Adolf Meyer
His Achievements and Legacy
Paul R. McHugh, MD

Abstract: This lecture, given to celebrate the centennial of the founding of the Henry Phipps Psychiatric Service at Johns Hopkins, addresses the career and contributions to psychiatry and neurology of Adolf Meyer, the first Phipps Professor. It reviews his achievements historically describing the bleak clinical situation of psychiatry when he began as a neuropathologist at Kankakee Hospital in Illinois in 1892, what he did to address them, the sources of help he found and exploited from leading figures in the emerging Progressive Era (1890–1917) in American life, and how he confronted and overcame resistances to his empirical, psychobiological conceptions of mental illness as he advanced. His legacy is reflected in the signal contributions of four leaders of American psychiatry (Drs. Leo Kanner, Alexander Leighton, Jerome Frank, and Paul Lemptau) who had been his residents and in those aspects of contemporary teaching and research at Hopkins that reflect his thought.

Key Words: History of psychiatry, Meyerian psychiatry, psychobiology, Johns Hopkins University, Perspectives of Psychiatry

I am honored to launch the centenary celebrations of the Phipps Clinic by describing the achievements and legacy of Adolf Meyer—the Clinic’s first Psychiatrist-in-chief and predecessor to me and Dr. Raymond DePaulo as Henry Phipps Professor of Psychiatry at The Johns Hopkins School of Medicine.

I welcome the opportunity for two reasons. First, I think the Hopkins community should know more about Meyer—to most he is but a name on a building and lacks the renown of Osler, Halsted, or Welch whose names grace other buildings. But second, and of greater warrant, Meyer has been getting a poor press in recent texts on the history of psychiatry and deserves some defense.

In criticizing Meyer, contemporary historians may underestimate the problems he confronted, the fortitude it took to correct them, or the ingenuity involved. He is not above criticism, but what he did achieve was real and his legacy significant.

There are two aspects to his contributions—his personal achievements and those of students taught and inspired by him. One who understands both these direct and indirect offerings to psychiatry will know why he is entitled to honor even as the discipline progresses beyond what he accomplished.

MEYER’S CONTRIBUTIONS TO NEUROLOGY AND NEUROSURGERY

Let me first justify the local decision to place his name on a large building at Hopkins devoted, as the signs along its passages proclaim, to the Departments of Neurology, Neurosurgery, and Psychiatry. As the signage implies, he contributed to all three of these medical domains.

For example, Meyer identified the distinguishing brain pathology of Pellagra by demonstrating how the Betz Cells of the cerebral cortex took on an appearance resembling the so-called axonal reaction of the spinal anterior horn cells when their axonal extensions to the muscles are damaged or cut.

With them, the cell body swells and rounds losing its normal angular outline; the cellular nucleus is displaced towards the side of the cell and itself becomes swollen; and the particulate intracellular Nissl bodies that customarily give the neural cytoplasm a tiger-stripe appearance fade and fragment to render it a gauzy broth. These cellular changes are characteristic of a nerve cell synthesizing nucleoprotein—in the case of the anterior horn cell for the purpose of restoring the integrity of its peripheral axon.

Meyer showed that the Betz cells in the cerebral cortex of Pellagra patients displayed a similar change. He entitled this transformation “central neuritis” and proposed that the basic disorder—niacin deficiency we now know—must be damaging the axonal fibers from these cortical neurons to the rest of the brain.

The localization of this patho-cellular change to the cerebral cortex, he argued, made sense of the dementia syndrome that is such a prominent feature of Pellagra. Pellagra is now an uncommon disorder in the USA—although not so uncommon as never to be seen as I can attest. This may explain why his contribution here has been rather overlooked.

Meyer discerned the vital neuropathological feature of a more common neurological disorder when studying the pathology of what was then referred to as “Pachymeningitis Hemorrhagica Interna.” Meyer demonstrated that, contrary to what is implied by the expression “meningitis,” close examination of the pathological material revealed only blood products with no inflammatory features. He encouraged the substitution of the term “Subdural Hematoma” used to this day for the condition.

His diagnostic emphasis, by implication, redirected investigators away from a search for inflammation or infection and towards a bruising trauma and intracranial bleeding in the patients. And, also by implication, his concept encouraged efforts at surgical relief when and if a diagnosis could be achieved in life.

Harvey Cushing drew more neurosurgical attention to Adolf Meyer. Cushing’s team at Hopkins had failed to recognize a small upper-quadrant visual field defect in a patient with a tumor in the temporal lobe that impinged on the anatomical course of the ventral portion of the optic radiation that Meyer was first to describe as sweeping out to and around the temporal pole. Only after Meyer had him look for it in his patient did Cushing find the visual defect on the perimeter and, when he described the case (Johns Hopkins Hospital Bulletin 22: 190: 1911), Cushing—and anatomists to this day—entitled this feature of the optic radiation “Meyer’s Loop.” Surgeons operating today in the temporal region strive, whenever possible, to spare this tract and preserve its contribution to vision.

The obvious point to draw from noticing the Meyer Building on the grounds of the Johns Hopkins Hospital: Look to the history of those named and you will find things that mattered in medicine and surgery.
MEYER’S PSYCHIATRY AND AMERICAN HISTORY

Meyer’s neurological and neurosurgical contributions do not represent our major interest in him. His contributions to psychiatry brought him prominence, and it is here he is being criticized today by medical historians. Shorter finds him a “second-rate thinker” (Shorter, 1997, p. 111); Noll, one whose “confidence...outstripped his competence” (Noll, 2011, p. 38); and Scull as teaching “a ‘commonsense psychiatry’ [that] was peculiarly impenetrable” (Scull, 2005, p. 147).

These severe criticisms of Meyer fail to explain why Meyer could advance from rather inauspicious beginnings so steadily within his profession to be ultimately chosen, with international approbation, the first Henry Phipps Professor at America’s prime medical center. Or, for that matter, how he succeeded in being at one time elected President of the American Psychiatric Association and at another President of the American Neurological Association, or again, why peers found him worthy to receive honorary degrees from both Harvard and Yale, and finally, how a man today reputed limited in intellectual gift became a close friend of illustrious and discerning people such as John Dewey and Harvey Cushing and was hailed for decades on both sides of the Atlantic as the Dean of American psychiatry.

The contemporary reviewers either do not bear in mind the problematic culture wherein he worked or they minimize how Meyer advanced his clinical discipline despite it. Let me see if I can do better—perhaps from the vantage point of standing in his shoes for some 26 years.

We are fortunate to have two good sources for re-evaluating Meyer today: Four volumes edited by Eunice Winters gather and cluster his publications in Neurology, Psychiatry, Medical Teaching, and Mental Hygiene. His correspondence is available in the Allen Chesney Archives at Hopkins collected and organized splendidly for students of Meyer and of the history of psychiatry by Ruth Leys.

These sources reveal how Meyer spoke to his era like no other American psychiatrist did. Just what did Meyer see, do, and say that so many of his contemporaries came to appreciate?

Consider his biographical trajectory here in America. In 1892, a 26-year-old Zurich School of Medicine graduate specializing in neurology and neuropathology, Meyer immigrated to the USA and by dint of desperate effort and a bit of luck found work in the Illinois State Asylum System as a neuropathologist. By 1917—25 years later—he was firmly ensconced as Director of the Phipps Clinic at Hopkins drawing to Hopkins and his department many gifted students who not only believed in what he was teaching but were prepared to come to Baltimore to study with him.

What was happening in those years 1892 to 1917? What do we know about them—especially in places like Chicago—and what would an American historian say about that time we might consider when thinking about Meyer’s place in psychiatry?

The question answers itself. The period from 1890 to 1917 is known as the Progressive Era. Meyer took to its themes and it took to him as though they were meant for each other. A brief excursion to describe that historical era will, I believe, help explain why Meyer gained such enthusiastic support for his psychiatric ideas and thus make better sense of his rise to prominence.

The Progressive Era

The Progressive Era’s dates, 1890 to 1917, i.e., from the year of the Sherman Anti-trust Act to the year America entered the First World War, form an historical period when ground-breaking changes transformed the society and its government.

The names of its leading figures still resonate with distinction: In politics, both political parties contribute as with the Republicans Theodore Roosevelt and Robert (“Battling Bob”) La Follette of Wisconsin and the Democrats William Jennings Bryan and Woodrow Wilson; in education and philosophy, there is John Dewey, George Herbert Mead, and Hopkins’ own Daniel Coit Gilman; in social services, there is the settlement house movement led by Jane Addams at Hull House in Chicago and Lillian Wald in New York City; in journalism, there is Upton Sinclair, Ida Tarbell, George Creel, Lincoln Steffens, and all the “muckrakers” exposing political bassism and corruption wherever they found it; and there is the great “dissenters” on the Supreme Court: John Marshall Harlan, Oliver Wendell Holmes Jr., and Louis D. Brandeis striving to emphasize the not-so-subtle exploitations of the public that social and economic inequalities can sustain.

The accomplishments of the people during the Progressive Era were many and included several Anti-trust actions against such “Big Businesses” as the Standard Oil Company, and social legislation such as the Pure Food and Drug Act, Child Labor and Educational laws, and four significant Amendments (Sixteenth, Seventeenth, Eighteenth, and Nineteenth) to the Federal Constitution.

Our predecessors here as faculty at Hopkins encountered the salutary support of the progressive spirit when this School of Medicine, having been functioning for but 25 years, was identified in 1910 by Abraham Flexner as the model all American medical schools should follow. Flexner’s report to the Carnegie Foundation not only advanced a coherent and contemporary vision of the structure of medical education—with Hopkins as the paradigm—but also, by encouraging standards for licensure and assessment, brought about the closure of over a hundred second-rate proprietary medical schools that were at the time filling the country with poorly equipped physicians.

The Progressive Era was an awakening of the moral temper of Americans—middle class Americans mostly—who, concerned with the growing miseries of the poor, the vulnerable, the sick, and the exploited, were aroused to provoke change. It was partly inspired by what was revealed by the investigative enterprises and the personal examples of those I have named and partly inspired, as was Abolition, by traditional American religious sentiments.

In that sense for all that it had good reasons and dramatic examples to advance its cause, the Progressive movement just like the anti-slavery movement worked on an emotional level with the American public and during its duration promoted ideals that transcended class, political party, religious affiliation, or nationality (McGeer, 2003)

Meyer: The Progressives’ Psychiatrist

Returning to our theme, where and with what progressive thought and example did Adolf Meyer’s life, work, and enterprise come in? And how did he contribute to that historical period?

He was in Illinois—at the start of the Progressive Era—faced with a most specially neglected and vulnerable group of people, the numerous mentally ill held within the State Asylum Systems. His first real job—one that paid him a modest salary—begun May 1, 1893 as the pathologist to Illinois Eastern Hospital for the Insane cited in Kankakee, a small town 60 miles south of Chicago, where 2200 patients—mostly from that great city—were held in cottage wards on grounds of over 200 acres.

Initially, Meyer’s responsibility was to study the bodies and brains of patients who died in the institution. The Asylum’s psychiatrists expected him to provide for them some explanation of the nature of their brains of patients who died in the institution. The Asylum’s psychiatrists expected him to provide for them some explanation of the nature and cause of the conditions that had afflicted their patients, kept them confined to the institution, and ultimately led to their death.

This was quite a challenge to this young immigrant, and just how he met it tells much about who he was. Two decisive ideas occurred to Meyer at Kankakee. The first (grasped by him at the time but not admitted until much later) was, “I know very little psychiatry.” But, Meyer’s second idea (grasped a few months after he began) was, “No one else knows much about psychiatry, here or anywhere else for that matter.” He aimed to correct both these problems.
He started in the most basic way—by explaining the role of a pathologist to the physicians and administrators at Kankakee. He declared it pointless to merely roll the sad corpse of a patient into his morgue and expect him to discern from autopsy findings much about the disorder that afflicted that person in life. To correlate autopsy findings with the clinical problem requires a full and detailed history of the patient’s illness and a reasonably complete physical and mental examination of that patient before his or her death.

Unless the physicians could say more than, “This patient has been in the hospital for some years and was quite insane,” the most thorough autopsy would provide little more information than that he or she had died of some immediate cause—such as pneumonia or cardiac failure. It would seldom illuminate the chronic mental disorder that had afflicted the patient for years and the psychiatrists had tried to help.

But, the physicians at Kankakee—each caring for some 300 patients—were overwhelmed by the practical and administrative problems of supporting them. They were given no systematic way of gathering a clinical history and had no time to review the mental or neurological state of each patient as his or her mental condition advanced or changed.

Kankakee was no different from most other State Mental hospitals in the country. Patients in all these institutions were essentially anonymous folk miles from home and family, receiving care that was uniform, collective, and, although usually intended kindly, rested on the sense that psychiatric patients were indistinguishable from one another in any significant way.

Meyer may have occasionally wondered how he, a 27-year-old German-accented foreigner, small in stature, fresh out of medical school, and without qualifications as a psychiatrist or psychologist could succeed in the face of these conditions and the clinical culture of this grim asylum. But, what else was there for him?

The problem was not that Meyer was ignorant of good psychiatry being practiced and available elsewhere than Kankakee. In 1893, he, like other young asylum psychiatrists, was “on his own.” No Emil Kraepelin had ascended the international psychiatric scene to make some sense of the scattering of facts that 19th century psychiatrists had established (his ground-breaking “5th edition” Text book did not appear until 1896). Neither was there a Sigmund Freud on offer (his foundational “Interpretation of Dreams” does not appear until 1900).

If nothing else Meyer had pluck and in a rather backcountry asylum began hacking a trail with a gusto that drew notice to him and to his institution. After explaining the pathologist’s role at Kankakee, he began teaching (and learning) some ABCs of clinical psychiatry.

He organized a lecture course that combined some elementary neuropsychology with principles for examining patients that gave purpose to his clinicopathological exercises. This course gradually moved from the lecture room onto the wards where, in unofficial but regular group meetings with clinicians, Meyer demonstrated—at the bedside—how to gather information from patients and revealed how a thorough personal history and psychological assessment improved on what was known about the patient. He even found occasions where he could suggest obvious treatments for him or her.

Meyer in fact started up what everyone, including himself, needed—a systematic way of gathering simple and standard information about mental patients that brought the individual to life and drew him or her forth from the shadowy crowd of the “insane” with much benefit in care given and received.

He acted and reacted thusly to his situation all of 1893 and into 1894—not without some resistance from (as he described them later) a “medical staff hopelessly sunk into routine and perfectly satisfied with it.”

Meyer found support from other sources beyond his own natural fortitude. The first was his growing familiarity, through the University of Chicago, with the emerging intellectual leaders of the Progressive movement clustered in Chicago. John Dewey became his close, indeed lifetime, friend and made sure Meyer learned much of what was new in American thought such as the “pragmatist” philosophy of Charles Sanders Peirce, the “action” psychology of William James (whose two-volume “Principles of Psychology” was a signal publishing event of 1890), and the social psychology of George Herbert Mead and Charles Horton Cooley who emphasized the crucial role in human life of the family and other personal associations.

Dewey saw to it that Meyer met and came under the spell of the ardent Jane Addams, founder of Hull House, the first American “Settlement House” where urban social work had its beginnings. Meyer even stayed at Hull House for a few days after mildly injuring himself in a fall at the Chicago World’s Fair.

Through his alliance with these energetic progressives, Meyer became more confident that psychiatrists should strive to understand the associations and travails, both physical and mental, their patients’ lives entailed. Not only did his proposal fit the moral emphasis of the times but the information it could provide would, he believed, do more to explain the mental disorders the patients expressed (and offer themes for their treatment) than did any of the crude symptom-based diagnostic labels such as mania, melancholia, dementia, or idiocy that were stuck upon them in less than standard ways at Kankakee and elsewhere.

Crucially, once he started, he was encouraged by the professional enthusiasm he evoked in many of the younger psychiatrists at the hospital—a touch of the emotional energy advancing other progressive causes in that era and one that Meyer could ever skillfully sustain among students to come.

Meyer’s idea—know the patient in his or her life—first tentatively proposed and tried at Kankakee—would carry him throughout his career. He would refine it as he practiced it, but ultimately it would translate reforming premises of the Progressive Era into practical advances in clinical study, humane care, and direct service to the mentally ill.

An early stroke of good luck from an unexpected corner helped the young pathologist/psychiatrist. Meyer, for all his resolve, needed a champion, someone or something from “without” official psychiatry to confirm, support, and corroborate that what he was expecting of the staff was likely to advance the care and treatment of patients—at Kankakee and everywhere else.

In May 1894, a year after Meyer began at Kankakee, Silas Weir Mitchell, a professor of medicine and neurology at the University of Pennsylvania (and close friend of William Osler), was invited by the officials of the Association of Medical Superintendents of Institutions for the Insane (later the American Psychiatric Association) to give the keynote address at their annual meeting primarily because he was reasonably eminent and also accessible in Philadelphia where that year’s meeting was held. But, in his talk, Mitchell tore into the assembled psychiatrists so as to shake their professional assumptions in ways few others would dare—certainly not young Adolf Meyer.

A few quotes from Mitchell’s lecture reveal its curious character: “We ask you ’experts’—what have you taught us of these ninety-one thousand insane whom you see or treat?”

Why, he said, “You’ve presided over assemblages of living corpses—pathetic patients who have lost even the memory of hope, and sit in rows, too dull to know despair, watched by attendants: silent, gruesome machines which eat and sleep, sleep and eat.”

He noted, “In your monasteries of Madness…You’ve isolated yourself from medicine, sought no new scientific information through your work. Your medical records are inadequate, and your educational efforts amongst your profession are minimal.”

And again, “Your ways are not our ways. You live out of range of critical shot; you are not preceded and followed in your ward work. ...
by clever rivals, or watched by able residents fresh from the learning of school.”

And finally and with more than a touch of scorn, “Contrast the work you have done in the last three decades with what the little group of our neurologists have done…. What is the matter?”

Meyer did not hear Mitchell’s talk because, being, as he later recounted, one of the “lesser known and less favored beginners,” he had not been sent to Philadelphia. But, he soon learned of this stormy rebuke of the practices and assumptions he was striving to correct at Kankakee, and he circulated copies of Mitchell’s address around the asylum to salvage his maverick position. He even, through his influential Chicago friends, found a way to get the “progressive” governor of Illinois John P. Altgeld to read and consider what Mitchell had said and how it might apply in the state asylums of Illinois.

Encouraged in all these different ways (and still under 30 years of age), Meyer provocatively organized the junior asylum psychiatrists of Michigan, Illinois, and Iowa into their own “Association of Assis tant Physicians of Hospitals for the Insane”. This “Young Turk” group sought a forum where matters of psychiatric interest rather than matters of asylum administration would be discussed and where, as Meyer said, “It will be our duty to collect systematically whatever may give us a clue for progress and for formulating distinct problems.”

The first members of this group became Meyer’s team—a collection of youthful, vigorous, optimistic psychiatrists who would come to work with him, support him, draw others in, and enrich the intellectual surrounds wherever he went—a small platoon that came to see him as their “Chief” and encouraged other students to join them in the several clinical and academic settings that he led after Kankakee. And things did follow on. Meyer left Kankakee for the State Mental Asylum at Worcester Massachusetts in late 1895—now to be a chief of service with clinical as well as neuropathologic responsibility for a small number of patients whom he and his team could study thoroughly. He was already more assured of himself and, with social views inspired by Dewey, Mead, and Addams, he taught a vigorous, optimistic, and comprehensive approach that held that knowing as much as one could of what impinges on a person in life would enlarge what a psychiatrist understood and ultimately what a psychiatrist could do for that person.

His specifically “progressivist” thought in psychiatry would direct much of his activities in the years that followed. He taught that the well-intended public “asylum” system for the insane taken up in all the American states during the 1840s after the reformer Dorothea Dix had grown unmanageable. The pastoral sanatoriums had become overcrowded, patients had fallen into anonymity within those throngs, and the supportive services—diagnostic and therapeutic—were stultified, failing to progress.

He taught that psychiatric patients, like medical patients, needed to be individuated and their lives thoroughly scrutinized. For this reason, he encouraged State Hospital Systems to develop smaller subsidiary centers closer to or even in the cities and preferably tied to universities. He was not alone in this idea; psychiatrists in Michigan, Massachusetts, and Iowa began to think similarly but Meyer brought broad neuropsychiatric capacities, popular support, and great moral energy to the enterprise.

Teaching and practicing with eager students, Meyer stayed in Worcester Massachusetts from 1896 to 1901. From there in 1902 to 1910, he went to direct the Pathological Institute of the New York State System. He would change its name to the Psychiatric Institute of New York and forge an affiliation between the State of NY and Columbia University’s College of Physicians and Surgeons that thrives today.

Ultimately, in 1910, Meyer elected to accept the invitation to come to the model university medical setting in America, The Johns Hopkins University Hospital and Medical School. There he planned, and, a hundred years ago, on April 1913 opened the Phipps Clinic. Here his program unfolded, here he demonstrated what was special about it, and from here his concepts and modes of practice were disseminated widely in psychiatry.

**MEYER’S BASIC CONCEPTIONS AND HIS RESPONSE TO CONTEMPORARIES**

Three fundamental ideas structure Meyer’s proposals for a psychiatry that could emphasize, in ways that spoke to the progressive tradition from which he emerged, the individual and his or her mental disorders.

First idea: mental disorders do not “strike” a life so much as “emerge” from it. For this reason, the entire life of a patient must be evaluated so as to understand—in terms of biographical setting and time—how symptoms appeared and how the derangement they represented brought him or her to psychiatric attention.

Second idea: From this presumption about the emergent nature of these conditions, Meyer held that psychiatrists “formulate illnesses” rather than “diagnose disorders.” That is, psychiatrists, as they study and work with their patients, individuate their problems. They study their patients’ lives thoroughly from their earliest beginnings. In this way, he expected psychiatrists to find critical factors that in a dynamic, interactive, and individual way made sense of each presenting mental illness as a kind of “reaction” of the patient to matters within and without his or her active mind.

This “bottom up” approach of Meyer’s was radically different from the diagnostic “top down” approach that he first encountered at Kankakee (and came to be encouraged by Kraepelin) where psychiatrists identified mental disorders by their symptomatic presentations, gave them codifying labels, but offered no sense of their origins or generation.

Third idea: All the many sciences related to mentality—that Meyer encompassed under his term “Psychobiology”—contributed information from which psychiatrists could hope to advance rational practice. “Psychobiology” has been confusedly defined—sometimes by Meyer himself given his tendency to the “wordiness” his critics condemn. But, by the term he meant simply the “study of life” at the psychological level. Psychobiology is conceptually synonymous with “molecular biology,” the study of life at the molecular level.

Meyer taught that by making careful clinical observations, psychiatrists were “doing psychobiology.” But, as a brain pathologist, he knew that other contributions would come from basic scientists studying the further reaches of the “psychobiological” realm. Hence, he drew into his department at Hopkins such pioneering scientists as the behavioral psychologist J.B. Watson, the physiological psychologist Curt Richter, the Pavlovian W. Horsely Gantt, and the neuroscientist Othello Langworthy—each of whom contributed to the expansion of psychobiological thought in directions beyond those of clinicians.

A psychiatrist thinking and working within a “psychobiological” interpretive framework would, Meyer taught, emphasize and attend to the patient as a “body-mind” unit—a person distinctive in biology but also in the life setting and social environment from which he or she emerged. Most of the mental disorders the patient displayed should be understood as “reactions”—dynamic, functional, comprehensible responses often habitual in nature and open to thoughtful correction from psychiatrists.

Meyer described his ideas as pragmatic, realistic, a kind of “informed commonsense” which strove to honor the complexity of individual human lives and yet see within habitual assumptions and social contexts sources of most mental disorders.

As one might expect from this foundation, Meyer emphasized public health. Social prevention was an obvious corollary to his views. Here, his “progressivism” was most evident as with his encouragement of such public enterprises for care and support of vulnerable families as
he had witnessed Jane Addams and the settlement house movement providing in Chicago.

Psychiatric social work was promoted by his efforts. Mrs. Meyer, herself, was an early social worker, keenly interested in the network of family, community, and occupation within which patients were embed-ded. She brought the plight of the poor and discriminated minorities to Meyer’s attention as he considered how to understand the place of these matters in the generation of mental disorders. Together, he and his wife implemented an energetic social work service at the Phelps Clinic and forged the beginnings of what we now identify as beneficial “team psychiatric care.”

Meyer, as were many a Progressive Era supporter—advocated forthrightedly for alcohol prohibition and particularly the 18th Amendment to the US Constitution. He was a teetotalist all his active life believing that the public health evidence tying many mental ills to alcohol and alcoholism represented one of the clearest of psychobiological findings.

One can best understand Meyer’s response to his contemporaries from his “commonsense” psychiatry and its social presumptions.

His most distinguished psychiatric contemporary was Emil Kraepelin of Munich who, after 1896, published a series of influential editions of his textbook of psychiatry intended to describe distinct mental illnesses and so to provide a comprehensive diagnostic system for psychiatry. After a period supporting him, Meyer became averse to Kraepelin’s approach believing it made too much of “categor-ical” distinctions given the many aspects of mental distress Meyer observed to emerge from the misadventures and misdirections of individuals in social and psychological conflict. Meyer wanted to make more of the choices, potentials, accidents, and assumptions within a patient’s life when explaining his or her disorder than Kraepelin did.

Meyer was equally struck—and discomforted—by the genetic explanations for mental and behavioral disorders that were emerging at the turn of the century. These inspired the socially and politically powerful eugenics movement that ultimately swept over the nation producing inauspicious even hostile attitudes towards the mentally ill. “I am skeptical about the premature Mendelian simplicity in the etiological explanations of psychobiological disorders” Meyer said. First because, I “see too many more direct, non-heredity causes in many disorders of total behavior,” and second because “I’m staggered by the sweeping simplicity of the few points picked out for heredity statistics.”

Meyer taught that “Mendelian rules [are but] a stimulus to research” rather than modes discerning the “fit and the unfit” of society.

It would be in the realm of psychotherapy that Meyer (strive as he would to retain a generous and open approach in therapeutics of all kinds) fell to quarrelling and especially with Freudian psychoanalysis as it emerged in the early years of the 20th century. Meyer’s factual, “commonsense,” detailed biographic approach would provoke con-flicts that began shortly after 1909 when Freud and Carl Jung visited America and spoke—as did Meyer—at the now legendary conference on Psychiatry at Clark University in Worcester Massachusetts.

The Freudians in explaining psychiatric patients envisioned and appealed to hidden, latent themes—uncertain, conflicted, universal, and unconscious—that they discerned, in often symbolic form, within a patient’s symptoms and signs. They considered Meyer’s pragmatic explanations based on conscious, unadorned life experiences and “commonsense” reactions to be ideas with a simple-minded, “middle-class” origin that skipped over (and may, the analysts implied, be pur-posefully ignoring) the disguised, intensely subjective, dynamic, usually libidinal, mental urges that generated, so they alleged, the disrupted lives that Meyer floundered to explain.

Contrary to the “progressivist” Meyer, the Freudians were “mod-ernists,” distrustful (and ready to subvert) the whole notion of a simple, verifiable, transparent reality as the source of any “important” explana-tions especially in human mental life, intentions, and behavior.

Meyer, when he discussed psychoanalysis, offered only a few but telling criticisms. He thought that psychoanalysts tended to blur the distinction between fact and theory in such a fashion that the theory became facile and irrefutable. An analyst could explain away any criti-cism or discount any unexpected observation by condemning the critic as willfully blind to his own libidinal conflicts, i.e., “repressing” them from conscious acknowledgement.

Meyer also contended that it was hard to shake the “mytical” romantic features of psychoanalysis given its origins from thoughts about dreams. He held that this artful “mystical” aspect of psychoanalysis appealed to many as had faith healers of the past.

But still, Meyer did not hit any therapeutic proposals hard even as he did not promote them at Hopkins. Hence the recent criticism by historians about his slack and permissive stance not just towards psychoanalysis but towards “focal infection” therapy and frontal lobotomy. In the Meyer archives at Hopkins are notes to himself revealing that Meyer also saw his leniency towards unproven therapies as a problem. “Why did I fail to be explicit… I should have made myself clear and in outspoken opposition, instead of a mild semblance of harmony… What was it that failed to get across? Did I pussyfoot too much?”

Perhaps, to give Meyer some due, the lack in his times of any clear and specific therapies for mental disorders made him reluctant to squash enthusiasms that would keep psychiatrists working with their patients and perhaps discovering more that might help them. It cannot be denied though that he failed on many occasions to condemn and reject with any vigor therapies that injured more than they helped.

THE MEYERIAN LEGACY

These then were Meyer’s direct achievements and, understood in relation to their times, they are significant. In fact, they helped redirect the discipline. The history of psychiatry from 1910 to 1940 in America is justifiably identified as the Meyerian Epoch.

The most telling criticism to direct against him is that, supportive and thorough as his study of patients was, it did not bring about promising research nor advance the discipline beyond what was apparent to him.

For all the “common-sense” on which his understanding of hu-man mental distress and disorder rested, Meyer never proposed testable hypotheses as to their causes or mechanisms, hypotheses that might challenge his or others’ assumptions and provoke experimental studies that by confirming or refuting them pushed the field forward. His psychi-atriy was one of “ingredients” rather than experimentally proven “recipes,” a psychiatry that remained ever humane and comprehensive but was never heuristic.

Many contemporary criticisms note how, because of these flaws and because of the almost endless searches of each patient’s biography for some “key” to his or her disorder, his approach could be swept from American academic psychiatry immediately after he retired to be re-placed by Freudian psychoanalysis with its own assumptions about which life experiences made sense of mental disorders.

This Psychoanalytic Epoch dominating American academic psychiatry from about 1945 to 1975 brought ways of assessment and treatment that were, however, open mostly to those with financial means. Not only did psychoanalysts neglect the care and treat-ment of the poor and the seriously ill, but, given their presumptions of knowledge and suspicion of challenges to it, they paralysed sci-entific progress in psychiatry far more thoroughly than did Meyer who could at least encourage followers to strike out along paths he had not taken.

When the critics of Meyer blame him for not providing a strong resistance to psychoanalysis, they tend to overlook how he inspired sev-eral distinguished investigators and psychiatrists who bridged what
Edward Shorter has called the Psychoanalytic Hiatus— that followed after Meyer’s retirement (Shorter, 1997, pp 145–189).

Four men in particular should be identified in American psychiatry doing important work in this period from 1945 into the 1970s and 1980s. Each of them now is honored for his considerable investigative contributions, and each of them was ever ready to tell how Meyer motivated and encouraged the work for which they became known.

Leo Kanner, essentially the founder of modern child psychiatry, was trained and selected by Meyer for that purpose. His textbook “Child Psychiatry,” which first appeared in the 1940s, remains a “good read” cast in Meyerian concepts and terms. And, of course, he was the first psychiatrist to identify Early Infantile Autism as a distinct mental disorder of children.

Alexander Leighton, one of Meyer’s last residents, pioneered long-term studies of populations for the prevalence and incidence of psychiatric disorder. He combined his education as an anthropologist with psychiatry and led the Stirling County study in Nova Scotia along with his wife Dr. Jane Murphy. They ever ready to note how their enterprise was inspired by Meyer’s belief that only long follow-on study will reveal the nature and problems in living tied to mental disorders. A powerful product was Jane Murphy’s classical demonstration in Science (Murphy, 1976) that put an end to the strange craze that presumed that mental illnesses were only cultural artifacts of psychiatrists and that disorders such as schizophrenia were “myths.”

Jerome Frank, also one of Meyer’s last residents and a graduate psychologist, brought a Meyerian capacity for assessment to the study of patients in psychotherapy and in that process transformed the understanding of that vexed issue. In his now classical text “Persuasion and Healing,” he demonstrated that contrary to many psychotherapeutic presumptions based on Freudian thought, patients coming to psychotherapy were not similar in what provoked their distress—as from unconscious libidinal conflicts. Rather they were similar in their presenting a state of mind Frank described as “demoralization”—a state of mind that had emerged from any of an almost infinite sources of social and psychological conflict that had deprived the patient of a sense of “mastery” of life’s challenges. This essentially Meyerian concept is now embedded in most empirically tested forms of psychotherapy such as Cognitive Behavioral Psychotherapy.

Paul Lemkau, also a graduate of Meyer’s program, inherited Meyer’s enthusiasm for public health and eventually founded the Department of Mental Hygiene (now the Department of Mental Health) in the Hopkins Bloomberg School of Public Health. Under Lemkau’s leadership, the first community-wide study of the prevalence of mental illness was done here in Baltimore and from this study came many important clinical realizations including the role of obstetrical injury in the provocation of several forms of childhood and adolescent psychiatric disorders. The ECA study done across the United States by the NIMH in the late 1980s modeled itself on Lemkau’s Baltimore Study.

These four psychiatrists—Kanner, Leighton, Frank, and Lemkau—led the few enterprises that advanced the field during the Psychoanalytic Epoch. They, “honored in their generation and the glory of their times,” were all Meyerians. Any assessment of their teacher that overlooks how he inspired these students will misjudge him.

THE ENDURING MEYER

What though of Meyer finds expression as legacy in our department today?

First, we retain the Meyerian approach to case taking. His idea that a mental disorder springs out of a life and should be revealed by organizing the case taking method around a full biographical sketch remains honored at Hopkins today where case notes still begin with the family history and end with the presenting complaint. This practice, in a time of “check-list” diagnoses based on symptoms, renders the Hopkins method special, its ties to the Meyer tradition obvious, and its suitability for a diagnostic “formulation” of each patient’s condition clear.

Second, we retain his commitment to the formulation but have strengthened Meyer’s mode by proposing a structural approach with clear heuristic features. We, like others, certainly noticed that Meyer’s psychiatry, although humane, did little to differentiate the causal nature or identify distinct ways mental problems could be generated. He thus failed to propose different pathways for either their treatment or their scientific study.

With our publication “The Perspectives of Psychiatry,” we (McHugh and Slavney, 1998) distinguish mental distress and disorders according to obvious features of their derivation. We see and approach differently those mental disorders derived from brain diseases, from personality vulnerabilities, from habitual behaviors, and from distressful life encounters.

The formulations at Hopkins now demonstrate how each of these “Perspectives” represents a matter of greater or lesser salience in explaining the distressed state of mind for every patient. Diagnosis is included within our contemporary formulations of human plights, but the influential ways life experience, choice, temperamental habit, and assumption shape such presentations—just as Meyer noted—are given attention in assessment, treatment, and research.

Finally, we have continued Meyer’s overall aim for Hopkins psychiatry. The department, he said, should combine clinical and investigative efforts advancing psychiatric knowledge about particular disorders with a commitment to provide excellent psychiatric services to the Baltimore neighborhood.

The Hopkins specialty services exemplify and expand upon directions from the Perspectives of Psychiatry. Hence, there are specialty services aimed to illuminate (1) the Disease Perspective such as Affective Disorder, Schizophrenia, Alzheimer’s, and Huntington’s Disease services (and link basic research into genetics and neurobiology directly to them); (2) the Behavioral Perspective such as Anorexia Nervosa, Addiction, and Sexual Disorder services (and link basic research into physiological psychology directly to them); (3) the Dimensional Perspective such as Obsessive Compulsive Disorder and Anxiety Disorder services (and link basic epidemiologic and psychological research into temperament to them); and (4) the Life Story Perspective such as the Chronic Pain service (and link collaborative research with pharmacology, anesthesia, and neurosurgery to it).

At the same time we have grown and sustained a comprehensive Community Psychiatry program for our neighborhood in East Baltimore with both outpatient and in-patient services. This program has generated much public health research and has received national recognition.

Perhaps, in summary, the similarities and differences in interest and emphasis between Meyer’s department and the Hopkins psychiatry department today are revealed by examining two autobiographical books dealing with manic-depressive illness.

Meyer often praised the 1908 book “A Mind that Found Itself” by Clifford Beers because he believed it demonstrated how a “commonsense” approach addressing the troubled habits of a distressful life helped a man through his abnormal moods. Meyer tended, though, to minimize the recurrences of these mood disruptions that Beers suffered and the social decline they produced.

We put forward as a counterpart the contribution of our colleague Kay Redfield Jamison who in her brilliant book “An Unquiet Mind” describes not only the life and best efforts of the suffering individual as did Beers but explains just how Manic-Depressive Disorder drove aspects of her clinical picture and how she responded favorably to its diagnosis and pharmacologic treatment.

We see the progress we have made when we note, with Jamison’s help, how a thoughtful formulation—that incorporates the Disease
Perspective but is not restricted to it—improves psychiatric understanding of a person’s mental and behavioral affliction. We believe that Meyer would understand and embrace this development of his psychiatry.

In fact, we think Meyer would be “at home” with us if he could visit Hopkins today as his ideas endure here even as they have been elaborated and enhanced in the light of new knowledge that came after his time.

DISCLOSURE

The author declares no conflict of interest.

REFERENCES


