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Annotation

Adolf Meyer

Some Recollections and Impressions

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Adolf Meyer was famous when I first met him in 1933. I was at that time a psychiatric resident at Bellevue Hospital, and Meyer was Psychiatrist-in-Chief at Johns Hopkins Hospital. He had been asked by the sponsors of a fellowship I was given to act as guide and supervisor, and had agreed. I met and corresponded with him throughout the tenure of that fellowship, to 1940, spending a year in his department in Baltimore in 1938–1939, and saw him irregularly thereafter.

His department at Johns Hopkins was the most prestigious in the country: everybody aspired to train there. He sat on nearly every committee of importance, on editorial boards, on important commissions, and his advice was sought for many key professorial appointments at leading universities. Though Meyer was well aware of his authority, his bearing was modest and simple. In his office he would not address you from a big chair behind his desk, but placed you in an easy chair, while he moved to an ordinary chair himself. He was short of stature, with thin hair and high forehead, wore a Van Dyke, spoke with a German-Swiss accent, and was very much the European professor.

He was not the kind of person who called you by your first name on brief acquaintanceship: we knew each other for 15 years, but he never addressed me by my first name. He was abstemious in his habits, started his day early, worked through the luncheon period and left a little early when his wife, who drove the family car, generally called for him. He regretted the separation of home and place of work. "When you live away from your work place," he remarked, "you lead a divided life." He did not smoke, and I do not think I ever saw him drink a cocktail, or indeed any wine. At large social gatherings it was generally Mrs Meyer who would maintain the conversation: Meyer was more passive, and would remain observantly quiet or responsive to attentions. He seldom engaged in casual conversation with members of the house staff, but would invite all of us in small groups in succession to have dinner at his home once a year.

His manner was always mild. He was a good listener, and when he spoke was never peremptory, but cautious and moderate in his pronouncements, modifying or qualifying his phrases to produce a very characteristic circumlocution. His thinking also seemed to be many-faceted and complex rather than incisive or decisive, a quality that hampered his writing ability. He used to complain that he was educated in too many languages and could never attain literary proficiency in one, but I think the real difficulty was his tendency to excessively complex formulation.

Adolf Meyer had entered the American scene at the turn of the century at a crucial point in American psychiatry. There was on the one hand the vast custodial system for the psychotic in the state hospitals, and on the other hand the private practising neurologists (like Weir Mitchell) who were being called upon increasingly to deal with 'neuroses'. Aside from the state hospital system, psychiatry was privately practised by the neurologists. Scientific activity in psychiatry was mostly limited to descriptive or nosologic interests (Kraepelin) or to neuropathology. The new psychodynamic trend (Janet and Freud) was just beginning to emerge. At this juncture Meyer, based in the state hospital system, schooled and distinguished in neuroanatomy and neuropathology, and committed to the biographic individualized approach to case study, embodied the special combination of background and interests that the times required. The creation of a psychiatric chair for him at Johns Hopkins was innovative and set the pattern for similar developments in medical schools throughout the country.

He gathered a remarkably good staff around him. It was not only that Meyer picked good people: the most promising or best connected people also sought him out. Dr Esther Richards was perhaps the first woman to hold an important post in the Johns Hopkins faculty (the Phipps Clinic always had a high representation of women), Richter, Gantt, Diethelm, Muncie, Rennie, Kanner, Katzenelbogen and others all made their mark, and innumerable distinguished careers—both American and foreign—began there. For a long time there were always a few young residents from Britain in training there, and other foreigners came and went.

Though Meyer was by no means a system builder, the Phipps Clinic was a model of quietly efficient operation, achieved in an atmosphere of friendly relaxation. Everything had its place and everybody his or her role. Commands were not issued, but things were expected and had to be done, otherwise you would be embarrassingly conspicuous. The morning conference in the little library for example would start at nine: if you came late, everybody would see, and you would miss part of the presentation. Before nine Dr Meyer would regularly confer with his senior staff in his office, where news would be exchanged and decisions made: nothing of importance escaped attention. The non-professional staff was stable and loyal and stayed on for years. Senior staff similarly had little turnover. If there were rivalries and factions they were kept within discreet and polite limits, though Meyer once told me with a mischievous smile that whenever anybody left the staff he had a feeling of relief.

Meyer opposed the formal diagnostic preoccupations of the Kraepelinians, came to oppose the extreme and intense psychodynamic concerns of the psychoanalysts, and moved psychiatry a considerable distance from medicine. Though he maintained a broad all-inclusive frame of reference for psychobiology, in practice he discouraged and discounted the medical dimension. He refused to admit cases of general paresis to the Phipps Clinic because he considered them essentially medical problems. He maintained his love for neuroanatomy (every resident was expected to make a plasticine brain model under his tutelage) but considerations of neuroanatomy or neuropathology practically never arose in clinical conference, and I recall one case of brain tumour in an inpatient at the Phipps Clinic that was long undetected. The psychophysiological laboratories of Richter, Katzenelbogen, and Gantt intruded hardly at all into the clinical thinking at Phipps. As an example of Meyer's catholicity of interest they told a story of an announcement at the Phipps Clinic of a lecture at the hospital on 'The Chemistry of Doubt'. Nobody showed any surprise, until it was disclosed that it was all a typographical error: it should have read "The Chemistry of Gout".

With the widely publicized advent of insulin shock therapy, Meyer was quite seriously concerned, for he regarded this as a threat of resurgent medical emphasis in an area where he felt humane psychological interest should prevail. He accepted an invitation to speak at a meeting at the New York Academy of Medicine devoted to the sensational new treatment, but wrote me (1937):

> There are two extremes in the attempts to play the savior role in psychiatry: work at the root — which is evidently *not* insulin work — and importations which have next to nothing specific to do with psychiatry but exploit the patient and resources through and for imported interests; and this is the case with insulin. I am always sorry to see the latter get on the top. Whenever it does, my interest wanes. I have allowed the paresis problem to pass into the domain of the lues department because paresis is a 'dirty' experiment of nature without localizing or any other control being possible. I am willing to leave it to the spirochaetist. And with insulin we deal with even more of an importation apt to divert the attention completely from the illness by absorbing the attention in the direction of something pharmaceutical. I am not belittling the interest and the experiment, but I hope you understand me fully.
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> It is too easy for non-psychiatrists to assume a dominant position and to become more or less antipsychiatric in the field. Therapy by the way of experimental pathology, along lines which have nothing to do with the disease process except as a starter and in the role of medical dominance acceptable to the patient and relatives and the profession will always have to prove itself. As soon as it becomes dominant by diverting the attention from what after all is the crux of it all, viz., the therapy at the root and in terms of life, it should only hold itself if success justifies the always disturbing disruption and usurpations by some narrow technician. I naturally shall not inject this note into the discussion of January 12. The meeting will anyhow be one *in partibus infidelibus*; i.e., governed by non-psychiatric interests and all I can expect to do is not to stir up the problem of psychiatry, but to balance what is sound in the work.

When insulin treatment was finally used at the Phipps Clinic, and the results were positive, he discouraged publication.

Meyer did bring into his conferences a broad medical culture and a strong moral commitment. His wide travels, his knowledge of languages and his studious habits gave him a breadth of information, much of it based on personal knowledge, that raised his discussions to a high level. At the same time it came as a pleasant shock to me, after my years at Bellevue Hospital, to hear Adolf Meyer insistently ask after every case presentation, "What are we going to do for this patient?" a query that was seldom heard amidst the prevailing psychodynamic interests in New York City.

Meyer's remarks at the daily morning conferences were often rambling and hard to understand. I sometimes felt like the little boy in "The Emperor's New Clothes" and was tempted to cry out that the emperor had nothing on, but deference to the aura of his presence was too pervasive to be dissipated. Actually the aura, in spite of its diffuseness, was beneficient; one could get the drift even when the details were obscure: the fog was luminous. The drift

generally involved an eminently humane effort to see a patient's symptoms and problems in the full context of his past life and present situation, to approach him sympathetically, to utilize his positive attitudes and assets and to teach, guide, assist in any way that would help the patient to return to his society and to his social goals.

Meyer's prominence and moral commitment often lead to cautious involvement in liberal causes. The involvement was always cautious because Meyer respected the established order and would do nothing that might appear to be disruptive. He was identified in those years, for example, with the effort to develop friendly relations with the struggling new socialist proletarian USSR, but at the same time was much disturbed by the attempts of some physicians at Bellevue to join a bargaining union. I am sure he did not think he was tainted by any racial bias, but he acquiesced to local custom: no Negro was ever admitted to the Phipps inpatient service, and Blacks held only menial jobs at the Clinic.

He had no interest in private practice, and was a strong believer in medical planning, in preventive medicine, in the public health model, and in government participation in all levels of health service. He wrote to me (1937):

> The ideal of medicine is to make itself unnecessary. I wish it could be taken out of the economically competitive ranks. But in a power-crazy period the power-craze will be a deplorably strong item if not a necessity, whether under the sheepskin of "communism" or under the bald display of dictatorship, both living on might and hatred. It looks as if a new species of animal ought to sweep aside the present 'regimes'. The problem of self-maintenance of worker and work is difficult to solve since the sound features of 'bourgeoisie' were corrupted by greed and anti-greed and supergreed.

In an earlier letter to me (1934) he wrote:

> Science has played too lone and high and mighty a game; so has industry and so have the humanities. They made puppets of man and are reaping their harvest. And who are 'they'? *We*, who are part of them and have to learn to sense the responsibility.

He preserved a polite but distant relationship with his fellow Swiss professor at Johns Hopkins, Henry Sigerist, whose book on Soviet Medicine was causing a stir. In spite of his general approval of government support of health services, he tried to dissuade me from joining an effort to set up a conference at Johns Hopkins in 1938 to promote national health insurance, because it was associated with Sigerist's name and was regarded by some as radical. He was strongly opposed to the rising threat of Hitlerism, and devoted one morning's conference in 1938 to a discussion of Hitler. The occasion was a telegram he received from one of the Washington news agencies asking whether he thought Hitler was psychotic. The formulation of his response was typically Meyerian: The trouble was not that Hitler was diseased, but that he was healthy. And yet, Meyer went on to say, he had a disorder, and the cause of his disorder was his success: the treatment must therefore be his failure.

Another worthy cause for which Meyer's help was solicited (in 1938) involved the effort to rally support for a well known musician who had been sentenced to a very harsh long term of imprisonment because of a homosexual act. Meyer asked me to visit the prisoner and to prepare a report on the case, and was very helpful in securing his parole, and later his pardon. In asking me to report on the case, he wrote:

> That some humans are homosexual may be completely beyond their control, either a matter of start (or heredity-determined spontaneity), or due to particular factors in habit-formation, special experiences such as seduction, or owing to narrowing factors in the sex opportunities and tendencies, or by venture and accident, and unwillingness to know and live up to the rules and laws of the body social. What then are the facts that bring the case to observation and judgment? The first concern to me in such a case is the nature of the charge and the facts at hand.
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> Without specification of the events I should not consider the mere accusation: solicitation and seduction and corruption? Public nuisance? Likely to have caused damage or to forebode damage to additional victims? In what way and to what extent is his case different from the partner? What is to be punished and what to be attained and how? For the protection of society? For treatment of his predicament? As a public deterrent (in general principle or as a clear demonstration of what the facts are and what the law aims to cover)? What does the letter of the law allow in the way of latitude? Were there ever any efforts to get treatment before or since the events and what would such 'treatment' aim at? What evidence is there on the question of dependability in the past and in case of release? It may be that your conversation and discussion of the case and the facts furnished give the picture needed. I lack the data. It may have been mutual masturbation with a minor? I should like to make clear that my letter will be based on an intimate knowledge of the facts of the case.

He had his own mild style of waging polemics. One adversary would mimic Meyer by saying, "Never mind the theory: let us have the facts. What you believe is theory; what I believe is fact." Meyer for his part said this person reminded him of Charlie Chaplin (to whom he did indeed have a certain resemblance). Of another unfriendly soul, he simply said, "He is not a man of strong personal

attachments." He wrote to me when I was seeing Freud in Vienna:

> Freud interested me from his debut in the literature and while I felt from the beginning of my medical work keen on the inclusion of all of human nature in the scientific reality and objective world even just as I found it, the systematic organization he gave to it all was and is always stimulating and like a fabric of true art and life. I saw and heard him at Worcester in 1909 and called on him in 1923 and regret that the personal contacts could not have been more frequent and closer. I hope you will be a live link to whom I may turn when you get back to these shores. To cover such a life-work with the author while you allow yourself to vibrate true to yourself and to the atmosphere must be a great satisfaction.

When I complained of what I regarded as Freud's narrow dogmatism, he wrote:

> Do not let yourself be misled by the natural concentration and limitation Professor Freud puts on himself. It is a mixture of temperament and wisdom and fate, which had best be accepted so that it gets its fullest expression. I sometimes envy that capacity; at any rate I see its great force, actually I am able to put myself in the position of the varieties of personalities and movements without any sense of resentment, although one regrets at times the lack of reciprocity. I should give a great deal to have or to have had your opportunity so as to be in a position to be thoroughly fair toward a force that crystallized some of the most fateful meanderings — perhaps too fatefully. I understand your dilemma, but trust that you can get a most interesting sense of the principles in pure culture without loss to your ultimate digestion of it all.

Because of his special prominence his chairmanship was renewed year by year after normal retirement age, but he finally began to fail, and his successor John Whitehead was appointed. Though Meyer was invited to retain his beloved neuroanatomy laboratory, he made little use of it, and was offended by what he regarded as Whitehead's excessive independence. When he was struck down by a cerebrovascular accident soon afterwards he made only partial recovery and never fully regained his faculties.

In June 1948 my wife and I had occasion to spend some time in Baltimore; I thought I would revisit Meyer. I knew that Meyer was an aged invalid; then in his 82nd year, and that this might be my last opportunity to see him. I sent a note ahead to which Mrs Meyer responded cordially asking us to join them at dinner. Since I recorded some notes in the evening after returning to our hotel, I can recall many details.

We found Mrs Meyer as vivacious and hospitable as ever; their daughter Julia and grandchild Kiki were there as well as Dr Meyer's devoted former neurological laboratory assistant. We arrived a few minutes late and Mrs Meyer told us that Dr Meyer already had to take his seat at the table because it was so hard for him to get about. He sat with a napkin pinned to both of his lapels looking pathetically like an animated wax effigy bearing a certain resemblance to his former self.

Mrs Meyer took the initiative at the table conversation, with Dr Meyer from time to time making amiable and measured remarks, sometimes of questionable relevance and intelligibility. Very early in the evening he described his neurological disability as "a hemiplegia without hemiplegia." He went on to explain that he could grasp an object such as a glass quite well and could negotiate it, but could not control involuntary movements: his right hand jolted whenever he coughed. He said he found he had more dexterity if he twisted his head and body around to the left and he persisted in repeating these neurological observations about himself throughout the evening, later rising three times to demonstrate his prowess. He appeared to have no realization of any intellectual decline and even said explicitly that his conscious thinking processes were quite intact.

He displayed very little curiosity about anything I was doing, and spoke casually of his own isolation and of the disfavour in which the psychoanalysts seemed to hold him "because I was never analysed." "Grinker was here" he said, "sitting right here at the table. He is a somewhat colourful person who has given himself a name but I felt somehow that we were not in agreement." Indeed Meyer spoke in a friendly way of a whole series of associates and common acquaintances and did not say a harsh word about any of them. Of Whitehorn he said with what sounded like a remote approximation to bitterness, "He has been here just twice." He remarked gratefully that "the neurological association seems to have remembered me," a reference to his recent election as an honorary member of the New York Neurological Society.

I recall his saying, "The analysts are always interested in putting things in their place. I have always wanted to put things together to see the relationship of things." He deplored the fact that no one seemed to be at hand to explore his neurological disability systematically. "Why don't you do it yourself?" I asked. "One cannot examine one's own unconscious," he replied, "You cannot study your own sleep, because you are asleep." With typical perseverance he came back to the phrase about examining one's own unconscious again and again.

He seemed to approve of my derogatory reference to private psychiatric practise as an unfortunate necessity, but when I spoke of the emerging interest in social psychiatry he said, "You have to be careful not to give it a political connotation." He stretched his hands forth as if arranging something on the table and added enigmatically, "There is communism, and yet I am not a communist."

Toward the end of the evening he said, "My library is in order, I have my study and my books where anyone who wishes to read may come. But," he went on, shrugging his shoulders, "who will want to come?" Later he said, "Death is an indeterminate sentence. It may come in 24 hours, though that is unlikely, but still," he repeated, "death is an indeterminate sentence."

This was an evening with the invalid Adolf Meyer some 20 months before he died. In retrospect little that was meaningful was said. There was not a single reference to any important current event nor was any important relationship with anybody described. There was in a sense something hollow about the occasion, but there was still something about Meyer which suggested an epoch, a breadth and a certain grandeur.

His thoughts were still immersed in his past work and interests. Since Meyer had always been opposed to medical overemphasis in psychiatry it seemed ironic that his efforts to recall the past were so hampered and fragmented by his neurologic failings. He was aware only of the motor components, but the diffuse and elusive quality of his talk seemed like a caricature of his earlier tendency to complex and sometimes perplexing expression. "I have a hemiplegia" he had told me that evening, "but no alexia. I have no agraphia because I can write in a scribble though it is hard, but still I can write. I feel there is a difference between my sides, but what it is I do not know. Something is lacking, but I do not know what. A man cannot read his own unconscious."

He added, I thought perhaps significantly, that in 1933 following the Detroit psychoanalytic meeting he first noted a difference between his sides. I had the disturbing thought that a slight asphasic insult may have developed at that time which was glossed over respectfully through the years by the many devoted pupils and associates.

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