

THE ACADEMIC LECTURE

HOPE

KARL MENNINGER, M.D.²

INTRODUCTORY REMARKS

President Gerty's invitation to address this assembly of the future leaders of our Association was one of the great pleasures and honors of my life.

I can well remember my excitement when, in company with my father and my teacher Ernest Southard, I attended my first annual meeting—the 75th anniversary. This was 40 years ago, here in Philadelphia. I think I have missed only one meeting since then. In those days we were a small, intimate, informal group of a few hundred; everyone knew everyone. The program was simple, the entertainment lavish and the whole meeting a kind of family reunion. Southard and father and many others are gone now—but there are new elements of a family affair for my brother Will and myself of which we are proud.

In the years since then there has been a vast development in the numbers and complexity of our organization. I am glad to have had a part in the planning for its re-structuring, even though the immediate impact of the suggestions made by the Committee on Reorganization was a shock reaction. That 14 of our 16 recommendations have been put into effect is gratifying. But I find the greatest satisfaction in the emphasis which the program committees and officers have placed on our continued self-improvement, on psychiatric education, on, for example, academic lectures!

It is from a background of teaching that the topic which I propose to discuss emerged. I would like to warn you not to expect a scientific analysis of it along conventional lines. The subject does not permit of that; we don't yet know enough about it, and it would be presumptuous to make the attempt. I am not reporting a

research or a discovery, and it is no dark hour, calling for exhortation or comfort. I speak, rather, to the point of focussing attention upon a basic but elusive ingredient in our daily work—our teaching, our healing, our diagnosing. I speak of hope.

Long before love became medically respectable, long before Sigmund Freud demonstrated it to be a basic consideration in psychiatry, philosophers and poets and the common people of the world knew that it was essential to our mental health. Perhaps the most beautiful essay ever written was about love and its manifestations in personality.

To that essay is appended a footnote which is often quoted as if it were a summation. True, observed the writer, there are other permanent goods in the world beside love: there is faith, and there is hope. But, he added, "the greatest of these is love." With this concluding phrase most psychiatrists, I presume, would agree. Most of us, I think, would also agree to include faith—the faith that sustains our conviction that what we are doing is worth doing, the faith that our existence has meaning and the faith that our concern for one another reflects the concern of a Creator.

Our shelves hold many books now on the place of *faith* in science and psychiatry, and on the vicissitudes of man's efforts to *love* and to be loved. But when it comes to hope, our shelves are bare. The journals are silent. The Encyclopaedia Britannica devotes many columns to the topic of love, and many more to faith. But hope, poor little hope! She is not even listed.

I confess I was astonished to discover this. And yet, I realized that this avoidance of the theme reflected my own attitude. Time was when for this occasion I should have chosen as my subject "Love" or "Hate" or "Conflict" or "Instinct" or "Sub-

¹ Read at the 115th annual meeting of The American Psychiatric Association, Philadelphia, Pa., Apr. 27-May 1, 1959.

² The Menninger Foundation, Topeka, Kan.

This One

481



NX7R-Z43-RY6Q

limation" or "Symptom Formation"—but never such a thing as "Hope." It seems almost to be a tabooed topic, a personal matter, scarcely appropriate for public discussion. And yet—since when has psychiatry eschewed examination of our innermost thoughts and feelings? Should we not adhere to our professional habit of self-examination and contemplation? If we dare to hope, should we not dare to look at ourselves hoping?

This is not the way I began to think about the topic. Nor did I come to it fresh from struggles with Kierkegaardian logic, or from brooding over Greek pessimism, or from apprehensiveness concerning the muddled management of unsettled world affairs. It was all in the day's work, so to speak, some preoccupations with the motivations of the young doctors I teach. The miracle of growth has long intrigued me: the growth of the child, the growth of plants, the growth of cultures and the growth of young psychiatrists. I have seen one after another young doctor step forward, fresh from his internship or from his military duty, to enter the mysteries of psychiatric training. I have seen these young men approach the abstruse and puzzling material of our field of medicine with resolute courage—let us say, rather, with hope.

But behind the façade presented by these acolytes there are often tumults of conflicting voices, fearful insecurity and bold over-self-confidence. The dramatic picture of psychiatry fascinates them, the reputed resistance to treatment challenges them, the multiplicity of method appalls them. They are assigned to wards filled with vacant or frantic faces, turned now upon "the new doctor." It is usually long after their initiation into the uncanny world of mental illness that they can distinguish the moving process, or would have the personal experience of interaction with a recovering patient.

Nevertheless, the novitiates assail their tasks headlong, sometimes with a *furor therapeuticus*. There is nothing mercenary or aggressive about this. They are not working for money. They are struggling to become effective in a new kind of relationship with patients. Sometimes they go too

far, they presume, they expect or promise too much. More often frustration, sad experience, or self-depreciation erodes the confidence required for persistent effort, and the little candle of hope, which for awhile burned so brightly, weakens, sputters and goes out. We see the beginning of a repetition of scenes so common 25 years ago—hopeless physicians presiding, passively, over hopeless patients. "Psychiatry," we will hear, "has been oversold. The enthusiasm of inexperience only awaits the disillusionment of time. It is enough if we bestow kindness and wait for the inevitable. Hope is for the hopeless, and for fools."

We would like to think that the young men who pass through our training programs mostly emerge with certain limits put upon their expectations and certain guards upon their implied promises, but with the flame of their hope unextinguished and unextinguishable. We like them to believe that there is no patient for whom something helpful cannot be done. But we also like them to realize that the changes the patient desires in himself, or the physician desires in his patient, may not be the ones which come about, may not even be, in the long run, the changes that it were best to have sought for. It is a responsibility of the teacher to the student, just as it is of the young doctor to his patient, to inspire the right amount of hope—some, but not too much. Excess of hope is presumption and leads to disaster. Deficiency of hope is despair and leads to decay. Our delicate and precious duty as teachers is to properly tend this flame.

I propose, therefore, that we examine this essential constituent of both treatment and teaching. How shall we think of it? Is it something which *deserves* our concern as scientists? Or only as philosophers and poets? Is it only an epiphenomenon of life and the healing art? Do we, perhaps, tacitly ascribe hope to temperament, a sort of fringe benefit deriving from certain fortuitous congenital arrangements of glands and neurons? This is slight improvement upon the humoral theories of sanguinity and melancholy treasured by our forebears. If we ascribe hope, as some psychoanalytic writers have done, to recollections of maternal infallibility and recurrent oral grati-

fications, what combination of these experiences shall we regard as optimum? Others have seen in hope a prevailing note of fear, a counter-phobic denial of the horror and despair born of self-destructive trends or of the immanence of existential doom.

More congenial to my thinking is the ascription of hope to the mysterious workings of the repetition compulsion, the very essence of which is a kind of relentless and indefatigable pursuit of resolution and freedom. I would see in hope another aspect of the life instinct, the creative drive which wars against dissolution and destructiveness. But some will say, with Freud, that this is only our speculative abstractions to supply a model for practical thinking and behavior. Our mythology, he called it.

Here we might pause a moment to consider another mythology about hope. Pandora, it will be recalled, was an agent in the infliction of revenge of mankind by an angry Zeus. Curiosity led to her opening the box from which all the evils now in the world emerged. Biting, stinging creatures flew through the air and attacked mortals; but remaining behind was one good little sprite, man's consolation, Hope. But if Hope was a blessing, why did she remain in the box? And if, on the other hand, she was an evil like the rest, perhaps even the worst evil of all, why did she not fly out with them and begin work?

The Greeks mostly did consider hope an evil. The Greek philosophers and the later Greek literature tended more and more to the view that since fate was unchangeable, hope was an illusion, "the food of exiles" (Aeschylus) and, indeed, "man's curse!" (Euripides). Quotations from Solon, Simonides, Pindar, Thucydides and others say this in different ways. The Greek feeling about hope is vividly expressed in Anouilh's adaptation of Sophocles' *Antigone*, where, referring to herself, the heroine cries, "We are of the tribe that asks questions, and we ask them to the bitter end—until no tiniest chance of hope remains to be strangled by our hands. We are of the tribe that hates your filthy hope, your docile, female hope; hope, your whore. . . ."³

From this one can see that it was intrepid

indeed of St. Paul, writing to Greek friends, to declare that hope should stand along with love. In this Paul was loyal to his Hebrew heritage (Psalms 42, Isaiah 40) as well as his Christian convictions. For while the Jews were, to be sure, people of faith, they were also at all times a people of hope who, despite tribulation, clung to the expectation that the Messiah would come and the world get better. Hence, with the spread of Christianity and the dispersion of the Jews, hope had its missionaries, and Paul was one of them.

Martin Luther, like St. Paul, shook his fist at Greek fatalism and declared: "Everything that is done in the world is done by hope." Samuel Johnson opined that "where there is no hope there can be no endeavor," and our own countryman, Emerson, took up the cudgels for hope: it is by his hope, he said, that we judge of a man's wisdom. "You cannot put a great hope into a small soul," said another (Jones) and Tennyson's words, "The mighty hopes that make us men," now echo in our ears.

But many poets have tended to accept (rather bitterly) the fatalistic if not cynical view of the Greeks:

Hope—fortune's cheating lottery, where for one prize a hundred blanks there be. (Cowley, 1647)

Worse than despair, worse than the bitterness of death, is hope. (Shelley: *The Cenci*, 1819)

Hope is the worst of evils, for it prolongs the torment of man. (Nietzsche: *Human All-too-Human*, 1878)

I have had some patients who agreed with these poets. Partly that is why they were patients. But when I searched the literature for some kind words about hope, I experienced some uneasiness lest I find that very little (that my colleagues would accept) had ever been said for hope! And very little I found, indeed. But the cupboard proved not to be entirely bare. Particularly Dr. Thomas French, in his 5 volume examination of the psychoanalytic process, has dealt extensively with hope as the activating force of the ego's integrative function.

³ Which Creon interrupts with "Shut up! If you could see how ugly you are, shrieking those words!"

Anouilh, Jean: *Antigone and Eurydice: Two Plays*. London: Methuen, 1951.

Twenty years ago Mrs. Menninger and I submitted the thesis in *Love Against Hate* that hope was the dim awareness of unconscious wishes which, like dreams, tend to come true. We said,

There is no such thing as "idle hope." The thoughts and hopes and wishes that we entertain are already correlated to the plan of action which would bring these about, even though the whole project is ultimately renounced as too difficult or too dangerous. . . . This essential identity of hoping, wishing, purposing, intending, attempting, and doing is a little difficult for the practical common-sense man to grasp, because for him it makes a great difference whether a thing is executed or only planned or only hoped for. There *is* an external difference, to be sure; and there is an internal difference, too. But internally, (psychologically) from the standpoint of *motive*, there is no difference. There is a difference in the *fate* of the impulse, the degree with which it is correlated with reality, inhibited by internal fears, supported by other motives, *etc.*—but the motive force is the same. . . . The hopes we develop are therefore a measure of our maturity.

At that time it seemed to me that education best expressed the hope of the human race. But today I think I see the expression of hope in many clinical phenomena, as well.

Each of us here who has been in practice more than a decade has seen the "hopeless case" recover. And we have sometimes seen, or so it seemed, that a mother's or father's indomitable hope was a factor in this recovery. True, we have also seen hope deferred making the heart sick. But hope must be distinguished from expectation. "We are saved by hope," wrote St. Paul to some Roman Christians, "but hope that is seen is not hope: for what a man seeth, why doth he yet hope for?"

Nor is hope identical with optimism; optimism always implies some distance from reality, as Marcel points out, so that obstacles appear attenuated. The optimist, like the pessimist, emphasizes the importance of "I." But hope is humble, it is modest, it is self-less. Unconcerned with the ambiguity of past experience, hope implies process; it is an adventure, a going forward, a confident search.

When Doctors Bartemeier, Romano, Kubie and Whitehorn and I went to the European Theatre of World War II for my brother Will and the surgeon-general, we arrived at the Buchenwald prison camp a few days after it had been entered by our armed forces. What I remember most vividly of that terrible place was something we didn't actually see. But we heard it at first hand. The night before we got there, our U. S. Army doctors had given what they called a "smoker" for the physician prisoners they had discovered and released. It was a kind of unearthly medical society meeting. Army rations were put out as refreshment, with some wine and tobacco, incredibly relished by the emaciated but overjoyed guests. Communication in words was imperfect because of language difficulties, but the spirit was unmistakable. The members of a fraternity were reunited. And in the spirit of the fraternity, experiences were exchanged.

These doctors, prisoners along with all the others, had followed the same routines of 4:00 a.m. rising, shivering roll calls, day-long drudgery on the Autobahn, shivering roll calls again, and finally a cold bowl of thin soup. They were starved and beaten and overworked like all the others, with no reason to expect any other fate than the miserable death and cremation which they observed about them daily.

But now comes the surprise. At night, when the other prisoners were asleep, these thin, hungry, weary doctors got up and huddled together in a group, and talked. They discussed cases. They organized a medical society. They prepared and presented papers. They made plans for improving health conditions. Then they began to smuggle in materials to make various medical instruments. And finally they built, of all things, an X-ray machine! The pieces had to be found somewhere; they had to be stolen, they had to be concealed in the prisoners' clothes; they had to be carried back to the prison on the long, weary marches after work. The guards had to be bribed or otherwise thrown off the scent. But little by little, with the aid of some engineers and electricians among the prisoners, these doctors put together a workable X-ray machine and used it, secretly,

at night, in their efforts to ameliorate the lot of their fellow prisoners. This was what dedication to medicine and humanity could do—*kept alive by hope*.

But, someone who remembered may ask, bitterly—what of the thousands who died miserably for *all* the hopes they nurtured? Even here I would not concede that hope had altogether failed. I would believe that hope had sustained them in their martyrdom, and that their hopefulness, however frail and tortured and ultimately defeated, was communicated on down through prison generations to those who were ultimately freed and brought us the record of this medical miracle. Who can read the eloquent last messages of the condemned as collected by Gottwitzer, Kuhn and Schneider and published as *Dying We Live*, and fail to catch a spark of hope from them?

Confirmation for the sustaining function of hope in life has recently come from a most unexpected quarter—the psychobiological laboratory. At the annual convention of the American Psychological Association in September 1956, Curt Richter of Johns Hopkins reported an astonishing phenomenon. It was simply this, that when placed in certain situations which seemed to permit of no chance for escape, even vigorous animals gave up their efforts and rapidly succumbed to death. This was observed experimentally in both laboratory rats and wild rats. "After elimination of the hopelessness feature," reported Richter, "the rats do not die . . . (Indeed, the speed of their recovery is remarkable). A rat that would quite certainly have died in another minute or two, becomes normally active and aggressive," swimming vigorously for 50 to 60 hours. Richter emphasized that not the restraint alone, nor the immersion, nor the exposure, nor the trimming of whiskers will explain the phenomenon. It is, he insisted, the loss of hope.

Richter added some confirmatory data from other fields and suggested an extrapolation from his laboratory observations to explain the occurrence of sudden death in rabbits, chimpanzees, foxes, raccoons, some birds, musk oxen, otters, mink and even human beings. "Some of these instances," he said, "can best be described in terms

of hopelessness, all avenues of escape appearing to be closed."⁴

This is not an isolated observation or hypothesis. For example, from a large amount of psychosomatic investigation Engel and his associates in Rochester, New York, consider that what they describe as "helplessness" and "hopelessness" reflect a necessary if not a sufficient condition for the development of organic disease.⁵

And then there is the Queequeg phenomena of "Voodoo Death" in Moby Dick which Walter Cannon and others have amply substantiated with authentic data from primitive societies. No doubt most of us can recall instances in which the loss of hope seemed to accelerate the arrival of death for a patient. There are many such stories, unconfirmed of course but highly suggestive, in the daily press.⁶

All of these things seem to me to support the theoretical proposal that hope reflects the working of the life instinct in

⁴ Richter, C. P.: Sudden Death Phenomenon in Animals and Humans. Unpublished Manuscript.

⁵ Schmale, A. H., Jr.: Relationship of Separation and Depression to Disease (1) A Report on a Hospitalized Population. *Psychosomatic Medicine*: July-Aug. 1958. pp. 259-277.

⁶ For example: "Blasts End Mother's Will to Live," Tucson, Arizona.

Twelve days ago, Mrs. Helen E. Hopke lay in her bed fighting to stay alive to see her daughter's wedding.

Incurably ill for the past five years, Mrs. Hopke had been indirectly responsible for the meeting about a year ago of her daughter, Rose Marie, 20, and the girl's intended husband, Arthur Woodrow Hudson, 26.

Rose Marie had acted as nurse and housekeeper to her bedfast mother. While buying medicine she met Hudson, a pharmacist in a local drug store. Friends said it was the girl's first romance.

They also said all that kept Mrs. Hopke alive in recent months was the thought of the impending marriage.

The 56-year-old mother heard the couple enter the house laughing and talking about the April 4th wedding. She heard them enter the next room.

Their chatter ended in three blasts from a shotgun. Police said Hopke, opposed to the marriage, wanted his daughter to continue to care for her mother. He became enraged at reading the wedding notice in the paper, shot the couple then turned the gun on himself.

Rose Marie was taken to one hospital where she is recovering. Her mother was taken to another.

Tuesday night, Mrs. Hopke died.

(*Topeka Daily Capital*,
Thursday, April 2, 1959)

its constant battle against the various forces that add up to self-destruction. It would be too narrow to regard it as a form of refined narcissism since, as Marcel points out, there is something essentially unnarcissistic and beyond self in hope. One sees this in the hopefulness, not of the patient but of the physician. How much our patients do for us doctors!

We in Kansas have lived through the experience of a state hospital revival. Although we have built almost no new buildings, and although our admissions have increased tenfold in 15 years, our once overcrowded patient population has steadily diminished until we now always have available empty beds. We have even closed some wards as unneeded. We are proud of this, and proud that the voters and officials of our state appreciate it, and consider the cost per *stay* more significant than the commonly used cost per day. A distinguished governor visited us for several days, determined, as he said, to "discover the secret." "Our state has more men and more money than Kansas," he said. "Why can't we do these things?"

He didn't discover the secret partly because he didn't believe what we told him. Many of my colleagues in this audience may not believe it now, either. But we consider the crucial element in the Kansas state hospital program to have been the inculcation of hope. Not in the patients directly, but in the doctors and all those who help them, in the relatives of the patients, in the responsible officials, in the whole community, and *then* in the patients. It was not just optimism; it was not faith; it was not expectation. We had no *reason* to expect what happened, and what still happens, and our faith was only that which all scientists share. But we did have hope.

We had more than hope, you will say; we had had experiences which encouraged hope. But these experiences were themselves based partly on hope, confirming the assumption that hope fires hope. This is not a conscious process, or at least not entirely so. I have wondered if we might perhaps understand the placebo effect in this way, a transmitted hope or reinoculation, as it were? In control research studies of the new drugs, for example, patients who

receive only placebos sometimes show much improvement. In one study that I know about, testing an excellent drug, more patients in the group which had only placebos were able to be discharged from the hospital than from the group of those who got the actual remedy (although a larger number of the latter showed marked improvement).

Another phenomenon that is perhaps related to hope is the sudden improvement and even recovery of patients who have been for a long time fixed, as it were, at low levels of organization and regression. A new doctor arrives, or a new aide, and the patient promptly and most unexpectedly begins to recover.⁷

Whatever the explanation offered for such phenomena, to invoke suggestion or coincidence (whatever *they* are) will not suffice. There is more to it. And yet we doctors are so schooled against permitting ourselves to believe the intangible or impalpable or indefinite that we tend to discount the element of hope, its reviving effect as well as its survival function. Because of the vulnerability of every doctor to the temptation of playing God and taking the credit for the workings of the *vis medicatrix naturae*, we are necessarily extremely cautious in attributing change to any particular thing and least of all to our own wishful thinking.

There are many sufferers in the world, and there are many who seek to afford them relief. Among the latter there are those who use intuition and magic, and there are those who attempt to derive basic principles checked by experiment and observation, which we call the scientific method. For the former group, healing is more important than truth; for the latter, truth is more important than healing. Indeed, the search for truth, the desire to heal, and the earning of one's living are three persistently conflicting forces in medical practice.

⁷ But it is also true that just the opposite occurs: A patient on whom intensive efforts have been made fails to respond and is given up in despair, dismissed by her physician or removed to a custodial hospital. We have all frequently seen this result in a prompt improvement and even recovery. Perhaps we could regard this as an awakening of dormant hope by a desperate and unintentional shock-type method.

In the daily performance of healing acts, the scales are weighted heavily against scientific truth. Patients long to be deceived. Driven by pain and desperate with fear, they are ready to seize at "straws of hope." They prostrate themselves before the doctor; they queue up in weary, straggling lines awaiting the opportunity to submit themselves to humiliations and new sufferings, or even to hear a few words of reassurance. Besieged by such multitudes of petitioners, often with gifts in their hands, the doctor, knowing his limitations, must try to be patient, kind and merciful—but simultaneously "objective" and honest. The desire to bring comfort, the need to earn one's living, the suppressed longing for prestige and popularity, the honest conviction of the efficacy of a pill or a program, sympathy for the pleading sufferer—all of these throw themselves upon the scales in the moment of decision. Every physician in the world has heard the devil whispering, "Command that these stones become bread . . . All these things I will give thee if thou wilt fall down and . . ." And sometimes he falls down. He exploits the patient's hope.

Against such dangers there have been for 25 centuries an oath of loyalty, a tradition of humility, and certain maxims of practice. One of the latter is the putting of diagnosis before treatment, empiricism before hope. Even in pre-scientific days it was indefensible for a doctor not to indicate some comprehension of what one claiming to be a healer was dealing with. For the patient, even a diagnosis offered *some* hope, since it showed that his condition was not unique. But for the doctor, who was better acquainted with the implications of a diagnosis for which he had no real treatment, the temptation was ever present to neglect diagnosis in the interests of hope, or at least in the interests of treatment.

It should be remembered that there were once many different kinds of competing healers. There were the apothecaries who in 1617 were granted a charter permitting them to sever their 200 year association with the grocers. There were the various trade guilds: the barber-surgeons, midwives and bone setters; and then there

were the physicians, with their plasters and clysters. All were busy "treating."

Out of this confusion, under the leadership of a gallery of immortals on pillars erected here and there over a wide area, there slowly arose the magnificent edifice of modern, scientific medicine. The elimination of superstition and magic took a century, but the purge strengthened medical science mightily. Thousands of remedies were tested, found wanting and discarded. Many improvements in diagnostic techniques and instruments were introduced. Treatment, except for the most superficial palliation, was apt to be regarded with great suspicion, while the memory of recent quackery, pretention and deceit was fresh.

In psychiatry, the efforts of our predecessors to bring order out of the apparent chaos of the phenomena of madness were reflected in assiduous efforts to describe disease entities, to name them, to identify them, to graph them, and to seek for "etiologies." This was the traditional concept of diagnosis and it offered little to justify hope. The broken or misshapen personalities coming under medical observation were described or christened with tens of thousands of names and groupings, painstakingly put together by assiduous workers, only to be discarded by those of a later generation. These old labels, like epitaphs on tombstones, may be read with sober reflections that life is short and the art long, that our grasp of human phenomena is limited and narrow, and that our concepts are ever changing and unclear.

Once diagnosis in the sense of recognizing, naming, classifying and distinguishing between different forms of behavior disorder seemed of fundamental importance. The best psychiatrist in my early days was one who could most convincingly distinguish between some of the many varieties of "paranoia" or "dementia praecox"⁸ or "psychopathic personality." Some of my colleagues "discovered" new varieties of these; I even thought that I did.

Today it seems to me most important that we *not* do that. Our impressive labels only

⁸ A term introduced 99 years ago by B. A. Morel in 1860 describing the mental condition of a boy of 14 years.

reify and freeze a phase of a process ; they misrepresent our modern concepts and they strike a blow at hope, and hence at treatment. Words like *non compos mentis* or "responsible" and "irresponsible" really indicate only whether or not we think an accused person is able to appreciate being executed. "Psychotic" and "neurotic" cannot be competently defined, since what they mean at any one moment depends upon who is using them to describe whom. Many of us have urged their abolition, but they persist as weapons in scientific name-calling. Some colleagues incline to label "psychopathic personality" all patients who admit having broken the law. And surely it is more than a little disturbing to us all to contemplate the results of the recent researches by colleagues Hollingshead and Redlich exposing the fact that what one gets called by psychiatrists depends to a degree upon what class of society one comes from.

But over and above the matter of social and political and medical misuse of terms, these diagnostic designations belie the progress we have made in understanding the nature of illness. A name is not a diagnosis. It does not determine treatment. Its original purpose, perhaps, was to distinguish between wise and foolish expectations, but its net effect has come to be that of destroying hope.

Today there is a trend away from names, states and entities and toward dynamics, relativity and process. Just as the nature of matter has assumed a new aspect, so the nature of disease has come to be understood differently. The only entities in disease, said Allbutt long ago, are the individual patients, Smith and Jones, in certain phases of their being. "Diseases are not specifics such as cats and mushrooms ; they are 'abnormal' behaviors of animals and plants." Today we are following Allbutt.

It is the privilege of some of us to be called doctors. And if the peculiar phases of existence which Jones and Smith are experiencing lead them to approach us in the belief that we can help them, they can then be called patients and their afflictions may be called disease. But we cannot discharge our responsibility by "calling." We may not exorcise Smith's afflictions by

giving them a name. That is not the basis of our hope, and if it is the basis of Smith's hope, it is one we should not exploit.

It is our responsibility as physicians to instigate some change in the relations of Smith to his environment—directly if possible, indirectly and gradually most likely. To do this we must attempt to understand the man, how he has become what he is, what goes on inside of him, what goes on around him and how these interact. By observing the internal and external processes we can discover what in his world is good for Smith and what is unbearable, what damage he inflicts upon himself and others, and what potentials within him remain underdeveloped. And here enters in hope, for we acquire, thus, a rationale for therapeutic intervention.

This is what we now call diagnosis. It were better to call it *diagnosing*, to indicate its transitive, continuing nature, its look toward the future rather than toward something static or past. Diagnosing is the first step in a cooperative relation between patient, physician and environment working toward the betterment of a situation, especially as it affects our patient. This is based upon hope, hope implicit in our effort and hope nurtured in our patient.

The practice of medicine today is vastly different from that of a hundred years ago when Samuel Gross wrote (1861) :

It requires no prophetic eye, no special foresight, to discover that we are on the very verge of one of the most fearful and widespread revolutions in medicine that the world has ever witnessed.⁹

That revolution came about (Dr. Earl Bond reviewed it this morning) but not so soon as Gross expected. Yet it is hard to believe today that there was ever a time when a doctor had to defend himself to his colleagues if he claimed to have cured someone. In those days hope was faint and precious. Today it seems sometimes almost as if hope was considered unnecessary.

The revolution that elevated our medical profession from a discouraged, submerged

⁹ Gross, Samuel : Quoted by Leikind, Morris C. : The Evolution of Medical Research in the United States. In *History of American Medicine*. (ed. Felix Marti-Ibanez) N. Y. : MD Publications, 1958. p. 126.

state to a progressive and confident one was partly the result of new discoveries, and partly from the recognition of psychology as one of the basic medical sciences, along with physics and chemistry. This came about from the experiences of World War I, and from the discoveries of Sigmund Freud. The latter were introduced into American psychiatry about 1920, the way prepared for them by J. J. Putnam, Ernest Southard, Adolf Meyer, William A. White, A. A. Brill and Smith Ely Jelliffe.

I cannot describe all of these old friends here, but I must say a word about Southard, because he was my teacher and because above all men I have known, and entirely out of keeping with the spirit of his day, he placed great hope in psychiatry. He said here, long ago, in 1919, *remember* :

May we not rejoice that we (psychiatrists) . . . are to be equipped by training and experience better, perhaps, than any other men to see through the apparent terrors of anarchism, of violence, of destructiveness, or paranoia—whether these tendencies are showing in capitalists or in labor leaders, in universities or in tenements, in Congress or under deserted culverts. . . . Psychiatrists must carry their analytic powers, their ingrained optimism and their tried strength of purpose not merely into the narrow circle of frank disease, but, like Seguin of old, into education; like William James, into the sphere of morals; like Isaac Ray, into jurisprudence; and above all, into economics and industry. I salute the coming years as high years for psychiatrists!

These “high years” really began after Southard died. The public had been alerted by the literary dissemination of the discoveries of Freud and also by the growing “mental hygiene movement.” Most doctors had had almost no psychiatry in their medical school training. Twenty-five years after Southard had spoken those prophetic words—and died—we were in the midst of another World War. There was a shortage of psychiatrists. To enlist interest and recruit doctors, I visited medical schools over the country and talked at length to students, deans and faculty members. I found that a common objection to entering psychiatry was an impression that our patients “never get well.” It is such a hopeless field,

they said. Penicillin and the other miracle drugs are more definite and exciting than the dreary wards of state hospitals, filled with silent, staring faces.

We can see, now, that these students had been shown the wrong side of psychiatry, its failures rather than its successes. But one thing struck me then which has remained in my mind indelibly. I perceived vividly how hopelessness breeds hopelessness, how the non-expectant, hope-lacking or “unimaginative” teacher can bequeath to his student a sense of impotence and futility, utterly out of keeping with facts known to both of them! Surely even these misled students knew that *some* psychiatric patients recover, even if they didn’t know that the vast majority does so. But like their teachers, they adopted some of the very symptoms of their patients: hopelessness and goal-lessness! Physicians in state hospitals at that time did not expect their patients to recover, and were a little surprised when recovery occurred. Some superintendents quite unabashedly announced (published) recovery rates of 5% per year!

This experience only reinforced my conviction that hope, that neglected member of the great triad, was an indispensable factor in psychiatric treatment and psychiatric education.

At the end of the war, veterans requiring continued psychiatric treatment began returning to this country in large numbers, and at the same time the physicians who had seen these phenomena of stress and overstress develop and recede were demobilizing. Many of these doctors now sought to learn more about this psychiatry which seemed so important in understanding these cases. During the first few months of its existence, the Menninger School of Psychiatry received over 600 applications. Other training centers were similarly flooded.

Some of them no doubt came into psychiatry because of an awareness of their own threatened disorganization and the dim realization that this human-all-too-human tendency was one against which penicillin and heart surgery and all the discoveries of modern medicine offered no protection. By Freud discoveries of quite

another sort had been made and knowledge of them had slowly become common property. These discoveries promised no miracles, no instantaneous cures; they did not seem to justify hope. In fact, Freud was frequently accused of a devastating pessimism. Surely hope has rarely entered medical science through so narrow and tortuous a crevice. But it did enter and its rays transformed the face of modern psychiatry in our lifetime. A whole new viewpoint in medicine developed, one that gave authority and technique to efforts at systematic self-scrutiny, a kind of extended and continuous diagnostic case study.

In a way it seems curious that the psychoanalytic process, which is so obviously diagnostic, has generally come to be called treatment. Diagnosis is the hopeful search for a way out; but the setting forth on the way which one discovers and the unflinching persistence in making the effort—that is the treatment; that is the self-directed, self-administered change.

The psychoanalytic treatment method is a great discovery but this is not what changed psychiatry. It was the new understanding that psychoanalytic research gave us concerning men's motives and inner resources, the intensity of partially buried conflicts, the unknown and unplumbed depths and heights of our nature, the formidable power each of us holds to determine whether he lives or dies. It was the realization that we must encourage each individual to see himself not as a mere spectator of cosmic events but as a prime mover; to regard himself not as a passive incident in the infinite universe but as one important unit possessing the power to influence great decisions by making small ones.

It was not the treatment technique of psychoanalysis that changed psychiatry; it was the new understanding of men's motives and inner resources, of the intensity of partially buried conflicts, the unknown and unplumbed depths and heights of our nature, the formidable power each of us holds to determine whether he lives or dies. Wrote William James:

Will you or won't you have it so? is the most probing question we are ever asked. We are

asked it every hour of the day, and about the largest as well as the smallest, the most theoretical as well as the most practical things. We answer by *consents* or *non-consents* and not by words. What wonder that these dumb responses should seem our deepest organs of communication with the nature of things! What wonder if the effort demanded by them be the measure of our worth as men!

"Ye shall know the truth and the truth shall make you free," said another wise One. For this emancipating truth Freud searched not in physics or chemistry or biology, but in the tabooed land of the emotions. From the Pandora chest of man's mind, full of harmful and unlovely things to be released upon a protesting world, there turned up—last of all—Hope.

Selfishness, vengefulness, hate, greed, pettiness, bitterness, vindictiveness, ruthlessness, cruelty, destructiveness and even self-destructiveness—all these are in us. But not only those. Invisible at first, but slowly pervasive and neutralizing came love, and then—perhaps because of it—came faith, and then hope.

Love, faith, hope—in that order. The Greeks were wrong. Of *course* hope is real, and of course it is not evil. It is the enemy of evil, and an ally of love, which is goodness.

Freud's great courage led him to look honestly at the evil in man's nature. But he persisted in his researches to the bottom of the chest, and he discerned that potentially love is stronger than hate, that for all its core of malignancy, the nature of men can be transformed with the nurture and dispersion of love.

This was the hope that Freud's discoveries gave us. This was the spirit of the new psychiatry. It enabled us to replace therapeutic nihilism with constructive effort, to replace unsound expectations—first with hope, and then with sound expectations.

This is what it did for us, for psychiatrists. And for our patients—miserable, apprehensive, discouraged and often desperate—what can we do better than that? What can we do better than to dispel their false expectations—good and bad—and then light for them a candle of hope to show them possibilities that may become sound expectations?

And we who are teachers—can we do better by our eager, young seekers for the keys to wisdom than to help them sharpen the accuracy of their expectations without extinguishing the divine fire?

But there are many people in the world who are neither our patients nor our students, and who are nonetheless filled with great apprehensiveness, partly from ignorance and mistrust of one another. They are afflicted with great suffering which all our discoveries have not ameliorated, and awed by vast discoveries which none of us fully comprehend. Some of them look to us for

counsel, to us whom they have so highly honored and so generously rewarded with prerogatives and opportunities. They are our friends, our brothers and sisters, our neighbors, our cousins in foreign lands. For these people—for them and for ourselves—are we not now duty bound to speak up as scientists, not about a new rocket or a new fuel or a new bomb or a new gas, but about this ancient but rediscovered truth, the validity of Hope in human development,—Hope, alongside of its immortal sisters, Faith and Love.