By S. D. Lamb (2014)

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In 1925, a group of specialists with a common interest in speech disorders declared themselves an organizational entity, one separate from already established professional organizations that had subsumed their specialty of ‘speech correction.’

There are many stories that need telling when revisiting that period early in the twentieth century. The most direct story would feature the players who were charter members of the organization (e.g., Malone, 1999; Paden, 1970; Van Riper, 1981). Another would be to examine the cultural and professional milieus within which those early meetings took place (e.g., Duchan, 2021a, 2021b). A third and less direct account would be to focus on what alternative paths were available to our ancestors at that time – paths they must have known about but chose not to pursue. This fairly recent biography of Adolf Meyer (2014) offers a view of that third option, a road that our predecessors chose not to travel. Had this alternative been pursued or adapted at that time, it would have offered those pioneers in our field a version of today’s social model practices.

We learn from Susan Lamb’s biography that Adolf Meyer pioneered progressive and socially based methods for working with the mentally ill. Many of Meyer’s experimental methods were developed at the Henry Phipps Psychiatric Clinic in Baltimore, Maryland, a clinic that he directed from 1913 to 1941. Meyer designed treatments such as social adaptation programs, mental hygiene clinics, and habit training to help his patients adapt better to their social environments. His interventions were individualized, in that he based each treatment plan on an analysis of the patient’s life stories and on
observations of how that patient accommodated and reacted to their every-
day life circumstances.

Most of today’s renditions of social model practices locate the origins of the
movement in the late twentieth century. They treat it as an outgrowth of the
disability rights movement (Byng and Duchan, 2005; Duchan, 2001; LPAA
Project Group, 2000; Simmons-Mackie, 2000). This biography of Adolf Meyer
calls for a revision of that history. The writings and methods of Adolf Meyer,
along with others he worked with and borrowed from, provide many examples
of social model practices that took place almost a century earlier. The move-
ment instigated by Adolf Meyer is part of a crucial history that has yet to be
entered into our field’s historical accounts, even as a side story.

Meyer’s work is relevant today for two reasons. First, it offers a new slant
on today’s social model practices. Further, it provides a wider understand-
ing of paths that our founding parents turned away from as they shaped our
profession.

The Phipps Psychiatric Clinic opened on April 16, 1913, in Baltimore,
Maryland, under the directorship of Adolf Meyer (1866–1950). The clinic had
its own building, under the administration of Johns Hopkins Hospital. Shortly
after the building opened, Meyer’s socially focused approaches were taken up
by others. His psychobiology theory and its attendant approaches were dis-
seminated in the press, adopted by Meyer’s fellow practitioners in psychia-
try, and incorporated into the newly developing fields of occupational therapy
and social work. Meyer’s methods also gave rise to a mental health move-
ment in America, as witnessed by the openings of regional mental hygiene
and child guidance clinics. In 1952, shortly after Meyer’s death, his approach
to mental illness was incorporated into the first version of the *Diagnostic and
statistical manual*, a manual used throughout the world (American Psychiatric
Association, 1952).

Central to Meyer’s psychobiology theory was the notion of regulation.
His was a dynamic view of how people construct their reality. He postulated
that through a process of ‘mentation’ normal as well as abnormal individu-
als continually adjust their primal and their higher order processing mech-
anisms to be in keeping with their social understandings. Adjustments to
one’s social-cultural habitats made up what Meyer called a person’s ‘common-
sense consensus.’ When mentation no longer functioned optimally, lower level
primitive nervous mechanisms took over, leading to a person’s misinterpreta-
tion of their experiences. These ‘substitutive reactions’ undermined a person’s
biological equilibrium, upsetting their common sense understandings. Meyer
deduced from his psychobiological model that treatments of mental illness
should involve patients’ lives, not just their symptoms. His aim was to work
with patients to modify their maladaptive psychobiological reactions.
Meyer considered the respectful and collaborative relationship between the patient and the psychiatrist as key to therapeutic success. He saw a patient's account of their lives and their introspective interpretations of their faulty adaptive patterns as central to the creation of their psychobiological equilibrium. Patients were encouraged to write down their thoughts, dreams, and their sense of progress or lack thereof. These patient writings were an integral part of the patient’s case records and became a source of topics to talk about in frequent patient–client interviews.

The case history record was an integral part of Meyer’s research and clinical practice. Case histories took the form of well-organized dossiers containing descriptions of his patients’ reported life experiences, notes on their behavior in natural contexts, their test results, and insights derived from staff following clinical interactions. The case history was organized as a ‘life chart.’ Case histories were to be read as a life story showing a patient’s dynamic interaction with their environments over time (Leys, 1991).

Treatment for Meyer was a kind of social rehabilitation for coping better in everyday situations. He decentralized his service provision locations, moving from the clinic to workplaces, schools, and homes. His community-based focus led to the emergence of the fields of occupational therapy and social work.

Meyer departed from traditional medical model practices. He replaced the medical construal of mental illness as a pathological condition located in the body with one that depicted mental illness as a maladaptive way that individuals interact with their environment. He divided mental illness into different kinds of maladaptations to difficult life problems. In so doing, he shifted away from treating mental disorders as medical symptoms of hysteria, depression, or schizophrenia toward seeing them as types of maladaptive habits. His therapies were aimed at changing those maladaptive habits to adaptive ones – ones that were more culturally acceptable, ones that took place in everyday situations rather than in in clinics.

Smiley Blanton, a charter member of the American Speech-Language-Hearing Association (ASHA) and a key player in the development of the profession, was a student of Adolf Meyer. In 1924, Blanton and his wife Margaret Blanton established a child guidance clinic in Minneapolis, Minnesota. Blanton described his clinic’s goals using the vocabulary and ideas of Adolf Meyer, expanding on Meyer’s scope of practice to include children with speech problems. Blanton described his efforts as follows.

Mental hygiene deals with the laws of the mind whereby a child is able to adjust himself in a healthy manner to the world in which he lives. It teaches us to understand those emotional forces that make for success or failure in each individual life. It helps us
to understand … the speech defects of children which so often cause failures in life.
(Blanton, 1926, p. 36)

This is but one indication that our founders must have been aware of Meyer’s social model methods. It is not a stretch to assume that they could have incorporated these social model principles and practices into their theories and practices. They did not take the bait. Instead, they relied solely on traditional medical model approaches. Their wholesale adoption of the medical model is evidenced by their early focus on medically based taxonomies (Ogilvie, 1942; Stinchfield and Dorsey, 1926; Stinchfield and Robbins, 1931), on their use of medical frameworks to select research topics and develop clinical practices (Duchan, 2020), and on their construal of speech disorders as pathological symptoms, arising from diseases located in individuals (see Duchan and Felsenfeld, 2021, for an example). Most of their treatments were aimed at minimizing or eliminating presenting symptoms (see Duchan, 2021b, for an example).

Today’s social model practices in the field of speech-language pathology resemble those of Meyer. There are life participation approaches that look like the habit training approaches of Meyer (e.g., LPAA Project Group, 2000). In both Meyer’s and today’s approaches there is a move away from focusing on diagnosis and toward focusing on adaptation (e.g., Jorgensen, McSheehan, and Sonnenmeier, 2010). There is an emphasis in both Meyer’s and today’s social model treatments on egalitarian and person-centered treatments and away from clinician-driven ones (e.g., Resources for Integrated Care, 2021). And there are efforts today, like those of Meyer’s a century ago, to shift the locale of therapies from the medically focused clinic to situations of everyday life (e.g., LPAA Project Group, 2000; Pound, Duchan, Penman, Hewitt, and Parr, 2007).

There are also interesting differences between Meyer’s practices and those of speech pathologists working with social models today. The most obvious is that Meyer’s attention was focused on providing services for those with mental illness, not those with communication disorders. Also, today’s social model practitioners have incorporated an access model drawn from the disability movement, a model that was not part of Meyer’s theory or practice. The effect of the disability movement has been to alter aspects of the environment in order to promote access, such as training conversational partners to support the communication of those with aphasia (e.g., Kagan, 1998). Meyer focused instead on improving the patient’s adaptation to the environment, rather than making changes in the environment.

Nonetheless, had our ancestors been more open to Meyer’s pioneering efforts early in the twentieth century, one cannot help but think that they
wouldn’t have had to reinvent the social model wheel in the twenty-first century.

References


