# The Alan Gregg Lecture

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## SOME ILLNESSES OF MENTAL HEALTH

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Everybody who is asked to give the Alan Gregg Lecture must feel honored and touched. Almost everybody must experience more than a twinge of humility and many moments of self-doubt. I must feel more honored and more humbled than my predecessors since Alan set so many of the standards of behavior for what he liked to characterize as philanthropoids. And, for better or for worse, a philanthropoid is what I have spent twenty years of my life trying to be.

When my colleague Warren Weaver gave this lecture, he remarked with becoming, but quite unnecessary, modesty that as a layman he felt unable to comment upon Alan Gregg's impact on medicine. This task he left to some future lecturer. I do not propose to take on the whole job, but I do think this is an appropriate time to say something about his relationship to that part of medicine known as psychiatry. Beginning in 1931 and for approximately the next two decades, Alan Gregg was responsible for the Rockefeller Foundation program in psychiatry which absorbed approximately two-thirds of the Foundation's expenditures in the medical sciences. For several years thereafter until his death in 1957, he maintained close contact with many of the leaders of the field and continued to influence its development by serving on the Council of the National Institute of Mental Health and other advisory bodies.

During all those years and in the seven subsequent ones, psychiatry has changed in several unexpected ways. Most unexpected of all perhaps for those who lived through the stringent thirties, psychiatry and its allied disciplines recently have fallen heir to large sums of money. Finally, to make the task of stock-taking easier, there has recently come to hand the detailed report of the Joint Commission on Mental Illness and Health (1) and in July of this year the collection of highly personal and impressionistic essays published by the *Atlantic Monthly* in a Special Supplement on Mental Illness.

Toward the end of this talk, we might use Alan Gregg's career as a text to develop some views of how change takes place—how much can it be consciously

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2/3 of Foundation exp. in Psychiat.

influenced from outside; how much are events determined by some inner dynamic of their own; and how much do they come about by pure chance. Incidentally, I am sure that in one of his whimsical after-dinner moments when Alan was indulging his interest in *le mot juste*, he must have asked himself or his companions why we so often refer to chance as "pure."

Alan Gregg's influence on psychiatry was exerted in numerous ways, but it is convenient to consider two broad categories—his work as an officer of The Rockefeller Foundation and his influence as an individual human being. The second seems to have been far the more important. But first let us get the vulgar matter of money out of the way. Among other things, it may give us some clue as to what manner of man Alan Gregg was and from where he felt that progress in psychiatry might most likely spring.

The first thing that strikes the observer in 1964 is how small the amount of money really was—a little over $16 million in twenty years for psychiatry and related disciplines. As a matter of fact the related disciplines—neurology, neurophysiology, neuroanatomy, neurochemistry, and psychology—absorbed nearly two-thirds of the funds. As might be imagined by anyone who remembers how long it took American psychiatry to develop any competence in research, virtually all the research supported during this period was in the related disciplines and not in psychiatry per se. The grants were few in number and not very large in size by today's standards, but they almost all went to men of the very first rank: Cannon, Penfield, Yerkes, Richter, Gantt, Bremer, Granit, Penrose, Eysenck, Adrian, Gray Walter, Lennox, and Gibbs. Any study section today would vote any projects of these men a priority in the very top percentile.

Help to psychiatry itself went largely for the development of full-time teaching departments in medical schools, with smaller portions to training fellowships and some experiments in the application of psychiatry, as in mental health and child guidance clinics. Emphasis in the teaching departments was on bringing the specialty more fully into the mainstream of medicine. Often the emphasis was on psychiatry as seen in a general hospital. The hope here was twofold. On the one hand, it seemed that psychiatry was bound to profit by breaking out of its far from splendid isolation in the state asylum and coming to learn some of the new techniques which had proven so effective in medicine as a whole. Conversely, it was felt that psychiatry had much to do in humanizing the increasingly impersonal scientific practice of medicine which, excellent though it had become at prolonging life, still seemed to lack interest and skill in making life more tolerable for many who sought its help.

Finally, the policy of generous support for the development of teaching rested on the thesis that the obviously backward state of psychiatry was directly traceable to its failure to attract and train adequate numbers of capable young people. The departments which received the most substantial help during the first half of this period were those at Yale, Chicago, Washington University in St. Louis, McGill, and the University of Pennsylvania. Only two grants were made to a psychoanalytic institute as such—one of $100,000 and

the other of $120,000, the first in 1935 and the second in 1938, both to the institute in Chicago.

What can one reasonably say about the result of the grants made by The Rockefeller Foundation almost wholly on Alan Gregg's recommendation during this twenty-year period? So many other things were going on at the same time that it is very hard to single out the specific results of specific causes. But we can be fairly sure about some matters. For example, the Montreal Neurological Institute presumably would not have existed in anything like its present form had it not been for the help it received from the Foundation. Even more certain is the influence of this Institute in consolidating and extending the North American tradition of the scholarly neurosurgeon pioneered by Harvey Cushing.

Some of the work in Montreal and even more, perhaps, the devotion of Bill Lennox and his colleagues in Boston turned epilepsy from an almost unmentionable horror into an understandable and largely controllable inconvenience.

Much of the other research was of a basic nature which laid the groundwork for the recent great expansion in neurophysiology and neuropharmacology and the even more recent and even more promising synthesis of these two subjects with physiological psychology. Certainly the work of such pioneer human geneticists as Penrose, Tage Kemp, and Kallmann has compelled attention to the important hereditary element in certain incapacitating types of mental disorder. Similarly, Jordi Folch-Pi and Heinrich Waelsch in this country and Derek Richter in England must receive a significant share of the credit for the recent upsurge of interest in the biochemical background of higher nervous function. The original memorandum prepared by a subcommittee of the Trustees which led the Foundation to psychiatry as a field of concentration had stressed the importance of a biological approach, and the program of research grants as actually developed reflects this emphasis very strongly. A clear majority of the grants went to laboratories of genetics, physiology, and biochemistry. Toward the end of the period, an increasing number involved departments of psychology, but here again a high proportion supported work firmly based on the experimental method—the studies of Yerkes and Lashley at Orange Park, of Hebb at McGill, or the classical observations on the behavior of small groups by Elton Mayo at Harvard.

That part of the program directed at the development of psychiatry as an academic discipline succeeded in an almost spectacular way. Indeed, there are those who may feel that the plan to orient teaching more closely around the emotional problems seen in a general hospital succeeded perhaps almost too completely. Virtually all American medical schools have now made a large place in the curriculum for the department of psychiatry, and psychiatrists are commonly seen either on the general wards or in units closely associated with the general hospital. But what are we to say about the results of this successful effort to put psychiatry back into the mainstream of medicine? Has psychiatry really learned how to do productive research from its colleagues in

the basic sciences and in the other clinical disciplines? Have internists, surgeons, and gynecologists learned how to recognize and to deal with the psychological aspects of ordinary illness? The answers are not written clearly enough to be read at a distance, and I can only leave them to you who are nearer to the situation than I am.

Particularly difficult to trace is the effect of a series of grants to the National Committee on Mental Hygiene and the National Mental Health Foundation, the forerunners of the present National Association for Mental Health. Alan Gregg was enough of an American to recognize the importance of voluntary association for improving the public welfare. In spite of many discouragements he continued to foster the efforts of the at times pitifully small group of individuals dedicated to enlarging public awareness and arousing public participation in the mental health movement. How much of the recent improvement in psychiatric care in some of our more progressive states and the increasingly favorable attitude of Congress can be traced to such efforts is hard to say, but one suspects that their influence has been considerable.

One thing does seem pretty clear and perhaps rather painful. Academic psychiatry has found it too easy to become preoccupied with the psychological problems of reasonably normal people and to leave the hard-core problem of major mental illness to others. Generally speaking, the big advances in caring for the really seriously ill have not come from American medical school departments of psychiatry. Many of them have in fact come from the old-fashioned nerve clinics of Europe. Some of the more recent and very promising drug therapies and even some aspects of so-called milieu therapy have been developed in those despised state hospitals in the United States. Actually, Alan Gregg was aware of these facts, and shortly before his death, I can remember him somewhat ruefully reflecting that it was not too comforting to recognize that most, if not all, the apparently effective therapies had originated in places remote from active Foundation interest.

But Alan was far too sophisticated a person to be either surprised or unduly upset to find that things had not turned out exactly as planned. Indeed, he was fond of quoting a former colleague (my informed guess is that it was Beardsley Ruml) who said as he looked back on his career that the only times he had failed completely were when he had an idea and had gone about hunting for some individual who would accept a grant to carry it out. Alan knew better than most men how useless it is to try to force events into some preconceived mold. Fated as he was to spend most of his productive years in close association with a field which is so complicated that it drives many men to oversimplified solutions, he never became doctrinaire; he never even pretended to see where the solution was likely to be found. If he favored one path over another, it was only because he felt that majority opinion might be unduly neglecting an obvious possibility. At a time, for example, when it was almost un-American to admit the possibility of hereditary differences, he could be found championing the importance of human genetics. Incidentally, he publicly deplored the

rather curious fact that at one time the *American Journal of Heredity* had fewer physicians than lawyers on its subscription lists. Many of his addresses contain explicit recommendations to pay more attention to this field and the only time I personally remember his deliberately offering financial support to someone to work on an idea of his own, the project was one in the field of genetics and behavioral differences. But on occasion he could be an equally strong champion of psychoanalysis or of the Kinsey studies. In all such instances his motivation was the same, an anxiety to make sure that a new approach to an obviously important problem not be held up by irrelevant prejudice.

It is here, I think, that the really good foundation officer differs most markedly from the really good research worker. The good research man must believe that the solution he is working on is obviously better than all the other solutions so far proposed. The foundation officer must keep his mind constantly open to many different possibilities at once. He must be able to recognize a high quality of operation more or less regardless of the particular content. Alan was very nearly superb at this. He gave his support to many different kinds of research, but the particular projects, whether in genetics, neurophysiology, neurosurgery, clinical psychology, or, yes, even psychoanalysis were tops in their class. He could well leave it to another generation of judges to pick the "best of show."

Actually, he was an outspoken member of that school of thought that holds that in psychiatry there is little utility in the "best of show" concept. Always he could be found emphasizing the view that human behavior is the result of a complex interaction of an almost infinite number of variables. One must be prepared to look at them all and use every stratagem in the hope of understanding the whole.

Indeed, it seemed to many of us that he was happiest when thinking in terms of medicine as a whole rather than of the specialty of psychiatry to which he was bound by what the jargon of his trade refers to as "program limitations." Actually, only a small proportion of the papers or addresses in his bibliography deal with strictly psychiatric subjects, and he looked to psychiatry perhaps primarily as a means for improving the practice of medicine in general. One of his finest addresses (2) deals with the experiences shared by each of us on the way to becoming a doctor, whether in "Buenos Aires or Bangkok, Kyoto or Karachi, Utah or Uppsala." Widely read and equally widely traveled, he was more ready than most Americans of his generation to admit that life is after all a difficult and troubled business. He knew also that in the 20th century, more and more people are bringing their troubles and difficulties to doctors. Much of his energy went into seeing to it that the doctors would be better prepared for this kind of responsibility. He even went so far as to ask the American Psychiatric Association at its centenary meeting, "Is it not a proper concern of psychiatrists to find those conditions and factors both physiological and social which offer the greatest opportunities for beauty and balance in the life of the spirit?"

As final evidence of his devotion to the broadest possible approach to the doctor's job, we may cite the fact that the only paper I have been able to find which mixes a measurable amount of acid with its irony is called "Narrative for a Specialist." It deals with Preserved Jones who in his fifth decade arrived "at the undisputed status of an experienced specialist, overloaded with work, too busy to be lonely, and too tired to be able to reflect without falling asleep." Finally in his sixties, "From his deliberate ignorance he cannot impart wisdom or, from his embitterment, serenity."

For some minutes past we have been talking about both my first and my second categories together, Alan Gregg's impact on psychiatry first as a foundation officer and second as an individual. We must now turn a little more exclusively to the second. In preparation for this talk, I wrote to a dozen or so prominent psychiatrists for their appraisal of Alan Gregg's impact on their field. Most of them responded generously in apparent eagerness to let as many people as possible know how they felt. I am tremendously grateful for their help and especially for their perspective since, for the most part, I was too close to Alan Gregg to see the kind of figure he cut on a wider horizon.

When I received the first of these letters, I couldn't help noticing how intensely personal it was in tone. It seemed that the writer had interpreted my question about Alan's impact on psychiatry as actually about Alan's impact on him. Reaching into my bag of technical terms, I found myself asking whether my old friend had fallen prey to some newfangled mid-life sort of narcissism in which he mistook the image of his field for himself. But then the other replies began to arrive and I found that all my correspondents had interpreted the question in the same way. Obviously, Alan Gregg's impact on the field was mediated through his extraordinary impact on individuals. He was the physician's physician, the psychiatrist's psychiatrist, the administrator's administrator. It seemed that all of my correspondents had been in trouble at one time or another, had had a difficult decision to make, or a tricky personnel problem to solve. Without telling them what to do, Alan had shown them what ought to be done, or better still had put the problem in such perspective that the solution stood out almost automatically in bold relief.

Many of you will remember how often he quoted Robert Walpole's formula of "good sense, good manners, good humor, and good faith." This typically 18th century emphasis on form and decorum strikes with particular force in a 20th century America which prides itself on having reduced etiquette and social convention to a minimum. Doubtless this neglect of the older amenities has enabled us to concentrate more fully on content and substance in a way which has greatly advanced the physical conditions of living. But when Alan Gregg first came into contact with psychiatry (and some of us may feel that it is still true today), the field had relatively little in the way of agreed upon content and substance. This lack of agreed upon substance often led in turn to feelings of inadequacy, guilt, frustration, and anxiety. The resulting emotional charge in the psychiatric atmosphere made it difficult to establish sound working relation-

ships with the rest of medicine and even within the field itself. Into this rather confused set of vortices walked Alan Gregg, if not exactly the glass of fashion and the mold of form, at least a physician with a very unusual sense of style and cosmopolitan urbanity which transcended the ordinary limitations of time or space; and he said in effect, "Look here gentlemen, if you are really not very sure of what you are trying to do, at least you can do it with 'good sense, good manners, good humor, and good faith.'" The effect on individuals was very great, and one may guess that a good deal of the acceptance gained for psychiatry from other branches of academic medicine came from Alan Gregg's success in making psychiatry look like a reasonable bet.

As I think back on this aspect of his personality, I find myself wondering if it may not have a wider meaning for us today. If we are frank with ourselves, I think most Americans of my generation would have to admit that they were brought up to be just a little suspicious of good manners and even to think of good sense as being a little bit stuffy. In the development of a new continent there were occasions in which good manners seemed awkwardly out of place and when good sense might hold a man back from taking the risk which would lead to fame and fortune. Even in Europe there was so much that was wrong with the old society of good manners that it finally broke down in a series of unmannerly wars and revolutions. Those of us who were especially interested in science or the creative arts were not particularly struck by the importance of good manners or even of good humor. It would have seemed incongruous to have approached a Pasteur engaged in one of his vigorous scientific controversies with the admonition that "manners maketh man." Those who actually did attack the first great impressionist painting, "Le Déjeuner sur l'Herbe," on the ground that it was bad manners look pretty ridiculous now.

But maybe we have begun to push our luck too far. It may well be that a continent which will soon be bounded by 1,000-mile-long cities on both its eastern and western coasts will find increasing need for good manners and good humor. The doctrine of unconditional surrender which we proudly flaunted in the faces of our enemies for almost exactly a century was never very good manners nor good sense. Today it well may be suicide.

Now let us return for a closer look at where psychiatry stands today, how it got that way, and what we may hope and try for in the future. The two rather different documents mentioned earlier, *Action for Mental Health,* the report of the Joint Commission on Mental Illness and Health, and the *Atlantic Monthly* symposium, both agree that we are not doing nearly as much as we might for sufferers from major mental illness. Worse than this, we in the United States are probably not doing as well as several European countries have already been doing for several years. Even the fragmentary reports we have from the Soviet Union suggest very strongly that at least a considerable number of the mental hospitals there are more fully staffed and present a pleasanter, more friendly atmosphere than one finds in comparable institutions in this country.

On the other hand, visitors from abroad are struck by the amount of time and effort spent on psychiatry in our medical schools and they marvel even more at the amount of psychiatric consultation made available in our schools and colleges. It is interesting to observe that the number of psychiatrists employed in mental hospitals has increased only rather slowly between 1930 and 1960, while the number at Harvard College has grown from something less than one to seven, counting only those on the full-time staff. And the Harvard phenomenon is merely an index of the extent to which upper-class America has come to rely on the psychiatrist to help it bear the stresses and strains of what used to be thought of as normal life. To put the matter in its harshest terms, American academic psychiatry seems very largely to have ignored the already existing demand for its services and instead has devoted most of its energies to creating (or at least bringing to light) a demand which was scarcely felt before 1930. Note that I am not saying that interest in major mental illness and its care has not increased and improved during the last thirty years. As the report of the Joint Commission makes clear, improvement has taken place, more slowly than the Commission thinks should have been the case, but improvement nevertheless. It is not clear how much of this improvement can be credited to academic psychiatry and how much to the efforts of inspired laymen who in the tradition of Dorothea Dix and Clifford Beers have constantly sought to enlighten the public and obtain bigger appropriations for mental health. As we have seen, technical improvements in patient care have come almost entirely from outside the country and in a manner which bypassed much of academic psychiatry—insulin from Austria, metrazol from Hungary, electric shock from Italy, the therapeutic community from Holland and England, the day ward from the Soviet Union via Canada, reserpine from India, and chlorpromazine from France.

Actually, there seems to be relatively little dispute about the facts, uncomfortable though they may be. It is not so easy to accept some of the proffered explanations for these facts. By far the simplest that has so far been offered is that one put forward for several years by certain English observers, most recently in the *Atlantic Monthly* symposium. It is a one sentence explanation and it leans heavily on the "great man" theory of history which so upset Tolstoy. It runs like this: The care of the mentally ill in the United States is deplorable because medical school psychiatry is under the spell of psychoanalysis because, in turn, The Rockefeller Foundation insisted that all important psychiatric chairs be filled by persons who had had a training analysis. Again one must accept the fact that the care of the mentally ill in the United States is not good and we also must agree that psychoanalysis has played a far greater role in the outlook of academic psychiatrists in the United States than anywhere else in the world. Furthermore, most of us will probably have to agree also that psychoanalysis has contributed relatively little to the care of the seriously ill mental patient in spite of the work of a few devoted students like Harry Stack Sullivan and his followers and in spite of the insight psychoanalysis has given into the meaning

of certain symptoms. But it seems far too simple to blame psychoanalysis as the only or even the most important source of American backwardness in the case of major mental illness. I can think of a number of other reasons, none of which does us much credit I am afraid. A historian might point at the headlong, rough and tumble life of the frontier where the enterprising and the vigorous succeeded and the incompetent disappeared. The sociologist might point to our weaker sense of community life: Americans are typically on the move and therefore do not develop deep ties to a given place or a sense of responsibility for the members of the community who have slipped from sight. Certainly, family ties are less strong and the feeling of obligation to look after parents and relatives as they grow older and less competent mentally is far weaker than in most of the rest of the world.

In addition to being influenced by these general attitudes, the medical profession in the United States remains curiously preoccupied with private practice, to a far greater extent than is true anywhere else in the world, except possibly Latin America. For some reason that is very difficult for the outsider to grasp, the typical physician in the United States still feels that the only really honorable way to be paid is on a fee-for-service basis and that there is something just a little bit degrading about working for a salary—more than a little bit, if the salary comes from government. Adding injury to insult, of course, is the fact that government salaries, especially in mental hospitals, are pretty low. Finally, there may be a feeling, never fully expressed to be sure, that the kind of patients seen in private practice may be more recoverable and potentially more valuable to society than those seen in mental hospitals. Given this natural bias toward private practice, it is scarcely necessary to invoke a psychoanalytic demon to explain why so many American psychiatrists have chosen to work in a private consulting room rather than in the ward of an asylum. Of course it must be admitted that the great expense of psychoanalytic training has helped to make the profession more money minded than it might otherwise have been, and it is also probably significant that the psychoanalytic training undergone by so many young American psychiatrists in the last two decades has apparently fitted them better for private practice than for dealing with the mass problems of mental illness.

I find, as a matter of fact, that many of my friends who hold faculty positions are quite willing to agree that psychoanalysis did for a considerable time exert a preponderant influence on the development of academic psychiatry, and there is growing satisfaction that this influence is now being increasingly balanced by a greater interest in basic biological and social factors.

Why then did psychoanalysis gain this relative ascendancy? Was it really the result of deliberate planning on the part of a single foundation and a single unusually influential foundation officer? To those who knew Alan Gregg, the very idea seems so incongruous as to scarcely merit comment. Nevertheless, it may be instructive to review some of the factors which apparently worked together to make things turn out the way they did. Among other things, it may

give us a greater sympathy for that argument about the nature of history which so laboriously fills the last chapters of *War and Peace.*

For those of you who find it easier to remember Natasha and Prince Andrey than Kutuzov and Barclay de Tolly, let me quote a few of paragraphs (3).

". . . the human intellect, unable to search the infinite variety and complicated tangle of conditions accompanying phenomena—every one of which may seem to be the ultimate cause—seizes on the first and most obvious coincidence, and says, 'This is the cause!' "

Somewhat later on Tolstoy says the same thing in a more forthright fashion (3).

"A locomotive is in motion. The question is asked, What makes it move? The muzhik answers, ' 'Tis the devil moves it.' Another says the locomotive goes because the wheels are in motion.

"A third affirms that the cause of the motion is to be found in the smoke borne away by the wind.

"The peasant sticks to his opinion. In order to confute him, it must be proved to him that there is no devil, or another peasant must explain to him that it is not the devil, but a German, that makes the locomotive go."

If we are reluctant to accept the peasant's explanation for the growth of psychoanalysis, what other forces shall we look at?

I can think of at least three factors that played important parts in the ascendancy of psychoanalysis during the period 1934 to perhaps 1954, and I am sure there are many more: (a) The desire to bring psychiatry more fully into the "mainstream of medicine"; (b) The desire of American medicine to be rational rather than "empirical"; and (c) The Nazi terror.

The foundations and especially perhaps the General Education Board and The Rockefeller Foundation bear a considerable responsibility for fostering the first two attitudes and on the whole they are proud of it. They were also involved in the operation of the third factor—the Nazi terror—in that they helped a number of refugee scientists and clinicians to leave Europe and become established in the United States. Why do I say that the desire to put psychiatry more fully into the mainstream of medicine had the paradoxical effect of casting it under the spell of analysis? The argument runs as follows: Putting psychiatry into the mainstream involved, among other things, the giving of increasing attention to emotional and mental disturbances as observed on the wards of a general hospital. Coupled with this was an interest in, almost an anxiety for, the increased instruction of medical students and residents. The syllogism here was that psychiatry was backward because it lacked a sufficient number of good people. Good people did not go into psychiatry because they didn't know how interesting it was nor how to learn more about it. The obvious way to unwind this vicious spiral was to increase the amount of teaching and to teach in such a way that mental abnormalities became interesting and understandable rather than frightening or boring.

Certainly the reasoning appears to be sound and few of us can disagree with it even with the benefit of hindsight. It turned out, however, that the work of the classical investigators and teachers was not well adapted to these purposes. Such inspired clinical observers as Kraepelin or Bleuler were great phenomenologists and nosologists, but they tended to base their work on assumptions about disease entities which have not yet been borne out in practice. In any case, nosology provides a doubtful framework for persuasive teaching, as classical zoology and botany have long known. Adolph Meyer with his emphasis on the many different factors—biological, psychological, and social—which combine to produce mental disease was perhaps closest to the present eclectic attitudes of our best teaching clinics, but he never seemed able to present his ideas in a way that could influence students beyond the immediate circle of his devoted followers in Baltimore. Finally, at the time we are speaking of, experimental approaches to behavior centered on theories of learning and such matters as sensation and perception, which seemed to bear little relationship to mental aberration as observed in the clinic.

Whatever else may be said of Freud, he is endlessly interesting and full of brilliant new ideas, insights, and deductions, all well worked out and clearly expressed. Obviously greatly influenced by 19th century physics—especially thermodynamics, perhaps, and by physiology—he slipped easily into a chain of cause and effect analysis, simple to understand and, what was more important, simple for the teacher to reproduce once he had grasped a few basic ideas like the trinitarian nature of personality structure, the relationship of frustration to anxiety, the ambivalence of love, the repression of socially unacceptable wishes, and so on. There seems really very little room to doubt that psychoanalysis provides an unusually effective framework for understanding the meaning and significance of many of the symptoms of mental illness. Thus, it made it possible for the teacher of psychiatry to talk about his subject in much the same way that the internist discussed the physiological background of physical symptoms. The apparent rationality of the analytic approach proved particularly seductive to American medical teachers who have long prided themselves on being in the vanguard of the scientific approach to medicine. Many of us will remember even a generation ago the contemptuous tone in which our teachers would remark, "Treatment is symptomatic only." It was difficult to avoid the conclusion that it was hardly worth while trying to do anything for a patient if we didn't understand what was wrong with him.

Many of our friends in Europe and especially, perhaps, in Great Britain have taken a different view and have tended to glorify the practical, empirical approach as the medical equivalent of the time honored political procedure of "muddling through." Science was something for queer chaps in laboratories, but it would be dangerous for anyone contemplating a clinical career to have too much to do with it.

The two different stereotypes, like all such generalizations, represent extremes and there is much less difference between the average English and the

average U.S. doctor than one might be led to believe. Great Britain has in fact contributed heavily to the advancement of scientific medicine ever since William Harvey first introduced the experimental method into clinical investigation. Indeed, it is rather hard to think of the country that produced Harvey, Mackenzie, Lewis, McMichael, and Pickering as a nation of crude empiricists, even though George Withering did learn about foxglove from the recipe of a local wise woman. On the other hand we may not be entirely safe in thinking of the home of Dorothea Dix and Clifford Beers, or in our own day of Howard Rusk, as a nation of starry-eyed theorists. Nevertheless, most of us would be pleased to agree that American academic medicine is typically dedicated to understanding the natural history of disease, its etiology and pathogenesis, and to basing its control measures on such understanding. Indeed, to almost all of us it seems unnecessary to argue that in the long run scientific understanding forms the best basis for prevention and treatment.

If psychiatry went wrong in basing so many of its hopes on psychoanalysis, it did so not because it was seeking to be rational but for a somewhat more subtle reason (4). The difficulty appears to have lain in the assumption that if one understands the cause—or perhaps more accurately the meaning—of a symptom, one is on the way to understanding the cause of the illness of which it is a part. To put the matter rather crudely, psychoanalysis has given us an understanding of the origin of symptoms in the sense that we understand why most men wish to kill their fathers rather than their mothers. But it has done rather less well at explaining why so few men actually do kill their fathers while the great majority do not. In other words, it has not helped us much to understand why in common sense terms some people are sick and others remain reasonably healthy. It is no good trying to get around the problem by lining up beside the old Philadelphia Quaker and agreeing that everyone is a little bit queer except me and thee and I have doubts about thee. Admittedly, there may be a kind of sophistication in recognizing that everyone is neurotic and that some very celebrated and creative people are very neurotic indeed. We also may recognize that in a mathematical sense there may be a sickness-health continuum along which people arrange themselves according to the rules of Gauss. But as a practical matter, there is a world of difference between people who get up in the morning, go off to work more or less on time, get back to help for an hour or two with the children, and make some attempt to satisfy their wives at night and another class of people who goof off, slug the employee at the next bench, lock their children up in dark attics, abandon their wives, and finally shoot their neighbor, jump off a bridge, or retire to a world of phantasy.

The funny part of it all is that this distinction—important though it is to most of us in our role as man in the street and obvious though it is to us as everyday clinicians—is not very easy for psychoanalysis to deal with. This fact should be no more than ordinarily embarrassing since no other school of

psychology has been very good at separating the sick from the reasonably healthy or at predicting who will break down under stress and who will not.

It may help to understand the problem better if we look at an analogous situation involving a purely physical illness. Over 300 years of careful clinical observation and experimental work have given medicine what seems like a very satisfactory picture of the motion of the heart and blood. We know, in other words, a good deal about the dynamics of the circulation. This knowledge is useful in supporting a cardiac patient on the edge of failure, but only very indirectly does it tell us much about the cause of his illness or its future course. Fifty years ago the average doctor had seen so many young people become incapacitated and die of rheumatic heart disease that he tended to regard any youngster with an unusual sound over his precordial region as potentially ill. Innumerable perfectly healthy children were therefore kept from normal physical development by the restricted activity enforced by physicians following this hypothesis. Working purely with a knowledge of circulatory dynamics, the doctor took a long time to discover that in some children a mild valvular incompetence could be of little or no consequence while in others it signalized a genetic tendency to develop an auto-immune disorder which would periodically result in greater damage to the valves of the heart and finally bring its victim to an early grave. It is becoming clearer to many of us that just as a knowledge of circulatory dynamics helps us to understand cardiac failure without solving the problem of rheumatic heart disease, a knowledge of psychodynamics helps us to understand the Oedipus complex but falls painfully short of solving the problem of schizophrenia.

To complete our analysis of the factors which led to the luxuriant flowering of psychoanalysis in this country, it remains only to note that increased interest in and support for the teaching of psychiatry naturally increased the demand for articulate teachers and that this increase in demand coincided with a sharp increase in the supply of experienced psychoanalysts brought about by the rise of the Third Reich. Hitler and his colleagues were not only anti-intellectual in general but specifically and bitterly anti-Freudian so that by 1939 there was scarcely a single analyst left in the great centers of Berlin and Vienna. Many of them, perhaps a majority, came here to exert a significant influence on the generation of psychiatrists then in training.

It certainly seems unlikely that the members of the Rockefeller Boards, or the deans and faculties of certain leading medical schools who started working together in the 1930s to put vigor and life into academic psychiatry, were planning for a day in which every major chair would be held by a man who had undergone a training analysis. It seems even more unlikely that the organizers of the famous Putsch in the Munich beer hall at about the same time had the future of American psychiatry very high on their agenda. But both these groups worked together to produce the situation we have seen.

If it is impossible to foresee events in advance, it is foolish to regret them after they have come to pass. Knowledge is where you find it and we know

very little about how to schedule the growth of knowledge in an orderly way. Presumably, fewer children would have died of heart failure during the last 300 years if Pasteur and Fleming had done their work in 1628 when Harvey was working in circulatory dynamics, but it would certainly be ungrateful to regret Harvey or to wish that Sir Thomas Lewis had devoted his life to gas chromatography of the blood lipids instead of fathering modern electrocardiography. When Einthoven provided medicine with the string galvanometer, it was both inevitable and necessary that a number of first-class investigators explore every possibility of its usefulness in the diagnosis and treatment of heart disease. It would be as silly to deplore its limitations as to overrate its contributions and it certainly is no indictment of electrocardiology to point out that penicillin has been more useful in controlling luetic and rheumatic heart disease. Similarly, the power which psychoanalysis apparently gives us to understand the behavior of certain kinds of disturbed people demanded an all-out exploration of its potential for understanding and controlling mental illness. We should be neither surprised nor too seriously upset if the results of this exploration have fallen short of the hopes of its most ardent supporters. At the very least, we can and should return with renewed vigor to an even more intense exploration of the genetic, biochemical, social, and psychological determinants of mental disease and to its treatment with the ever increasing number of effective procedures placed in our hands by that sturdy group of investigators who never abandoned a healthy and receptive eclecticism.

I have gone into some detail to show how plans directed to one objective sometimes have unexpected effects. I have done so in part because I tend to follow H. J. Muller (the historian not the geneticist, though both are at the University of Indiana) in believing that one of the uses of history is the cultivation of a sense of irony (5). And it *is* ironic that one of the most urbane, cosmopolitan, and broadly eclectic philosophers American medicine has produced should momentarily be cast as a doctrinaire conspirator.

The past needs no defense, but it may have a lesson for the future. As we come to spend hundreds of millions and even billions of dollars on research, there is a natural and perhaps growing tendency to want to see that it is spent in ways that will produce some demonstrable benefit to the taxpayer who supplies the money. One way of trying to satisfy this wish is to plan and to package research for sale like a commodity. And some of it comes in very large packages indeed. It would certainly be stupid to deny that there are some very important questions which can only be solved by getting large numbers of doctors to give the same drug to a large number of patients in different parts of the world, or by following a large number of mothers through pregnancy and their offspring through childhood and adolescence. This kind of thing certainly demands planning and what I have called packaging. Presumably, we will have to find out how to do it properly. All we know now is that we haven't learned yet. We do know however that reasonable amounts

of money and modest encouragement given to individuals who think they have found a way of advancing knowledge will in the long run bring returns several orders of magnitude greater than the original research effort.

If we cannot plan in advance to produce a Harvey, a Pasteur, or a Florey, we must as deans, foundation officers, and government officials try to recognize and help them once they are here. If the good administrator has few opportunities to produce the tides of history, he can and he must do his best to work with them when they appear.

It seems fitting, therefore, to close this presentation with a quotation from an informal talk on the support of research which Alan Gregg gave toward the end of his career. There is nothing particularly original about it, perhaps, but it reflects a ripeness of wisdom which those of us who are sometimes tempted to overinterpret history or to overorganize the future might do well to bear in mind.

"When we can get a first-rate man on a presumptively likely lead or problem, with good attendant circumstances and good collaboration around him, we won't make any very sharp distinction as to whether the research problem is in psychiatry or in geriatrics or in internal medicine or in economics of medicine, because the fellow's brain and the likelihood of the field providing good material for him is far more important than anything that a G.H.Q. of strategy can imagine."

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