicating factors. See Tierney et al., *Essentials of Diagnosis and Treatment, 2nd Edition.* (New York: Lange Medical Books/McGraw-Hill, 2002,

pg. 342.

2. Post & Robins

3. Kenneth Walker, "Medical Condition of Leaders Often Hushed up." *Chicago Sun-Times*, February 15, 1998, p. 44.

4. Robert Robins, ed., "Recruitment of Pathological Deviants into Political Leadership," *Psychopathology and Political Leadership* (New Orleans: Tulane University, 1977), 53-78.

5. For more on this issue, see Ian Kershaw, *The Hitler Myth* (New York: Oxford University Press, 2001), Daniel Jonah Goldhagen, *Hitler's Willing Executioners* (New York: Vintage, 1997), and Fritz Redlich, *Hitler: Diagnosis of a Destructive Prophet* (New York: Oxford University Press, 2000)

6. On Hitler, see Fritz Redlich, *Hitler: Diagnosis of a Destructive Prophet*. (New York: Oxford, 1998) and Post & Robins, *When Illness Strikes the Leader* (New Haven, CT: Yale University Press, 1993). For review, see Jerrold Post, *New England Journal of Medicine*, May 27, 1999.

7. *Ibid.*, 14.

8. For more on this fascinating case, see the superb book by Robert Gilbert, *The Tormented President* (Westport, CT: Praeger, 2003).

9. The first author to systematically address the effects of age on leadership was Jerrold Post, "On Aging Leaders: Possible Effects of the Aging Process on the Conduct of Leadership," *Journal of Geriatric Psychiatry* 6 (1973) 109-116.

10. Jerrold Post and Robert Robins, *When Illness Strikes the Leader: The Dilemma of the Captive King* (New Haven, CT: Yale University Press, 1993).

11. See Robert Robins and Robert Dorn, "Stress and Political Leadership," *Politics and Life Sciences* (1993).

12. Sapolsky, *Why Zebras Don't Get Ulcers: A Guide to Stress, Stress-Related Disease and Coping*.

13. For an excellent discussion of this distinction, see Stephen Peter Rosen, *War and Human Nature* (Princeton, NJ: Princeton University Press, 2005), chapter four.

14. See Post & Robins, chapter 5.

15. Bert Park, "Presidential Disability: Past Experiences and Future Implications," *Politics and the Life Sciences* 7, (August 1988): 55.

16. A. Becker and E. Weeks, "Post Operative Cognitive Dysfunction" *Best Practice* 17, no. 2, (June 2003): 259-272.

17. J. R. Flatt and others, "Effects of Anesthesia on Some Aspects of Mental Functioning of Surgical Patients," *Anesthesia and Intensive Care* 12, (1984): 315-24; Bert Park, *The Impact of Illness on World Leaders* (Philadelphia, PA: University of Pennsylvania, 1986).

18. J. Riis and others, "Immediate and Long Term Mental Recovery from General vs. Epidural Anesthesia in Elderly Patients," *Acta Anaesthesiologica Scandinavica* 27, (1983): 44-49; Bert Park, *Ailing, Aging, Addicted: Studies of Compromised Leadership*. (Lexington, KY: University of Kentucky Press, 1993).

19. Post & Robins, pg. 174.

-
20. J. Heaver, "Toxicity of Anesthetics," *Clinical Anesthesiology* 17, no. 1, (March 2003): 1-3.
 21. J. T. Moller and others, "Long Term Postoperative Cognitive Dysfunction in the Elderly," *Lancet* 351, no. 9106, (March 21, 1998): 857-61.
 22. R. Gorna and others, "Assessment of Short Term Neuropsychological Change After Monothermic vs. Hypothermic Coronary Artery Bypass Grafting," *Psychiatric Politics* 35, no. 5, (September-October 2001): 781-95.
 23. Jerrold Post, "The Seasons of a Leader's Life," *Political Psychology* 2, (Fall 1980): 35-49.
 24. *Ibid.*, 45.
 25. David Wang, Schott Koehler, Cary Mariash, "Detecting Graves' Disease," *Physician and Sportsmedicine* 24, no. 12 (December 1996): 35.
 26. Hugh L'Etang, *Fit to Lead?* (London: William Heinemann Medical Books Ltd, 1980).
 27. Herbert Abrams, "Sudden Incapacitation," in *Presidential Disability: Papers, Discussions and Recommendations on the 25th Amendment and Issues of Inability and Disability in Presidents of the United States*, ed. James Toole and Robert Joynt, (Rochester, NY: University of Rochester Press, 2001).
 28. *Ibid.*
 29. *Ibid.*
 30. Jerrold Post, "Behavioral Disorders" in *Presidential Disability: Papers, Discussions and Recommendations on the 25th Amendment and Issues of Inability and Disability in Presidents of the United States*, ed. James Toole and Robert Joynt, (Rochester, NY: University of Rochester Press, 2001).
 31. *Ibid.*, 52.
 32. Herbert Abrams, "Disabled Leaders, Cognition and Crisis Decision Making in Accidental Nuclear War," Proceedings of the Eighteenth Pugwash Workshop on Nuclear Forces, special issue, *Canadian Papers in Peace Studies*, 1990 Science for Peace, University of Toronto

 33. For a wonderfully rich and textured account of Coolidge's depression, see Robert Gilbert, *The Tormented President: Calvin Coolidge, Death and Clinical Depression*. (New York: Praeger Publishers, 2003).
 34. DSM-IV, pg. 322.
 35. Robert Robins and Jerrold Post, *Political Paranoia: The Psychopolitics of Hatred* (New Haven, CT: Yale University Press, 1997).
 36. *Ibid.*, 5.
 37. See Jerrold Post, "Saddam Hussein of Iraq: A Political Psychological Profile," *Political Psychology* 12 (1991), 279-89. Also Jerrold Post, *Leaders and their Followers in a Dangerous World*. (Ithaca, NY: Cornell University Press, 2004).
 38. *Ibid.*
 39. Robert Robins, "Recruitment of Pathological Deviants into Political Leadership," in R.S. Robins, ed, *Psychopathology and Political Leadership*, 53-78, (New Orleans: Tulane Studies in Political Science, 1977).
 40. C.H. Owen, "Diseased, Demented, Depressed: Serious Illness in Heads of State," *Quarterly Journal of Medicine* 96, no. 5, (May 2003): 325-336.
 41. Jerrold Post, "Saddam Hussein of Iraq: A Political Psychology Profile," *Political*

Psychology 12, (1991): 279-289.

42. Post and Robins, *When Illness Strikes the Leader: The Dilemma of the Captive King*.

43. For a wonderful psychobiography of Pittman, see Betty Glad, Key Pittman: The Tragedy of Senate Insider (New York: Columbia University Press, 1986).

44. Post & Robins

45. Ibid.

46. William McKim, *Drugs and Behavior: An Introduction to Behavioral Pharmacology*, 4th ed. (Upper Saddle River, NJ: Prentice Hall, 2000).

47. Roy Lubit and Bruce Russett, "The Effects of Drugs on Decision Making," *Journal of Conflict Resolution* 28, no. 1 (March 1984): 85-102.

48. William McKim, *Drugs and Behavior: An Introduction to Behavioral Pharmacology*, 4th ed.

49. Ibid.

50. Ibid.

51. McKim, pg. 259.

52. L. Judd and others, "Effects of Psychotropic Drugs on Cognition and Memory in Normal Humans and Animals," in *Psychopharmacology: A Third Generation of Progress*, ed. H. Y. Meltzwer, 1467-1475, (New York: Raven Press, 1987).

53. MD Majewska, "Cocaine Addiction as a Neurological Disorder: Implications for Treatment," *NIDA Research Monograph* 163, (1996): 1-26.

54. McKim, pg. 233.

55. William McKim, *Drugs and Behavior: An Introduction to Behavioral Pharmacology*, 4th ed.

56. Post & Robins, L'Etang, and Bert Park, *The Impact of Illness on World Leaders* (Philadelphia: University of Pennsylvania Press, 1988). Bert Park, *Aging, Ailing and Addicted: Studies in Compromised Leadership* (Lexington, KY: University of Kentucky Press, 1993).

57. This is a point made by Post & Robins, Park and Kucharski as well.

58. Post and Robins, *When Illness Strikes the Leader: The Dilemma of the Captive King*.

59. Ibid.

60. Ibid.

61. Post & Robins, pg. 65.

62. (Attree et al, 2003)