

**White's Restraint and Progressive American Psychiatry at St. Elizabeths Hospital**

**1903-1937**

Suzanne Nortier Hollman, Psy.D., MSc.

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## **UCL Doctorate Thesis declaration form**

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:



Name: Suzanne Nortier Hollman

Date: 07/20/2020

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## **Abstract**

This dissertation represents the first systematic study of William Alanson White's tenure between 1903 and 1937 at The Government Hospital for the Insane, later known as St. Elizabeths Hospital in Washington, D.C. White's influential position as superintendent of the largest hospital in the United States had a significant impact on the practice of psychiatry, and the solidification of the technique and language of the psychoanalytic method, in the hospital setting. Historians of psychoanalysis have largely neglected this contribution, alternately portraying White as a populist and unoriginal thinker, or neglecting his contribution altogether. White was most widely known as a hospital administrator. This role appears to have obscured a more nuanced view of his personal involvement in the field of psychiatry and psychoanalysis, and also the significant contributions to the evolution of psychiatric practice that can attributed directly to his administrative policies related to the treatment of patients. There has been no methodical study of archival case material and primary sources as it relates specifically to White and his stewardship of St. Elizabeths. I utilize this material to analyze the formative personal, theoretical, and philosophical influences that contributed to White's view of hospital psychiatry with particular emphasis on the operationalization of psychoanalytic language and practice. I argue that White was a product of the Progressive Era that embodied an optimism in which the principles of the scientific method, and the emphasis on the importance of environmental adaptation, stood alongside the psychoanalytic method. For White, these ideas were not in conflict, and co-existed effortlessly in the inpatient ward. Case notes by treatment teams, as well as White's personal correspondence and scholarship, support this broader view in which the intrapsychic

and the environmental have mutual influence. Optimism in the scientific method did not, however, always dominate White's narrative. His personal papers also offer a glimpse into the struggles and complexity of overseeing the magnitude of human suffering found in a large hospital, and reveals a more multifaceted, and more personal representation of White's life and his work. I argue that twentieth-century American psychiatry, and psychoanalysis, was practiced in parallel tributaries, in both the private consulting rooms, but also in the hospital setting. White's psychiatry, and his views on the analytic method was informed mostly by the challenges and opportunities of the latter, and the excerpts of the lives of patients documented in the National Archives helps to reconstruct a piece of psychiatric history that has been overlooked.

## **IMPACT STATEMENT**

The history of psychoanalysis and psychiatry within the United States has been written. This history will, however, benefit from the inclusion of a detailed account of the life and work of one of the most prominent psychiatrists at the turn of the century, Dr. William Alanson White. There is no detailed examination of White's life and work, nor of his stewardship of St. Elizabeths Hospital, the largest hospital in the nation for the treatment of the insane. St. Elizabeths was as much a laboratory for the emerging science of psychiatry and the discipline of psychoanalysis as it was a proving ground for the social environment in the United States. Through an examination of White's involvement with the treatment of patients, the personal and professional affiliation that shaped him, and the work of staff and clinicians affiliated with the hospital, it becomes possible to locate an important, hereunto largely missing part of history. White's ability to fuse and operationalize psychoanalytic theory, psychobiology, and the philosophical principles borne from the Progressive Era was remarkable. Yet, in part as a result of his dissent from the Freudian school, he remains a largely neglected player in the history of psychoanalytic psychiatry and psychoanalysis in the United States. This study is an attempt to re-situate White within this history.

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## Introduction

In the fall of 1927, a homeless man sought shelter for the night in an abandoned shack in the state of Oklahoma. He took with him a stack of old newspapers that he had found on the railroad tracks nearby. A few weeks later a letter addressed to the Superintendent was delivered to St. Elizabeths Hospital in Washington, D.C. This transient individual, whose name remains unknown, explained how he came to write this letter:

...Among them I found the magazine section of a Sunday paper. It contained an article concerning yourself. The paper was much discolored and broken by the sun, and rain, but from the little I could read I gathered that you are interested in cases of mental disorder. Hardly knowing at the time why I did so, I jotted down your name in my note-book and this letter is the result.<sup>1</sup>

Such was the reach of the recipient of this letter, Dr. William Alanson White, the superintendent of St. Elizabeths Hospital from 1903 until his death in 1937. While it is impossible to identify with certainty which newspaper article the homeless man came across,<sup>2</sup> it is in no way surprising that an in-depth piece concerning Dr. White was in circulation in the popular press. Between 1903 and 1937, White was referenced approximately fifty-nine times in newspapers in the United States. His presence in the

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<sup>1</sup> Quoted in William Alanson White, *William Alanson White: The Autobiography of a Purpose*, 1st ed. (New York: Doubleday, 1938), 164.

<sup>2</sup> On Sunday, May 8, 1927, the *Brooklyn Daily Eagle* (Brooklyn, New York) published a lengthy article on White's work titled "Mind of Man Improves by Creative Evolution." This was the only piece published in a magazine section in 1927 and could likely be the relevant article.

public consciousness, however, pales in comparison to his influence within the fields of psychiatry and psychoanalysis. He published approximately 200 papers and 19 books, including *Outlines of Psychiatry* (1907), the definitive textbook for US psychiatrists-in-training in hospital settings. *Outlines* remained the most used text in the academic discipline of psychiatry for three decades, with fourteen edited and updated editions published between 1906 and 1936.<sup>3</sup> In 1913, along with his colleague and friend Smith Ely Jelliffe, he launched the *Psychoanalytic Review*, a prominent journal that is still published on a bi-monthly basis and described by the current editors as “the oldest continuously published psychoanalytic journal in the world.”<sup>4</sup> White delivered regular lectures in his capacity as professor of psychiatry at the medical schools of both George Washington and Georgetown Universities in Washington, D.C.

He was prominent not only in academic, but also in professional circles. While at St. Elizabeths, White held the positions of president of the American Psychopathological Society (1922), the American Psychiatric Association (1924–25) and of the American Psychoanalytical Society (1928). He was a member of the Board of Directors of the National Committee for Mental Hygiene, and he advanced the ideas of the mental hygiene movement through the professional roles that he held.<sup>5</sup> In his powerful role as superintendent of St. Elizabeths, he played an important, albeit at times contentious, role in introducing and popularizing psychoanalysis in the United States.

This dissertation represents the first systematic study of White’s clinical and intellectual contributions to the way in which the mentally ill, and the criminally insane,

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<sup>3</sup> Nathan G. Hale, *Freud and the Americans: The Beginnings of Psychoanalysis in the United States, 1876–1917* (New York: Oxford University Press, 1971).

<sup>4</sup> *The Psychoanalytic Review*, <https://npap.org/the-review/>.

<sup>5</sup> See Gerald N. Grob, *Mental Illness and American Society, 1875–1940* (Princeton, N.J.: Princeton University Press, 1987).

were understood and treated during the early to mid twentieth century in the United States. While biographies of many prominent psychiatrists and psychologists, such as Erikson,<sup>6</sup> Menninger,<sup>7</sup> C. G. Jung,<sup>8</sup> Skinner,<sup>9</sup> Adler,<sup>10</sup> Meyer,<sup>11</sup> and even White's closest collaborator, Jelliffe,<sup>12</sup> have been written, White remains conspicuously absent from this list. This analysis of White's place in medical history will illustrate that American psychoanalysis in particular has been neglectful of White's contributions, and furthermore, that historians of psychiatry, while acknowledging his role in broad strokes, have not offered an in-depth analysis of how his clinical and intellectual contributions became manifest in the lives of his patients, students, and colleagues.

## **The Hospital**

Any attempt to examine White's life and work inevitably raises the question: To what extent is White's history simultaneously the history of St. Elizabeths Hospital? While the available asylum studies and primary source material thoroughly document the history of this institution, these contributions offer a unidimensional picture of White as superintendent and administrator, and seldom as a clinician and theorist. An examination of Francis Rives Millikan's and, most recently, Thomas Otto's historical account of St. Elizabeths Hospital reveals a primary focus on the institution itself, as

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<sup>6</sup> Lawrence J. Friedman and Robert Coles, *Identity's Architect: A Biography of Erik H. Erikson* (New York: Scribner, 1999).

<sup>7</sup> Lawrence J. Friedman, *Menninger: The Family and the Clinic* (Lawrence: University Press of Kansas, 1992).

<sup>8</sup> Sonu Shamdasani, *Jung and the Making of Modern Psychology: The Dream of a Science*, 1st ed. (Cambridge: Cambridge University Press, 2003).

<sup>9</sup> Daniel W. Bjork, *B. F. Skinner: A Life* (Washington, DC: American Psychological Association, 1997).

<sup>10</sup> Edward Hoffman, *The Drive for Self: Alfred Adler and the Founding of Individual Psychology* (Reading, MA: Perseus Books, 1994).

<sup>11</sup> S. D. Lamb, *Pathologist of the Mind: Adolf Meyer and the Origins of American Psychiatry*, 1 edition (Baltimore, MD: Johns Hopkins University Press, 2014).

<sup>12</sup> John C. Burnham and William McGuire, *Jelliffe: American Psychoanalyst and Physician and His Correspondence With Sigmund Freud and C.G. Jung*, 1st ed. (Chicago: University of Chicago Press, 1983).

opposed to an emphasis on White's role.<sup>13</sup> This study aims to extend the current scholarship on White's life and work by situating him firmly alongside, as opposed to subsidiary to, the history of St. Elizabeths Hospital.

At this point, it is necessary to address an important issue related to a change in terminology that took place during White's tenure and which, while not of White's doing, was very much in line with his advocacy of the mental hygiene movement. Between 1855 and 1916, St. Elizabeths Hospital was known as the Government Hospital for the Insane.<sup>14</sup> I have elected to use the term "St. Elizabeths Hospital," or "St. Elizabeths" throughout for two reasons: First, this was the name for the majority of the years that White was superintendent, and, second, the initial title of the hospital fell out of favor long before the name was legally changed. The psychiatric, and soldier patients housed there during the Civil War, were very averse to the word 'insane,' and instead started referring to the hospital according to the name of the tract of land that it was built upon: St. Elizabeths. When Dr. Nichols, the superintendent from 1852 to 1877, also started referring to the hospital as such, it laid the groundwork for Congressional approval in 1916, whereby the name was legally changed.<sup>15</sup> During his tenure at St. Elizabeths in the early to mid 1900s, White was one of the most influential psychiatrists, managing one of the most prominent psychiatric hospitals in the United States, and arguably, in the world. In light of the way in which White's life was intertwined with his hospital work, it makes sense that a substantial part of this history is to be found in the archives of St. Elizabeths Hospital, located in Washington, DC.

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<sup>13</sup> Frank Rives Millikan, *Wards of the Nation: The Making of St. Elizabeths Hospital, 1852–1920* (Ann Arbor, Mich.: UMI, 1990); Thomas Otto, *St. Elizabeths Hospital: A History*. (U.S. General Services Administration, May 2013).

<sup>14</sup> The Records of St. Elizabeths Hospital, Record Group 418, National Archives [hereafter RG 418, NA].

<sup>15</sup> Millikan, *Wards of the Nation*. 111.

## Sources

The National Archives in Washington, DC., contains approximately 428 cubic feet of material pertaining to the history of St. Elizabeths Hospital, spanning 161 years.<sup>16</sup> In order to keep the focus on White, out of all the materials contained within this extensive collection, I utilize the primary source material dated between 1903 and 1936, when White was the administrator at St. Elizabeths. This period of time was when White was most productive, and also most prominent in the field. Contained within these archives are thousands of patient files, correspondence between White and prominent psychiatrists, such as Jelliffe, Brill, Menninger, and Meyer, as well as documents pertaining to hospital policies and clinical presentations. A multitude of documents illustrate White's competence as a hospital administrator, political actor, and forensic analyst. The archives detail in over one thousand pages the three congressional investigations on Capitol Hill that White endured and, in separate files, also the forensic testimony that he was often called upon to provide. A detailed analysis of White's managerial, political, and forensic contributions from a social-history perspective, that is, how these contributions influenced and were in turn influenced by American society, is beyond the scope of this research project. While this is a limitation, I take the view that White's intellectual and clinical contributions to the fields of psychiatry and psychoanalysis have been underestimated, precisely because of his successes in the more politically visible and publicized domains of his work. I therefore utilize records pertaining to White's managerial prowess, forensic contributions and political savvy

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<sup>16</sup> Record Group 418 in the National Archives was made available for research in 1976. It contains documents from 1820 to 1981 that reflect the history and evolution of St. Elizabeths Hospital.

only insofar as these records illuminate White's intellectual and clinical contributions to the field of psychiatric medicine and psychoanalytic thought. Patient files, clinical consultations, lectures, and clinical presentations, in particular, provide a rich mosaic within which White's fusion of psychobiology, psychoanalysis, and mental hygiene can be located. The Latourian perspective of "science in the making" provides a particularly useful frame as I trace, through careful scrutiny of archival records, how White attempted to construct a scientific approach to mental functioning in 'real time': the patients whose lives are traced through these records become, in Latourian actor-network theory, the actors instrumental in making meaning within the network of psychoanalytic psychiatry during this time period.<sup>17</sup>

The primary sources that speak directly to White's philosophical and theoretical orientation to psychiatry and psychoanalysis are found in his personal correspondence, including material that he set aside for his self-authored *Autobiography of a Purpose*.<sup>18</sup> There are also extensive records pertaining to patients, consultations, and requests for medical advice in which White was involved between 1906 and 1937. Patient case files, even though not all patients were directly under White's care, are important sources of demographic and clinical information that offer invaluable insight into White's theoretical conceptions and treatment approaches. Many of these case studies include the analytic method. White introduced psychoanalysis as a treatment modality at St. Elizabeths, and patient case files illustrate the unique manner in which he developed and put into practice a hybrid treatment method that incorporated elements of psychobiology and psychoanalysis.

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<sup>17</sup> Bruno Latour, *Science in Action: How to Follow Scientists and Engineers Through Society*, reprint edition (Cambridge, Mass.: Harvard University Press, 1988).

<sup>18</sup> William A. White, *William Alanson White: The Autobiography of a Purpose*, 1st ed. (New York: Doubleday, Doran & Company, 1938).

Additional sources of primary material are found in printed form. The annual reports that were published between 1903 and 1937 provide a wealth of information, including how White's views of human nature and the nature of pathology shaped patient admissions policies and procedures. Additionally, the minutes from the Board of Visitors, which had oversight of St. Elizabeths, provide an important perspective on how White's theories based upon mental hygiene and psychobiology were implemented at the clinical level. The Records of the Office of Interior contained in Record Group 48 offer a valuable source within which the new brand of 'scientific psychiatry' can be located. Another important source is the local and national press coverage of White's work, and, accordingly, these contributions will be included in the attempt to situate his work historically.

White was a prolific writer, and his books and articles provide a window through which to observe the evolution of his thought, his profession, and the state of the psychoanalytic world that he found himself both at the center and on the periphery of. A systematic analysis of his academic contributions, not in isolation but against the backdrop of extensive primary source archival material and patient case studies, lends itself to a much-needed rereading and reinterpretation of his work.

### **William Alanson White and the Historians**

In the early summer of 1914, Dr. Charles W. Burr launched a scathing attack against psychoanalysis and the Freudians at the 70<sup>th</sup> Annual Meeting of the American Medico-Psychological Association in Baltimore. He was joined in his criticism by the discussant, Dr. Francis Dercum, who argued that psychoanalysis is a cult and is in

opposition to the rigors of the scientific method.<sup>19</sup> White was in attendance, and in what he describes as his “first public defense of psychoanalysis,”<sup>20</sup> offered the following commentary, as quoted by Burnham:

I am a psychoanalyst. I want the truth and I am willing to welcome any light that may be thrown upon the situation. I appreciate psychoanalysis for I have been confused by actual clinical contact with patients in regard to the underlying principles and meanings involved, and so I know there is an element of truth in the movement, which would be extremely unfortunate for us to discard at this point.<sup>21</sup>

White’s advocacy for the merits of the analytic method in such a hostile and public venue is important. By 1914, he was in the midst of a very significant career ascension and was already regarded as one of the most prominent psychiatrists in the United States. The facts that he was the superintendent of St. Elizabeths, the largest government-run hospital in the country, and that he had been directly appointed by President Roosevelt at age 33,<sup>22</sup> positioned White to exert considerable influence in the field. Historians of psychiatry are in general agreement concerning his prominence, but they emphasize different aspects of his contributions to different degrees. Millikan, while acknowledging White’s important stature and impact, argues that it remains difficult to measure his legacy and relies upon statistics related to areas such as the

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<sup>19</sup> Arcangelo R. T. D’Amore, ed., *William Alanson White: The Washington Years 1903–1937: The Contributions to Psychiatry, Psychoanalysis and Mental Health by Dr. White While Superintendent of St. Elizabeths Hospital*, (Washington, DC: National Institute of Mental Health, 1976).

<sup>20</sup> White, *William Alanson White*, [[relevant page number?]].

<sup>21</sup> John C. Burnham, “Psychoanalysis and American Medicine, 1894–1918: Medicine, Science, and Culture,” *Psychological Issues*, 5, no. 4 (1967): 322–23.

<sup>22</sup> David Evans Tanner, *Symbols of Conduct: Psychiatry and American Culture, 1900–1935* (Austin: University of Texas Press, 1981), 23.

increase in research activity, staff and patient numbers, and architectural expansion during White's tenure to make his case.<sup>23</sup> While there is mutuality between the history of psychiatry and the history of psychoanalysis, White appears more prominently in the former. This is perhaps in part as a result of the circles he moved in. White was a hospital psychiatrist and administrator, not only a psychoanalyst, and he was not a member of Freud's inner circle. This may, in part, explain why his presence in the history of psychoanalysis appears more peripheral in the literature. Another consideration in the distinction between the history of psychiatry and the history of psychoanalysis is that White's books and journal articles were widely read in medical schools and formed the backbone of training for medical students. These publications are however, seldom referenced by the Freudian analysts. Historians of psychoanalysis such as Nathan Hale, Lawrence Friedman, and John Burnham do mention White,<sup>24</sup> but it is in the history of psychiatry where authors such as Gerald Grob and Arcangelo D'Amore provide a more detailed analysis of his place in history.<sup>25</sup> The implications of this positioning will be discussed in further detail in Chapter Six. Nathan Hale credits White, more than any other psychiatrist of his time, for having the ability to "put into general circulation ideas that had belonged only to the enlightened minority,"<sup>26</sup> while Friedman, in his very brief mention of White in his biography on the Menningers, states that White was perhaps "better equipped than any other American physician to teach

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<sup>23</sup> Millikan, *Wards of the Nation*, 112.

<sup>24</sup> See Hale, *Freud and the Americans* 16-53; Friedman, *Menninger* 2-37; and Burnham, "Psychoanalysis and American Medicine, 1894-1918," 251.

<sup>25</sup> See Gerald Grob, ed., *The Inner World of American Psychiatry 1890-1940: Selected Correspondence*, 1st ed. (New Brunswick, N.J: Rutgers University Press, 1985); and Arcangelo R. T. D'Amore, ed., *William Alanson White: The Washington Years 1903-1937: The Contributions to Psychiatry, Psychoanalysis and Mental Health by Dr. White While Superintendent of St. Elizabeths Hospital*, (Washington, DC: National Institute of Mental Health, 1976).

<sup>26</sup> Hale, *Freud and the Americans*, 380.

psychoanalytically informed psychiatry.”<sup>27</sup> The Menningers established their clinic in Topeka, Kansas, in 1919. Karl Menninger held White and St. Elizabeths in such high regard that he insisted that his son, Will Menninger, an internal medicine specialist with little background in psychiatry, complete a four month long residency with White in Washington, DC, in 1927. While Will did not show much interest in psychiatry, and elected not to complete a training analysis with White, he conducted meaningful research while there, and his subsequent views on managing a psychiatric hospital did come to incorporate some of White’s views. Friedman argues that Will Menninger relied mostly upon the Freudian model, European institutions, and the psychobiology of Meyer when developing what he viewed as the non-negotiable scientific basis for the asylum. Friedman, however, also points out that Menninger, like White, was focused on adaptation, and that, similar to White, Menninger held the view that “drive displacement skills” had to be incorporated in the design of the hospital and in the treatment of patients.<sup>28</sup> The Menninger Clinic showed many of the similarities found at St. Elizabeths, including a library, amateur theater productions, a beauty parlor and a hospital bulletin. There is not enough evidence to show that these features can be attributed directly to White, although it is clear that the Menningers regarded St. Elizabeths highly, as evidenced in part by Will Menninger’s positive experience there.

Both David Tanner and Matthew Gambino regard White as “eminent,”<sup>29</sup> although Gambino argues that White’s prominence in the field was not only a positive contribution, but in fact contributed to the pathologization of the African American patients who were resident in his institution, and by extension then, the pathologization

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<sup>27</sup> Friedman, *Menninger*, 54.

<sup>28</sup> Friedman, *Menninger*, 65.

<sup>29</sup> Tanner, *Symbols of Conduct*, 128.

of this racial group within the broader field of psychiatry.<sup>30</sup> Barbara Sicherman is the only author who describes White as “inspiring” and at the forefront of a new type of psychiatry characterized by enthusiasm for the scientific method to study and treat maladies of the mind. Sicherman also makes the important point that, while White was prominent, his contributions have been underestimated in the clinical sense; however, she does not address this deficit in any detail.<sup>31</sup> Indeed, there is a notable contrast between White’s productive life and career, and the dearth of historiographic analysis of the significant clinical contributions that he made to the field of psychiatry, and the evolution of psychoanalysis, during the first half of the twentieth century in the United States.

While the history of psychoanalysis and psychiatry in America has been written, White’s often-conspicuous absence from the historiography of psychoanalysis, or at most, the brevity with which he is mentioned in the history of psychiatry, can further inform the history of the evolution of these disciplines during the early twentieth century. When White’s role within psychoanalysis is acknowledged, it is mostly within the frame of White as “popularizer” of psychoanalysis. This depiction of White can be viewed at most as a tepid acknowledgement of his place in history. It also contains within it a veiled criticism, namely that, while White did contribute to solidifying psychoanalysis as an intellectual discipline and treatment in the United States, he was not a sophisticated thinker, and did not engage much with clinical case material, but rather was someone who merely promoted the original ideas of others. I argue that

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<sup>30</sup> Matthew Gambino, “‘These Strangers within Our Gates’: Race, Psychiatry and Mental Illness among Black Americans at St Elizabeths Hospital in Washington, DC, 1900–40,” *History of Psychiatry* 19, no. 76, pt. 4 (December 2008): 387–408.

<sup>31</sup> Barbara Sicherman, “The New Psychiatry: Medical and Behavioral Science, 1895–1921,” in *American Psychoanalysis, Origins and Development: The Adolf Meyer Seminars*, ed. Jacques Quen and Eric T Carlson (New York: Brunner Mazel, 1978), 20–38.

White's contributions to psychoanalysis are to be found not only in his voluminous writings, or in the numerous popular press articles that he was featured in. A significant part of White's legacy can be located within the confines of the St. Elizabeths asylum, and can be traced within patient files, grand rounds, internal case conceptualizations, and in the work of the psychiatric residents, nursing staff, and psychologists who were trained by him.

While there is often overlap between the practice of psychiatry and the methods of psychoanalysis during this time period, these disciplines have treated White's contributions differently. The historiography of psychiatry appears to be more inclusive of White's contributions than the historiography of psychoanalysis. With regard to the development of psychoanalysis in particular, understanding how and why one of the main proponents of the analytic method—the first physician to introduce psychoanalysis to the American hospital, infusing St. Elizabeths with an atmosphere described by Bernard Glueck, one of the physicians there, as “charged with psychoanalytic enthusiasm”<sup>32</sup>—has been minimized by the analytic movement itself, is essential in order to understand the history of psychoanalysis more fully.

The first significant work on the history of psychoanalysis that includes White in some detail is the first volume of Nathan Hale's *Freud and the Americans*.<sup>33</sup> Hale's analysis of the importance of Boris Sidis's influence upon White's early formation as a psychiatrist and psychoanalytic thinker is particularly valuable, and Hale effectively locates the philosophical influences, such as a Bergsonian faith in the Progressive Era,

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<sup>32</sup> “St. Elizabeths Hospital Centennial Celebration,” *The New England Journal of Medicine* 281, no. 20 (November 13, 1969): 1129.

<sup>33</sup> Hale, *Freud and the Americans*, vol. 1, 23.

American Pragmatism, and Spencerian principles,<sup>34</sup> in White's approach to the human mind and body. Hale furthermore examines the influence of Carl Jung's theories, Freudian thought, and the collaboration with Jelliffe to illustrate how White's holistic thinking and views on psychobiology evolved. Hale's account of White is, however, only one aspect of a much larger analysis of Freud's encounter with the Americans. Accordingly, Hale is not able to examine how these theories and philosophical influences translated into White's understanding of patients, except to offer an early case of hypnosis undertaken in collaboration with Sidis. In large part, Hale's analysis of White's work is more within the realm of social history, and, while this is an invaluable contribution, I instead emphasize that which is missing from Hale's account, namely the clinical application and utility of White's theories to the mentally ill at St. Elizabeths.

In 1976, D'Amore published one of the most detailed, and personal, portraits of White in a short chapter [[in what work?]]. By utilizing a few carefully chosen excerpts from White's correspondence, D'Amore makes the case for White as a psychoanalytic thinker and proponent of psychoanalysis, and by citing White's academic contributions he provides a brief sketch of the evolution of his career as a psychoanalytically informed psychiatrist. D'Amore refers to White, quite accurately, as a "pioneer psychoanalyst" in the title of his paper and describes the political struggles within the early-twentieth-century analytic landscape, including White's interactions with Jung, Freud, Sidis and Sullivan.<sup>35</sup> In one subsection, the author discusses the personal characteristics and character that enabled White to function as a psychoanalyst. While this sounds promising, D'Amore's analysis relies principally upon White's rather bland

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<sup>34</sup> In his autobiography, White describes how he first read Spencer's *Factors of Organic Evolution* at age 13, feeling particularly drawn to his views on evolution. White, *William Alanson White*, 7.

<sup>35</sup> D'Amore, *William Alanson White: The Washington Years*, 28-34.

autobiography, and the brevity of his paper does not allow for more than a cursory biographical glance, which paves the way for a more detailed historiographic analysis. John Burnham has examined White's place in the rise of psychoanalysis in America in his 1967 monograph titled *Psychoanalysis and American Medicine* wherein he offers brief, albeit important glimpses of White's contributions.<sup>36</sup> Burnham credits White as being the first American to publish a book on psychoanalysis,<sup>37</sup> and, later, he describes White as one of a handful of American psychiatrists who fully understood the place of Freud's Lamarckian determinism in relation to psychoanalytic theory.<sup>38</sup> Despite these important acknowledgements, White disappears within the larger context of the psychoanalytic world described by Burnham.

Burnham extended the scholarship in the history of psychoanalysis and examined this discipline specifically within the Washington-Baltimore environment. Burnham identifies White and Meyer as the two preeminent leaders in the field of psychiatry and credits both for the flourishing of psychoanalysis. He describes St. Elizabeths under White as "a beehive of translational activity,"<sup>39</sup> reflecting White and Jelliffe's commitment to making European psychoanalytic thought accessible to America. Within this context, White emerges as an eclectic, inclusive thinker who contributed to solidifying psychiatry as a profession and advancing psychoanalysis. While providing a solid biographical overview of White's involvement, Burnham's focus on the broader context of mid-Atlantic contributions to the emergence of the analytic

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<sup>36</sup> John C. Burnham, *Psychoanalysis and American Medicine, 1894–1918: Medicine, Science and Culture*, ed. George Klein, Psychological Issues, Vol. 5, No. 4, Monograph 20 (New York: International Universities Press, 1967), 253.

<sup>37</sup> *Ibid.*, 23. Burnham was referring to the following work: William A. White, *Mental Mechanisms* (University of California Libraries, 1911).

<sup>38</sup> Burnham, *Psychoanalysis and American Medicine, 1894–1918*, 7-241.

<sup>39</sup> Donald Burnham, "Orthodoxy and Eclecticism in Psychoanalysis: The Washington-Baltimore Experience," in Quen and Carlson, *American Psychoanalysis*, 93.

subculture within psychiatry does not allow for more than a cursory sketch of White's thinking.

White is often discussed in relation to a larger context, within which he often quickly fades into relative obscurity. In the 2012 book edited by Burnham, *After Freud Left: A Century of Psychoanalysis in America*, the single time that White is mentioned is in relation to his mentorship of Sullivan.<sup>40</sup> There is little doubt that this volume is a very significant contribution to the history of psychoanalysis in America. Burnham's argument that the scholarship on the evolution of psychoanalysis has often been organized around the ebb and flow of Freudian ideas in American society is especially applicable to the way in which historians of psychoanalysis have treated White. It is therefore somewhat ironic that, once again, White's contributions after Freud departed America remain conspicuously absent.

It is remarkable that the first author of a book on psychoanalysis in the United States, pioneer of the analytic method in the hospital setting, proponent of the application of analytic theory in service of the poor and the incarcerated, and founder and editor of the first English language journal dedicated to psychoanalysis, has become the stepchild in the history of psychoanalysis. Tanner's view that "White's position in the history of American psychoanalysis has been little appreciated" remains true.<sup>41</sup> However, through a thorough analysis of White's clinical contributions found in archival material, I will challenge Tanner's assertion that, with the exception of White's appreciation of personality within the context of early neo-Freudian ego psychology,

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<sup>40</sup> John Burnham, ed., *After Freud Left: A Century of Psychoanalysis in America* (Chicago: University Of Chicago Press, 2012), 61-80.

<sup>41</sup> Tanner, *Symbols of Conduct*, 167.

White has a “shallow understanding” of psychoanalytic theory and technique.<sup>42</sup> Once again, this assumption stems from a heavy reliance upon White’s academic contributions, as opposed to the acknowledgment of his clinical work with patients, his impact upon the medical staff and the institution of St. Elizabeths as a whole, as the measure of his understanding of psychoanalytic theory, psychobiology, and the practice of psychiatry.

Thomas Otto, in a recent work documenting the history of St. Elizabeths, takes an approach similar to that of Millikan, emphasizing White’s administrative prowess and his oversight of the architectural expansion that the hospital underwent during his tenure. Otto describes White as a pragmatist, intimately involved in the minutiae of hospital administration. He does briefly touch upon the superintendent’s concern for patients, emphasizing that White’s ultimate goal in hiring hospital staff was to find individuals with the “education and temperament to take charge of vulnerable patients.”<sup>43</sup> Otto does not, however draw upon the hospital archives to make this point, but instead relies upon an article that appeared in the *Washington Post* in July of 1917 in which White expressed his concerns around this issue.<sup>44</sup>

The historiography on White contains common elements that have contributed to the continued neglect of his contributions. First, his contributions are summarized with an over-reliance upon his academic writing, and a neglect of his clinical influence ‘in the trenches’ of daily life at St. Elizabeths. His analyses of patients’ dreams, or course of treatment, is almost entirely absent from the historiography. Second, White is almost always mentioned as an outsider within the larger landscape of psychoanalysis,

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<sup>42</sup> Ibid., 188.

<sup>43</sup> Otto, “St. Elizabeths Hospital: A History,” 212.

<sup>44</sup> “Nurses at Asylum Ask a Shorter Day,” *The Washington Post*, July 11, 1917, 12.

contrasted with those in Freud's inner circle. In this way, most authors collude with Freud and his followers by marginalizing White, relegating him to the periphery of psychoanalytic thought. White regarded himself as a psychoanalytic thinker. This thesis aims to evaluate his contributions not only as an administrator, but primarily as a psychoanalytic theoretician within the evolution of psychoanalysis against the backdrop of his clinical work, personal reflections, and academic insights.

## **Overview**

In Chapter One I examine the early philosophical, biological, historical and personal factors that laid the groundwork for White's ascension, at age 33, to the powerful position of superintendent of one of the most prominent psychiatric facilities in the United States. I examine the status of psychiatry and of scientific medicine in late nineteenth, and early twentieth century America in order to provide a context for White's evolution as a psychiatrist and clinician. I argue that the antecedents to his views on psychobiology, mental hygiene, and his commitment to fusing psychobiology and psychoanalysis, can be found in his formative years in medical school, during his residency as an ambulatory physician, and under the influence of Boris Sidis, among others, at Binghamton State Hospital. In Chapter Two I examine the significant reforms that White instituted at St. Elizabeths Hospital. These reforms, including the architecture of the hospital, record keeping practices, and new laboratories, laid the foundation for reforms in treatment methods, including the removal of restraints, and the introduction of psychoanalysis. In Chapter Three, I analyze patient records, case consultations, and academic lectures in order to trace the connections between theory and practice. I reconstruct a narrative that shows how White applied his views on

psychobiology, and on the person within societal context, to the patients who resided at St. Elizabeths Hospital. I draw upon primary sources, including autobiographical material, patient records, and private and public correspondence, in order to connect his theory of ‘organism as a whole’ with the practices at St. Elizabeths.<sup>45</sup> I demonstrate how these theories were applied and used as conceptual tools to deal with the Great War, which had a very significant impact on the operations of the hospital. In Chapter Four I examine the intellectual and academic collaboration, and also the very personal relationship between White and Jelliffe. I also examine how psychoanalysts received White’s approach of synthesis, and how this reception affected his legacy. Through a careful review of White’s correspondence and his psychoanalytically oriented scholarly works, I attempt to shed light upon the etiology of the maintenance of the often-contentious relationship between White and the Freudian psychoanalysts. Several factors, including White’s philosophical stance on the origins of mental illness, his eclecticism, views on the fusion of psychobiology and psychoanalysis, and the ways in which the particular brand of psychoanalysis that he introduced in the hospital setting was qualitatively different from psychoanalysis in the private consulting rooms of Vienna, London, and New York, are offered as potential explanations for his exclusion from the Freudian inner circles. Tanner’s argument that White was ostracized in large part because of Freud’s disapproval of White’s willingness to engage with Freud’s rivals, Jung and Adler, and the impact that this in turn had upon the American psychoanalytic community’s willingness to engage with White, will also be explored in this chapter. In Chapter Five, White’s contributions to the criminal justice system are examined; in particular, I will look at how he utilized psychoanalytic theory and the principles of

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<sup>45</sup> On White’s “organism-as-a-whole” theory, see D’Amore, *William Alanson White: The Washington Years*, 17.

mental hygiene to advocate for reform in this area. I conclude this final chapter with an examination of White's legacy, in part through the extensive press coverage that followed his death in 1937.

The frequent characterization of White as meticulous and controlled in work and temperament may have contributed to the minimization of his intellectual and clinical contributions. He was not known as a divisive or messianic figure, and he showed remarkable restraint in a difficult political, funding, and psychoanalytic climate. As administrator of one of the largest and most prominent asylums in the world, White is widely credited for removing the restraints that bound the mentally ill at St. Elizabeths. "White's Restraint" is an attempt to analyze his life and work during the height of his career, namely, his years at St. Elizabeths Hospital, and in doing so, to add to the narrative of psychoanalysis and psychiatry in the United States in the early to mid 20<sup>th</sup> century.

## Chapter 1

### **The Making of a Psychoanalytically Oriented Psychiatrist: Historical, Personal, Biological, and Philosophical Influences**

When William Alanson White was asked to be the keynote speaker at the forty-third opening exercises at Howard University School of Medicine in Washington, DC, in 1910, his instructions to future physicians were as follows:

The real individual does not reside in the bony levers of the skeleton, the delicate contracting fibres of the muscle, the wonderfully intricate and complex functions of the internal organs, but in the wishes, the hopes, the desires, the ambitions, the sorrows and the joys which he experiences, and whether you will or no, you must be physicians of the mind when you deal with him, for, after all, the body is only a means to an end, and the end is a mental one.<sup>1</sup>

White was in the seventh year of his tenure at St. Elizabeths Hospital when he expressed this view of the human person. While his understanding of the nature of mental pathology was refined further over the next twenty-seven years, by 1910, the foundation of his views on psychobiology was well established and continued to form an integral part of his views on the etiology and treatment of pathology. White appears to use the term 'psychobiology' to denote the myriad of ways in which the human mind and body is simultaneously organized at the mental and the biological levels,

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<sup>1</sup> William A. White, "Forty-Third Opening Exercises of the Howard University School of Medicine," *Howard University Journal*, October 7, 1910, 3–4.

functioning as a whole. The ways in which this is expressed varies across pathological states, expressed on an individual level. While White does not use the term 'psychobiology' with regularity, rather writing about the intersection between the mental and the biological, he does use this term in 1921. The attempt to establish what he refers to as a "Philosophy of Psychiatry," in 1921 in *Foundations of Psychiatry*, encompasses what he refers to as the "psycho-biological":

In this work I shall endeavor to set forth these same principles...gathering them together and discussing their biological, psycho-biological, and sociological foundations and ramifications in a general philosophy of the foundation principles which underlie an adequate approach to the problems of psychiatry. This is no less an effort to formulate a *Philosophy of Psychiatry*.<sup>2</sup>

White did not arrive at St. Elizabeths in 1907 fully formed in his views on the etiology, treatment, and interaction between biological and mental pathology, but he had a direction that evolved with increasing complexity over the course of his career.

In this chapter I examine the historical context, personal forces, biological bases forged in the hospital setting, and philosophical influences that contributed to White's formulation of the structure of mental disease. It would be an error to focus solely on the evolution of White's medical training as the primary backdrop to his professional contributions to the fields of psychiatry and psychoanalysis. Such an approach does not

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<sup>2</sup> William Alanson White, *Foundations of Psychiatry* (New York: Nervous and Mental Disease Publishing Company, 1921), 8.

capture his commitment to the doctrine of 'organism-as-a-whole' and would gloss over the complexity of his approach to human nature and psychopathology. The way in which White integrated and utilized these different spheres of influence not only influenced his thought, but also shaped the discipline of psychiatry in the United States, heavily influenced the treatment regimens for the patients at St. Elizabeths, and solidified the discipline of psychoanalysis in the United States. White's relationship with Freud and the New York psychoanalysts was complex, and his views on the end goal of individual analytic treatment diverged from those views held by the private practitioners. Given the intricacy of White's encounter with this group and this theory, I devote Chapter Three exclusively to a detailed analysis of White, the psychoanalysts, and the ways in which he was able to merge theory and practice in the treatment of patients.

There are no existing biographies of White, and by his own admission he did not keep any personal diaries. His autobiography is written in an at times impersonal manner, which leaves the reader with unanswered questions about pivotal moments in his personal and professional development. One such an example of the restraint in his writing involves an incident in which a patient died in front of a full lecture hall. White describes entering the amphitheater at the moment that the diseased patient is carried into the adjoining room, and he observes that the medical students are in a state of stunned silence. He concludes this account by simply stating "I have never forgotten the impression that incident made upon me."<sup>3</sup> Another telling example occurs when White describes visiting the home of his first patient, a child who suffered from diphtheria. He

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<sup>3</sup> White, *William Alanson White*, 8.

arrives at the home and finds crape on the door. He does not elaborate on this experience except to state that “I shall never forget my feelings”.<sup>4</sup> Those who worked directly with him, however, observed his intellect and clinical acumen, and the clinical case files of Record Group 418 further support this alternate view of him. In this chapter, I attempt to identify and reconstruct those influences that provided the foundation for White’s future work at St. Elizabeths, with the caveat that this does not yet complete the narrative.

### **The Historical: 1890–1937**

White was born in the era of Functional Psychiatry. No longer content with a reductionistic approach to the etiology of mental disorder, White and his generation started conceptualizing disease not only in terms of Kraepelin’s classification structure; they increasingly looked towards the interaction between the individual and environmental demands that impinged upon functioning. While Hale argues that there was a “crisis in the somatic style” that paved the way for psychobiology as a medico-philosophical approach, and psychoanalysis as a clinical intervention,<sup>5</sup> not all scholars are in agreement that the shift from the organic to a more all-encompassing understanding constituted a crisis. This ‘crisis,’ as characterized by Hale, holds that disillusionment with the organic theory upon which the conceptualization and treatment methods of mental disorders was based, left a vacuum, enabling psychobiology and psychoanalysis to fill these deficiencies. Eric Caplan, however, dissents from Hale’s analysis, arguing that this constitutes only a small part of the story of the emergence of modern psychotherapy. For Caplan, there was no ‘crisis.’ Caplan

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<sup>4</sup> White, *William Alanson White*, 36.

<sup>5</sup> Hale, *Freud and the Americans*, 43.

argues that cultural forces, and shifts in the legal landscape, including the increasing emphasis on environmental influences, contributed to the shift away from the organic.<sup>6</sup> Influential physicians, most notably Edward Cowles, superintendent at McLean Hospital from 1879 to 1903, became increasingly interested in environmental stressors, such as fatigue, and examined their effect upon the nervous system. Noll and Kendler argue that Cowles can be seen as the founder of biological psychiatry in the United States, and he is credited with establishing the first laboratory in the United States where psychiatric research was conducted.<sup>7</sup> The aim was to attempt to emulate what was viewed as the scientific rigor of the European, and more specifically German, laboratory practices as it pertained to psychiatry. Between 1898 and 1902, Boris Sidis utilized the methods of suggestion and other hypnoid states in his investigations of the subconscious. In doing so, Sidis solidified the role of the psychological as an investigative method.<sup>8</sup> Sidis, a Ukrainian American immigrant, studied under William James at Harvard and was a psychiatrist and founder of the *Journal of Abnormal Psychology*. He was particularly interested in the etiology of psychopathology and investigated the place of evolutionary biology within this context.<sup>9</sup> White was very impressed with Sidis's work and was instantly drawn to the psychological method, in part perhaps because it satisfied his desire to find a method with which to make sense of the most irrational, unreasonable and inexplicable acts and characteristics of the human psyche.<sup>10</sup>

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<sup>6</sup> Eric Caplan, *Mind Games: American Culture and the Birth of Psychotherapy* (Berkeley: University of California Press, 1998).

<sup>7</sup> Richard Noll and Kenneth S. Kendler, "Edward Cowles (1837–1919)," *American Journal of Psychiatry* 173, no. 10 (October 1, 2016): 967–68, <https://doi.org/10.1176/appi.ajp.2016.16060636>.

<sup>8</sup> Boris Sidis and Adam Alonzi, *The Complete Works of Boris Sidis: Volume One*, Alonzi: 2018.

<sup>9</sup> Boris Sidis, *Psychopathological Researches: Studies in Mental Dissociation, with Text Figures and Ten Plates* (1908; repr. London: Forgotten Books, 2015).

<sup>10</sup> White, *William Alanson White*, 7-23.

Any discussion about White will inevitably raise the question about his association with Adolf Meyer, chief psychiatrist at the Phipps Clinic at Johns Hopkins Hospital, who practiced a stone's throw away from White in Baltimore. Meyer, who trained in Zurich under the neuroanatomist and psychiatrist Auguste Forel and, later, under the neurologist Jean-Martin Charcot, operationalized the principles of psychobiology in the treatment of patients at Phipps.<sup>11</sup> While White and Meyer had much in common in terms of their conceptions of mental illness, they also had many differences. While Meyer outright dismissed Sidis's conception of psychopathology as related to neurone theory, White supported Sidis. Both men were committed to psychobiology, yet Meyer viewed it as separate from the analytic method, while White thought that it could, and should, be merged with the theory and practice of psychoanalysis. Both Meyer and White framed mental disease as an 'organism-as-a-whole' phenomenon. Meyer moved American psychiatry further away from a purely humanitarian and somatic approach, instead advancing American functionalism that looked toward heredity and environmental influences.<sup>12</sup> He also strongly advocated for clinical observation as a method, rejected the Kraepelian approach as too reductionistic, and incorporated Williams James's patterns of malfunctioning habits in his conceptualization of dementia praecox. When Meyer presented the possibility of classifying patients not merely on the basis of their diagnosis, but primarily based upon patients' response to adverse environmental influences, it set the stage for discerning the early stages of disease, and to respond accordingly.<sup>13</sup> While there was mutual influence between Meyer and White—for example, Meyer's views on the removal of

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<sup>11</sup> Lamb, *Pathologist of the Mind*, 11-29.

<sup>12</sup> See Roy W. Menninger and John C. Nemiah, *American Psychiatry After World War II (1944–1994)* (Washington, DC: American Psychiatric Press, 2008), 231.

<sup>13</sup> See Hale, *Freud and the Americans*, 111.

restraints at Phipps appear to have been influenced by White's recommendations—they rarely collaborated directly. A recent comprehensive biography on Meyer by S. D. Lamb makes mention of White, very briefly, on only two occasions, affirming the view that they practiced psychiatry in what appears to be separate fiefdoms.<sup>14</sup>

By the early 1900s American psychiatrists had acknowledged the role of early childhood experiences in the formation of the adult character. However, upon Freud's arrival, the American medical landscape was still very hesitant in its engagement with the role of infantile sexuality. While it was acknowledged that children had sexual feelings, the role of this dimension in character formation was viewed as unimportant. Habits and maladaptive responses to the environment remained central within the American moralistic social environment.

By 1907, Meyer had made some progress in terms of advancing a psychological understanding, but the somatic view was still dominant. American neurologists remained skeptical, regarding the analytic method as faddish, lengthy, and overly focused on the role of infantile sexuality. Four years later, however, things had rapidly shifted, and psychoanalysis emerged as a method with which to study the psychological. Freud's conception of the primacy of the psychological at the expense of what is hereditary, put forth between 1893 and 1896, finally found an audience approximately a decade later. Freud's critique of the somatic style was scathing, and his followers joined the chorus of those who viewed this approach as mechanistic and reductionist. With heredity in decline as a method with which to explain pathology, the door was left wide open for the psychological, and more specifically, psychoanalysis, to

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<sup>14</sup> Lamb, *Pathologist of the Mind*, 56-63.

enter as the primary method of inquiry.

White began his work at St. Elizabeths firmly situated within this newfound enthusiasm for “the cause” that permeated American psychiatry. In 1909, he wrote enthusiastically about the analytic method, expressing the hope that it would provide a new and coherent way of making sense of the mind. By 1914, when attending the Annual Meeting of the American Medico-Psychological Association, he had retained this initial enthusiasm, although it is clear that he had not yet found the analytic method to provide all the answers he was seeking. In an impassioned defense of the theory of psychoanalysis, he stated:

I have no doubt that many hypotheses will be laughed at in years to come as being in fault, perhaps some of them ridiculous, but what we want is their correction at this point; we want more light; we want more truth...<sup>15</sup>

The same year that White offered this defense of psychoanalysis, he wrote a letter to the Karolinski Institute in Stockholm, nominating Freud for a Nobel Prize in Physiology and Medicine.<sup>16</sup> It wasn't long, however, before White's willingness to incorporate Jung's and Adler's theories relegated him to the very edges of the Freudian circles in New York and Vienna. His eclecticism, refusal to adhere to the supremacy of intrapsychic dynamics at the expense of environmental influences, and his belief in the greater goal of the social utility of psychoanalysis, rendered White an antagonist of Freud and, by proxy, of his followers. His relationship with Freud remained problematic throughout his life, despite Jelliffe's attempts at mediation.

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<sup>15</sup> D'Amore, *William Alanson White: The Washington Years*, 71.

<sup>16</sup> Letter from W. A. White to Karolinsky Institute, Personal Correspondence. RG 418, NA.

Between 1909 and 1917, the discrepancies between Puritanical views and progressive views around sexuality were increasingly evident. White expressed his views more indirectly through the language of science and psychobiology. His approach was restrained, still focused on the idea of the civilizing mission, and mostly framed in terms of the language of psychiatry. White de-sexualized the libido theory, instead utilizing a Jungian approach that was more generally focused on life force and biologically based energy.<sup>17</sup> In doing so, he made his methodology more palatable to the world of psychiatry, and less so to the classical analysts. His approach therefore held a wider appeal to medical men, also those outside the field of psychoanalysis. It is important to consider that it was perhaps precisely this departure from classical theory that allowed for the analytic method to become a part of the fabric of the hospital treatment setting. When White died in 1937, psychoanalytically informed psychiatry was firmly ensconced at the largest asylum in the United States.

### **The Personal**

An examination of archival material shows that White possessed good organizational abilities and a conscientious work ethic that contributed to his success as an administrator. This history is acknowledged.<sup>18</sup> White's history as a clinician is not, however, well known. His analytical ability to observe and make sense of psychopathology and the human condition, expressed in a humanitarian and measured style is evident from the way in which he engages with clinical case material, both his own, and with the cases treated by others. Chapter Three provides ample illustrations of the way in which White is in dialogue with case conceptualization, and the associated

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<sup>17</sup> Tanner, *Symbols of Conduct*.

<sup>18</sup> Otto, "St. Elizabeths Hospital: A History," 32.

psychoanalytic theoretical concepts. His personal background provided the foundation for his ability to be both obsessively organized, yet simultaneously humanely engaged.

White cites his Anglo-Saxon Puritanical upbringing as a major influence in what he refers to as his “streak of hyperconscientiousness,”<sup>19</sup> which he retained throughout his life. At times, this attribute culminated in what can be viewed as excessive attention to mundane details. In his personal papers, White’s correspondence contains numerous letters to cobblers, to Jelliffe, to his wife’s tailor, to a furrier, and to a medical society concerning small amounts of money or minor disagreements. He prided himself on being astute in financial and administrative matters. This, however, became a liability for White when he attempted to manage matters that were more academic, for example, with the *Outlines of Psychiatry* text that he jointly oversaw with Jelliffe, in what was perceived as an overly mercantile manner.<sup>20</sup> Tanner argues that White’s commercialism and penchant for control did not have an immediate impact upon the quality of the scholarship in the *Psychoanalytic Review*, or in *Outlines*.<sup>21</sup> By the late 1920s, however, this approach did start to affect the quality of these publications, as his overly principled management style, penchant for control, and unwillingness to engage more freely with classical Freudian theory made it difficult for these journals to remain current with the latest developments in psychoanalytic thought.

The features of what can be characterized as an obsessional personality organization can be located in his early years. In his autobiography he refers in some detail to an eccentric attachment to his grandfather’s clock, which he came to own as an

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<sup>19</sup> White, *William Alanson White*, 13.

<sup>20</sup> William A. White, *Outlines of Psychiatry* (New York: Nervous and Mental Disease Publishing Company, 1907), <http://archive.org/details/outlinesofpsychi00whit>.

<sup>21</sup> Tanner, *Symbols of Conduct*, 132.

adult. He describes the constant awareness of the seconds ticking off through the metered pendulum, stating “I have listened to this clock all my life.”<sup>22</sup> White was not unaware of these character traits. He attributes his preference for order and linearity, in part, to being raised in Brooklyn, where the layout of the streets is either parallel or at right angles in relation to the river. He admits that when this spatial organization is not followed in other cities, he feels disoriented. This capacity for order was perhaps particularly useful when he was confronted with the recesses of the minds of the insane. White’s case descriptions, which I will analyze in more detail in Chapter Three, are characterized by the ability to identify recurring patterns within chaotic mental content. His capacity to identify the ways in which the experiences of the insane make sense within their unique inner world, and in turn within the realm of their external environmentally based reality, contributed to the fusion of psychoanalytic theory with the realms of social and the biological.

White’s predilection for order and capacity for compassion came together in his practice to answer, without exception, every letter that he received from any person suffering from a mental disease. The author of such a letter need not have been a current or past patient of St. Elizabeths for White to send a reply. He expresses this duality of thought in his autobiography when he states that answering the multitude of these particular types of letters that he received was not only a matter of duty. He reflects upon this type of personal correspondence as follows:

It would be impossible for me, receiving a letter which recounts years of great suffering and sorrow, to throw such a communication into the

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<sup>22</sup> White, *William Alanson White*, 9.

wastebasket just because it is obviously written by a person of deranged mind. I have always felt that wails of human anguish of this sort should be answered and that an attempt, at least, should be made to be helpful in the answer.<sup>23</sup>

There is much evidence from White's autobiography, patient case files, and testimonies from his peers that he was deeply sympathetic toward the unquiet minds that he encountered. Until the end of his life, he retained a strong humanitarian bent that defined his life's work.

#### *The conscientious humanitarian*

White was born on January 24, 1870, in Brooklyn, New York. He lived almost exactly half of his life within one century, and half in the next. In his autobiography, White expresses an awareness of how his life had straddled the nineteenth and twentieth centuries, forcing him to consider both the accepted principle of determinism that marked the century of his birth, and the inadequacy with which the following century viewed this concept.<sup>24</sup>

White was aware that his parents were from different social classes, and, while he states that this was never talked about at home, he refers to this circumstance as a significant yet silent feature in his upbringing. He was exposed to both the more pragmatic aspects of current affairs, such as business and politics often discussed by his father, and what he refers to as the "more intellectual and artistic aspects of life" that

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<sup>23</sup> White, *William Alanson White*, 273.

<sup>24</sup> *Ibid.*, 25.

interested his mother.<sup>25</sup> In his autobiography, White expresses that he felt more drawn to the latter. His only other sibling, a brother ten years his senior, became a successful businessman. There were no other physicians on either side of his family. As a result of the age difference between White and his brother, he came to regard himself as an only child, and he consequently had to look outside of his family for peer relationships.

White found a significant friendship in the three sons of Dr. Jarvis S. Wight, who was a professor of surgery at the Long Island College Hospital and Medical College. His association with this family represented a significant influence in the formation of his future professional identity, ultimately enabling him to complete his medical training.<sup>26</sup>

#### *The biological as personal*

White's childhood was filled with the sights and sounds of the general hospital. The combination of living half a block away from the hospital and having three childhood friends whose father was a surgeon spurred what he describes as a lifelong curiosity about the human body. From a very young age the boys would chase the blaring ambulance through the street, guessing at the condition of the occupant. Other rather macabre pastimes involved observing blood-soaked straw mattresses being dragged into the hospital courtyard and set alight, or scaling walls and peering through windows in attempts to get a glimpse of the surgery rooms. White was most likely one of few children in the United States who was permitted to observe surgeries in a hospital. During the summer months he spent significant amounts of time in the dissection rooms of the medical college. This constituted an early and informal education in anatomy. He credits the combination of his own curiosity and initiative,

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<sup>25</sup> Ibid., 27.

<sup>26</sup> Ibid., 27.

and his relationships with others, in particular with the Wight boys, the doctors, the hospital janitor affectionately known as “Old Billy,” and his closest friend and fellow future medical student, Frank L. Washburn, as positive influences that enabled him to pursue his interests. The benignly neglectful parenting style that White alludes to in his writing is not described with resentment. He seems to interpret this hands-off approach taken by his parents as a communication that encouraged his independence, and also a clear message that he was to be a self-made man.<sup>27</sup>

At age 15, White took matters into his own hands when he gained admission to Cornell University by lying about his age. The minimum age for applications was 16 years, but out of fear that he would not have another scholarship-based opportunity to receive an education, White stated his age as 17 years old on the application. He takes a pragmatic approach to what he refers to as a “moral delinquency,”<sup>28</sup> framing it as a necessity in light of his family’s poor financial circumstances. Washburn had drawn his attention to scholarships available to those residing in Brooklyn, and White passed the entrance examination. Having had no formal college preparation in the Brooklyn schools, White failed the algebra portion of the entrance examination numerous times. When he arrived in Ithaca the following Fall, he describes himself as woefully underprepared for a college education, “almost frightened” and “very homesick.”<sup>29</sup> White was, however, able to navigate challenging personal and financial circumstances, and his education in embryology, histology, and anatomy was now underway. His dire financial circumstances contributed to his acceptance of the position of laboratory assistant under Professor Wilder, who was the head of the Physiology Department.

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<sup>27</sup> Ibid.

<sup>28</sup> Ibid., 21.

<sup>29</sup> Ibid., 27.

Despite the density of training in physiology and anatomy, White characterizes his early interests as “psychological.”<sup>30</sup> He completed courses in physiological psychology and general psychology alongside the more traditional courses in biology and physiology, but he remained primarily interested in issues of character. This interest remained when White re-entered, this time as a medical student, the place where he had spent many of his childhood days: The Long Island College Hospital Medical School.

### *Medical school*

White continued to solidify and integrate biological bases with his psychological interests during his years in medical school. By this time, his parents had lost his childhood home through foreclosure proceedings, and he took lodgings with the father of his childhood friends, Dr. Wight. Wight, through his academic position in the surgery division, was able to arrange for a reduced tuition rate, and also included him as a surgery assistant whenever possible. White writes that he suspects he was often not needed in the surgery room, but his well-off proprietor remunerated him in order for White to make ends meet. Once again, as had his laboratory work at Cornell, White’s impoverished background resulted in increased exposure to the physiological and anatomical aspects of medicine.

Despite the theoretical and practical immersion in the physiological, White never lost sight of the human elements within the practice of medicine. The centrality of this approach is expressed clearly in his autobiography when he states:

The practice of medicine is filled with drama. The human story in all its

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<sup>30</sup> Ibid., 28.

ramifications is interesting beyond comparison with anything else...I am sure that it was a very large factor in attracting me to medicine in the first place.<sup>31</sup>

White not only credits the “human story in all its ramifications” as one of main reasons that he elected to study medicine, but he also cites this as a primary reason for his sustained interest in this discipline throughout his life. He was particularly interested in the only course on nervous and mental diseases offered in medical school. Despite a paucity of exposure to the burgeoning discipline of psychiatry,<sup>32</sup> he remained attuned to the varying degrees and permutations of human suffering throughout his training.

His first clinical position upon graduation was as an ambulance surgeon for the Eastern District Hospital of Brooklyn. He writes about this placement with ambivalence, describing it as a rich training experience simultaneously filled with tragedy and suffering, and occasional humorous occurrences. In one of the more revealing statements in his autobiography, White admits that “I seem to remember very little of the humor and most of the tragedy.”<sup>33</sup> White’s next clinical position was as a physician who tended to the residents of an almshouse at the Alms and Workhouse Hospital on Blackwell’s Island. Here he encountered what he describes as humanity in the most desperate set of circumstances. Countless of his patients died, mostly anonymous, always destitute. This experience left White feeling quite despondent:

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<sup>31</sup> White, *William Alanson White*, 33.

<sup>32</sup> *Ibid.*, 35.

<sup>33</sup> *Ibid.*, 41.

They came without medical history...except the merest outline as to name, age, etc., on the card that accompanied them. One can hardly imagine a richer museum of pathological material in living patients or a sadder well of despondency and dejection and hopelessness.<sup>34</sup>

It is not clear how long White remained on Blackwell's Island. He states that he did not stay in this position for very long, and that he elected to leave because he did not receive adequate supervision. Based upon his recollections of what he experienced in this position, it is not unreasonable to consider the possibility that the plight of the patients with whom he worked hastened his departure. He next found himself back at the Long Island College Hospital as an intern, and he recalls this training experience with a sense of gratitude and enthusiasm. It also marks the formal beginning of White's trajectory as a psychiatrist, as he completed courses in philosophy and psychology. When a position opened up at Binghampton State Hospital, White applied, despite not having had any background in the discipline of psychiatry. He remained at Binghampton hospital from April of 1892 until his departure for St. Elizabeths in 1903.<sup>35</sup>

#### *Binghampton: 1892–1903*

White describes a sense of bewilderment when he arrived at Binghampton. The paucity of his psychiatric training quickly became very apparent to him. He felt so out of his depth that he describes his initial observations as not dissimilar to what any layman would observe in a psychiatric hospital. While at Binghampton he again describes being acutely aware of the maladies of human existence, and he gives voice to his misgivings

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<sup>34</sup> White, *William Alanson White*, 42.

<sup>35</sup> D'Amore, *William Alanson White: The Washington Years*, 2-15.

about the role of civilized society in the treatment of “worlds of unfortunates, people again who were crushed by forces over which they had no control.”<sup>36</sup> White appeared to question the ways in which modern society was complicit in the anguish and suffering that he observed around him. At one point in his autobiography he quite skeptically opines that the patients in large institutional settings are rendered “human material that had been cast aside by the machinery of so-called civilization and progress.”<sup>37</sup>

At this point in his career, White viewed the large asylums at the turn of the century as ill equipped to address mental afflictions. During the first four years at Binghampton, he lamented what he viewed as an overly simplistic approach to psychiatry in state institutions. For White, part of the problem was an unsophisticated classification system of categorizing psychiatric conditions, a system that failed to identify appropriate treatments. In 1896, when Kraepelin introduced the clinical method of classification as a counter to the symptomatic method that had preceded it, White embraced this view. He thought that the practice of psychiatry, and most especially the way in which patients could be understood and treated, had finally begun to acquire the complexity and nuanced approach that had been absent. Throughout his life, White remained ambivalent about the symptom-based classification of mental disease. In his otherwise measured autobiography, he forcefully critiques the misuse of the classification of mental disease as follows:

Giving something a name seems to have a deadening influence upon all our relations to it. It brings matters to finality. Nothing further needs to be done. The disease has been identified. The necessity for further

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<sup>36</sup> White, *William Alanson White*, 47.

<sup>37</sup> *Ibid.*, 51.

understanding of it has ceased to exist. And so classification, then as now, had a sterilizing effect upon further inquiries into the significance and origin of symptoms.<sup>38</sup>

One of the most significant encounters of White's career occurred when he travelled from Binghamton to New York to visit the Pathological Institute of the New York State Hospitals. Here he met Boris Sidis, who, at the time, was researching the phenomenon of multiple personality through the method of "hypnoidization."<sup>39</sup> White credits his encounter with Sidis as the catalyst for his assigning meaning to symptoms, and in turn for his understanding of symptoms as being rooted in past experience. He viewed his work in hypnosis with Sidis as a window that allowed him access to parts of the human mind that were previously inaccessible. White had now found a way to make sense of even the most perplexing symptoms, and it confirmed for him that all human behavior had an antecedent that could be identified and understood. "Hypnoidization" in White's view, therefore becomes wholly compatible with Spencerian philosophy. In his autobiography, White acknowledges that, in hindsight, although he was not able to articulate this association between the psychological technique of hypnosis and his views on determinism, he subsequently came to understand the degree to which he had in fact made this connection, concluding that

every mental fact had its adequate causal antecedents and, even if I did not appreciate it at the time, [I] based my conduct upon a philosophy of

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<sup>38</sup> White, *William Alanson White*, 54.

<sup>39</sup> *Ibid.*, 64.

psychological determinism.<sup>40</sup>

White was thus able to reconcile the biological, in the form of a Spencerian view of the nervous system, within the context of the emotional, utilizing Mercier's classification of feelings.<sup>41</sup> Mercier was primarily interested in the classification of emotions, and did not emphasize the origins of these feelings. Emotions were a subset of feelings, which in turn encompassed all emotional states. Mercier's theory was, in essence, cognitive. His assertion that the proclivity of an emotion is dependent upon how the relationship between the organism and the environment is cognized, provided further support for White's burgeoning views on psychobiology.<sup>42</sup> White's attachment to psychobiology remained until the end of his life. A year prior to his death he recalled how it was the country doctor who, through his knowledge of the local families, could be viewed as an inadvertent advocate for psychobiology. During his rounds in the community surrounding Binghampton, White was struck by how the local physician held a holistic view of his patients that combined issues of temperament, family circumstance, and physical illness.<sup>43</sup>

In his autobiography, White notes with some relief that mid-twentieth-century psychiatry returns to the conception of 'organism-as-a-whole,' emphasizing the psychological aspects of illness, the personality components that are involved, and the mental symptoms that accompany bodily symptoms. White remained adamantly convinced of the place of psychobiology, because it denotes the whole being as larger

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<sup>40</sup> White, *William Alanson White*, 77.

<sup>41</sup> Charles Mercier, "A Classification of Feelings," *Mind* 10, no. 37 (1885): 1–26.

<sup>42</sup> Mercier, "A Classification of Feelings," 24.

<sup>43</sup> White, *William Alanson White*, 260.

than the sum of its parts, and he emphasizes that the parts can never be seen as separate from the whole. While the physician may momentarily, and by necessity, focus on alternately “the physical, the physiochemical, the physiological, the chemical, the anatomical, the psychological,”<sup>44</sup> that which is mental and that which is bodily cannot be placed into separate categories. Offering further evidence for this holistic view, White cited Jennings’s work on genes that emphasizes the overall impact on the organism, and also Coghill’s research on bodily reflexes in support of his view of the supremacy of psychobiology.<sup>45</sup> White and Meyer both envisioned an approach to psychiatry that embodied an amalgam of the principles of psychobiology and this holistic view of human functioning. Psychoanalysis and mental hygiene became natural allies in White’s conception, and his position at St. Elizabeths provided the ideal setting within which to fuse and put into practice the principles exemplified by these approaches.

*Washington, DC, and St. Elizabeths Hospital: 1903–1937*

White was a pragmatist and a problem solver. These attributes may in part explain why he was appointed as superintendent of the largest government hospital in the United States at age 33. Roosevelt’s faith in White does not appear to have been misplaced. In 1903 when White began his tenure at St. Elizabeths, the hospital housed approximately 2,300 patients under less than perfect circumstances. By 1937, the final year under his governance, St. Elizabeths housed 6,000 patients under more modernized circumstances than when he first arrived.<sup>46</sup> White’s early years at St. Elizabeths arguably solidified his role as administrator and public figure to a much

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<sup>44</sup> Ibid., 265.

<sup>45</sup> Tanner, *Symbols of Conduct*, 114.

<sup>46</sup> Frank Rives Millikan, *Wards of the Nation: The Making of St. Elizabeths Hospital, 1852–1920* (Washington, D.C., The George Washington University, 1990).

greater extent than it did his identity as a psychiatrist and psychoanalyst. The thirty-three well-publicized congressional hearings in which White testified were front-page news on numerous occasions, as was his testimony in the highly publicized Loeb trial, explored in more depth in Chapter Five. White appears to have found these experiences immensely stressful. He indicates in his biography that he felt weighed down by the potential that these events had to destroy his career as a psychiatrist, had the outcomes been different.<sup>47</sup> An unintended consequence of White's public persona was that he was not viewed as a serious player in the inner psychoanalytic circles of New York and Washington. This is ironic, for, arguably, White utilized the principles of psychoanalysis and psychobiology to relieve human suffering for thousands of patients, as opposed to the much smaller numbers treated in the private consulting rooms of Manhattan and Washington, DC.

White's methods of putting into practice the principles of psychobiology are especially relevant within the hospital setting. His understanding of how psychiatry and psychoanalysis are intimately connected to psychobiology can in part be located within the reforms that he instituted at St. Elizabeths. These reforms were detailed and extensive and provide an important window through which to observe White, and the principles of psychiatry to which he adhered in action. Bruno Latour's notion of "Science in the Making" is of import here: Latour's emphasis on the importance of tracking, in this instance, the evolution of psychiatric practice in 'real historic time' provides a mechanism with which to revisit the narrative of American psychiatry and psychoanalysis. When we deconstruct White's practice and writing, his refusal to focus

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<sup>47</sup> White, *William Alanson White*, 28-31.

almost exclusively on the intrapsychic, as would have been the case with classical theory, shows that he could have gone in a very different direction with the reforms at St. Elizabeths. He instead chose a path of scientific discovery that was, in many ways, akin to Latour's black box. The input of psychoanalytic psychotherapy, the removal of restraints, the experimentation with hydrotherapy, occupational therapy, and malarial therapy had never before been attempted in the United States on the scale that it was instituted at St. Elizabeths. The eventual output was not known until these reforms were attempted in real time. The practice of psychiatry and the role of psychoanalysis in the hospital therefore evolved alongside White's reforms. It is, accordingly, important to look closely at what these reforms entailed from both an organizational and a clinical perspective.<sup>48</sup>

### *The Reforms at St. Elizabeths*

One of White's first encounters with the less than optimal conditions at St. Elizabeths hospital occurred when he found four hundred patients sleeping on straw mattresses, overseen by night watchmen with glowing, flammable lanterns.<sup>49</sup> He immediately took action to change this situation. While his administrative prowess is not the principal focus of this discussion, White was, by all accounts, a gifted hospital administrator. Ironically, his success in this role contributed to his being pigeonholed by some in the psychoanalytic community as a very capable proprietor of a large institution, as opposed to an insightful thinker.

One of the most dramatic changes that White made early on during his tenure at St. Elizabeths was to free patients from physical restraints. In one particularly poignant

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<sup>48</sup> Latour, *Science in Action*, 7-9.

<sup>49</sup> White, *William Alanson White*, 23.

example, he recounts how he came upon a restraint device known as a “bed saddle.”<sup>50</sup> He found the device to be so cruel and inhumane that he ordered the hospital staff to refrain from ever using it again. He felt strongly that physical restraint was generally unnecessary, and this view extended also to chemical restraints. Although he did not entirely abolish the use of restraints at St. Elizabeths, he all but eliminated this practice. White viewed the use of restraints as a management tool as cruel and thoughtless, and, in this vein, he was profoundly affected by the mental hygiene movement that was spearheaded by Clifford Beers in 1909. White became a Board Member of the National Committee for Mental Hygiene, and when this organization published the first edition of its flagship journal, *Mental Hygiene*, White authored an article outlining the principles of this movement.<sup>51</sup>

White held the view that the human mind was far too complex to be responded to through the rudimentary methods of restraint. In an attempt to study additional treatment methods and refine existing protocols, he visited asylums in Europe for five consecutive summers. While he concluded that there was a universality of experience in how human beings experience mental disease, he quickly realized that there is not necessarily universality in treatment methods. Two aspects of European institutional psychiatry particularly impressed White. The first important feature that stood out for him was the humanitarian family- and community-based approach to treating the insane. While White realized that the United States, with its large immigrant population and geographic challenges, did not lend itself as comfortably to such a model, he nonetheless retained the compassionate and inclusive aspects of caring for patients in

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<sup>50</sup> The bed saddle was a restraint device used in nineteenth- and twentieth-century asylums. Patients would be secured to a bed with thin strips of metal in a crucifixion position.

<sup>51</sup> William Alanson White, “Underlying Concepts in Mental Hygiene,” *Mental Hygiene* 1, no. 1 (1917): 41.

this manner. Second, he was impressed with the emphasis on scientific research. In his autobiography he grapples with how to combine the European emphasis on scientific research with what he viewed as the American emphasis on patient care:

To my mind the chief distinction between the hospitals on the Continent and those of this country are [sic] that the European hospitals exert their efforts primarily along the lines of scientific advancement, with the American institutions exert their efforts primarily in the care of the patient. In the former instance if one or the other must suffer it is the care of the patient, in the latter instance, scientific research work.<sup>52</sup>

White did not view these aims as mutually exclusive. Modeled upon the European approach, St. Elizabeths soon became a hub of scientific and scholarly activity. Within a decade this institution became one of the most important research centers for the field of psychiatry and, by proxy, for psychobiology in the United States. Research articles poured out of St. Elizabeths and were widely disseminated. In 1905, shortly after his arrival, the staff of St. Elizabeths had published thirteen articles. Three years later, White established the *Bulletin of St. Elizabeths Hospital* in order to propagate scientific ideas both inside and outside the confines of the hospital. By 1912, approximately fifty articles per year were being published by hospital staff.<sup>53</sup>

White also oversaw the opening of the Psychological Laboratory, trained medical military personnel, and established a Department of Internal Medicine, widely regarded as the first such department in the country. In terms of patient care, his goal was to

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<sup>52</sup> White, *William Alanson White*, 95.

<sup>53</sup> Millikan, *Wards of the Nation*, 32.

transform St. Elizabeths into a model institution by training his staff in the scientific method, which in turn would ensure high standards of patient care firmly situated within the humanitarian template. White instituted an approach that he referred to as “social therapeutics.” He believed that part of the cure for mental maladies was to re-engage with the social world. He introduced team sports such as baseball, offered movie screenings, music, social events, and plays.<sup>54</sup> The role of the physical body in mental functioning was further solidified through the collaborative presence of the Red Cross on the grounds of the hospital. An athletic director coordinated sports for patients, for example, calisthenics, baseball, and basketball. The importance of athletic activity is reflected in the Annual Reports. For example, in 1920, the athletic director had arranged 109 activities related to physical activities for patients, and tickets to major sporting events such as football and baseball games were routinely made available to patients to enhance overall well-being.<sup>55</sup> In what harks back to the underlying principles of moral treatment of the nineteenth century, White introduced a beauty parlor, as he believed that it would benefit the female patients psychologically. His aim was to create a more egalitarian sense for patients relative to the world outside the asylum walls. In his autobiography, the strength of his conviction about the curative effect of outward appearance, self-esteem, and psychological recovery is expressed in no uncertain terms. He articulates a holistic view of the complexities involved in illness and recovery, merging the environmental and the psychological:

In all these little ways her personality is preserved where before it was annihilated. These things may not seem to be important at first but they

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<sup>54</sup> Otto, “St. Elizabeths Hospital: A History,” 32.

<sup>55</sup> Saint Elizabeths Hospital (Washington D.C.), *Annual Report of the St. Elizabeths Hospital to the Secretary of the Interior* (U.S. Government Printing Office, 1920).

are of tremendous importance at some time in the course of the illness...These little things cost almost nothing in a great big institution where the top cost is spread over thousands of patients, and they mean everything.<sup>56</sup>

In 1919, White granted the Occupational Therapy department formal status at St. Elizabeths. Occupational therapists worked alongside psychotherapists in the wards, indicative of White's 'organism-as-a-whole' approach. While there can be little doubt about the fiscal advantages to be had from hundreds of patients working, and selling products that they created, White regarded generative activity as necessary for psychological recovery. Patients engaged in woodwork, gardening, tying hammocks, sewing and weaving baskets, and making toys, among other activities. As much as White believed in the utility and strength of the principles of psychoanalysis, and in the value of science and biology, he did not regard these approaches as sufficient in treating patients. White considered the activities that were directed by occupational therapy as essential to creating a curative environment and as having "distinct therapeutic value."<sup>57</sup>

By 1930, the American Medical Association had accredited only one mental hospital in the United States for a rotating internship, and it did so for St. Elizabeths. Despite these progressive scientific and scholarly advances, White was extremely cautious about introducing novel invasive treatment methods that claimed causality between parts of the human body and the etiology for insanity. He viewed lobotomies, the removal of teeth, Cotton's colectomies and sterilization as "mutilating operations"

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<sup>56</sup> White, *William Alanson White*, 111.

<sup>57</sup> Millikan, *Wards of the Nation*, 99-110.

that were unproven and perhaps also ideologically driven.<sup>58</sup> White's skepticism endured throughout his career: one year prior to his death, when Walter Freeman, the main proponent of the psychosurgery method of lobotomy, made a request to perform this procedure at St. Elizabeths, White flatly refused.<sup>59</sup> His first priority always remained "the care of the patient."<sup>60</sup>

White's humanitarian stance towards his patients also found expression in the architecture of the hospital. While an exposition of the specific architectural reforms implemented by White is beyond the scope of this chapter,<sup>61</sup> the humanitarian and psychological bases for these structural reforms are relevant to this discussion. In keeping with his belief that the physical environment had the potential to significantly affect a person's emotional state, White was careful to include these considerations in his lobbying efforts for the expansion of the hospital. He believed that overcrowding was connected to increased suicidality, that architectural variation was "psychologically stimulating" and that patients required some measure of privacy for their healing.<sup>62</sup> He also adhered to the idea of personalizing the patient's immediate environment in the least suppressive way possible. These architectural changes had implications for clinical practice. White was able to group together patients with different diagnoses, and the admissions buildings separated patients not only by gender but also according to the severity of pathology. This meant that more violent newly admitted patients and those with acute presentations could be separated from new admissions who presented as

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<sup>58</sup> Grob, *The Inner World of American Psychiatry*, 112.

<sup>59</sup> Millikan, *Wards of the Nation*, 111-114.

<sup>60</sup> White, *William Alanson White*, 123.

<sup>61</sup> See Otto, "St. Elizabeths Hospital: A History," 34, for a more detailed description of the architectural changes during White's tenure.

<sup>62</sup> Millikan, *Wards of the Nation*, 188.

less severe in symptomatology.<sup>63</sup> This principle of grouping according to pathology and gender also extended to the buildings where patients were housed.<sup>64</sup> The modernization of the architecture of St. Elizabeths therefore also influenced patient care.

Architectural design also influenced how cases were documented. With more physical space at his disposal, White was able to utilize part of this space to house better patient records. When he arrived at St. Elizabeths White found an antiquated and disorganized system of record keeping. Many patient files were incomplete, or impossible to locate. White instituted a card catalog system and employed a dedicated administrator to keep track of both the contents and location of correspondence and clinical records. This new system enabled hospital staff to easily locate patient records, which in turn improved clinical care. He furthermore set out to standardize the way in which hospital staff documented the treatment and progress, or regressions, of the residents at the hospital. The forms that White introduced are representative of his views on psychobiology, and also reflect his efforts to merge the psychoanalytic method with psychobiology. Not only did the forms include details about the ongoing physical and mental condition of patients, but case files now also contained details about the progress and outcome of the analytic method if a patient received this form of treatment. Efforts were made to photograph new patients upon their arrival, and in what was most likely a nod to the centrality of the past in psychoanalysis, every file included personal history that could be employed in case conceptualizations.<sup>65</sup>

In terms of staffing reforms, White appointed a clinical director, who was the personal

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<sup>63</sup> William Alanson White, *Forty Years of Psychiatry* (New York: Nervous and Mental Disease Publishing Company, 1933).

<sup>64</sup> Otto, "St. Elizabeths Hospital: A History," 41.

<sup>65</sup> Otto, "St. Elizabeths Hospital: A History," 44.

representative of the superintendent. Together they served as consultants, especially in complicated clinical cases, and would direct staff to relevant and current literature. On Sunday mornings, when assumedly the frantic pace at the hospital slowed somewhat, White presided over discussions of the latest research papers, often translated from the French and German by White himself. These times were also an opportunity to review and discuss acute admissions, and White or the clinical director would suggest different treatment methods that they may have observed in settings outside of St. Elizabeths.<sup>66</sup> The minutes of these Sunday morning colloquia therefore represent an important source of information relating to how psychobiology and psychoanalytic principles became manifest in the clinical setting.

Another important reform that White instituted was the creation of a scientific department. White's vision was not only that the scientific department would generate research, but also that the medical and the scientific departments would collaborate, and that ultimately this collaboration would lead to more accurate clinical diagnoses.<sup>67</sup> Similar to Meyer at Phipps, White also embraced hydrotherapy as an important treatment. By 1904, it was the most frequently used form of intervention, in large part because White had all but eliminated physical and chemical restraints. When patients were particularly disruptive, violent, or treatment resistant, hydrotherapy took on the form of continuous baths. The numbers of patients undergoing what was regarded as a 'modern' treatment increased exponentially over the following decades. David Shutts reports that by 1924 the warm tub had been used by over 4000 patients approximately

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<sup>66</sup> Millikan, *Wards of the Nation*, 123.

<sup>67</sup> William A. White, "Memorandum to Medical Staff," July 19, 1915, RG. 418, NARA.

106,817 times.<sup>68</sup> While the method of hydrotherapy was widely regarded by the medical community as effective on its own, White was careful to point out that he regarded the additional attention given to patients by hospital staff during the course of these treatments as contributing to the cure.<sup>69</sup>

White's enthusiasm for hydrotherapy and scientific research existed alongside his interest and belief in the efficacy of psychoanalysis as a treatment method. After meeting Carl Jung for the first time at the International Congress for Neurology and Psychiatry in Amsterdam in 1907,<sup>70</sup> (also referred to as the "Amsterdam Congress"), White returned to St. Elizabeths with an increased fervor for the analytic method. Bernard Glueck, a physician who joined the staff in the fall of 1908, described the atmosphere as "charged with psychoanalytic enthusiasm."<sup>71</sup> Two significant additional developments cemented the analytic method at St. Elizabeths in 1914 under White's direction: he established a psychoanalytic society that was based at the hospital, and he founded a new position, that of clinical psychiatrist. The sole responsibility of the first clinical psychiatrist, Dr. Edward Kempf, was to treat patients with psychoanalysis. By 1915, seventy patients received psychoanalytic treatment under Dr. Kempf.<sup>72</sup> The shift from more traditional treatment methods to this 'new' method required some effort. Patients needed to be persuaded that this approach would be beneficial to them. White and Kempf utilized the internal St. Elizabeths publication, *The Sun Dial*, as well as lectures, to expound upon the benefits of engaging in this form of treatment. Despite these early challenges, White remained committed to the method of psychoanalysis, and

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<sup>68</sup> David Shutts, *Lobotomy: Resort to the Knife* (New York: Van Nostrand Reinhold, 1982).

<sup>69</sup> White, *William Alanson White*, 98.

<sup>70</sup> Shamdasani, *Jung and the Making of Modern Psychology*, 189.

<sup>71</sup> Glueck, quoted in Millikan, *Wards of the Nation*, 43.

<sup>72</sup> St. Elizabeths Hospital Annual Report, 1915, RG 418, NA.

by 1920 there were specialized wards throughout the hospital where the emphasis was on psychoanalytically informed psychotherapy as a treatment method.<sup>73</sup> Every ward thus designated was assigned a psychotherapist, who oversaw patient care within this modality, and 12 percent of the residents at St. Elizabeths partook in the talking cure.<sup>74</sup> In Chapter Three, through an examination of patient records, internal lectures, and case conferences, I explore in detail how the analytic method was implemented, and what the outcomes were for the patients and the institution. Alongside the introduction of psychoanalysis in the hospital setting, White never lost his roots in the laboratory. In 1924, the Blackburn Laboratory opened on the east side of the hospital grounds. The primary aim of this modern facility was to employ the principles of anatomy and the scientific method to study the etiology and evolution of mental pathology.<sup>75</sup> White's view that not only could psychobiology and psychoanalysis coexist, they could function in an integrated manner in the clinical setting was thus advanced.

One of the most powerful events in human history, the First World War, occurred during White's years at St. Elizabeths and resulted in additional reforms. Not only did White lose most of his experienced personnel in the draft, but simultaneously approximately two thousand wounded veterans were admitted as patients. The War provided further opportunities for White to put into practice his views on mental hygiene and psychobiology. Perhaps the best example of how he accomplished this was when White convinced the surgeon general of the army that a separate unit for military mental patients was essential in light of the many soldiers who returned from the War

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<sup>73</sup> The number of patients treated with psychoanalysis as opposed to psychoanalytically oriented psychotherapy is not clear. Scholars who have written about the history of St. Elizabeths appear to use these terms interchangeably or avoid making the distinction between these methods.

<sup>74</sup> Millikan, *Wards of the Nation*, 124.

<sup>75</sup> Otto, "St. Elizabeths Hospital: A History," 46.

with psychiatric conditions. White was able to accomplish this, in large part, by utilizing the organizing influence yielded by the National Committee for Mental Hygiene. In his autobiography, he chronicles the establishment of this separate ward for mentally wounded soldiers as one his greatest accomplishments. He felt strongly that this represented a triumph for the field of psychiatry in general and that it solidified psychiatry as a standalone discipline within the larger landscape of medicine. In White's work, *Thoughts of a Psychiatrist on the War and After*,<sup>76</sup> which I will analyze in detail in the Chapter Five, he outlines how the War had influenced his thinking about the interaction between the individual and the social environment, and the responsibility and place of psychiatry in mediating this relationship. After the War, the complexities of caring for war veterans continued, and White was heavily involved in attempts to standardize a protocol of care in hospitals across the country. The war effort increased expenditure at St. Elizabeths enormously, and three more congressional hearings investigating the financial management at St. Elizabeths followed in 1926. After many months of a full-time audit, White's stewardship was found to be beyond reproach. While Tanner writes about White's business-minded and overly controlled approach to administration in a mostly critical manner,<sup>77</sup> I argue that it is precisely this attention to detail that was instrumental in solidifying psychiatry and the principles of psychoanalysis within the United States hospital system. The psychoanalytic method thus found protection within a large system. By this point, the superintendent of St. Elizabeths was a public figure, subject to immense scrutiny. I take the view that it was not only White, but, to a large degree, also the discipline of psychiatry, that survived the

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<sup>76</sup> William Alanson White, *Thoughts of a Psychiatrist on the War and After* (New York : P.B. Hoeber, 1919), <http://archive.org/details/b29817432>.

<sup>77</sup> Tanner, *Symbols of Conduct*, 111-115.

numerous Congressional hearings; and it was the place of psychoanalysis within this frame that prevailed. Had White alienated the Washington establishment and the general public, so too would the practice of psychoanalytic psychiatry have suffered a defeat. This observation is more in line with Harry Stack Sullivan's view that, at that time, White "was American psychiatry."<sup>78</sup> He was also very much an American, rooted in the philosophy of his cultural identity and of his time.

### **Philosophical Influences**

White began his career as a medical man, an adherent to the advances in physiology and pathology and in the laboratory. He also firmly located himself within the philosophy of Spencer, Bergson, and American Pragmatism. His social background primed him to be receptive to these particular philosophical influences and predisposed him to adopt his later views on social justice and the centrality of environmental influences on human behavior. The degree to which White viewed philosophy as an essential component in medical science is obvious when he quotes Hippocrates in his autobiography: "Godlike is the physician who is also a philosopher."<sup>79</sup> He makes the case that "whether we wish it or do not wish it, we all have a philosophy,"<sup>80</sup> and then proceeds to apply the principle of determinism even to this idea when he argues that the development of one's own philosophy is an inevitability.

White revisited the purpose of psychiatry, psychoanalysis and psychoanalytic concepts from a philosophical perspective. When he was 13 years old he read *Factors of Organic Evolution*, by the influential British philosopher, biologist, and political theorist, Herbert

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<sup>78</sup> Harry Stack Sullivan, *Conceptions of Modern Psychiatry: The First William Alanson White Memorial Lectures* (New York: Wm. Alanson White Psychiatric Foundation, 1945), 4.

<sup>79</sup> White, *William Alanson White*, 34.

<sup>80</sup> *Ibid.*, 37.

Spencer.<sup>81</sup> Throughout his career White retained the principles related to the ideal of the progressive development of the individual and society. During his years at Binghamton, White, by his own admission, was very much influenced by Spencerian ideas of evolution. He also credits Spencer's *First Principles* as an enduring and powerful influence on his thinking. Spencer's synthetic philosophy was a dominant force in his constructions of mental life, and he in particular identified the ideas of *evolution* and *energy* as central to the progression of his thinking in this area. The Spencerian notion that science can inform those general laws that govern nature and by extension, then, human nature,<sup>82</sup> appears to have held particular appeal to White. In his autobiography, White concedes that, over time, there had been a modification in his understanding of Spencerian principles, but he held fast to the fundamental idea of patterns of thought and behavior that persist over time. White also very carefully considered Darwin's ideas, and he expressed an appreciation for what he viewed as the merits of the "carefully controlled thinking" that characterizes Darwinian theory.<sup>83</sup>

White appeared particularly drawn to *determinism*, and he solidified his thinking around this concept further through works such as Mitchell's *Evolution and Dissolution and the Science of Medicine*, and also Buckle's *History of Civilization*. When White read Mercier's *The Nervous System and the Mind*, the unmistakable beginnings of his stance on psychobiology can be identified.<sup>84</sup> By taking a teleological stance he was able to translate theoretical concepts into the practical applications that would be needed

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<sup>81</sup> Herbert Spencer, *The Factors of Organic Evolution* (New York: D. Appleton, 1887; repr. Project Gutenberg, 2016), <http://www.gutenberg.org/ebooks/52801>.

<sup>82</sup> Herbert Spencer and Charles William Eliot, *The Complete Works of Herbert Spencer: The Principles of Psychology, The Principles of Philosophy, First Principles and More*, (New York: D. Appleton 1898; repr. Charlottesville, InteleX), 2011.

<sup>83</sup> White, *William Alanson White*, 49.

<sup>84</sup> *Ibid.*, 51.

within a large hospital setting. As was mentioned before, ultimately, White believed that psychiatry and psychoanalysis should have a social utility. He believed in what Hale describes as “practical idealism”<sup>85</sup>: the notion that the ideals of psychoanalysis should be translated into a pragmatic action to the benefit of civilization as a whole. In *The Meaning of Disease*, White affirms this view, stating directly that service to society was ultimately the primary function of the physician, and of psychiatry.<sup>86</sup> This is in line with Elizabeth Danto’s analysis of the alignment between the practice of psychoanalysis and social conscience. She argues that between 1918 and 1938, psychoanalysis was accessible to the indigent urban population, and that at least 20 percent of the work of first and second generation psychoanalysts occurred within this demographic.<sup>87</sup>

Disease was not only cured for the individual, but ultimately the cure would also extend to curing the ills of society as a whole. White viewed personality characteristics, such as excessive introversion, not only in terms of the impact that it might have upon a person’s individual functioning, but also in terms of the potential consequences of what such a turning inward might have upon society. In *Principles of Mental Hygiene*, White stated that psychopathology was a “disorder of individual-society relations.”<sup>88</sup> In his autobiography he makes the case that society will be understood only once man has “acknowledged those aspects of himself which are most significant in social integrations.”<sup>89</sup>

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<sup>85</sup> Hale, *Freud and the Americans*, 23.

<sup>86</sup> William Alanson White, *The Meaning of Disease: An Inquiry in the Field of Medical Philosophy*. (New York: The Williams & Wilkins Company, 1926).

<sup>87</sup> Elizabeth Ann Danto, *Freud’s Free Clinics: Psychoanalysis and Social Justice, 1918–1938* (New York: Columbia University Press, 2007).

<sup>88</sup> William A White, *The Principles of Mental Hygiene* (New York: Macmillan, 1917), 23.

<sup>89</sup> White, *William Alanson White*, 76.

White employs evolutionary concepts in service of pragmatism. He took the view that finding out about the inner workings of the mind can enable the discipline of psychiatry to serve the goal of advancing civilization:

...for years I have been writing and speaking along these lines, trying to interest all and sundry in the importance of the questions involved and in the necessities, which arose therefrom of finding out something about man's psyche, so that we might proceed along the lines of evolution and development without being everlastingly tied to the materialistic concepts of the nineteenth century.<sup>90</sup>

White frequently lamented the mechanistic philosophical principles of the nineteenth century, and he considered the continuous interaction between man's psyche and societal influences as a great progression for both psychiatry and philosophy. White made the case that such integration enables the physician to ask questions in a developmental and systemic manner. According to him, this had not been previously possible within the mechanistic frame that emphasized separate parts constituting the whole, as opposed to an conception in which the starting point was the integrated whole, with its constituent parts.<sup>91</sup> In White's formulation, the 'whole' represented society, and the 'part' represented the individual. Tanner argues that this view implies that the individual can fully realize his or her potential only within the context of social order.<sup>92</sup> This appears to be only partly true, because it does not fully take into account the inherent systemic view that White held, namely that there is a

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<sup>90</sup> Ibid., 252.

<sup>91</sup> Ibid., 252–53.

<sup>92</sup> Tanner, *Symbols of Conduct*, 88-97.

reciprocal relationship between the individual, who possesses agency, and society.

When one examines White's scholarly works, there is a definite emphasis on the construct of social order, and it does appear to create the impression of the supremacy of society in relation to the individual. Tanner regards White as "a Victorian masquerading as a modernist."<sup>93</sup> This view appears overstated, in part because the same could be said of the disciplines of psychiatry and psychoanalysis in general. These disciplines are still constantly grappling with the degree to which social control is implied in their theories and practice. It was no different for the physicians of White's time, and many others in the American school. Another counterargument comes from an examination of the views of those physicians who worked with White directly at St. Elizabeths. White's unmistakable emphasis on the individual in the clinical setting, and his nonjudgmental style is remarked upon on numerous occasions. Dr. Kleinerman, for instance, recounts how he introduced White to every new patient on Monday mornings, and how White displayed genuine interest in every individual case, on both a personal and a clinical level. He remembers vividly that White believed "no case was hopeless and that every patient in the Hospital deserved the best treatment that was available,"<sup>94</sup> and moreover, that the only way a patient could ultimately benefit from psychiatric treatment was if the individual felt that the psychiatrist was truly interested in him or her as a person.

Dr. D'Amore, who also worked alongside White on a daily basis, also affirms this

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<sup>93</sup> Ibid., 192.

<sup>94</sup> Morris Kleinerman, "William Alanson White, M.D., as Superintendent," in D'Amore, *William Alanson White: The Washington Years*, 111.

view of the primacy of the individual within the institution.<sup>95</sup> Here one again finds the disconnect between reading 'about' White's work and views, as opposed to entering the clinical setting through patient case files and consultations. While the former offers a valuable perspective, I argue that the latter completes the picture.

Bergsonian influences later in White's life appear to have refined his views on evolution within the Progressive context. With William James's blessing, Henri-Louis Bergson rapidly gained cachet among the American intelligentsia. He appealed to the psychoanalysts in part through his pedigree as a continental philosopher, but it was his inclusion of intuition, emotion, and instinct that was entirely compatible with the 'new' psychiatry that White in particular felt drawn to.<sup>96</sup> In a letter to Freud, James Jackson Putnam, Harvard professor of neurology, referred to Bergson as "the keenest psychologist alive."<sup>97</sup> A full exposition of the importance of Bergson's philosophical contributions to the evolution of psychoanalytic theory and practice lies beyond the scope of this discussion. Bergson appealed to the medical men with his emphasis on the physiology of dreams, and he satisfied the philosophers and psychoanalysts with his inclusion of repression as a mental mechanism. As a medically trained psychiatrist who regarded himself as a psychoanalyst, White too embraced Bergson and effortlessly folded his ideas into the emerging frame of psychobiology, in part because the Bergsonian concepts of motion, evolution, and change were compatible with White's

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<sup>95</sup> D'Amore, *William Alanson White: The Washington Years*, 89-110.

<sup>96</sup> See Hale, *Freud and the Americans*, 56.

<sup>97</sup> Nathan G. Hale, ed., *James Jackson Putnam and Psychoanalysis: Letters between Putnam and Sigmund Freud, Ernest Jones, William James, Sandor Ferenczi, and Morton Prince, 1877-1917* (Harvard University Press, 1971), 143.

views on adaptation. Bergson's 1907 work, *Creative Evolution*,<sup>98</sup> appears to have been of particular importance to White as he refined his views on human potential and the problem of how to remove impediments to reaching this potential on both individual and societal levels. By bringing together Spencer and Bergson, Hale argues that White became the representative of the Bergsonian faith in evolution.<sup>99</sup> Bergson's particular appeal to White furthermore appears to have been the application of the concept of energy, which had the capacity to unite the constituent parts of man-in-relation-to-environment in a holistic manner. Spencer's determinism could be thought of in Bergsonian terms, because if one is able to discern the teleological underpinnings of human behavior, control over conduct could be achieved. White applied this principle quite literally to his work in the forensic arena. Aggressive tendencies and criminal conduct, seen from the perspective of his Spencer-Bergson integrative view, could be understood as a throwback to an earlier evolutionary stage where this type of conduct may have been adaptive.<sup>100</sup> Using a modified version of evolutionary theory, White thus argued for compassion and understanding for the delinquent, and he argued fervently for a Bergsonian view that would allow for the inclusion of the social environment as an etiological agent in human conduct. It is worth noting that, although Bergson's philosophy had a profound effect on White, he did not share the heady optimism that characterized the Emmanuel movement. The Emmanuel movement, founded by the influential Dr. Elwood Worcester, rector of the prestigious Episcopal church in Boston, claimed that religious authority could supersede psychological difficulties through the use of the mind and the redirection of emotions. This form of self-help delivered

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<sup>98</sup> Henri Bergson, *Creative Evolution*, trans. Arthur Mitchell (New York: Henry Holt, 1911; repr. Mineola, N.Y.: Dover Publications, 1998).

<sup>99</sup> Hale, *Freud and the Americans*, 53.

<sup>100</sup> Hale, *Freud and the Americans*, 55.

through the church structure was the antidote to failures of the medical profession in the treatment of psychological ailments.<sup>101</sup> It represented an alternative, widely covered in the press, during a time prior to the establishment of psychoanalytic thought. White was far more restrained in his views about the immediacy of the impact of the supremacy of mind and free will to cure serious psychopathology. His Spencerian roots, as well as his clinical observations in the trenches, provided the checks and balances that prevented him from declaring this movement to be a panacea. White was furthermore able to refine his ideas about philosophy, psychobiology, psychiatry, and psychoanalysis through his lifelong friendship and collaboration with Eli Smith Jelliffe, who often served as a sounding board for the evolution of his thinking.

### **White and Jelliffe**

White met Jelliffe in 1896 at Binghamton hospital, and they remained friends and colleagues until White's death in 1937. His friendship with Jelliffe is one of the few detailed documented personal relationships that he had, and this in itself speaks to the closeness of their association. White spent many summer vacations with Jelliffe at Lake George in New York State, where they appear to have conducted a variant of informal psychoanalysis on each other. Jelliffe described it as follows:

For some ten or more years almost interruptedly he has spent a month or so at my summer home with me and my family. We were continuously at each other, our dreams, our daily acts and aberrations, not for an hour but sometimes all day. I owe much more than I can tell at this time to these

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<sup>101</sup> Katherine McCarthy, "Psychotherapy and Religion: The Emmanuel Movement," *Journal of Religion and Health* 23, no. 2 (June 1, 1984): 92–105, <https://doi.org/10.1007/BF00996152>.

contacts not alone psychoanalytically but in many other relations.<sup>102</sup>

In light of Jelliffe's narrative of how close the association was between himself and White, Adolf Meyer's description of White and Jelliffe as "neuropsychiatric twins" is perhaps not too far-fetched.<sup>103</sup>

White's association with Jelliffe had an undeniable and strong influence on his thinking, and further evidence for this relationship of mutual influence is found in the numerous articles that they published jointly. This lifelong collaboration, from both a personal and a theoretical standpoint, is explored in more depth in Chapter Four. The textbook on psychiatry and neurology that White co-authored with Jelliffe went through six editions from 1915 to 1935, and the *Psychoanalytic Review* that they launched in 1913 is still in publication. In light of these collaborations it is not surprising that Jelliffe, in a letter to White, agreed that their ideas are often in sync when he stated: "Master or pupil, I-you-me-yourself it makes no difference."<sup>104</sup>

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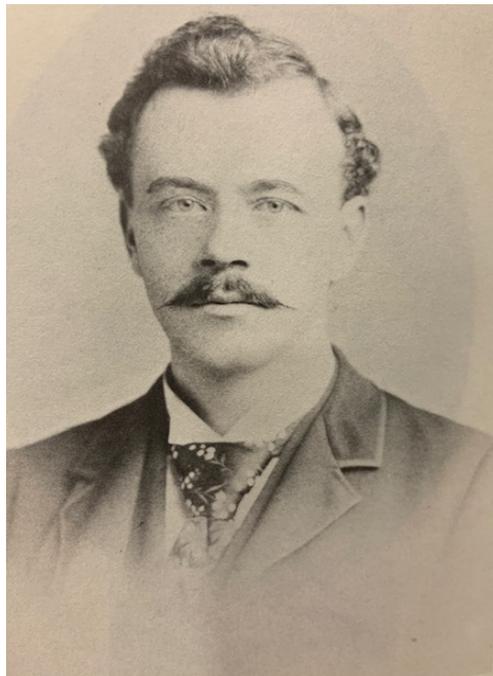
<sup>102</sup> Smith Ely Jelliffe, "Glimpses of a Freudian Odyssey," *Psychoanalytic Quarterly* 2 (1933): 318–29.

<sup>103</sup> Adolf Meyer, *The Collected Papers of Adolf Meyer* (Baltimore, MD: Johns Hopkins Press, 1950).

<sup>130</sup> Smith Ely Jelliffe to W. A. White, January 20, 1925. Smith Ely Jelliffe Papers, Library of Congress, Washington, D.C.



*Figure 1.1 William Alanson White (National Archives RG 418-P-407 Box 6)*



*Figure 1.2 Smith Ely Jelliffe (Library of Congress, Jelliffe Papers)*

White and Jelliffe were initially in agreement about many of the fundamentals

that characterized how they conceived of the human mind. They emphasized the role of Bergsonian energy transformations in psychiatry, the idea of ‘organism as a whole,’ the centrality of the nervous system and its concomitant implications for psychobiology, and the influence of the social environment on the individual. They also found common ground in their critique of what they viewed as the reductionist approach to dream interpretation advanced by Freud. Not content with dreams as expressions of unmet infantile wishes, White and Jelliffe took a more optimistic approach when they incorporated the Jungian analysis of dreams as signifying the wish to pursue life goals. For both, symbolization held the key to the unconscious, and, ultimately, one’s conduct was the hallmark of optimal psychological health.<sup>105</sup> White and Jelliffe were both adherents to the principles of psychobiology, albeit with a different emphasis. While White, perhaps through his work in an institutional setting, remained steadfast in his conviction of the centrality of the influence of the social environment as an etiological factor in mental disease, Jelliffe appeared to start incorporating an individual psychology to a greater degree than White. In 1917, in *The Mentality of an Alcoholic*, Jelliffe argued that “man’s enemy lies only within himself.”<sup>106</sup>

White and Jelliffe both remained staunch adherents to the progressive American School until approximately 1925, when the landscape of American psychoanalysis started shifting. In contrast to White, who stopped travelling to Europe after World War I, Jelliffe frequently traveled to Vienna, and his contact with the European psychoanalysts designated him a less contentious figure in Freudian circles. As I will outline in more detail in Chapter Four, Jelliffe desired a closer association with the New

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<sup>105</sup> Hale, *Freud and the Americans*, 57.

<sup>106</sup> Smith Ely Jelliffe, “The Mentality of the Alcoholic,” *New York Medical Journal* 105 (1917): 630–37.

York analysts and with Freud, whereas White showed far less enthusiasm for rekindling this association. In conceiving of the etiology of psychopathology, White was not willing to prioritize the intrapsychic at the expense of what he continued to view as the fundamentally important influences of adaptation to the environment. After enduring some derision from Freud himself, and following controversy within the New York Freudian circles prior to the early 1920s, Jelliffe, in February of 1925, rejoined the inner circle when he was nominated by Brill, and elected for full membership in the New York Psychoanalytic Society.<sup>107</sup>

Jelliffe's re-entrance into the inner sanctum appears to have exacerbated his editorial differences with White in terms of the types of articles that were to be published in the *Review* and administrative matters related to *Technique*. His attempts to re-engage White with the broader psychoanalytic community had failed in the past, and White's insistence that he had no interest in ingratiating himself with those whom he regarded as enemies in the Freud camp, is evidence of the growing theoretical schism between Jelliffe and White. There was also a growing schism in terms of how White and Jelliffe prioritized the potential contributions that they could make to their profession. White remained convinced that psychoanalysis and psychiatry should be instrumental to social reform. In his forensic and post-war writings in particular, White expressed an optimism about the capacity for psychiatry to effect societal change.<sup>108</sup> Psychoanalysis, merged with psychobiology and operating alongside the mental hygiene movement, could not only be utilized to understand and treat psychopathology, but could ultimately change society. In White's view, psychoanalysis would provide the

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<sup>107</sup> Hale, *Freud and the Americans*, 61.

<sup>108</sup> Hale, *Freud and the Americans*, 53.

tools needed to identify the etiology of what ails civilization.

The fact that the starting point of this process was the individual was not problematic for White, because the end goal remained the improvement of society. Jelliffe's starting and end point, in contrast, was the individual. Jelliffe shared the concerns of analysts in the New York Psychoanalytic Society, who were growing increasingly concerned about what they viewed as the unregulated practice of psychoanalysis. He worked to bolster the professionalism of the practitioners of psychoanalysis by setting standards for practice and for increased regulation, standards that would ensure that psychoanalysis retained its foundation within the medical sciences. Tanner points out that Jelliffe's understanding of psychoanalysis became increasingly tied to an understanding of the impact of the aggressive drives inherent in human nature, while White remained committed to the idea of psychoanalysis as "moral education."<sup>109</sup> By the late 1920s, Jelliffe was formally ensconced in the European School, while White remained firmly within the American School.

It would be erroneous to interpret Jelliffe's newfound appreciation of Freud's ideas, or his being firmly ensconced within the inner circles of the New York psychoanalytic elite, as signifying that there was now no common ground between White and Jelliffe. Their friendship persisted, and many of their shared philosophical principles endured. Jelliffe's loyalty to White was undoubtedly a risk to his relationship with Freud, yet in 1929, Jelliffe defended White in a letter to Freud. Jelliffe offered the following response to Freud's criticism of White and the *Psychoanalytic Review*:

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<sup>109</sup> Tanner, *Symbols of Conduct*, 88.

I am quite sure that Dr. White is quite free from either personal resistances or resistances to psychoanalysis. I can say this since I know him so well and what analysis I have had has been from him chiefly.<sup>110</sup>

Jelliffe's letter to Freud continues on, outlining the many responsibilities that White has in his role as superintendent that have precluded him from focusing on "individual analytic research," and also paying homage to White's political acumen. Jelliffe concluded his letter by stating:

He outlines the principles of psychoanalysis everywhere and has done more for its extension over the U.S.A. than any other individual. I think you should know this.<sup>111</sup>

Throughout his life, Jelliffe shared with White the holistic view of the human person, albeit with a different emphasis on the constituent parts of this model. White's psychoanalysis could be located within the realm of the hospital, with the ultimate goal being that of societal improvement, perhaps as much as individual healing. In contrast, Jelliffe's psychoanalysis was found in the private consulting rooms of Manhattan, very much focused on the well-being of the individual. Two years prior to White's death, and despite their numerous editorial disagreements or theoretical points of divergence, Jelliffe increased his own editorial workload in order to lighten White's burden. Burnham argues that White's death "profoundly changed the pattern of Jelliffe's

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<sup>110</sup> Jelliffe to Freud, Personal Correspondence, 1929, Smith Ely Jelliffe Papers, Library of Congress.

<sup>111</sup> Jelliffe to Freud, Personal Correspondence, 1929, Smith Ely Jelliffe Papers, Library of Congress.

activities” in subsequent years.<sup>112</sup> There is little doubt that White benefitted immensely from Jelliffe’s presence in the evolution of his theoretical orientation, and also in his personal life through the informal analyses that they conducted on one another. Both remained independent thinkers and steadfast in their individualized perspectives and applications of psychoanalytically informed psychiatry. The American landscape of psychiatry and psychoanalysis benefitted not only from their agreed-upon perspectives, but also from their divergent points of view.

In this chapter I attempted to identify the historical, personal, biological, and philosophical influences that were instrumental in the making of the “Chief Psychiatrist of the United States,”<sup>113</sup> described by his successor at St. Elizabeths, Dr. Winfred Overholser, as “the most eloquent, forceful and, progressive psychiatrist in this country.”<sup>114</sup> White was, however, not only a psychiatrist but also a psychoanalyst. His relationship with those of the psychoanalytic community who adhered to only classical theory was complicated and fraught with philosophical, personal, and theoretical divergences. White was interested in the unseen psychological forces at play in the complexity of the human mind. One example of this can be located in his autobiography when he discusses the problem of suicide in some depth. He compassionately describes the often-disparate behaviors observed in those who commit this final act, and he then offers a classically based analytic theory of the workings of defense mechanisms as a possible explanation.<sup>115</sup> By examining the case histories, patient records, treatment regimens, and clinical-staff conceptualizations found in the archival case files, alongside

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<sup>112</sup> Burnham and McGuire, *Jelliffe*, 7.

<sup>113</sup> D’Amore, *William Alanson White: The Washington Years*, 9.

<sup>114</sup> Quoted in D’Amore, *William Alanson White: The Washington Years*, 94.

<sup>115</sup> White, *William Alanson White*, 72.

White's utilization of treatment methods designed to positively influence environmental influences on the intrapsychic, I hope to demonstrate that William Alanson White was not merely a 'popularizer' or an administrator, but a central figure in the history of psychoanalysis, most especially so within the hospital setting.

## Chapter 2

### The Reconstruction of St. Elizabeths Hospital

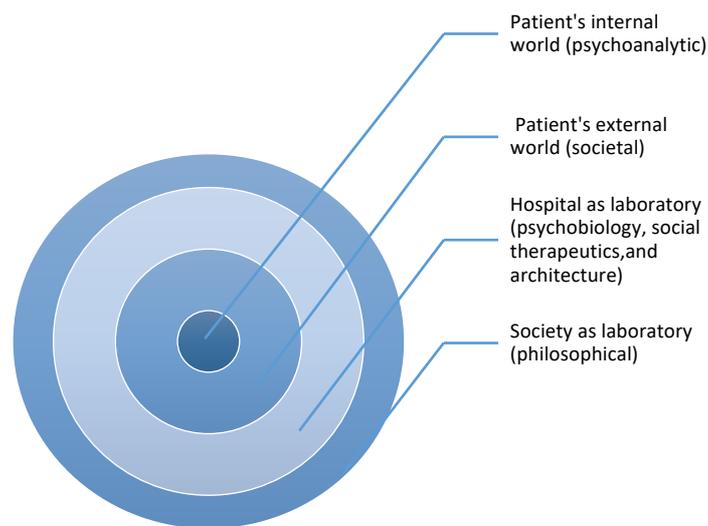
In this chapter I examine the way in which White ‘designed’ the physical, clinical, and research environment at St. Elizabeths to accommodate his vision of a new type of psychiatry. The ‘making’ of St. Elizabeths under White evolved over time, and the archival material found in his personal papers and in hospital records contain a narrative that includes personal reflections and ‘experiments,’ consultation with European hospitals, political stresses in terms of securing funding, and the rejection of commonly used methods in sister institutions, for example, sterilization and lobotomies. White’s ‘construction’ of St. Elizabeths was not only physical or clinical, but also philosophical. The strands of Bergson, American Pragmatism, and Spencer come together in his view of psychobiology and “social therapeutics,”<sup>1</sup> a modern iteration of moral treatment. White designed his hospital with the psychological, the biological, and the philosophical in mind. His conviction of treating the individual as an ‘organism as a whole’ culminated in an environment where psychobiology and psychoanalytically informed psychotherapy could function seamlessly. This approach was in keeping with White’s view that psychobiology and the analytic method can and should be merged.

In the introductory chapter I argued that White’s presence at St. Elizabeths Hospital was transformative, because he was able to translate his humanitarian stance toward the human condition, his philosophical positions on American society, and the

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<sup>1</sup> Investigation of St. Elizabeths Hospital, House Document 605 (69-2), serial 8722.

academic convictions that he held into actionable changes that can be located in patient care, administrative matters, and the psychoanalytic training of the hospital staff. Primary source material elucidates the ways in which White applied the laboratory method to internal and external lived experience, to psychiatric care, and to individuals' roles within society. White's laboratory was therefore located not only within the confines of St. Elizabeths. Source material indicates that White spent a great deal of time investigating questions related to the human condition outside of the hospital, which findings he then imported back into the hospital. Very often the starting point can be found within the plethora of social structures that he references in his personal papers. White's thought appears to move within the context of concentric circles: the outer layers denote the characteristics of society as he perceives it, while the inner layers represent the patient and the inner workings of the hospital (figure 2.1). In his personal reflections he utilizes his understanding of these different areas in a mutually inclusive manner that is aimed at constructing a narrative of both the psychiatric institution and the human person.



*Figure 2.1 Elements in White's construction of the hospital*

## Constructing the Psychiatric Hospital

Scholars such as Otto and Hale have shown that White's presence at St. Elizabeths transformed the hospital into a laboratory in the traditional sense.<sup>2</sup> During White's tenure, voluminous research studies, publications, training programs for hospital staff, and academic rigor in documenting the treatment of patients, situated the institution at the center of what Jack Pressman describes as a "psychiatric renaissance."<sup>3</sup> Pressman argues that the early twentieth century brought two major shifts in psychiatry. First, a shift towards the professionalization and consolidation of psychiatry as a distinct discipline, and second, a shift in American psychiatry away from an exclusive focus on the interior world of the individual and towards a recognition of the impact of environmental influences on the individual. In this new conceptualization, the individual was seen as maladjusted, as opposed to merely diseased. The idea of maladjustment was conceptually more hopeful, as is reflected in the "diseases of civilization," for example, in the condition of neurasthenia.<sup>4</sup> By changing their environments from tropical to temperate, or by slowing down their pace of life, afflicted individuals could substantially alter their psychological functioning. Through the practical applications of psychobiology, the principles of mental hygiene, and the moral obligations of social control, St. Elizabeths brought the outside world into the hospital. In this context, the traditional laboratory stood firmly beside the social laboratory, and White's psychiatric hospital embodied both.

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<sup>2</sup> See Otto, "St. Elizabeths Hospital: A History," 43; and Hale, *Freud and the Americans*, 143–208.

<sup>3</sup> Jack D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge University Press, 2002), 222.

<sup>4</sup> David G. Schuster, *Neurasthenic Nation: America's Search for Health, Happiness, and Comfort, 1869–1920* (New Brunswick, N.J.: Rutgers University Press, 2011).

White's transformation of St. Elizabeths into a traditional and a social laboratory was informed not only by scholarly influences that are widely known in his work, but also by deliberately sought-out personal experiences and personal reflections. In particular, White writes in some detail in his personal papers about 'experiments' within social settings. The majority of these notes are handwritten, some are illegible, and a great many are undated, which therefore makes it impossible to reconstruct a chronology that can be correlated with specific policies and events at the hospital. However, White's personal reflections provide an important window into the evolution of care at St. Elizabeths and can broadly be divided into the areas of the social and the psychobiological.

### **Society as Laboratory**

White appears to have been preoccupied not only with the divisions in society, but most especially with the impact of such divisions on individuals' well-being. The Progressive Era within which White lived and worked is often cited as the main contributing factor to his efforts to bring about reforms at St. Elizabeths. While there can be little doubt that the national discourse of reform, adjustment, and social adaptation played a prominent role in White's thinking, the current scholarship on White has neglected the very personal nature of this quest. White grappled constantly with the inequities and differences in social circumstances, financial or otherwise, that he observed around him, and also within his own experience.<sup>5</sup> Tanner's observation of White's mercantile disposition toward the journal that he founded with Jelliffe,<sup>6</sup> White's careful description,

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<sup>5</sup> White, *William Alanson White*, 72.

<sup>6</sup> Tanner, *Symbols of Conduct*, 124.

in his *Autobiography*, of his parents' different social classes,<sup>7</sup> as well as the constant awareness that his education had been funded and his career supported by a wealthy family, all provide important data points in support of the idea of a more personal quest. It is White's personal notes, however, that provide the most poignant commentary on his attempts, from the time of his youth, to make sense of societal inequity on both personal and professional levels. The tone observed in his personal papers reveals a level of emotionality very rarely associated with White in the public sphere, where he has been widely credited, and critiqued, for unadulterated restraint. Those closest to White did not know him only for his restraint. A commentary on his early temperament is outlined in a letter dated July 1, 1929. White received a letter from Lois Sincebaugh, the daughter of his benefactor, in which she recollects a conversation that she had with White during his youth. White was talking to Lois Sincebaugh's mother about his future plans, and Mrs. Sincebaugh recalled that when she entered the room and lightheartedly suggested that White would become a country doctor he interrupted her rather forcefully when he said

No such thing – I am not going to be any such doctor! You'll see my name in the paper! You'll see my picture in the paper and you'll see me famous!<sup>8</sup>

According to Mrs. Sincebaugh, her mother “held tenaciously to the fact that you would be just what you said.” White was viewed as ambitious, committed, and upwardly mobile before he embarked on a medical career. Reflective perhaps of White's conflicted relationship with moving between the different layers of society, that is, the position

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<sup>7</sup> White, *William Alanson White*, 75.

<sup>8</sup> W. A. White to Lois Sincebaugh, RG 418, NA: Entry 34 (Correspondence, Box 21)

that he came from, as opposed to the position that he came to eventually hold, White's reply to Sincebaugh six days later is introspective:

The incident you describe therein I have not the slightest recollection thereof, nor have I, as a matter of fact, any recollection of feeling the way that incident would indicate I did, all of which makes it still more significant to me...It certainly would be interesting if that were the sort of thing I have been driving at all my life without knowing it.<sup>9</sup>

White never seems to connect his 'experiments' that involved travelling to exclusive summer resorts with his questions around social mobility, or lack thereof. It is also not clear from his writing how he was able to fund these explorations. He formulates his investigations while on vacation in terms of a systematic laboratory experiment, and carefully outlines his goals as being "to understand the general views of people in affluent circumstances, and to make a study of some of their children." In a later, more detailed version in his personal papers titled "Study of Summer Resorts," White refers to himself as "a student of little means" who "seldom has opportunity to understand the well-to-do or rich." He justifies the expense involved in visiting these exclusive resorts by stating that he is not married, and that for investigational purposes it is optimal to meet those of large means in "a natural and incidental way...for the purpose of learning their general ways of looking at things." His observations of social customs, and his attempts to adapt to these customs are framed in an empirically descriptive style. White systematically describes his preparations and actions prior to and at the time of his arrival at one of these resorts. He notes of the resort environment

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<sup>9</sup> Ibid.

that he had “not had much experience in such conditions,” and then states that, in order to create optimal conditions for his investigations, he “tried to learn all I could in advance and procured the so-called proper clothes and general act that I might appear as one of them.” Upon his arrival, was sure to give the bell boy a substantial gratuity in order to make a lasting impression. In a final preparatory gesture, White describes in some detail how he examined the location of his room, familiarized himself with the nearest fire exits, and then elected to walk downstairs, as opposed to taking the elevator.<sup>10</sup> It appears as though these forays into the world of privilege did not always go smoothly, as White states that the young, affluent men “did not take me seriously,” and he later laments the fact that it is very difficult to meet those of means, because “they already have more than they can attend to.”<sup>11</sup>

White, however, remains close to the experimental method during these summers. He carried with him his “instruments,” which included an algometer to measure pain sensitivity, a caliper to measure head circumference, and a dynameter to gauge grip strength. He states that the aim of these experiments was to compare the measurements of the wealthy to the middle and poorer classes. He concludes that those of significant means are heavier, taller, and more sensitive to pain. White states that the upper classes are at a disadvantage because their “luxuries and refinements seem to increase the general sensibility beyond normal limits,” and accordingly, “...a life of hardihood is advantageous.”<sup>12</sup> In his personal reflections, White appears conflicted about class differences. The young men that he describes as not taking him seriously in one reflection, are described in a later, more detailed personal account as “shy,” and

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<sup>10</sup> RG 418, NA: Entry 34 (Correspondence, Box 21)

<sup>11</sup> White, *William Alanson White*, 23.

<sup>12</sup> RG 418, NA: Entry 34 (Correspondence, Box 21)

while he sees the affluent classes as at a disadvantage in some ways, for example, with regard to pain tolerance, or difficult to interact with because of their insularity, he also appears to idealize this group. He concludes his account of his interactions at the exclusive resorts as follows:

Having spent several Summers in company with wealthy people, my general impression as to them personally is very highest. They were never rude or inconsiderate.<sup>13</sup>

When White refers to the leisure activities of the wealthy, he refers to these individuals as

...good people of wealth...who give themselves over to the pleasures of life but always of a wholesome nature, with such taste as indicates good breeding.<sup>14</sup>

When White located individuals in an inebriate asylum for the wealthy, he characterizes the patients as “refined,” “sensitive to strangers,” and “in the greatest of all struggles with themselves,” and their plight as one of “subdued suffering.” Despite White’s seeming idealization of the upper classes, his humanitarian stance toward all human suffering remains firmly intact in his writing. He employs the same ‘social laboratory method’ to other societal groups, including criminals, “feeble minded children,” university students, and school aged children. Throughout White’s investigations, he appears to grapple with what makes those who are suffering and

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<sup>13</sup> Ibid.

<sup>14</sup> Ibid.

unfortunate different from those who are not. His investigative methodology does not change much in relation to which group or individual he is performing his 'experiments' on. When White visits a correctional facility, he specifically requests from the warden to interview only "the most genuine cases of murder, theft and madness." In addition to the standard phrenological and body measurements, White adds to this a full life history as he attempts to reconstruct the inmate's past, which he then states he documents with precision. Unfortunately, White's accounts of the inmates' narratives are not contained in his personal papers, so it is not possible to determine the degree to which these interviews mirrored the case histories that he introduced and refined at St. Elizabeths. However, the manner in which he writes about the interview process appears very similar. In all of the groups observed by White, he starts with physical characteristics. When observing people riding on street cars, he notes facial features, for example, "irregularly shaped ears," and in the study of feeble-minded children and university students, White again emphasizes physical characteristics and habits, and, in some cases, behaviors that appear "unconsciously," before moving to a more psychological explanation. In a "Study of Feeble-Minded Children" in particular, White notes five prominent physical characteristics that he connects with "slowness of expression." He then moves to the psychological and societal impact when he states that these children are at risk of being misunderstood by their parents and teachers, and that "this type of treatment puts kids at risk to develop whatever latent criminal tendency to come to the fore".<sup>15</sup>

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<sup>15</sup> W. A. White, "Study of Feeble-Minded Children," RG 418, NA: Entry 34 (Correspondence, Box 21)

## **Social Architecture and the Construction of a Hospital**

White's investigations of the world around him included theoretical debates and constructs that he then translated into actionable elements of patient care at St. Elizabeths. These investigations included visiting other institutions, most notably European hospitals, and making intellectual evaluations of the medical utility and the philosophical merits of the psychiatric techniques and interventions used there. White was a pragmatic, independent thinker, as is evidenced by his willingness to go against the grain of prevailing medical opinion. He states his often forceful and contrarian views on physical restraint, sterilization, lobotomies, and even hospital architecture strongly. White's correspondence and personal papers contradict the narrative of him found in the history of psychoanalysis as a mere 'popularizer' of ideas. He took the constructs of psychoanalysis, philosophy, and medicine, and attempted to transform carefully selected concepts embodied by these disciplines into action. When one examines his views on restraint, sterilization, lobotomies, and hospital architecture, the aforementioned constructs blend together, forming a cohesive vision that is very much reflective of his overall humanitarian and egalitarian approach to the treatment of psychiatric patients, and the training of the staff who took care of these individuals. White tied the external to the intrapsychic, convinced that restraint, hospital architecture, and opportunities for work and leisure all had significant impact upon the inner life of the individual.

## **On Confinement and Restraint**

White had both a medical and also a moral interest in the commonplace practices of the confinement and restraint of psychiatric patients. Three years after the beginning of his tenure as superintendent, White wrote a *Report on European Hospitals* addressed to the Secretary of the Interior on October 23, 1906.<sup>16</sup> He based this report upon the twenty-three European and British hospitals that he visited in order to examine the practice of psychiatry within the asylum. White's report and his personal notes relating to these visits represent a combination of personal reflection and scholarly interest. He emphasizes the universality of the afflicted mind and quickly moves to measures that might be taken to treat such patients.

White commends the institutions that do not confine their patients, and is especially critical of the asylums that confine their occupants with mechanical restraints in what he regards as an inhumane manner. He makes special note of two contrasting models of confinement. The first encompasses a rigid definition of confinement:

For instance they were all surrounded by walls and seemed to adhere very strictly to distance rules as regards to visitation etc., there being very little effort made to accommodate friends and relatives at other times.<sup>17</sup>

Later, White offers an alternative model known as the "colony system" which he observed in Gheel near Antwerp. Instead of being confined in an asylum, patients would live with and be taken care of by local peasant families, and, in return, the patient would work "in terms of whatever his strength and intelligence may enable him to do." White

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<sup>16</sup> *Report on European Hospitals*, October 23, 1906, RG 418, NA: Entry 34..

<sup>17</sup> *Ibid.*

enthusiastically describes this system as an alternative to confinement, though he notes that the nature of American society as “much more restless and ever shifting” would not make the colony system a viable option.<sup>18</sup> White’s emphasis on social support and productivity seen in the treatment regimens at St. Elizabeths was informed and solidified by his willingness to contrast and compare different treatment approaches. White was, however, very cautious before adopting any new methods. He states, for example, that while he had heard of continuous baths as a treatment method, he would not consider adopting this therapeutic technique at St. Elizabeths until he was able to see it work.<sup>19</sup>

White appears to have reluctantly tolerated politics. Within the context of the congressional hearings that he underwent, he laments Washington politics. In a letter to Dr. Carlos McDonald dated May 17, 1906, White states that he has “been as truly a prisoner here in Washington as if I had been locked away.”<sup>20</sup> Despite his reservations about the political system, White was willing to enter the fray when the welfare of the residents at St. Elizabeths, or the treatment of the mentally ill more generally, was at stake. In 1907 his indignation came to a head in a strongly worded letter authored by White, Percy Hickling, associate professor of Psychiatry at Georgetown, and D. K. Shute, professor at The George Washington University Medical School. The letter, addressed to the members of the Society of Nervous and Mental Diseases, can roughly be divided into three parts. The plea for better facilities included, first, the requirement for more

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<sup>18</sup> Ibid.

<sup>19</sup> White, *William Alanson White*, 124.

<sup>20</sup> W. A. White to Carlos MacDonald, May 17, 1906, Box, RG 418, NARA. Carlos MacDonald, M.D., was chairman of the New York State Commission in Lunacy from 1880 to 1896, and superintendent and owner of Falkirk Sanatorium in Central Valley, New York, at the time of this correspondence.

thoughtful architecture to house the insane; second, the request for more funding for the insane; and, finally, better overall treatment of the insane, including admissions procedures for those to be confined.

The prior year, in his *Report on European Hospitals*, White had expressed reservations about admissions procedures for those deemed insane. He contrasts the European system with the system used in the District of Columbia. In the former, there are no “tedious legal formalities required...patients generally who show mental symptoms are sent to the asylums,” and hospital authorities are entrusted with the decisions as to who should be admitted. In contrast, White’s malcontent is clear when he laments the laborious jury trial system for committing patients, and he states that “the District of Columbia stands almost alone in the civilized world in its atrocious method of committing the insane.” In the 1907 letter White further formalizes his views on what he regards as an inhumane court system by emphasizing three main points. First, White and his co-authors argue that commitment procedures should not be held in open court before a jury “by inquisition,” and second, such an experience presents a hardship not only for the person being committed, but also for that person’s family. Finally, White takes exception to what he regards as the “humiliating” experience of the unfortunate person, who is placed in “the same category as one accused of a crime,” thereby being “placed on par with the criminal.” The dignity of the human person appears to have been a central concern for White. He believed that psychiatry is a medical specialty, and that it was uniquely equipped to deal with the issue of insanity, stating that “the question of insanity is solely and absolutely a medical one to be solved

by medical men.” White’s awareness of the impact of negative societal views of mental illness is further evident when he questions the motives of admission by jury:

Nothing appears to indicate that the unfortunate insane person is committed to the institutions for his own welfare to be treated for the disease with which he is afflicted and if possible be restored to health and useful citizenship, the implication being that he is removed from the community because he is a dangerous element therein.<sup>21</sup>

The theme of man’s inhumanity to man is a recurring one in White’s writing. White does not take the Freudian view of libidinal and aggressive drives as the etiological factors for inhumane behavior, but rather attributes it to ignorance, misconceptions, and self-indulgence. He argues that public health and sanitation came about as the result of fear, not benevolence, and he equates the psychological to the moral.<sup>22</sup> White’s personal papers reveal unexpectedly strong views about the role of both architectural design and hospital administration in the provision of moral treatment. He viewed the physical dimensions and character of building design, as well as the architecture of hospital procedures, as essential elements in scientifically based, humanitarian patient care.

### **The Architecture of Science and Humanitarianism**

White regarded himself part scientist, part humanitarian. In his *Autobiography*, he captures this duality when he describes St. Elizabeths Hospital as “controlled and

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<sup>21</sup>W. A. White, Notes on Autobiography, RG 418, NA: Entry 34.

<sup>22</sup>W. A. White, Notes on Autobiography, RG 418, NA: Entry 36.

dominated by the humanitarian spirit,"<sup>23</sup> but then acknowledges that he was determined to infuse the institution with the scientific method. Part of creating an environment that would embody both these ideals lay in the physical design of the asylum.

White arrived at St. Elizabeths in the midst of a large scale modernization project. Richardson, White's predecessor, had secured one and half million dollars in congressional funding for architectural improvements. The development included what was known as a cottage plan, and included eleven buildings that could accommodate a thousand patients, a new administrative building, a kitchen, a nurse's home, and a power depot. Richardson passed away unexpectedly on June 27, 1903, shortly after construction commenced.<sup>24</sup> The combination of such a large construction project, alongside a congressional investigation, all within a space of three years, proved to be very challenging for White on a personal level. In 1906, the same year that White referred to himself as a "prisoner" in Washington,<sup>25</sup> he wrote to Dr. Evans, the Medical Director at Binghampton State Hospital, stating that he "should be wonderfully relieved to live outside of a hospital."<sup>26</sup> At this point, White was weighing a move back to New York. White remained at St. Elizabeths and actively engaged in lobbying for changes in the architecture of the hospital so that it would encompass both his scientific and humanitarian ideals. He appears to have taken a utilitarian approach to the construction, framing it in service of his scientific ideals:

...the physical plant of the hospital, its buildings and grounds, and particularly its power house, were all essential before question of

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<sup>23</sup> White, *William Alanson White*, 33.

<sup>24</sup> White, *Forty Years of Psychiatry*, 33-45.

<sup>25</sup> White, Notes on Autobiography, RG 418, NA: Entry 34.

<sup>26</sup> White to Edwin Evans, March 19, 1906, RG 418, NA.

scientific care and management, innovations in treatment, and research work could even begin to function.<sup>27</sup>

White advocated for building a pavilion where potential cases of insanity would not be free-standing and separate as was originally planned, but rather be a part of the main hospital structure. He argued that those who were to be committed should be afforded the same initial treatment as any other medical patient, and that individuals experiencing mental distress would be less likely to seek treatment if they were singled out:

It would be, as it were, in a wing of the general hospital and the patients who were taken there for relief would go, not to an institution primarily known as one which dealt with insanity, but would go to the general hospital and there be assigned to a ward in the same way as any other general medical case applying for treatment.<sup>28</sup>

The building that would be utilized for the insane had to meet certain criteria in accordance with the principles of mental hygiene and humanitarianism, or what White refers to as “the first purpose, the care of the patient.”<sup>29</sup> The hospital architecture that White envisioned was tied to the different levels of pathology presented by patients. White designed the hospital so that patients who could be expected to improve were housed in the same quarters, and those whose symptoms were more acute, or became more acute, were housed in what he referred to as the “quadrangle.” His reasoning for

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<sup>27</sup> White, *William Alanson White*, 117.

<sup>28</sup> W. A. White to Members of Society of Nervous and Mental Diseases. Dec 5, 1907, RG 418, NA: Entry 34, Notes on Autobiography..

<sup>29</sup> White, *Forty Years of Psychiatry*, 123.

this architectural design was based upon his belief that those patients who were likely to improve should “not be subject to the vicissitudes of transference.”<sup>30</sup> The buildings on the east campus housed the more violent male patients, located approximately three hundred feet away from Nichols Avenue, and also away from patients with less acute symptoms.<sup>31</sup> White was very aware of the impact of psychologically based processes such as transference and societal stigma during the planning and expansion phases of St. Elizabeths.

In keeping with the principles of moral treatment and mental hygiene, White required that patients’ rooms be well constructed, well ventilated, large, and light.<sup>32</sup> He emphasized that overcrowding was to be avoided at all costs, as he viewed it as a hindrance to treating mental pathology. White believed that an environment as close to the comforts of home as possible was a necessary element of patient care. Refectory tables were replaced by smaller, round tables for meal times, and staff members were instructed to do all they could to simulate a homey environment, within the parameters of protocols related to safety and order.<sup>33</sup> White furthermore insisted that the superintendent’s living quarters be located on hospital grounds, in keeping with his conclusions about the central role of relationality as curative. During White’s visits to European hospitals, he refers to hospitals in pastoral settings, and those that have large and well-kept outdoor spaces, including agricultural areas for work, as beneficial

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<sup>30</sup> Ibid., 125.

<sup>31</sup> Otto, “St. Elizabeths Hospital: A History,” 43.

<sup>32</sup> Ibid.

<sup>33</sup> “Scores of Women Patients at St. Elizabeths Use Facilities Monthly,” *The Washington Post*, September 1928, 18. See also Investigation of St. Elizabeths Hospital, 69 Cong., 2d sess., 1926, H. Doc. 605, 49.

settings for patient care. The green spaces of St. Elizabeths emulated these aspects of the European systems as an important part of the treatment setting.<sup>34</sup>

White did not hold physical restraint in high regard, unless the patient was inebriated. He was also cautious in the use of chemical restraints. In 1904, White greatly expanded the use and availability of hydrotherapy. Whereas hydrobaths had formerly been available only in the Toner and Oaks buildings, White installed baths in the ward for African American females (Oaks B), and in the receiving wards for white males and females. In the “psychopathic wards,” the hydrobath represented what White regarded as the most humane form of physical intervention available to patients:

We know of no other single item that has done more to add to the comfort of the patients, relieve them when restless and disturbed than the proper use of the hydrotherapeutic apparatus.<sup>35</sup>

A more modern version of moral treatment, known as “social therapeutics,” became a prominent treatment modality at St. Elizabeths. In 1910, Hitchcock Hall, with a capacity of 1200, was constructed (see figure 2.2). Many social activities, for example, movie screenings and plays, became an integral part of the group-based activities comprised in “social therapeutics.”<sup>36</sup> On Tuesday and Friday evenings, Hitchcock Hall hosted dances or other forms of entertainment. In keeping with a humanitarian stance, White favored the methods of social therapeutics, occupational therapy, psychotherapy, and hydrobaths. The psychotherapy and psychoanalytic methods will be examined in detail in the following chapter, but a brief description of the role of occupational

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<sup>34</sup> Report on European Hospitals. October 23, 1906, RG 418, NA: Entry 34..

<sup>35</sup> Ibid., 49.

<sup>36</sup> Investigation of St. Elizabeths Hospital. House Document 605 (69-2), serial 8722.

therapy is necessary in order to contextualize this within the realm of social therapeutics. There can be little doubt that occupational therapy during this era had the distinct flavor of American Pragmatism, in which ideas were no longer only descriptors but instead became practical tools with which to solve problems, make prediction, and take action.<sup>37</sup> Otto argues that the dividing line that separated free labor from occupational therapy as a discipline became very blurry at times.<sup>38</sup> The first World War reinforced the pragmatic utility of this approach. However, there was also a therapeutic aim:

...so that he may thereby develop habits of life that will be helpful and enable him to live more happily, healthfully, and usefully in the hospital community.<sup>39</sup>



Figure 2.2 Interior of Hitchcock Hall. Circa 1910. (National Archives RG 418-G-141)

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<sup>37</sup> Cheryl Misak, *The American Pragmatists*, 1 edition (Oxford: Oxford University Press, 2015).

<sup>38</sup> Otto, "St. Elizabeths Hospital: A History," 44.

<sup>39</sup> Investigation of St. Elizabeths Hospital, 69 Cong., 2d sess., 1926, H. Doc. 605, 47.

At any given time, an average of six hundred male patients were involved in occupational therapy activities at St. Elizabeths. Some worked in the gardens, on the hospital farm or the poultry plant, while others were active in carpentry or toy making. At the height of White's tenure at St. Elizabeths during the 1920s, seven full time occupational therapists oversaw these activities. Through occupational therapy, most of the hospital's linen, towels, and other pieces of clothing were produced in house, and in 1917, Howard Hall was constructed almost entirely through labor provided by residents of the hospital.<sup>40</sup> White's tenure at St. Elizabeths, despite a difficult beginning involving construction and congressional investigations, has been favorably judged by the popular press. In 1930, the *Washington Post* columnist, James Hay, affirmed the view of White as an enlightened humanitarian within a sound scientific paradigm:

When Dr. White took charge of the place 26 years ago, he immediately began to show that in the care of the insane, strait- jackets, manacles, fetters, bars and chains were vastly overrated instruments and that kindness, understanding and a large mixture of the well-known garden variety of common sense were healing, efficient, and, up to that time, unappreciated drugs. He also showed that, instead of being weighted down by the superstition and pessimism of 500 years ago in regard to mental diseases, the thing to do was to turn the light of modern progress and science upon every patient in the hospital. The long-bearded doctors of Europe took to crossing the sea and dropping in to see how young

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<sup>40</sup> Otto, "St. Elizabeths Hospital: A History," 48.

William A. managed to get away with all he accomplished.<sup>41</sup>

Architectural features within the hospital reflected White's belief in the scientific method. St. Elizabeths now housed numerous laboratories, private offices for psychoanalysis and occupational therapy, padded cells, and lecture theatres where scientific studies could be presented and discussed. A chemical laboratory was located in the basement, a fireproof room housed flammable liquids such as alcohol and liquors, while the first floor contained both the histological and bacteriological laboratory. The autopsy room (see figure 2.3), was modern, designed for training medical personnel, and included an amphitheater that could accommodate forty people. In a report of the Board of Visitors, it is noted that the autopsy room contains

a revolving autopsy table and an arc light, so that work can be done readily at night. The refrigerator for the cooling of bodies is cooled by a brine pipe direct from the cold storage plant, so that the desired temperature can be readily obtained."<sup>42</sup>

These types of descriptions that emphasize the modernity of the facilities at St. Elizabeths are found with regularity in the archival material. The hospital was to be a model of the "new scientific method," which held that science and order could counter the disorganized and unquiet minds of the inhabitants. Blackburn Laboratory on the east campus was a state-of-the-art facility by 1926, and home to a multitude of scientific experiments. The imposing architecture of St. Elizabeths may be viewed as an antidote

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<sup>41</sup> James Hay, Jr., "Brickbats & Bouquets," *The Washington Post*, January 20, 1930, 3.

<sup>42</sup> Report of the Board of Visitors of the Government Hospital for the Insane, 59 Cong., 1st sess., 1905, H. Doc. 5, 761.

to societal perceptions, often lamented by White, of the insane as marginal in society. The imposing nature of the architecture, housing impeccable laboratories and treatment rooms, now shifted the insane from the recesses of society into a visible place where science and modernization could address their ills.



*Figure 2.3: Autopsy Room, circa 1915 (National Archives RG 418-G-288).  
The autopsy room on the first floor of the Rest could accommodate forty people and included a revolving table for instruction*

White was staunchly opposed to so-called invasive treatment methods, which were often framed as scientific by proponents of these methods. White's personal papers contain a plea by Freeman for White to consider allowing lobotomies at St. Elizabeths,<sup>43</sup> and also a strongly worded letter from Dr. J. T. Fisher with regard to the sterilization of so-called feeble minded patients,<sup>44</sup> a practice common in California, and federally supported by 1909. To White, these invasive, non-reversible treatment methods

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<sup>43</sup> Freeman to W. A. W., 1912, RG 418, NA: Entry 34.

<sup>44</sup> Fisher to W. A. W., November 4, 1912, RG 418, NA: Entry 34.

represented the opposite of the humanitarian ideals to which he aspired. When Fisher wrote to White on November 4, 1912,<sup>45</sup> the practice of sterilization was widely regarded as a panacea for depravity and crime. Fisher asked White to explain his extreme opposition to the practice, especially in light of a strong prevailing narrative that emphasized the perceived benefits to society. White wrote a lengthy and heated reply to Fisher in which he expresses his malcontent with the legal status of sterilization, the “lack of scientific attention” to this practice, and finally, he questions the morality of this method. White opposes sterilization from the philosophical, the scientific, and the moral perspectives in this letter to Fisher. He appears far less restrained in his personal papers than he is in his academic writing, and his humanitarian concern for those who are suffering is evident. From a philosophical perspective, White stated that sterilization is based upon Mendelian theory, and he disagreed with this theory. He referred to Mendelian theory as unreliable, and “merely a hypothesis and one among many theories.”<sup>46</sup> He furthermore viewed sterilization as antithetical to the humanitarian ideal. In what is one of the strongest worded statements found in his personal papers, White writes about this practice in the following way:

...a sadistic orgy of cutting out testicles and ovaries, which in my mind still harks back to the horrors of twenty years ago, when the surgeon cut out the ovaries with as much nonchalance as he would pare corns.<sup>47</sup>

White then criticizes the legal, and also the religious, institutions that support what he views as an extreme measure based upon a lack of scientific evidence. He cites

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<sup>45</sup> Ibid.

<sup>46</sup> W. A. W. to Fisher, November 15, 1912, RG 418, NA: Entry 34.

<sup>47</sup> White to Freeman, 1912, RG 418, NA: Entry 34.

the lack of scientific consensus along with division in the public debate around sterilization as additional important arguments for not codifying this practice into law. White was particularly distressed by the question of how one would make the determination of who would be a candidate for sterilization. He is derisive when he refers to the committees who make these public policy recommendations:

On the contrary they appear to sit upon a case in a casual sort of way, determining that so and so is a defective, whatever that may mean, and that they ought not to procreate.<sup>48</sup>

White's argument is that it is impossible to predict whether the offspring of a feeble-minded person will be similarly inclined, stating that "if we cannot predict we have no right to interfere." With regard to the insane, White argues that Mott's contention of insanity seldom reaching beyond the third generation renders sterilization redundant. He refers to sterilization as part of "the everlasting tinkering of things,"<sup>49</sup> stating directly that he has no patience with such an approach. White did not like to engage with unproven methods that might put patients in harm's way, and this stance not only was a matter of science, but was also rooted in what appears to be a deep-seated sense of responsibility to eradicate, not add to, human suffering.<sup>50</sup> He clearly expresses to Fisher toward the end of this correspondence why he absolutely will not change his mind with regard to sterilization when he states that "I am not

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<sup>48</sup> Ibid.

<sup>49</sup> Ibid.

<sup>50</sup> White, *William Alanson White*, 146.

willing to go into a new situation that involves unsexing and mutilating people until I have some pretty definite idea that I know what I am doing”.<sup>51</sup>

White’s skepticism extended to the lobotomies in the treatment of mental illness. When Walter Freeman wrote to White in 1936, requesting permission to perform this procedure at St. Elizabeths, White took a similarly firm stance on what he regarded as a radical measure. In a strongly worded, terse letter to Freeman, White wrote “It will be a hell of a long while before I’ll let you operate on any of my patients.”<sup>52</sup>

White cautiously evaluated, selected, consolidated, and applied knowledge. In doing so, he became a pioneer because he was able to bring disparate ideas together within a novel and comprehensive treatment regimen. Psychotherapy and the analytic method were a part of this innovative approach to treating mental afflictions. In the following chapter, this treatment method, although not as widely used as hydrobaths or occupational therapy, is analyzed. In the examination of approximately nine hundred case files, including case conference notes, correspondence, and grand rounds, White’s direct and indirect theoretical, philosophical and humanitarian ideals can be located through this history of psychoanalytic psychotherapy, or what was seemingly interchangeably referred to as psychoanalysis.

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<sup>51</sup> Ibid.

<sup>52</sup> White to Freeman, RG 418, NA: Entry 34.

## Chapter 3

### The Evolution of Psychoanalytic Theory and Practice at St. Elizabeths

White's personal reflections on how the person, the environment, and the institution are tied together in a mutually inclusive narrative can be located not only in his personal papers, but also within the practice of psychoanalytic psychiatry within the case files found in the National Archives on Pennsylvania Avenue in Washington D.C. These cases provide a glimpse into the evolution of his vision of a psychoanalytically informed treatment approach, in concert with the principles of psychobiology and moral treatment within the hospital setting. The attempt to situate White within the landscape of traditional psychoanalysis is complex, because he principally functioned outside of the established borders of private practice psychoanalytic theory and practice. Bergmann argues that during Freud's lifetime, there were only two types of contributors to psychoanalytic theory and practice, namely, *heretics* and *extenders*.<sup>1</sup> He defines extenders as those who "extend psychoanalysis into areas as yet unexplored, but their findings do not demand modification." Heretics are those who were once close to Freud, made important contributions, and then broke away and started their own schools of psychoanalysis. White does not appear to fit neatly into either of Bergmann's narrow classifications. Freud and his followers arguably viewed White as a heretic for emphasizing the relevance of the social environment in almost equal measure alongside intrapsychic forces in adult psychopathology. However, it was White's student, Sullivan, who formally meets Bergmann's criteria for a heretic in his role as one of the principal

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<sup>1</sup> M. S. Bergmann, "Reflections on the History of Psychoanalysis," *Journal of the American Psychoanalytic Association* 41, no. 4 (1993): 929–55.

founders of the interpersonal movement in psychoanalysis.<sup>2</sup> In terms of viewing White as an extender, I argue that while White's work did indeed cause enmity with Freud, and while his work was not appreciated in Freudian circles beyond hospital psychiatry, his contributions were appreciated within the traditional medical community. In this particular context, White can be viewed as an extender, meeting Bergmann's particular criterion for extending "psychoanalysis into areas as yet unexplored," but he does not meet the second half of Bergmann's requirement that "their findings do not demand modification."<sup>3</sup> One of the primary modifications that White and his staff made was not in terms of psychoanalytic technique per se, but was related to the type of patient deemed suitable for analysis. This extension of the application of psychoanalysis can be located during the first half of the twentieth century, when White and his staff attempted the analytic method with the type of primitively organized patient that Melanie Klein, decades later, would attempt to cure in the face of strong opposition. The case files describe a narrative of trial and error. Some patients improved, others did not. In this chapter, the narrative that represents a lost part of the evolution of psychoanalysis unfolds not only through treatment successes, but equally, through treatment failures. Patients with severe pathology such as *dementia praecox* or *acute mania* were not summarily excluded as candidates for the analytic method. White and his staff appears to have applied the criteria of who was analyzable to a far greater sphere of patients than was customarily seen in the private consulting rooms of Manhattan or Washington, DC. Bergmann affirms this when he states:

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<sup>2</sup> Harry Stack Sullivan, *The Interpersonal Theory of Psychiatry* (New York: W. W. Norton & Company, 1968).

<sup>3</sup> Bergmann, "Reflections on the History of Psychoanalysis," 171.

Freud was treating a relatively insignificant part of the world's population. His patients were middle-class, well-educated, articulate, and by-and-large secular Jews.<sup>4</sup>

The patients who resided at St. Elizabeths were not typically the eloquent and introspective individuals who self-selectively entered analytic treatment. To the contrary, admissions registers indicate that White's institutionalized patients were overwhelmingly of the lower socioeconomic classes, erratically educated and mostly of Catholic or Protestant origin. Most would never have heard of psychoanalysis, and there is no indication in the case files that any patient ever requested this form of treatment. In keeping with his optimistic stance as an adherent of Progressive Era ideals, White believed that psychoanalysis could be of use to many patients within the hospital setting, despite the impediments of class, education, or diagnosis. In the psychoanalysis practiced within the institutional setting, White's belief in the mutual influence between the social environment and intrapsychic dynamics came together in a concrete manner. As is seen in his *Autobiography*, White was, at his core, idealistic about the human condition, and it was in part this idealism that enabled him to lengthen the reach of psychoanalysis into the American psychiatric ward. The decision to situate the analytic method within the asylum was both courageous and hazardous, in part because the outcome of this method in the asylum setting was uncertain. This unpredictability is reflected in the case files as the determination of who was a suitable candidate for this type of treatment was arguably more complicated than it would have been in the private consulting rooms. The starting point was a population with a baseline of

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<sup>4</sup> Bergmann, "Reflections on the History of Psychoanalysis," 931.

pathology that was significantly more severe in nature than what one would have found in those private consulting rooms. In 1919 Lucille Dooley published guidelines for delineating which patients would most likely be analyzable within the confines of St. Elizabeths. Later in this chapter I outline these instructions, and I examine the myriad of ways in which it mirrored classical Freudian principles, but also its points of divergence.

Another important window through which the application and evolution of psychoanalytic theory can be observed is found in the cases written up and discussed in journals. Accordingly, a number of cases between 1903 and 1937 that were treated at St. Elizabeth and documented in the psychoanalytic literature databases are examined to further illuminate the place of psychoanalysis under White. The psychoanalytic principles and treatment approach within St. Elizabeths Hospital during White's tenure appear to fall naturally into two main periods. First, the time period before the arrival of psychoanalytically oriented researchers and clinicians, and then the period after the watershed year of 1915, when Edward Kempf arrived. The first period spans a little over a decade, from 1903 to 1915. During these twelve years, moral treatment, hydrotherapy, and modified confinement were dominant themes. Case files tell the story of a very particular approach to patient care that evolves gradually, but that is largely devoid of discussions pertaining to psychogenesis. In 1915, Edward Kempf, the renowned research psychiatrist, joined the staff, followed shortly thereafter by the psychoanalyst, Lucille Dooley, who arrived in 1916. Sullivan joined in 1922, thereby further solidifying the presence of psychoanalytic treatment in the institutional setting.

The case files between 1915 and 1937 appear noticeably different from the 1903–1915 files. Prior to 1915, files typically contained brief patient histories, ward

notes focused on occupational therapy, hydrotherapy, and restraint (often in the form of confinement to the patient’s room), and comments on the patient’s compliance and adherence to institutional rules. Table 3.1 provides a summary of the areas and categories of information gathered by the medical team in 1905, and the areas and categories addressed in 1915.

*Table 3.1: Treatment summary approaches based upon patient files: 1905 and 1915*

Categories of mental and physiological functioning covered in 1905 <sup>5</sup>	Categories of mental and physiological functioning covered in 1915 <sup>6</sup>
History of disease in relatives: insanity, epilepsy, chorea, hysteria, neurasthenia, tuberculosis.	Present symptoms at admission.
Family and patient history of addiction.	Family history (from patient and, where possible, collateral information from relatives).
Patient characteristics in terms of temper and conduct.	Personal history-- <ul style="list-style-type: none"> <li>i. Alcoholic history</li> <li>ii. Sexual history</li> <li>iii. Past illness</li> </ul>

<sup>5</sup> Summarized from case files 15120–15132; clinical record (1905).

<sup>6</sup> Summarized from case files 22552–22898; clinical record (1915–1916).

History of physical illness: epilepsy, apoplexy, syphilis, tuberculosis, heat exhaustion, other serious physical disease.	Present illness
Sexual excess of abnormal sexual habits.	Hallucinations and delusions (including type of delusion)
History of previous 'attacks' and when and how first symptoms became manifest. Prior institutional treatment.	Mental status— <ul style="list-style-type: none"> <li>i. General attitude on admission</li> <li>ii. Stream of talk</li> <li>iii. Emotional status and attitude of mind (e.g., depressed)</li> <li>iv. Memory for remote and recent events</li> <li>v. Insight and judgment</li> </ul>
Medical interventions for current conditions.	Physical examination
Previous change in disposition or evidence of physical or mental depression or disorder.	Laboratory findings
Description of present symptoms of insanity.	Diagnosis
Suicidal and homicidal tendencies.	

By 1920, the categories of dreams, “ethical reaction,” and “special memory” had been added to the existing categories of the 1915 case records, and, when relevant, these additional areas were added to case conference notes, which were now more routinely included in patients’ records. Patients’ family histories, beginning with birth, are often meticulously documented, and in many instances, files contain letters from family members corroborating or contradicting information obtained from the patient. Other notable additions that are particularly relevant to the evolution of psychoanalysis are more detailed sexual histories and questions about the content and recall of dreams. The language of diagnosis also becomes more precise and meticulous, but in the earlier period no case conceptualizations are found in the patient files. A typical description of a patient’s functioning during the 1903 to 1910 time period includes an emphasis on the symptoms, physiological condition of the patient, and the behavior observed, without elaboration as to the potential underlying causes of these observations. The only possible hypothesis offered is in terms of “hereditary traits,” but the function of these hereditary traits is also not explored in the case files.<sup>7</sup> Similarly, the admitting physician would frequently estimate the patient’s level of intelligence, but no connection between mental capability and symptom formation or behavior is made directly. Accordingly, a patient who presented with hallucinations and delusions in 1905, was described quite differently from a patient who was admitted with these same symptoms from 1915 onwards. For example, in 1905, a male patient suffering from hallucinations and delusions is described mostly in terms of his behavior, with ward notes emphasizing his physical condition. The patient is noted to have a “good appetite,” “sleeps well,” and is described as “agreeable.” In the patient’s case file, White writes that

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<sup>7</sup> See Case 15132, clinical record; case 15129, clinical record; and case 15141.

The active mental disturbance and excitement, together with the hallucinations and delusions that then existed have largely subsided and he is now generally speaking in a rational and tranquil frame of mind.<sup>8</sup>

In contrast, the case of a 39-year old male patient admitted in December of 1915, also suffering from delusions and hallucinations, is described in a detailed manner that draws upon psychoanalytic principles. This actively psychotic patient is described by Dr. Glueck as suffering from “well systematized persecutory delusions...which extends back about five years.”<sup>9</sup> The patient is furthermore described as euphoric and grandiose, but nonetheless intelligent. By 1926, when this same patient is presented in case conference, the medical team describes his psychological functioning and his symptoms in the language of psychoanalysis:

He has a very wealthy delusional system and is principally concerned with sexual matters...the delusional system is that he, [Anonymous], is both the executor and the victim in this process; he alludes to the persecutor here on the ward as being a man and then as being a woman; but this sexually interchangeable character is named [Anonymous].<sup>10</sup>

This level of detail is absent from earlier cases, despite the similarity in symptoms. It is worth noting that this particular patient never received psychoanalytic treatment at St. Elizabeths, as the patient was not deemed to be a suitable candidate. The patient received the standard treatment protocol of hydrotherapy, occupational therapy, and

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<sup>8</sup> Case 15132, clinical record (1905).

<sup>9</sup> Case 15132, clinical record (1905).

<sup>10</sup> Case 22550, clinical record (August 24, 1926).

medications, such as triple bromide and trional. This is an indication that even in cases where a patient was not a good candidate for psychoanalysis, by the 1920s, White's treatment teams conceptualized even the most severe cases utilizing psychoanalytic terms and concepts.

Alongside these developments, by 1920, almost every case file includes measures of intelligence, often linked with judgments about a patient's capacity for insight, and the presence or absence of adequate judgment.<sup>11</sup> In this chapter I examine the case files against the backdrop of these time periods. I outline how the language of psychoanalysis was, because of the unique institutional location, inextricably tied to and developed alongside the principles of psychobiology and moral treatment. I argue that these aforementioned principles were necessary for the evolution of psychoanalysis within the hospital. As opposed to viewing psychobiology and moral treatment as impediments to establishing psychoanalysis as a legitimate method of conceptualization and treatment, I argue that it is precisely White's vision that these could coexist that was formative in positioning psychoanalytic thought as a prominent theory. White's personal views that psychobiology and the analytic method can and should be merged found expression in the day to day lives of the patients and staff at St. Elizabeths. While the division of the time period White spent at St. Elizabeths makes sense from the perspective of tracking the evolution of the analytic method, it is important to bear in mind that the methods of hydrotherapy, moral treatment, and psychobiology remained throughout his tenure, and beyond. Nonetheless, the watershed year appears around 1915: for the first time, hospital records include the theoretical principles and

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<sup>11</sup> Given the high numbers of forensic patients and military personnel at St. Elizabeths, the inclusion of intelligence tests in the 1920 files and onwards makes sense. The Binet tests were introduced by [[first name?]] Goddard into the court system in 1914 for the first time.

techniques of psychoanalysis. Annual reports between 1915 and 1921 delineate the number of patients analyzed, but do not provide the numbers of sessions, duration of treatment, or other biographical information, other than diagnosis at admission. The impact of Kempf's arrival, and subsequent tenure, on establishing the analytic method under White's stewardship is captured in the numbers of patients analyzed at St. Elizabeths. During these seven years, Kempf and his clinical staff provided analytic treatment to a total of 2,327 patients. Cases were divided into three categories, those under the care of Junior Physicians, Senior Physicians, and those receiving "Special Analysis." It is not clear from the case records what the criteria were for assignment to a particular category, but the annual reports state that cases in this latter category received more consistent and longer term psychotherapeutic treatment. In 1915, the first year when psychoanalysis was introduced as a treatment method, diagnoses of patients who were analyzed included "anxiety depression," dementia praecox, manic-depression, paranoid patients, psychosis associated with epilepsy, and, in only one case, hysteria.<sup>12</sup> Subsequent reports between 1916 and 1921 show a similar pattern wherein dementia praecox remains the most common condition in patients undergoing psychotherapy, followed by manic-depression. Richard Noll's detailed exposition of the history of dementia praecox affirms the rise of dementia praecox in the United States asylums. He demonstrates how, in 1895, there were no reported cases of praecox, but by 1912, tens of thousands of cases are referenced in patient rosters.<sup>13</sup>

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<sup>12</sup> Government Hospital for the Insane (U.S.), ""*Report of the Government Hospital for the Insane to the Secretary of the Interior*, 1889.

<sup>13</sup> Richard Noll, *American Madness: The Rise and Fall of Dementia Praecox*, 1st ed. (Cambridge, MA: Harvard University Press, 2011).

Annual reports starting in 1922, the year after Kempf's departure, no longer listed the numbers of patients or the diagnoses of those patients who received individual psychoanalysis at St. Elizabeths.

*Table 3.2: Numbers of patients treated with psychoanalysis summarized from annual reports of St. Elizabeths Hospital, 1915–1937.<sup>14</sup>*

Year of Annual Report	Studies with Junior Physicians	Studies with Senior Physicians	Special Analysis	Annual Totals
1915	180	8	70	258
1916	600	1	98	699
1917	304	75	91	470
1918	107	-----	46	153
1919	-----	-----	111	111
1920	-----	-----	401	401
1921	-----	-----	235	235
Total number of patients seen for psychoanalytic treatment: <b>2327</b>				

The willingness of physicians within the hospital setting to combine the psychological and the somatic is borne out in the case files and also summarized in the annual reports. Patients undergoing psychotherapy routinely also received hydrotherapy and participated in the occupational therapy treatment programs. This

<sup>14</sup> Saint Elizabeths Hospital (Washington, D.C.), *Report of the St. Elizabeths Hospital to the Secretary of the Interior for the Fiscal Year Ended*. (U.S. Government Printing Office, 1921).

protocol of treatment at St. Elizabeths contradicts Edward Shorter's argument that there was near constant conflict between these two approaches.<sup>15</sup> Sadowsky, Raz, and Rasmussen have all similarly disputed this narrative, arguing instead for a complementary approach.<sup>16</sup> I adopt the complementary approach by arguing that the analytic method at St. Elizabeths was often adjunctive to, as opposed to exclusionary of, the well-established treatment practices that involved hydrotherapy, moral treatment, and the principles of psychobiology.

## **1903–1915: Hydrotherapy, Occupational Therapy, and the Principles of Psychobiology**

### *Hydrotherapy*

A bodily based therapy, hydrotherapy was first introduced at The Government Hospital for the Insane in 1897 by George Foster, an assistant physician, thereby making St. Elizabeths one of the first hospitals in the country to employ this method. Hydrotherapy soon became a treatment mainstay in government hospitals all over the United States,<sup>17</sup> and remained firmly in place when White's tenure ended. Prescribing physicians practiced this treatment method with what they viewed as scientific precision. Case files often reference the frequency of treatment, the water temperature

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<sup>15</sup> Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: Wiley, 1996).

<sup>16</sup> See Jonathan Sadowsky, "Beyond the Metaphor of the Pendulum: Electroconvulsive Therapy, Psychoanalysis, and the Styles of American Psychiatry," *Journal of the History of Medicine and Allied Sciences* 61, no. 1 (January 2006): 1–25, <https://doi.org/10.1093/jhmas/jrj001>. See Mical Raz, "Between the Ego and the Icepick: Psychosurgery, Psychoanalysis, and Psychiatric Discourse," *Bulletin of the History of Medicine* 82, no. 2 (2008): 387–420, <https://doi.org/10.1353/bhm.0.0038>. See Nicolas Rasmussen, "Making the First Anti-Depressant: Amphetamine in American Medicine, 1929–1950," *Journal of the History of Medicine and Allied Sciences* 61, no. 3 (July 1, 2006): 288–323, <https://doi.org/10.1093/jhmas/jrj039>.

<sup>17</sup> M. S. Legan, "Hydropathy in America: A Nineteenth Century Panacea," *Bulletin of the History of Medicine* 45, no. 3 (June 1971): 267–80.

as well as the type of hydrotherapy, for example, continuous baths or wet sheet packs. In *An Epitome of Hydrotherapy for Physicians, Architects and Nurses*, the hydrotherapy pioneer, Simon Baruch, instructed physicians to prescribe this therapy with the same care that one would take when prescribing drugs.<sup>18</sup> After the construction of the receiving buildings were complete, White instituted hydrotherapy that included modern equipment and facilities, and in 1905, hydrotherapy for white patients became a part of the standard treatment protocol. Figure 3.1 depicts a typical example of a hydrotherapy room at St. Elizabeths. The three primary methods of hydrotherapy used at St. Elizabeths were the *wet sheet pack* (figure 3.2), the *Scotch douche* (figure 3.3), and *continuous baths* (figure 3.4), and to a lesser extent the *shower bath* and the *needle spray*.



Figure 3.1 Hydrotherapy clinic in women's receiving building at St. Elizabeths.  
(National Archives RG 418-G-26)

Table 3.3 offers a summary description of each method of hydrotherapy. In terms of the restraint often used during hydrotherapy, in particular with regard to the

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<sup>18</sup> Simon Baruch, *An Epitome of Hydrotherapy: For Physicians, Architects and Nurses* (Whitefish, MT: Kessinger Publishing, 2008).

continuous bath, White once again took a position against the use of restraint. While restraint in the bath was part of a standard treatment protocol at other institutions, White regarded such measures as both unsafe physically, and also not therapeutic from a psychological perspective.<sup>19</sup>

Table 3.3: Description of hydrotherapy usage

<b>Hydrotherapy Method</b>	<b>Description of Treatment</b>
<i>Wet Sheet Pack</i>	Available in hot or cold temperatures. Patient was wrapped in a sheet that had been dipped in water and wrung out. This was followed by being enfolded in blankets and a rubber covering. The typical time that the patient was be kept in this state ranged from twenty minutes to two hours. <sup>20</sup>
<i>Scotch Douche</i>	A stream of water was applied to the patient’s spinal column from a distance of fifteen feet away. <sup>21</sup>
<i>Continuous Baths</i>	The patient was placed in a hammock, suspended in a large tub while water flowed over and around the patient in a continuous manner. <sup>22</sup>
<i>Shower Baths</i>	This was very similar to the standard shower. <sup>23</sup>

<sup>19</sup> William Alanson White, “Dangers of the Continuous Bath,” *Modern Hospital* 6 (1916): 10–11.

<sup>20</sup> Baruch, *An Epitome Of Hydrotherapy*, 12.

<sup>21</sup> *Ibid.*, 13.

<sup>22</sup> *Ibid.*

<sup>23</sup> Matthew J Gambino, “Mental Health and Ideals of Citizenship: Patient Care at St. Elizabeth’s Hospital in Washington, D.C., 1903–1962” (PhD diss., University of Illinois Urbana-Champaign, 2010).

<i>Needle Spray</i>	Jets of water from a lateral position at four entry points were directed at a patient simultaneously. <sup>24</sup>
<i>Sitz Bath</i>	The patient's pelvic area was exposed to continuously flowing water while the patient sat in a bath that resembled a chair. <sup>25</sup>
<i>Hot Air Cabinet</i>	A temperature differential was a key treatment method in the use of this device. Patients sat in an enclosed wooden cabinet in which they were exposed to hotter temperatures that led to perspiration, while nurses would simultaneously press cold towels to the back of the neck. <sup>26</sup>

By 1919, four years after he introduced psychoanalytic interventions, White acknowledged the utility of hydrotherapy for disturbed and agitated patients when he wrote in the Annual Report that

[W]e know of no other single item that has done more to add to the comfort of the patients and relieve them when restless and disturbed than the proper use of the hydrotherapeutic apparatus.<sup>27</sup>

Hydrotherapy was still regularly used in the cases of acutely psychotic patients. On January 18, 1925, a 39-year old male patient was prescribed wet sheet packs twice per day after “attacking those about him...he seized his bed, and threw it about the

<sup>24</sup> Gambino, “Mental Health and Ideals of Citizenship,” 111.

<sup>25</sup> Lois D Hubbard, “The Continuous Bath and the Affective Psychoses,” *International Clinics*, 33, no. 2 (1923): 106.

<sup>26</sup> Hubbard, “The Continuous Bath,” 108.

<sup>27</sup> Annual Report 1919, 799.

room.” One week after the prescription, the case notes indicate that he had become “quieter lately although it has been thought that he is to continue the packs for a short time.”<sup>28</sup> Another patient whose disorder was viewed as so severe that “the patient spends most of his time in outside cerebration and ...his interests are not of the outside world,” was given the prescription of hydrotherapy, and to a much lesser degree, occupational therapy in light of his almost constant psychotic state.<sup>29</sup> Ward notes indicated the frequency with which patients were treated with hydrotherapy. A severely incapacitated female patient, described as “hallucinated, disturbed and assaultive” was prescribed a combination of cold packs, the standing shower, and the needle spray three times a day between February 9 and April 14, 1932, totaling 148 hydrotherapy treatments. The case file indicates that her condition improved, although she remained “unreasonable.”<sup>30</sup> Given White’s belief in the effectiveness of hydrotherapy, it is reasonable to examine whether White regarded the somatic as superior to the psychological. During the first quarter of the twentieth century, the bodily benefits of hydrotherapy was widely accepted. White, a firm adherent of psychobiology, made clear his belief that hydrotherapy also serves a psychological function. In *Outlines of Psychiatry*, he explains that “the continuous bath, in spite of all that has been written about its physiology, to my mind accomplishes its results psychotherapeutically.”<sup>31</sup>

<sup>28</sup> Case 22550, Clinical note

<sup>29</sup> Case 36314, Clinical note

<sup>30</sup> Case 36323, Clinical note

<sup>31</sup> White, *Outlines of Psychi*



Figure 3.2 Patients wrapped in wet sheet packs as part of hydrotherapy.

Source: RG 418, NA: Entry 72 (General Photographic File: Series P, Box 7.)



*Figure 3.3 Patient suspended in a hammock per the continuous bath method.*  
Source: National Archives RG 418: Entry 72 (General Photographic File: Series P, Box 3.)



*Figure 3.4 The attendant operates the Scotch douche. Patient is in the shower bath being administered the needle spray from a typical distance of fifteen feet.*  
Source: National Archives RG 418: Entry 72 (General Photographic File: Series P, Box 3.)

Two years later an assistant physician and psychiatrist at St. Elizabeths, Dr. Lois Hubbard, published an article titled “The Continuous Bath and Affective Psychoses,”

arguing that the continuous bath “provides the illusion of a ...much desired intra-uterine existence, thus leaving the entire personality free to attend to the problems underlying the psychoses”<sup>32</sup>. Despite these conceptualizations, hydrotherapy was not always effective, and the case files are replete with cases in which hydrotherapy worked for circumscribed periods of time before patients relapsed, or when, as a result of violent gestures, this method had to be abandoned altogether. Hydrotherapy was, however, often used in concert with occupational therapy.

### *Moral treatment and occupational therapy*

The ease with which White and his colleagues were able to combine analytic conceptualizations with traditional treatment methods extended beyond the popular hospital mainstay of hydrotherapy. Karl Menninger viewed White as a reinterpreter of what he referred to as “the old moral treatment.”<sup>33</sup> He made this comment in relation to the method of occupational therapy instituted on a large scale under White. It is somewhat ironic then that White, in his autobiography, *Forty Years of Psychiatry*, concedes that “like many other things that have happened in the state hospitals in the last quarter of a century, it is difficult to evaluate occupational therapy.”<sup>34</sup> While White may have had questions about the overall efficacy of occupational therapy in terms of clinical outcomes, he did view this as a pivotal treatment method, and he framed it within the language and theory of psychoanalysis. In addition to the case files and case conferences where staff frequently connected the capability for engaging in occupational therapy with level of psychological functioning, White’s reflections on

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<sup>32</sup> Hubbard, “The Continuous Bath,” 106.

<sup>33</sup> Karl Menninger, Martin Mayman, and Paul Pruyser, *The Vital Balance: The Life Process in Mental Health and Illness* (Gloucester, MA: Peter Smith, 1983), 47.

<sup>34</sup> White, *Forty Years of Psychiatry*, 94.

what he viewed as a sublimation mechanism can be located in his writing. While there can be little doubt as to the veracity of Matthew Gambino's argument that the aim of treatment was mostly about social control, or as he puts it, "citizenship,"<sup>35</sup> I extend his argument by positing that the discipline of psychoanalysis developed in concert with the goals of moral treatment, and that the psychological meaning of occupational therapy as viewed by White has been neglected.

The Freudian ideal of calming the impulses of the id found expression in the asylum, as it did in the private consulting room, but in a very different form. White thought of the end goal as the same: controlling previously uncontrollable impulses, a goal that, of course, would also have a social function within a society that valued control over mind and body. He therefore did not appear to see any conflict in combining methods. I would argue that in the hospital setting, however, the talking cure as a singular method was not typically sufficient to attain either aim. Moral treatment, which encompassed occupational therapy, mostly in the form of performing work in the hospital and on the grounds, was an important part of the holistic treatment approach followed by White and his staff. The patient's psychological progress was often measured in terms of the ability to perform productive work. This also applied to a successful course of psychoanalysis that would include the inevitable consequence of social utility and virtuous occupational functioning. Psychoanalysis and mental hygiene, which included occupational therapy and the accompanying moral virtues of utility to society, were wholly compatible in White's view. It is perhaps here that one of the greatest differences between the psychoanalysis of the private consulting room and the psychoanalysis in the hospital can be located. White regarded work as both a catalyst

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<sup>35</sup> Gambino, "Mental Health and Ideals of Citizenship," 141.

and also a consequence of a successful analytic treatment. Historians such as Gambino and Otto point out that one of the principal characteristics of St. Elizabeths was that much labor was performed by the patients.<sup>36</sup> Many tended the gardens, harvested food grown on the grounds, and manufactured goods that could be sold. This is undoubtedly true, and was a prominent feature in the Annual Reports presented to Congress when lobbying for continuous funding. It would, however, be an error to underestimate the perceived psychological functions with which White and his staff viewed the ability to work within the institution. In *Principles of Mental Hygiene*, White makes the case for the psychological as follows:

Such therapy should be primarily addressed to the individual needs of the patient, first to help him overcome his psychological difficulties (his psychosis) and secondly, if possible, he should be given such work as he may use when discharged to help support himself—to re-establish his social relations.”<sup>37</sup>

The social utility existed alongside the psychological benefits and mechanisms underlying work. In *Psychoanalysis and Vocational Guidance*, White embraces the pragmatic aspects of work—social utility and functioning in society—alongside a psychoanalytic exposition. His optimism is palpable when he states in his opening remarks that “what psychoanalysis has done for psychiatry I believe it can do for vocational guidance.”<sup>38</sup> While White’s lecture principally addresses the intrapsychic dynamics that underlie choice of vocation, he also outlines his views that justify the

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<sup>36</sup> See Gambino, “Mental Health and Ideals of Citizenship”; and Otto, “St. Elizabeths Hospital. A History.”

<sup>37</sup> White, *The Principles of Mental Hygiene*, 115–16.

<sup>38</sup> W. A. White, “Psychoanalysis and Vocational Guidance,” *Psychoanal. Rev.* 10 (1923): 255.

necessity of work from a psychological stance. First, he argues that work provides the opportunity for sublimation. While this is not a unique view, it is interesting to note the way in which White combines tenets of conflict theory with the idea of sublimation in terms of moral treatment. He states that it is a “false assumption that work of itself, hard work, may produce neurasthenia,” and he argues that it is rather the internal conflict that an individual may experience in relation to work that is likely to become an etiological factor in psychopathology.<sup>39</sup> In White’s formulation, neurasthenia is the result of “the individual at war with himself, one half of him, as it were, arrayed against the other.”<sup>40</sup> The danger of hard work is therefore removed as being the cause of a potentially serious condition of neurasthenia, leaving open the avenue of occupational therapy as a legitimate and socially acceptable form of sublimation. The “fundamental instincts” that White identifies as “the self-preservative or ego instinct...and the...sexual or creative instinct,” represent “affective and emotional aspects of the personality that must be satisfied”.<sup>41</sup> Following this line of thought, sublimation, in the form of occupational therapy, transforms what White refers to as “selfish sexual desires” into worthy social aims.<sup>42</sup> White further bolsters his argument for occupational therapy by pointing out that individuals often choose vocations for reasons that are outside of their awareness, and that their willingness or unwillingness to engage in a particular activity cannot be taken at face value, but is largely instinct driven. He states that

Considering the emotional state of the individual as an energy system we can explain what happens by assuming that as a result of the lack of satisfaction of the instinctive needs of the individual a state of tension is

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<sup>39</sup> Ibid, 256.

<sup>40</sup> Ibid.

<sup>41</sup> Ibid.

<sup>42</sup> Ibid.

brought about which expresses itself psychologically as a degree of discomfort and which by finding an adequate means of expression is resolved and replaced by a state of equilibrium...<sup>43</sup>

He points out that in some patients, the energy of the drives is expressed in a destructive manner. Following White's argument, it is logical that he arrives at the conclusion that occupational therapy, in light of the violent behavior of the dysregulated inpatient, can be harnessed as a form of sublimation particularly suited to the hospital setting. The thoughtful approach with which White viewed the potential psychological benefits of occupational therapy is outlined in 1926 when he considers the value of this treatment approach in relation to dementia praecox. He argues that occupational therapy has "indirect value" in curing patients when he states:

...nobody is cured because he is taught to decorate a vase, but that the individualizing of the patient, the centering of attention and interest upon his specific problems, the setting up of a wholesome type of transfer between patient and teacher, the starting of the flow of interest to outside realities, the socializing of his tendencies to useful occupations...the different attitude toward the patient and its necessarily different influence upon him.<sup>44</sup>

When sublimation in the form of work is achieved on an individual level, this intrapsychic process benefits society by extension. Internal order begets social order in

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<sup>43</sup> Ibid., 259.

<sup>44</sup> W. A. White, "Some Considerations Bearing on the Diagnosis and Treatment of Dementia Praecox," *Psychoanal. Rev.* 8 (1921): 421.

a mutually influential sphere. White's views on occupational therapy illustrate how he did not view the individualistic psychological processes as divorced from the social environment. His staff held similar views of the compatibility of psychoanalytic theory with social utility. Dr. Kenna, in 1924, presented a paper affirming White's views on occupational therapy in the hospital setting. He argues for the psychological by stating that this treatment "lessens introspection and self-centeredness...[and] it weakens the tenacity of delusional trends and minimizes the danger of dissociated states," and later he confirms the role of work as sublimation when he describes the utility of structured activities involving crafts as "a very desirable occupational outlet."<sup>45</sup>

A more cynical view might be that White utilized the language of psychoanalysis as a means of social control, justifying the treatment protocol of forced work at St. Elizabeths, because, ultimately, the outcome was that of an orderly treatment facility that functioned well economically. While White's intentions cannot be gauged with accuracy, his admission that occupational therapy is "one of the avenues of approach in our attempts to solve the problems of psychotic behavior, and to accelerate, if possible, the process of social and economic readjustment,"<sup>46</sup> does indicate that he simultaneously held the psychological, the social, and the economic in his conceptions of moral treatment. In addition to the concession that there were economic and social benefits to the occupational therapy activities at the hospital, we can see in the way in which cases are documented that Kenna, White, and the treatment teams also clearly viewed occupational therapy as a psychological process.

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<sup>45</sup> W. M. Kenna, "Occupational Activities at St. Elizabeth's Hospital" (Lecture, April 29, 1924), 357.

<sup>46</sup> White, as quoted in Kenna, "Occupational Activities," 355.

The vast majority of files include notes on the patient's capacity for occupational therapy. The evaluation of suitability for particular tasks is explained in detail by Dr. Kenna. He describes the preliminary conference, during which patients' physical state and capability, current mental state, natural interests, and attentional capacities are discussed by the medical team, and he stresses that all work at St. Elizabeths Hospital is performed under medical supervision. As the case notes become more detailed around 1910, the affect and disposition that a patient displays toward the tasks that he or she has been assigned are documented with more regularity, and the language used often reiterates the early twentieth-century connections between work, morality, and improved psychological health. An acutely psychotic 34-year old male admitted on July 20, 1905, referred to himself as "fish glue" during the initial interview. His progress over the following year was often measured in terms of his disposition to work. In June of 1906, he is described favorably as "obedient," and later in November staff reports that he is "a great worker, continually doing something about the ward. Is clean in habits and dress...helps with yard work and around the ward."<sup>47</sup> The patient was discharged shortly thereafter. Another patient who suffered from melancholia and delusions of persecution, was released after a six-month stay. During the closing case conference, the absence of his delusions, in concert with his employment in the hospital Greenhouse, good behavior, and his "willingness to cooperate" were all cited as consideration in evaluating his recovery.<sup>48</sup> An improvement in the ability to work was also cited in a case conference involving a female patient's request that she be allowed to receive visitors.

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<sup>47</sup> Case 15142, Clinical notes (January–July 1905).

<sup>48</sup> Case 15172, Clinical notes (August, 1905).

In a statement by her physician, the rationale for granting this request was that “her mental condition is considered good. She is industrious on the ward, and is neat and tidy in her appearance.”<sup>49</sup> In the case of a long-term patient who remained at St. Elizabeths, his inability to engage in occupational therapy was viewed as a marker of the severity of his illness. Case notes state that he “assists with a little of the yard work but takes very little interest in it, and in fact has almost no interest in anything,”<sup>50</sup> and later, when the physician notes that there has been no improvement in the patient’s condition, he is described as “manneristic, silly, seclusive, does a little polishing of the floor in a lackadaisical fashion.”<sup>51</sup>

Despite the obvious social utility of the work that patients performed at St. Elizabeths, the idea that patients were forced to work beyond their psychological capabilities is not supported by case files. The psychological appears to have been prioritized over the occupational, most likely in part for very pragmatic reasons, such as the safety of those resident at the hospital.

In the case of another very ill patient diagnosed with dementia praecox, case notes document an inconsistent pattern of work, with many weeks passing without the patient engaging in any form of occupational therapy. At other times, he “will obey simple commands and sometimes helps about the ward.” Perhaps in a nod to the principles of psychobiology specific to hereditary influences, no moral judgment of character is present in the case notes spanning his three-year residence at The Government Hospital for the Insane.<sup>52</sup>

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<sup>49</sup> Case 36336, Clinical notes (May 14, 1931).

<sup>50</sup> Case 36327, Clinical notes (April 18, 1932).

<sup>51</sup> Case 36327, Clinical notes (July 28, 1932).

<sup>52</sup> Case 15169, Clinical notes (January 10, 1906).

For those patients who were not suitable candidates for psychoanalysis, White nonetheless retained the ideals of the Progressive Era. Occupational therapy, in addition to the obvious economic benefits, also kept open the door towards moral improvement. Social reform in White's vision was possible in the institutional setting, and even small strides made by very ill patients were carefully documented.

In the case of 25-year old male patient who spent a year at St. Elizabeths on account of a head injury and depressive mood, White documents that the patient performs "light duties in the Administration Building," and that he performs these duties in a "cheerful and contented" manner. In another case note a staff member points out that the patient "likes to work," which is seen as a positive sign towards recovery. During a conference in which a patient was considered for ground parole, the treatment team concluded that the request would be granted on the basis that "the patient has shown some improvement of late in that he appears to be active and alert on the ward. He now is working in the carpenter shop where he enjoys his work and is doing well."<sup>53</sup> By contrast, there were times when a patient's resistance to occupational therapy was conflated with a moral judgment towards the negative. In the ward notes written by an attendant in 1916, a 39-year old indigent patient who refused to partake in tasks assigned to him, was described as "not cooperative with work, untidy in habits...and an all around bad man."<sup>54</sup>

White was of the opinion that even those who are psychotic would be able to benefit from occupational therapy. He regarded it as "one of the avenues of approach in

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<sup>53</sup> Case 36359, Clinical notes (November 18, 1930).

<sup>54</sup> Case 22550, Clinical notes (January 1916).

our attempts to solve the problem of psychotic behavior, and to accelerate, if process, the process of social and economic readjustment.<sup>55</sup> With the exception of restraint in their rooms, patients who suffered from more acute forms of psychopathology received treatment regimens similar to the regimens of those patients who were less acute in presentation, and occupational therapy was no exception. When White introduced psychoanalysis through Kempf and Dooley in 1915 and 1916 respectively, this changed, because unlike with hydrotherapy and occupational therapy, those who received psychological treatment were the exception, not the rule. The issue of staff resources was certainly a factor, however, the psychoanalytic method was not an appropriate treatment method for all patients. Psychoanalysis within the hospital setting was therefore an experiment not attempted before; nonetheless the practice and theory of the analytic method took root in St. Elizabeths under White between 1915 and 1940. Patients who did not directly receive this treatment often benefitted indirectly with the arrival of language that treating physicians could draw upon as they attempted to make sense of the confounding clinical presentations that so often characterized hospital work.

### **1915–1937: Psychoanalytic Theory and Practice at St. Elizabeths**

#### *White's views on psychoanalysis*

A man seems to have been considered by the psychologist as an object of experiment and rarely as a human being in a social environment. True, the behaviorists may change all this but in the meantime a new psychology has come into existence, born of the sufferings and heart

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<sup>55</sup> White, *The Principles of Mental Hygiene*, 121.

aches of the mentally ill—the psychology which is called psychoanalysis and, no matter what remote history of events preceding its birth, properly also bears the name of its real creator, Prof. Sigmund Freud of Vienna—Freudian.<sup>56</sup>

In this introduction to psychoanalysis in *Mechanisms of Character Formation*, White was able to simultaneously hold the environmental and the intrapsychic. He formalized his views on psychoanalysis in his writing, including in some of his most well-known works: *Mental Mechanisms*,<sup>57</sup> *Outlines of Psychiatry*,<sup>58</sup> and *Mechanisms of Character Formation*.<sup>59</sup> He also dedicated a chapter exclusively to psychoanalysis in *The Principles of Mental Hygiene*.<sup>60</sup> In 1911, four years before White introduced psychoanalysis as a treatment method at St. Elizabeths, he attempts to define what psychoanalysis is, and he makes the argument for the therapeutic value of this method. He addresses what he states is a wide spread critique of psychoanalysis as primarily based upon suggestion. While White does not deny the role of suggestion, he argues that it is a very complex technique and widely misunderstood. He forcefully states that “It has been in the past a word to conjure with and use as a cloak for ignorance,” and later he argues that because of the complexity of consciousness, any suggestion is an amalgamation of complex associated mental content. Mental states are all interconnected. He argues that “every mental state reaches back through an immeasurable line of other mental states to the

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<sup>56</sup> William Alanson White, *Mechanisms Of Character Formation: An Introduction To Psychoanalysis* (New York: MacMillan, 1916; facs. Delany Press, 2009), v.

<sup>57</sup> White, *Mental Mechanisms* (University of California Libraries, 1911).

<sup>58</sup> White, *Outlines of Psychiatry* (New York : Nervous and Mental Disease Publishing Company, 1907).

<sup>59</sup> White, *Mechanisms of Character Formation: An Introduction to Psychoanalysis* (New York: MacMillan, 1916).

<sup>60</sup> White, *The Principles of Mental Hygiene*, chap. 3, p. 34.

very dawn of consciousness.”<sup>61</sup> In order to illustrate the complex role of suggestion in patient care, White outlines the role of suggestion in hypnosis, before moving on to the role, but also the limitations, of suggestion in psychoanalysis. To illustrate the former, he describes a case that he treated with hypnosis. In this case, a female patient presented with a phobia of the color red. He acknowledges that although he was able to remove the phobia, it was only for a short period of time. The patient then became suicidal, and White suggested a substitution of a bright flash whenever the patient had the thought that others hated her. Once again, a new symptom developed after he substituted the symptom with a different suggestion that involved the jerking of her right arm. By White’s description, the treatment of this case through hypnosis was unsuccessful, but he offers this account of what constitutes a treatment failure to illustrate that, while the hypnotic method was effective in addressing the patient’s phobia through suggestion and substitution, the symptom often reappears because the underlying mechanism that caused the symptom was not attended to.<sup>62</sup> White refers to an exclusive focus on treating psychoneurotic symptoms as “end-results.”<sup>63</sup> He argues that suggestion through the hypnotic method lacks the depth required for effective and longer term treatment of pathological symptoms. White’s remedy for the lack of depth that characterizes the hypnotic method is psychoanalysis. In order to reach the depth required, the analyst must have an understanding that conscious awareness is restricted, and that much of the complexity that characterizes symptoms and actions is located within the realm of the unconscious, in “the dimly lit, twilight regions from

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<sup>61</sup> White, *Mechanisms of Character Formation*, 118.

<sup>62</sup> White, *Mental Mechanisms*, 124.

<sup>63</sup> *Ibid.*, 122.

which the focus of attention has been removed.”<sup>64</sup> White self-discloses an instant during which he had pushed content out of awareness. He recounts how he had written to a woman, addressing the envelope, as she had requested, using only her given name and middle initial. Despite this request, White continued to address her in future correspondence in a different manner. When she questioned White as to why he had not heeded her request, his analysis of this situation revealed to him that he had felt conflicted every time he wrote to her because he connected the last name to a painful memory in his own life. Once White was able to bring into consciousness his “subconscious motives,” he was able to comply with her request. In addition to pointing out the powerful role of the subconscious, White also utilized this example to illustrate that, when mental states are not synthesized, the mind mobilizes defense mechanisms that he describes as follows:

The mind in self defense endeavors to crowd out, to relegate to the limbo of the forgotten, experiences and memories that are painful. These experiences are, so to speak, put aside, pushed into a dark corner, into the obscure regions of consciousness outside of the focus of the bright light of attention. To be technical, they are repressed.<sup>65</sup>

Repression, however, comes at a cost. The cost is that the repressed experiences take on a life of their own, leading the individual to act without access to conscious decision, and ultimately these repressed memories become organized in terms of complexes that are split off. White warns that locating the origin of complexes may be very difficult, as it

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<sup>64</sup> Ibid., 122.

<sup>65</sup> Ibid., 123.

may be expressed symbolically and may not be immediately obvious to the observer. There is a conflict between the defensive structure that seeks to keep the complex in place, and the complex itself, that is, the repressed experiences that continually struggle to emerge into consciousness. Ultimately, White takes the Freudian stance that a compromise is made between the defense and the complex, often resulting in a symptom that might be either physiological or mental. White states that the task of the psychoanalyst is twofold. First, identifying the therapeutic problem in need of treatment, and second, uncovering the underlying mechanisms through which the neurosis developed and is maintained.<sup>66</sup> If psychoanalysis is to be undertaken, White recommends that the analyst should conduct a thorough history that includes pivotal events in the patient's life. He cautions against the distraction of symptoms that the patient may present with, instead directing the analyst to attend to the "entire psychic life of the individual."<sup>67</sup> White states the initial session with the patient therefore does not only include an account of the symptoms but orients the clinician to the general personality constitution of the patient.

White's understanding of psychoanalysis is not only theoretical but also deeply pragmatic. It finds expression in his description of psychoanalysis as an applied method, not merely a collection of academic principles. He makes the distinction in the following way:

Psychoanalysis had its origin in an effort to help sick individuals. Unlike academic psychology...psychoanalysis from the first was confronted with

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<sup>66</sup> Ibid., 124.

<sup>67</sup> Ibid., 125.

the problems growing out of actual human situations taken from life as real human beings really live it and know it and so was intensely humanistic from the very first.<sup>68</sup>

White continues to make the argument that human experience and the human psyche require a “pulling apart” through the analytic method. While this process appears, at first glance, destructive, it is ultimately in service of “larger truths,” which pave the way for successful adaptation once the inner structure has been exposed. White draws parallels between the history of psychoanalysis and the history of the dissection of the human body. He argues that in both cases there were taboos surrounding the taking apart of that which was sacred, and he contends that the unlayering of the mind through psychoanalysis was perceived by some as even more fraught because it involves an inquiry “into that most personal of all elements in our make-up, sexuality.”<sup>69</sup>

Pulling apart, dissection, analysis, results in ugliness to the untrained eye...To the unprepared, a human soul, from which its surface has been removed and which thus discloses its inner structure, is an ugly sight; but as in the example of the botanist, the trained observer can only be thrilled with the wonderful beauty of the marvelous adaptations which are there disclosed to view.<sup>70</sup>

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<sup>68</sup> White, *The Principles of Mental Hygiene*, 288–89.

<sup>69</sup> White, *Outlines of Psychiatry*, 290.

<sup>70</sup> White, *The Principles of Mental Hygiene*, 289.

In *Mechanisms of Character Formation*, he addresses the critique that psychoanalytic theory is too attentive to sexual content, illustrating the degree to which he was an adherent to many of Freud's theories. He argues that at the beginning of a psychoanalysis, libidinal energy is organized at a more primitive level, and this often results in what may seem like a preoccupation with sexual matters. As the analysis progresses, however, the energy attached to the sexual becomes available for sublimation. Somewhat confusingly, he then states that this sublimated energy becomes "spiritualized."<sup>71</sup> White, however, does not define what he means by this term, instead moving directly into a defense of psychoanalysis when he states that

To accuse psychoanalysis...of dealing too much with the sexual is obviously an uninformed criticism. It is not the fault of the analyst that the facts of development are as they are, while as a matter of fact the object of psychoanalysis is to free the energy from its crippling sexual moorings.<sup>72</sup>

White's understanding of the function of psychoanalysis is that it provides a means by which the analyst is able to study, through the patient's unconscious, the role of instinctive motives, both past and present. The instinctive motives are in turn tied to symptoms. Once the symptoms are removed, the developmental history of the etiology and evolution of such symptoms may be examined through the patient's memories. In *The Principles of Mental Hygiene*,<sup>73</sup> White describes the process of psychoanalysis as a study that involves the unconscious, with the aim of uncovering the way in which instinctive motives play out in the life of the patient. Instinctive processes are also tied

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<sup>71</sup> White, *Mechanisms of Character Formation*, 100.

<sup>72</sup> *Ibid.*, 101.

<sup>73</sup> White, *The Principles of Mental Hygiene*, 34.

to memory. Through psychoanalysis, the history of symptom development can be traced through the client's recall of memories, and in doing so, etiological processes that contribute to symptom formation, including defense structures, become available for investigation by the psychoanalyst. White was able to simultaneously hold an optimistic view of human potential yet acknowledge the potential role of what he refers to as "unsuitable tendencies."<sup>74</sup> In his writing on psychoanalysis, White does not shy away from the potentially destructive role of the instincts and accompanying disruptive symptoms that may affect the capacity for health and productivity in a patient's life. He argues for a long view when unpacking pathology, one that is developmentally based:

For today, we know that the pathological symptoms are often nothing else than substitute formations for bad, i.e. unsuitable, tendencies, and that the conditions of the symptoms are established in the years of childhood and adolescence.<sup>75</sup>

White, however, does not remain within the realm of the unconscious, but segues into the role of the environment. He refers to the individual as "the object of education,"<sup>76</sup> and argues that education and therapy are mutually inclusive and reciprocal:

Education and therapy now appear in a reciprocal relation to each other. Education will take care that from certain dispositions and tendencies of the child, nothing harmful to the individual or society shall proceed.

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<sup>74</sup> White, *Mental Mechanisms*, 99.

<sup>75</sup> White, *The Principles of Mental Hygiene*, 292.

<sup>76</sup> White, *Outlines of Psychiatry*, 111.

Therapy will come into play if these same dispositions have already caused the unwished-for result of a pathological symptom.<sup>77</sup>

It is notable that White lists a large number of conditions that he refers to as “apparently physical disorder.”<sup>78</sup> These physical disorders include asthma, headaches, stammering, and neurasthenia, to name a few. In what can be viewed as a nod to psychobiology, White acknowledges that many of these disorders may be treated by traditional medical methods; however, he also provides examples of cases in which psychoanalysis was utilized in the treatment of conditions that at first presentation appeared mostly physiological. White cites three cases in particular to address what he argues is a psychogenic origin for symptom presentation.<sup>79</sup> In the first case, he references an instance in which psychoanalysis established that the swollen lips with which a young woman presented was tied to unwanted romantic advances on two occasions. In a second instance of psychogenic origin, a young woman’s skin eruptions remitted after analysis revealed that these exact locations had been where her mother in law had grabbed her forearms during a particularly tense emotional confrontation. White, however, argues that though analysis can aid in symptom diminution or remission, the underlying “character defect” that was a part of the etiology of the symptom formation predisposes the individual to further pathology.<sup>80</sup> He advocates for an inclusive use of psychoanalysis that goes beyond the treatment of symptoms. White cites a third case where a strange feeling in a 7-year old boy’s arm is seen as connected to his successful refusal to be vaccinated. However, the boy’s “infantile” way of dealing

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<sup>77</sup> Ibid.

<sup>78</sup> Ibid., 293.

<sup>79</sup> Ibid., 295.

<sup>80</sup> Ibid., 296.

with situations that he finds disagreeable remains untreated, and though he is asymptomatic, what is viewed as a defect in his character leaves him vulnerable to future episodes of psychogenic origin.<sup>81</sup> For White, part of the goal of psychoanalysis is to engage with the problems of everyday living through educating the patient about what ails him or her. Psychoanalysis is not only for the very ill, but is very much suited to those who suffer from common neuroses. White argues strongly that “unless psychology is willing to busy itself with such problems it may well be called upon to justify its existence.”<sup>82</sup> What it was that constituted the neuroses was a subject White engaged with in depth.

### *The neuroses*

White singles out the *compulsion neurosis* and the *anxiety neurosis* in Freudian terms as two primary forms of neuroses. In the case of *compulsion neurosis*, he points out that the underlying mechanism is very similar to that of hysteria. Unlike the French psychiatrist Pierre Janet, who, in his seminal work, *Obsessions and Psychasthenia*,<sup>83</sup> classified phobias and obsessions under the umbrella of psychasthenia, Freud categorized these primarily as compulsions. The affect is not converted into physical symptoms but is instead displaced. The unwanted idea remains out of awareness, however, the affect remains, connected to the mental content. White quotes Freud’s belief here that the resulting complex is of primarily a sexual origin. However, unlike in *Mental Mechanisms*,<sup>84</sup> he does not expand upon this idea in *Outlines*. It is notable that White leaves this idea unfinished, not offering his own views on the centrality of the sexual basis emphasized by Freud. He also references Freud with regard

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<sup>81</sup> Ibid.

<sup>82</sup> Ibid., 297.

<sup>83</sup> Pierre Janet, *Les obsessions et la psychasthénie* (Paris: Alcan, 1903).

<sup>84</sup> White, *Mental Mechanisms*, 241.

to the *anxiety neurosis*. In these particular cases where anxiety dominates and is seen as separate from the classes of neurasthenia, hysteria, and psychasthenia, the symptoms of the anxiety neurosis include “general irritability, anxious expectation, vertigo, phobias, and parasthenias.”<sup>85</sup> Other hallmarks of this type of anxiety are attacks that manifest physically and include changes in cardiac activity, respiration, increased perspiration, trembling and shaking, dizziness, diarrhea, changes in appetite, and paresthesia. This is ultimately explained in accordance with the Freudian theory that connects the failure of physiological adjustment with a lack of adjustment of the physiological functions of the sexual organs.<sup>86</sup> As is the case with the compulsion neurosis on which White quotes Freud, White again does not offer his personal views on this conceptualization, and it is therefore not clear to what degree White adhered to Freud’s views in this regard. Closely related to the neuroses, the condition of hysteria was frequently seen in the patients at St. Elizabeths. White’s views on hysteria is therefore of particular importance.

#### *White’s conception of hysteria*

In line with White’s integrated views of the organism-as-a-whole, integrated with his views on psychobiology, in Chapter Five of *Mental Mechanisms*, he frames the condition of hysteria as simultaneously *psychological, physiological, biological, and clinical*. He credits the evolution of science with providing a method of inquiry conducive to making sense of the phenomena that can manifest as hysteria, but he argues that despite these advances, there remain unexplained symptoms.<sup>87</sup> While White is in agreement with the predominant narrative in psychoanalysis that gives credence

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<sup>85</sup> Ibid., 248.

<sup>86</sup> White, *Outlines of Psychiatry*, 192.

<sup>87</sup> William Alanson White, “Current Conceptions of Hysteria,” *Interstate Medical Journal* 17, no. 52 (January 1910): 7.

to hysteria as predominantly a mental phenomenon that can be quite successfully analyzed, he points out that such an understanding is incomplete. White contends that while analytic theory can successfully trace the psychic origin and symptom picture of hysteria, it has been less successful in addressing the bodily symptoms, what he refers to as “the vaso-motor, secretory, and visceral” manifestations.<sup>88</sup> He makes a strong argument against the reductionism of excluding the bodily from the definition of hysteria, while also critiquing those who exclude the mental. For White, the definition of hysteria can be complete only with a recognition of the importance of both the psychic and the physiological.<sup>89</sup>

The *psychological* underpinnings of hysteria, according to White, are well established. He provides examples from Binet’s work with hysterical anesthetics, and automatic handwriting as instrumental in helping to solidify the theoretical underpinnings of hysterical conditions. In particular, he emphasizes the etiology of hysteria as it relates to the phenomenon of “double consciousness” coined by Binet.<sup>90</sup> Double consciousness can be understood as “two streams of consciousness flowing side by side, relatively independent, and separated by amnesia”.<sup>91</sup> White offers a case that he studied with Sidis. He describes the patient as a woman who had undergone hypnosis with him and Sidis, and who, through the suggestion of a visual hallucination, would write the answer to questions asked of her, while she simultaneously read a book. White notes, however, that while the patient was capable of performing these two tasks, one stream of consciousness interfered with the other; and post hypnosis, White and

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<sup>88</sup> White, *Mental Mechanisms*, 72.

<sup>89</sup> *Ibid.*

<sup>90</sup> *Ibid.*, 73.

<sup>91</sup> *Ibid.*, 72.

Sidis found that these streams of consciousness had been separated by amnesia. White argues that the hypnotic state represents a submerged stream of consciousness, and that in this case, the dissociative quality that characterized this patient's responses is connected to the dissociative theory of hysteria that was current at that time.<sup>92</sup> White gives credence to Pierre Janet's theory that hysteria is entirely a mental phenomenon, and in particular Janet's ideas around disintegration, splitting of the personality, and the notion that the hysteric is particularly susceptible to suggestion.<sup>93</sup> He also found Janet's positioning of the role of the subconscious mind in keeping traumatic memories out of awareness particularly applicable to his work in the hospital. White was particularly interested in how these unmodulated emotions have the power to exert a deleterious effect on the mind, as described by Janet.<sup>94</sup> He then moves on to what he views as Sidis's contribution to an understanding of hysteria. Sidis's emphasis on dissociation explains the condition of hysteria as resulting from the "independent, autonomous activity of the subconscious ideas or systems."<sup>95</sup> Dissociation, White emphasizes, is an abnormal phenomenon that becomes dynamic, and originates within the context of severe emotional shock, or a culmination of lesser shocks. Once the process of dissociation has been set in motion, it typically continues, as new material is added to this split off part of consciousness. This process involves unceasing splitting off, and as the dissociative material takes on a character independent of what is accessible through consciousness, it grows at its expense, until it dominates the organism's functioning. Unlike in the case of the normal individual, where there is

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<sup>92</sup> Ibid., 74.

<sup>93</sup> Pierre Janet, *The Major Symptoms of Hysteria: Fifteen Lectures Given in the Medical School of Harvard University* (New York: MacMillan, 1907; 2nd ed., 1920; repr. Wentworth Press, 2016).

<sup>94</sup> Janet, *The Major Symptoms of Hysteria*, 10.

<sup>95</sup> White, *Mental Mechanisms*, 77.

balance, and where tension is appropriately relieved higher level mental functioning, in the case of pathology, the accumulated tension leads to what White describes as “waves of disturbance.”<sup>96</sup> This spilling of energy, when it occurs outside of the hypnotic or sleep states, can manifest itself in sensori-motor disturbances, for example, in epileptic seizures or transient deliria. In its most pronounced form, these secondary unconscious states can become so powerful as to form a new personality that can crowd out the original personality constellation.<sup>97</sup>

Constellations of ideas cluster together around an event or an idea, and these constellations typically function independently at the subconscious level. Breuer and Freud’s contributions to dissociative states within hysteria are also cited by White. The emphasis that Breuer and Freud placed upon the role of psychic trauma helps to explain why the hysteria presentation can remain relatively intact long-term, as the combination of powerful affective states, divorced from the dissociated contents of the subconscious, requires psychotherapeutic intervention. Events that are unacceptable are repressed defensively, leading to “defense hysteria,” which is in turn connected to conversions, where bodily states find expression in “unreacted-to” emotion.<sup>98</sup> White quotes Freud’s views on trauma in some detail, especially as it relates to sexual trauma. White, however, emphasizes not only the psychic elements, but also the bodily. He argues that the sexual ideas are connected physiologically to genital excitement, which, when it occurs prior to sexual maturity, typically leads to a traumatic reaction that, when repressed, can manifest in dissociative symptoms.<sup>99</sup> Psychoanalysis can mediate

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<sup>96</sup> Ibid., 241.

<sup>97</sup> Ibid., 242.

<sup>98</sup> Ibid., 80.

<sup>99</sup> Ibid., 82.

the conflict between the libido on the one hand and the sexual repression on the other in what constitutes a compromise between “psychic streams.”<sup>100</sup> In doing so, the root cause of the hysteria is analyzed.

In *Outlines of Psychiatry*, White differentiates between symptoms of hysteria that are *constant* and those that occur on an *episodic* basis. He refers to symptoms that typically occur within the context of the former as *mental stigmata*, which include anesthetics, hyperesthesias, motor disturbances (including, for example, paralysis or catalepsy), partial or general amnesias, and weakness of the emotions (including the loss of volition in motivation and suggestibility).<sup>101</sup> He also includes states of exaltation, depression, delusions, lethargy, delirium, fixed ideas, and somnambulism and choreiform movements. Also included are delirium, dream states, clouding of consciousness, hallucinations, epilepsy, and alcoholism. For White, crises of hysteria are associated with subconscious ideas, connected with previous experience, and imbued with a substantial account of powerful emotion, all of which has been forgotten.<sup>102</sup>

White also includes the *physiological bases* of hysteria and, when he attempts to identify the role of the biological, draws upon the work of French psychologist and neurologist Paul Sollier.<sup>103</sup> He offers a definition of hysteria, based upon Sollier’s writing, as “a physical, functional disturbance of the brain...generalized, temporary or permanent...affected by vaso-motor or trophic, visceral, sensory and motor...”<sup>104</sup>. White is, however, simultaneously critical of Sollier’s conception, stating that it is conjecture and that it has no basis in fact. His insistence on including the physiological, despite his

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<sup>100</sup> Ibid.

<sup>101</sup> White, *Outlines of Psychiatry*, 91.

<sup>102</sup> White, *Outlines of Psychiatry*, 94.

<sup>103</sup> Paul A. Sollier, *L’hystérie et son traitement* (Paris: Alcan, 1901).

<sup>104</sup> White, *Mental Mechanisms*, 82.

own critique of this explanation, is in line with his adherence to a holistic model of pathology, always firmly rooted within the organism-as-a-whole. When he moves on to *biological theories* of hysteria, he attempts to expand upon this approach.

The biological approach to hysteria is connected to the psychological, in White's view. The psychological theory explains hysteria as based upon the dissociation of the personal consciousness accompanied by a breakdown or disintegration of the personality. The biological approach attempts to identify which individuals would be particularly vulnerable to this type of disintegration. This type of susceptibility is found "in persons in whom the elements that go to make up the personality are not being held together, not closely knitted by association but fall apart upon slight provocation."<sup>105</sup> For White, this constitutes the fundamental tenet of the biological underpinning of hysteria. He references Snyder's conception of hysteria—as connected to infantile states—in support of this hypothesis, and relates it to a development deficit.<sup>106</sup> Those susceptible to hysteria typically display a "mentality lacking in development and defective in judgment and critique."<sup>107</sup> White then connects this deficit to adaptation, arguing that individuals who are placed in a new environment, and who experience difficulties adjusting, may develop a hysterical type of reaction. As examples of challenges in mental development, White, in keeping with early attempts to delineate mental conditions in terms of ethnicity, cites pathology thought to be more prevalent in certain cultures. For example, he references inhabitants from the island of Java (quoted by Kraepelin) where dementia praecox was thought to be more prevalent, as evidence of the existence of biological susceptibility. In terms of failures in adaptation, White

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<sup>105</sup> Ibid., 82.

<sup>106</sup> Snyder, "Definition et nature de l'hystérie," *L'Encéphale*, August, 1907; cited in White, *Mental Mechanisms*, 167.

<sup>107</sup> White, *Mental Mechanisms*, 83.

concurr with Snyder, arguing that the outbreaks of hysteria among the masses during the middle ages was the result of the discounting of individuality by conservative societal forces, manifesting in “the repression of the human spirit.”<sup>108</sup>

Defense mechanisms related to the resistance to recalling painful material can be viewed as not only psychological but also biological. White quotes Claparède in this regard, including the role of sleep as a function of a defense.<sup>109</sup> In White’s line of reasoning, sleep, a biological process, is a precursor to fatigue. Hysteria, too, is a defense that is related to not only the mental but also the biological bases of being hypnotizable, and the hypnotic state is in turn related to the dissociative state imbued with both psychic and biological aspects.

White furthermore explores the role of suggestion in hysteria. He concurs with Babinski in that the very act of the examination by the physician can induce hysteria based symptomatology.<sup>110</sup> For White, suggestion in and of itself constitutes a defense, because the patient chooses the safety of suggestion over his or her painful affective reality. White, however concludes that Janet’s conception of hysteria makes the most sense, and settles on the following definition:

The personality, which is the highest expression of the psyche, the acme of complexity of association in a harmonious psychological synthesis, tends rather easily to fall apart. The associations are not sufficiently strong,

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<sup>108</sup> Ibid., 84.

<sup>109</sup> E. Claparède, “Quelques Mots sur le Définition de l’Hystérie,” *Archives de Psychol*, October 1907; quoted in White, *Mental Mechanisms*, 83.

<sup>110</sup> J. Babinski, “My Conception of Hysteria and Hypnotism,” *Alienist and Neurologist* 29 (February 1908), quoted in White, *Mental Mechanisms*, 84.

sufficiently binding and it splits up under the influence of certain kinds of stresses.<sup>111</sup>

Despite favoring Janet's definition as most comprehensive in capturing the essence of the condition of hysteria, White concludes with the critique that there is no final definition to adhere to. He argues that, ultimately, this symptom representation is not bounded. He states that

All these efforts to limit, to bind in, to define hysteria within certain prescribed boundaries are not at all convincing and they fail, it seems to me, simply because hysteria does not confine its manifestations to any definite limits. It spreads out into all the available and adjoining territory and is indefinite and hazy in its outlines quite like other natural phenomena.<sup>112</sup>

For White, any effort to draw a boundary between the physiological and the psychological is not only futile, but inaccurate. He is, in this vein, critical of Babinski's argument that hysteria is primarily a higher level psychological manifestation, referring to it as an "artificial boundary" that cannot be drawn.<sup>113</sup> In a nod to the organism as a whole, and overall emphasis on psychobiology, White argues that "...between the most definitely physical of bodily processes on the one hand and highest psychic on the other, an infinity of gradations exists and at no point can it be said that what was one has become the other."<sup>114</sup> It is these loose boundaries, connected to what White refers to as "a faulty synthesis of the personality" that

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<sup>111</sup> White, *Mental Mechanisms*, 87–88.

<sup>112</sup> *Ibid.*, 88.

<sup>113</sup> *Ibid.*

<sup>114</sup> *Ibid.*

are the recognizable hallmarks of hysteria.<sup>115</sup> Hysteria as a condition requires a broader understanding that lends itself to being related to more serious manifestations of pathology, such as dementia praecox. White concludes his discussion on hysteria in *Mental Mechanisms* by asking the question whether it is not possible for a hysterical presentation to gradually cause physiological changes, until organic changes (such as he believed to be present in praecox) became evident, leading to irreversible damage.<sup>116</sup> In cases where the hysteria may be transitory, the symptomatology can still be very significant. Such is the case in *hysterical insanity*.<sup>117</sup>

### *Hysterical insanity*

White classifies three conditions under the umbrella of hysterical insanity: hysterical delirium, stupor, and dream states. He argues that while these states are often transitory, at their most intense these conditions can be categorized as psychoses. He does, however, point out that there is a continuum, with hysteria on the one end, and psychosis on the other. Pathology occurs along this line of severity; though White acknowledges that situating hysterical symptoms along this continuum is not always clear. He concedes that hysterical symptoms can develop within or outside of the context of psychosis. He also acknowledges that deterioration in certain patients occurs.

Just where these cases belong is doubtful. We must, however, concede the possibility of hysterical symptoms developing in connection with almost any

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<sup>115</sup> White, *Outlines of Psychiatry*, 237.

<sup>116</sup> White, *Mental Mechanisms*, 36.

<sup>117</sup> White, *Outlines of Psychiatry*, 53.

other psychosis...the trouble is that we have not as yet been able to define with sufficient accuracy the limits of hysteria.<sup>118</sup>

White grapples with two diagnostic issues specific to hysteria. First, the differentiation between epileptic seizures and what he refers to as hysterical convulsions. He provides some guidance here in that hysterical symptoms are typically seen in the interproximal period, prior to when the hysterical convulsions occur. In the case of epilepsy proper, these symptoms will be absent. Second, he wrestles with the differentiation between hysteria and other psychoses and diseases, most notably, dementia praecox. White does not provide a direct answer here, instead settling on the idea that hysteria can be triggered by what he refers to as an “activating agent,” which can be of physiological origin.<sup>119</sup> He also argues for flexibility in diagnosis, in other words, the clinician should have the skill and the ability to alter a diagnosis from, for example, hysteria to dementia praecox based upon the patient’s presentation over time. He cautions strongly against what he refers to as a “one disease diagnosis.”<sup>120</sup> In terms of the treatment of hysteria, he offers the central recommendation that the clinician’s task is to “reestablish broken associations” with the ultimate aim of catharsis.<sup>121</sup> He recommends Sidis’s method of inducing the hypnoidal state in order to connect the patient’s subconscious with upper consciousness. The objective is to cure the patient by allowing for the recall of repressed traumatic material, which will then be worked through.

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<sup>118</sup> Ibid., 242.

<sup>119</sup> Ibid., 244.

<sup>120</sup> Ibid., 245.

<sup>121</sup> Ibid., 246.

If these events are recalled and lived through, the patient reacting emotionally fully to them, their abnormal effects will disappear. This is the so-called cathartic method of treatment.<sup>122</sup>

### *Psychasthenia*

Midway between hysteria on the one hand and epilepsy on the other, White locates the condition of psychasthenia. He utilizes Janet's definition, which includes obsessions, impulse control pathology, depersonalization, tics, and agitation, among other symptoms, as encompassing this condition. White states that the physical manifestations of psychasthenia find expression in the diagnosis of neurasthenia, and he argues that the two primary psychoneuroses are hysteria and psychasthenia. The primary feature of psychasthenia, and the commonality that binds all symptom expression in this condition, is the lowering of psychological tension. Whereas the perception of reality requires a high degree of psychological tension, in the individual suffering from psychasthenia, the tension is insufficient, which leads to an inadequate perception that distorts reality.

The hazy view of the world resulting from the lowered psychological tension results in hazy, inaccurate ways of thinking...While lack of efficient perception makes the world of reality seem strange, unknowable, and at times of stress it seems to the psychasthenic that this vast external world of reality would close in upon him and crush him. It is the strange, the not understood, the mysterious of which we are afraid and so are accounted for the states of fear and anguish.<sup>123</sup>

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<sup>122</sup> Ibid.

<sup>123</sup> White, *Outlines of Psychiatry*, 245.

The differentiation between psychasthenia and hysteria is explained by White in accordance with Janet's view. Janet held that epilepsy and psychasthenia have in common this lowering of psychological tension, thereby rendering psychasthenia as a form of epilepsy. While the epileptic, however, recovers after a sudden and profound lowering of psychological tension, the hysteric on the other hand, experiences the lowering of tension that is characterized by a "retraction in the field of consciousness."<sup>124</sup> The defect in optimal level of tension is pervasive and uniform across consciousness in psychasthenia, whereas in hysteria, certain areas of consciousness are not affected, and may appear normal.

White points out that the classification of symptoms of psychasthenia is complicated because of the myriad of ways in which the condition can manifest itself. He singles out *obsessions* as particularly important in psychasthenia, and designates three separate categories of obsessions, namely *emotional*, *intellectual*, and *volitional obsessions*. Under the category of *emotional obsessions* one finds phobias and "morbid desires".<sup>125</sup> Phobias in turn include agoraphobia, claustrophobia, astraphobia (a fear of thunder and lightning), and aerophobia (a fear of high places). White describes the anxiety associated with phobias as sudden in onset, overwhelming to the patient on an emotional level, and as including the physical sensations of trembling, sweating, and paleness. Under morbid desires he classifies the at-times-uncontrollable cravings for drugs and alcohol. The *volitional obsessions* include the manias, including pyromania, kleptomania, arithmomania (the impulse to count), and onomatomania (the obsession with a word). *Intellectual obsessions* are purely mental, and do not manifest in observable behavior. Excessive doubt and repeated existential questioning is included here. White emphasizes that the individual is fully aware of the irrationality of the

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<sup>124</sup> Ibid., 246.

<sup>125</sup> Ibid.

obsession yet is unable to control the urge to act upon it, whether it be a mental or a physical act, or both.<sup>126</sup>

The treatment of choice for psychasthenia, according to White, is psychotherapy. He recommends that a re-education be engaged in, and that the therapist be an experienced practitioner.

A rational psychotherapy is indicated. This should include a careful regulation of the mental life within the powers of the individual, a getting away from old and vicious habits of thought by being shown their error, but better, by being directed into new channels. The treatment involves a reeducation and is quite as delicate and skillful a matter as the reeducation of the muscular habits in ticquera. It is no field for the novice, much less the charlatan.<sup>127</sup>

The experienced practitioner will be well versed in the methods of free association, word association, and the analysis of dreams.

*Free association, word association, and dream analysis*

White held the view that there are three pivotal techniques upon which psychoanalysis should be based, namely, *free association, word association, and dream analysis*.

*Free association*

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<sup>126</sup> Ibid..

<sup>127</sup> Ibid., 248.

White alerts the analyst to what he refers to as “the real problem of psychoanalysis,”<sup>128</sup> the decision, on the part of the analyst, of what to attend to through the process of free association.<sup>129</sup> White explains that the rationale behind free association is that, if the patient does not direct his or her thoughts at all, every idea will necessarily, in some way, be connected to thoughts that preceded it, thereby connecting it to the prior event. He acknowledges that free association on the part of the patient does not always come easily, since not all thoughts may seem relevant, but he makes the case that “nothing is too trivial to be worthy of analysis.”<sup>130</sup> Free association, in White’s view, is the primary method for identifying and understanding the underlying mechanisms of complexes. He identifies slips of the tongue, incidents previously forgotten, points of reference in memory that don't always line up, witticisms, and the patient’s dream life in particular, as aspects of free associative content that should be studied.<sup>131</sup>

White is quite specific in his directions to analysts on the technique of free association. He offers the following guidelines that the analyst should adhere to before commencing treatment:

1. The patient and the physician need to be alone in a room;
2. There should be no distractions nearby, e.g., bright lights, loud noises;
3. The patient should be situated comfortably so that there is not physical discomfort or unease;
4. If possible, the patient’s eyes should be closed in order to eliminate any visual distractions;

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<sup>128</sup> White, *Mental Mechanisms*, 125.

<sup>129</sup> *Ibid.*

<sup>130</sup> *Ibid.*, 126.

<sup>131</sup> White, *Mental Mechanisms*.

5. A monotonous sensory stimulus, e.g., a faradic coil that buzzes continuously, will enhance a general state of passivity.<sup>132</sup>

Once the clinical setting has been established according to these guidelines, the analyst presents to the patient a particular aspect of the patient's history that, in the analyst's judgment, should be pursued further. The patient is then asked to

...hold that event before his mind, to make no mental effort of any sort, such, for instance, as trying to remember, but to tell absolutely every thought that comes to his mind, no matter how fleeting, no matter how inconsequential it may seem or no matter how little bearing it may appear to have on the question at issue.<sup>133</sup>

When White utilizes case material to illustrate the therapeutic action of free association, he offers a combination of the more traditional case narrative, but he also emphasizes the patient's word associations.

#### *Word association*

Word association and free association are connected, in that the structure afforded by word association acts as a potential springboard for free association. White recommends the technique of word association pioneered by Jung, most specifically when analytic treatment is perceived to be at an impasse. He elaborates on this by instructing the analyst to offer a list of approximately a hundred words, some of which can be located in general human experience, and some of which may be deemed to be of special significance to the particular

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<sup>132</sup> Summarized from White, *Mental Mechanisms*.

<sup>133</sup> White, *Mental Mechanisms*, 126.

patient. (In *Outlines of Psychiatry*, White offers a list of these suggested words;<sup>134</sup> his list is provided below, in the appendix). While some of the words on White's list are found also on Jung's original 1909 word association list,<sup>135</sup> it appears as though White significantly modified which words appear, although the final number remains at one hundred, which is the number originally recommended by Jung. These modifications were most likely made in accordance with his directive that some words should be drawn from the individual patient's experience and presentation. The clinician should then read the words on the list to the patient, with the instruction that the patient answer immediately with the first word or thought that comes to mind. The therapist then records the response, and also the response time. After the list has been read to the patient once, it is repeated, but the time is not recorded on the second administration. The patient is instructed to, if possible, repeat the same associations that were given the first time. Here the analyst listens for the "complex indicator,"<sup>136</sup> thus following Jung's directive related to the clinical use of the word association list.<sup>137</sup> White defines the complex indicator as any instance in which the word elicits a disturbance in the reaction of the patient. The analyst can identify a disturbance in a number of ways. The reaction may seem peculiar, the length of reaction time may be longer, there may be carryover from one association to the next, or a complete failure to repeat the same association. White emphasizes the importance of this method as a means of identifying a complex that may not have emerged through a regular line of questioning.<sup>138</sup>

When White includes the amount of time that it took a patient to respond to the content offered, he views this as evidence that the patient attaches particular significance to

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<sup>134</sup> White, *Outlines of Psychiatry*, 247.

<sup>135</sup> C. G. Jung, "The Association Method," *The American Journal of Psychology* 21, no. 2 (1910): 219–69, <https://doi.org/10.2307/1413002>.

<sup>136</sup> White, *Mental Mechanisms*, 130.

<sup>137</sup> Jung, "The Association Method."

<sup>138</sup> White, *Outlines of Psychiatry*.

certain themes over others. For example, in one particular case that White analyzed, he asked the patient to associate to the word ‘dog’, or ‘straw’. As can be seen in Table 3.4, the patient took Sto respond to these words, but when offered the words ‘carriage’ and ‘sky’, the latter two being themes that came up elsewhere in the patient’s analysis, she offered responses of four minutes and above. White’s return to remaining as close to the scientific method as possible is striking here. He reiterates once again the pragmatic and empirically oriented stance that he maintained throughout his life, and within the context of the psychoanalytic method. When reading this particular case, he moves seamlessly between the patient’s narrative, based upon dream content and free association, and the attempt at quantifying the patient’s mental content. The way that White tabulated the word associations gathered during the course of an analysis is included in the following example table that he offers.

*Table 3.4: Recording word associations during psychoanalysis*

Stimulus	Time	Reaction	Reproduction
Dog,	3.	Pet I had once.	+
To talk,	3.2	I’ve always loved to talk.	+
Carriage,	4	Carriage at home.	+
Sky,	4.6	Beautiful blue.	Blue, sunny blue sky.
Straw,	3.	Hay.	+

White is unequivocal in his view that dreams are not merely “foolish jumbles,”<sup>139</sup> but are meaningfully constituted by the content of the dreamer’s psyche. He argues that there is a reason for the dream material to occur in the particular way that it does. The logic of this approach to dream analysis is, according to White, entirely within the purview of “a scientific psychology.”<sup>140</sup> White defines dreams as “thinking by phantasy formation.”<sup>141</sup> Fantasy formations, in turn, are oriented toward wish fulfillment, and the mechanism through which this happens is the pleasure principle. According to White, a conflict now becomes apparent. The reality principle is at odds with the pleasure principle as the individual attempts to adapt to the demands of real life. Dreams, in this sense, become a part of the individual’s attempts to adapt to external reality. White, however, positions Freudian principles of dream theory comfortably alongside his views on environmental adaptation. He points toward the Freudian notion that dreams are almost always connected to material experienced during the last waking state. He points out that dreams are not only the result of the sensory experiences of this waking state, but rather, are more intimately connected to the *association* that stirred the complex into activity, which is then expressed in fantasy formation during the night.

...when some event in the previous waking experience, so to speak, vibrates in harmony with some fact of great importance buried beneath the threshold of consciousness, then that mental fact is stirred into activity, and that is why when it forms phantasies it uses the material which brought it into being.<sup>142</sup>

White furthermore emphasizes the symbolic nature of dreams, which requires the analyst to look beyond the immediately obvious content. The dream content has to disguise

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<sup>139</sup> White, *Mechanisms of Character Formation*, 117.

<sup>140</sup> White, *Mental Mechanisms*, 118.

<sup>141</sup> *Ibid.*, 120.

<sup>142</sup> White, *Mechanisms of Character Formation*, 127.

itself in symbolism as a shield against the reality principle. The dream is, however, not only wish fulfillment. From a physiological perspective, it conserves sleep. Another function is that it often also contains some mental fact which, in the waking state, has been repressed. The repression is connected to the *manifest* and the *latent* content of dreams. In order to illustrate how these terms operate in treatment, White offers the dream of a patient who could not recall the content of his dream, except that he was convinced that the word *diathesis* appeared in his dream. The patient, convinced that such a word did not exist, instead decided that he must have mistaken it for the word *dieresis*. Upon looking up the word diathesis, however, the patient discovers that the word does indeed exist, and that it denotes a tendency to disease. The word ‘dieresis’, on the other hand, means that something is being left out. In this particular case, the patient was ill, suffering from kidney disease. He had, however, repressed his fears around developing a more severe form of kidney disease by not allowing himself to explore this vulnerability. White concludes that the dream shows the patient’s fear of developing disease, the repression of this fear, and his wish, as symbolized by the word “dieresis,” that it be left aside. The latent content, the fear of disease, is adequately disguised, even from the dreamer himself through a confusing manifest presentation, that is, a word hereunto unfamiliar to the dreamer.<sup>143</sup>

Another important term that White explores within the context of dreams is *displacement*. The aim of displacement in the dream is to shift the emotion to another element within the dream in a defensive maneuver to conceal its true meaning. In explaining the mechanism of disguise, White utilizes the Freudian term *endopsychic censor* of consciousness. This censor permits only certain elements of the dream into consciousness. White points out that the dream is the culmination of a process of condensation, wherein an

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<sup>143</sup> White, *Mechanisms of Character Formation*.

immense amount of material is determined from a wide variety of sources, in other words, the material is *overdetermined*.<sup>144</sup>

White also uses the dream of a patient to illustrate the mechanisms of *condensation* and *identification*. In this case, the protagonist in the dream was an amalgamation of characteristics of a number of different individuals. This character in the dream was so well disguised that it was, however, only through an analysis of the dream that the patient was able to utilize the manifest content in service of her treatment by identifying with this newly constituted character in the dream. It was through the processes of condensation, and the subsequent identification, that the patient was able to allow herself to recognize her wishes for the love and affection of a very significant person in her life.<sup>145</sup>

White differentiates the *wish-fulfillment* aspects of dream from what he refers to as the *teleological* significance a dream may have. The latter appears to have a more existential meaning to the patient, defined by White as

...the way in which that individual must go in order to find fulfillment, and it therefore becomes of tremendous value in offering hints, in fact definite directions for the regulation of the life of the patient.<sup>146</sup>

White uses one particular dream to illustrate the teleological character that can be expressed in dreams. In this dream a female patient had what she regarded as a very significant transgression in her past. She had always wanted to confess this to her brother, but he died before she was able to share the nature of her transgression with him. In her dream, she was standing in front of a convent, and through a window, she saw her brother, a priest,

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<sup>144</sup> Ibid, 46.

<sup>145</sup> Ibid., 48.

<sup>146</sup> Ibid., 140.

putting on his vestments in order to hear confessions. They were not able to speak, as the window was closed, and when she started to approach him by entering the building, she was not able to reach him, and she felt depressed upon awakening. In the teleological sense, White equates the closed window with her brother's death. Emotions in dreams often do not find expression but are displaced, and become evident only in the manifest content of the dream. This allows the dreamer to explore, without the emotional charge, experiences ordinarily imbued with emotion. Returning briefly to the notion of adaptation, White refers the reader to Alphonse Maeder's work,<sup>147</sup> making the point that there is a "preparatory arranging function" in service of adjusting to the external reality, and that function forms a part of the dream work.<sup>148</sup> White makes the point that dreams ultimately fulfill the infantile wishes, long forgotten and repressed, as well as the current wishes, closer to the surface of consciousness. In light of this, the dream becomes a pivotal method of enquiry, especially so in cases where the symptom presentation may appear to be very illogical, namely the neuroses, the psychoneuroses, and the psychoses. He states that

...the dream shows what is really going on in the personality... through it, it is possible to attain to the real thoughts of the individual...if it is possible to analyze the dream, not only will an immense amount of material be uncovered which would be largely hidden otherwise, but it is possible to penetrate to the very depths of the personality, even into the realm of the unconscious, the long since forgotten, the infantile.<sup>149</sup>

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<sup>147</sup> Alphonse Maeder, Frank Mead Hallock, and Smith Ely Jelliffe, *The Dream Problem* (New York: Nervous and Mental Disease Publishing Company, 1916), <http://archive.org/details/dreamproble00maed>.

<sup>148</sup> White, *Mechanisms of Character Formation*, 58.

<sup>149</sup> *Ibid.*, 144.

Given White's view that dreams are of vital importance in understanding and treating mental disorders, it is not surprising that he offers specific and direct instructions not only for the dream analysis itself, but also for the types of questions that may aide a client in recalling dreams to begin with.

More specifically, White viewed the exploration and place of dreams as pivotal to the analytic process. In *Outlines of Psychiatry*,<sup>150</sup> he provides very specific instructions for inquiring about patients' dreams. These guidelines include asking the patient during the initial interview whether he or she dreams, and how often. White offers the following five questions with which the clinician is to make the inquiry:

- a. Do you dream of things that have happened to you recently, or some time ago?
- b. Do you dream of seeing things, or of hearing things, or of things tasted, smelled, touched, etc.?
- c. Do you dream of imaginary and of impossible things?
- d. Does the same dream come twice or more? Do they change every time?
- e. Are the dreams pleasant or disagreeable?<sup>151</sup>

Finally, he instructs that the patient should be asked to recount, as accurately as possible, one or more of their dreams. If the patient is unable to recall a dream at that time, the clinician should instruct the patient that the question will be asked at a later time, and that in the interim, the patient should try to remember any dreams that come to mind.<sup>152</sup>

White illustrates his views on dreams, including the role of symbolism, and the role of the dream life of the patient as connectors between "constellations in consciousness" by recounting the dreams of his patients. The fact that White writes in detail about the content of

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<sup>150</sup> White, *Outlines of Psychiatry*, 114.

<sup>151</sup> *Ibid.*, 80.

<sup>152</sup> *Ibid.*, 82.

the dreams of his analytic patients counters the narrative that he was not a practitioner of psychoanalysis. In *Mental Mechanisms*, he presents no fewer than eight separate dreams drawn from his analytic practice. In reporting one particular case, White writes about a male patient's dream as illustrative of how actual events become interwoven with dream content. This patient, previously having had a dream about a big gray wolf, was terrified after he saw an actual dead wolf for the first time in his life. .

One my patients dreamt of a log cabin in the mountains with which he was familiar as a boy. There appeared in the dream two dogs, then two wild cats, a house cat, a man and finally a big gray wolf. The two dogs, the house cat and the man belonged to the place as he remembered it. Wild cats, too, were plentiful in that locality and he had often seen them. He never saw but one wolf, however, and that one had been poisoned and was dead when he came upon him suddenly near the house one day, and he was badly frightened. This wolf though, was a yellow wolf while the dream wolf was gray.<sup>153</sup>

White also utilizes this dream to illustrate how a particular detail singled out by the patient is subject to modification based upon the patient's actual experience. In another, more complex example, White explores the role of symbolism in dreams. In this particular case, a young woman who presented for analysis had a dream about standing on the edge of a cliff. As she falls off the cliff, she sees that she is about to fall into a den of serpents. Interestingly, in her recall of the dream, she does not express distress at falling, but is distraught at the image of the snakes. In White's subsequent analysis of her dream, he concludes that the snakes have symbolic value. It is a symbol of sin, drawn from the story of Adam and Eve,

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<sup>153</sup> White, *Mental Mechanisms*, 34.

and it is also a phallic symbol in the art and legends of many cultures. Second, he identifies three separate instances in which the patient encountered snakes during the prior three weeks; these instances eventually take on symbolic value in the patient's dream. He states that he was able to use the method of free association in order to elicit these three occurrences directly related to the patient's dream. White argues that the free association in analysis that occurred prior to the patient's dream contributed to the eventual dream content related to the serpents, thus connecting all three of the mechanisms pivotal to psychoanalysis. In this case example, White used the technique of offering the patient word associations, which he then asked the patient to free associate to. These mechanisms led to the patient's experiencing a dream, which White was able to utilize in the treatment through dream analysis. The patient's hallucinations also frequently contained serpents, and, as the analysis continued, White uncovered additional instances from the patient's past in which the symbolism of snakes featured prominently.

With this same patient, White also connected what he referred to as the "coffin dreams" with symbolism and actual events in the patient's "waking state."<sup>154</sup> He summarized this patient's dream in a chapter titled "The Content of Consciousness," in *Mental Mechanisms*:<sup>155</sup>

She dreamt that she was standing beside a coffin in which she saw, instead of the body of the young man, her own dead body. The coffin of the dream was the coffin she had seen. It was black, it had silver handles, and was lined with white satin. Her hands were folded across her chest, too, just as his hands had been. There were certain differences, however. There was one candle burning

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<sup>154</sup> Ibid., 37.

<sup>155</sup> White, "The Content of Consciousness," chap. 3 in *Mental Mechanisms*, p. 36.

at the head and another at the foot of the coffin, and in her hands she held a red rose.<sup>156</sup>

White explores the symbolism of both the rose and the coffin as he analyzes the meaning of the dream in the context of Freud's wish fulfillment theory. He concludes that the meaning of the dream is that the patient "wishes to possess her lover, even though that possession were in death."<sup>157</sup> He furthermore cites the color of the rose, a vivid red, as indicative of symbolism connected to the "emotional coloring it received in her consciousness" when the patient recounted a visit to a florist. The patient's reality, her dreams, her associations, and her symptoms are all connected, and all become a part of the analytic case conceptualization when White concludes his discussion of this case. He explains that, during the delirium that the patient experienced in the asylum, she had a vision of her own funeral procession in the clouds. When her nose bled, the bleeding seemed to her like the red roses she dreamed about and also saw when she visited the florist shop. Moreover, her delusions were of blood that flowed endlessly, ran down the stairs, and scared others who fled away from her in terror. White does not provide information on how long he treated this patient in psychoanalysis, nor does he provide details on the course or conclusion of treatment. He instead utilizes parts of cases as illustrative of aspects of analytic theory and practice, and presents them in service of training medical students.

It is perhaps this piecemeal arrangement, what one could consider as incomplete versions of cases, that creates the impression that White's work lacks depth. Certainly Edward Kempf or Lucille Dooley wrote about their cases in greater detail, often devoting entire journal articles to only one case. White seldom presents a case in its entirety, showing

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<sup>156</sup> White, *Mental Mechanisms*, 37.

<sup>157</sup> *Ibid.*, 38.

instead a preference for carefully curated parts of a whole. He moves on to the next premise, and the next case example, when he judges that his point has been made adequately; for example, after offering a few excerpts of patients' dream in *Mental Mechanisms*, he writes, in characteristic style, "So much for the phenomena of dreams. These examples show the intimate relation of constellations in consciousness, and how they are associated."<sup>158</sup>

White does not, however, locate symbolism primarily in dreams. He makes the point that, while symbolism is most often expressed in the patient's dream life, it also occurs elsewhere. White argues that symbolism, outside of the realm of dreams, is an unsophisticated mechanism by which faulty analogies are frequently achieved, often within the context of superstition and folk-lore. For White, symbolism, if it is to be of use to the analyst and in service of elucidation of the patient's psychic conflicts, should be used primarily within the context of dream analysis. He argues that while the symbolism in myths is "flimsy, superficial, inconsequential," the symbolism in dreams is multifaceted and complex.

It is in the realm of dreams par excellence that the phenomenon of symbolism manifests itself in all its richness. The dream consciousness is uncritical; ideas come and go without direction, the whole scene suddenly shifts without calling forth even exclamation of surprise; the faintest resemblance is enough to cause one object to symbolize another.<sup>159</sup>

### *The practice of the psychoanalytic method at St. Elizabeths*

What type of patient at St. Elizabeths Hospital received psychoanalytic treatment? This became a central question that emerged through the review of case

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<sup>158</sup> Ibid.

<sup>159</sup> Ibid., 40.

files. In some instances, the indications were clear and unsurprising: patients whose status at discharge was documented as “Improved,” who suffered from relatively mild psychopathology, who had the capacity for good insight and judgment, a high level of education, compliant conduct, and a rich dream life. However, in other instances, patients suffering from dementia praecox or acute mania, diagnoses traditionally seen as untreatable, were also selected to undergo psychoanalytic treatment. If patients who were delusional and actively psychotic were not automatically excluded from psychoanalytic treatment in the hospital setting, were there clear guidelines for staff as to analyzability? This was uncharted territory, because White was the first to institute psychoanalysis within the acute hospital setting. In 1919, Lucille Dooley outlined the criteria used to determine suitability for analytic treatment in a systematic and comprehensive set of guidelines.<sup>160</sup> This document is framed within a clear structure of traditional psychoanalytic principles. Front and center, Dooley situates the principle of psychic determinism:

Psychoanalysis assumes that mental expressions have mental or psychic causes; every action is an expression of a trend already present, that is, every action is determined by some past incident in the life of the individual.<sup>161</sup>

The analytic emphasis on the psychogenic influence of the past on the present becomes manifest not only in the lives of the patients who were deemed analyzable. One would perhaps expect that the case files for patients deemed more suitable for

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<sup>160</sup> H. P. Walcott et al., “Varia,” *Psychoanal. Rev.* 6 (1919): 214–26.

<sup>161</sup> *Ibid.*, 214.

psychoanalysis would contain more detailed histories, or that lower functioning patients would not be asked about their dreams. This, however, is not the case, and provides evidence for the widespread influence of psychoanalytic conceptualization for the vast majority of patients who presented with mental distress. Even in cases that were regarded as untreatable with the analytic method, the terms and concepts of psychoanalysis were still employed, though the eventual treatment method may have been focused on occupational therapy, hydrotherapy, or measured restraint.

According to Dooley, a successful analysis hinges upon two main concepts: First, the “Type of Individual,” and second, the “Types of Psychosis.” The ideal analytic patient is both intelligent and adaptable. This patient will also display good motivation, referred to by Dooley as “those who wish to recover,” and, perhaps in a nod to the hospital environment where patient compliance was highly valued, also “those who are willing to yield to guidance.”<sup>162</sup>

Dooley, however, outlines not only what makes a patient analyzable, but also delineates prohibitive criteria. Patients not suitable for analysis include the “feeble-minded or defective,” although she does allow for the possibility that, while these types of patient will not be able to undergo a “true analysis,” some may have the capacity to be “reached by reeducation of the sort used with a child.” Additional exclusion criteria apply to individuals who display poor motivation for treatment, individuals who have become “rigid by reason of age or type of psychosis,” the “ignorant, untrained or childish person who cannot grasp an abstract idea,” and “very strong homosexual types,” because of what she viewed as potentially unmanageable transference.<sup>163</sup>

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<sup>162</sup> Ibid., 215.

<sup>163</sup> Ibid., 214–26.

The centrality of psychopathology in the decision to refer a patient for analysis is also outlined in Dooley's guidelines. The likelihood of an analysis being successful increases in cases of hysteria and neuroses, for example, psychoneuroses or anxiety neuroses. Manic cases are not excluded, as long as "the excitement has subsided." Patients suffering from cyclothymia, mild depressed states, the early stages of dementia praecox, as well as substance abuse could undergo psychoanalysis at St. Elizabeths as long as the individual characteristics of the person outlined earlier are met. Conversely, there are "types of psychosis that cannot be psychoanalyzed." These include psychoses of organic origin, senile states, advanced dementia praecox, acute manic states, catatonic states, and "deep depressions and suicidal states."<sup>164</sup> These categories of pathology, combined with the un-analyzable individual characteristics outlined earlier, would exclude many patients in the hospital from being offered psychoanalysis. The case files, however, do not provide as clear of a picture of who was deemed analyzable, and they do not always line up neatly with Dooley's guidelines. In most cases, level of education and capacity for insight appear somewhat predictive, but the degree of severity in terms of praecox or delusions was not always easy to gauge when recommendations for psychoanalysis were made. It appears as though analyzability was determined on a case by case basis, with Dooley's guidelines as a roadmap rather than a directive.

In an extension of the principle of psychic determinism, case histories became central, and this is reflected in the level of detail and length of documentation in this area. Dooley provided specific guidelines for taking case histories that would enable hospital staff to obtain the level of detail required for consideration as an analytic

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<sup>164</sup> Ibid., 215.

patient. In a section titled “Methods of getting at these causal incidents,” Dooley lists four principal areas of inquiry: “The fullest possible history,” “Childhood Memories,” “Dream analysis,” and “Free Association.”<sup>165</sup> The focus in Dooley’s guidelines shifts from the characteristics of the patient to the expectations and tasks expected from the analyst. Dooley specifies not only *what* clinical material should be responded to, but also offers guidance as to *how* the clinician should ideally respond. In one particular section titled “Material to be analyzed,” Dooley states that there are certain points that may be made by a patient that should be noted, but that the therapist should not respond to immediately. These include “spontaneous actions,” “all signs of embarrassment,” “bizarre actions,” and “all subjective complaints however unfounded.”<sup>166</sup>

Dreams and the client’s narrative of the etiology of the illness feature prominently in Dooley’s guidelines, and she refers to these aspects of the patient’s mental life within the context of the individual’s “past life, especially the period of infancy.”<sup>167</sup> In a section titled “Fundamental conceptions,” the importance of psychoanalytic terms and concepts is emphasized as an aid in the conceptualization of the case history and symptomatology. These terms include the *instincts* within a developmental frame from the fetal period through adulthood as the starting point for conceptualization. Also included are the *pleasure-pain principle*, the functions and roles of *play* and *regressions*, and the identification and function of *psychoses*. Dooley identifies two fundamental causes of psychoses, first, weaknesses in the individual’s personality or *character formation*, and second, feeling overwhelmed by the demands of

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<sup>165</sup> Ibid., 214.

<sup>166</sup> Ibid., 215.

<sup>167</sup> Ibid., 216.

the *environment*. She also includes *erogenous zones*, the *libido*, *repression*, *sublimation*, *painful affects*, and the roles of *social demands* and *parental influences* and the *Oedipus* as significant factors in case conceptualization and treatment. Finally, Dooley includes a section on the nature and treatment of *transference*.

One of the most important aspects of Dooley's instructions to the psychotherapists at St. Elizabeths can furthermore be located in the references that she used to compile these aforementioned guidelines when she attempted to isolate the "fundamental conceptions" needed for effective analytic treatment. She lists Putnam, Gross, Freud, Jung (the only author who appears more than once), White's *Mechanisms of Character Formation*, and Jelliffe's *Technique of Psychoanalysis*. This is a particularly relevant point in support of the notion put forth in this dissertation, namely, that White and his staff gathered psychoanalytic concepts and treatment methods that were broader than what would have been acceptable to the traditional Freudian psychoanalysts who worked mostly within a private practice setting. The asylum demanded a more inclusive perspective that went well beyond the work of Freud and his disciples in order to accommodate the severity of the pathology, and the wide range of family and social histories and circumstances, that were present at St. Elizabeths. In later sections of Dooley's guidelines, this pattern persists. The work of Freud, Jung, White, Frink, Jelliffe, Hall, Ferenczi, and Rank are used alongside one another in an effort to put together a comprehensive document that outlines how psychoanalytic work can be engaged in within the hospital setting. Dooley's document is inclusive of a multitude of well-known classical Freudian concepts, in many instances mirroring his papers on

technique first delivered in 1910.<sup>168</sup> A closer look at Dooley's approach however, also reveals important differences and aspects of treatment and conceptualization that appear antithetical to classical Freudian practice. It is worth noting that Freud's seminal paper on analytic technique, *Analysis Terminable and Interminable*, was first published in 1937,<sup>169</sup> eighteen years after Dooley outlined the guidelines used at St. Elizabeths. First, Dooley's guidelines include an emphasis on the external social environment to a far greater degree than Freud and his followers emphasized. The patient's station in life, socioeconomic circumstances, and abrupt changes in these circumstances are probed in detail, and are seen as predisposing etiological factors in symptomatology. In one such a case, a patient who changed jobs very frequently, had a tumultuous home life, and who reported a history of sexual assault, is interviewed in detail. Her delusions of a religious content emerges in the mental status summary, and her difficulties are connected to environmental stressors.<sup>170</sup> The second point of divergence from the Freudian model, a point more in keeping with the hospital setting, can be located in Dooley's use of the language of indications and contraindications firmly situated within the medical model as she focuses on the severity of psychopathology in gauging analyzability. Patients who are severely compromised in speech, catatonic states, or memory are not immediately referred for psychoanalysis. These cases are sometimes re-evaluated after hydrotherapy treatment, or when the capacity for occupational therapy becomes more evident. Related to the medical model is the emphasis on psychobiology. The patient's

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<sup>168</sup> J. Strachey, "The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume XII (1911–1915): Papers on Technique," *The Standard Edition of the Complete Psychological Works of Sigmund Freud Volume XII (1911–1913): The Case of Schreber, Papers on Technique and Other Works, Ii-Vii*. The Hogarth Press and the Institute of Psycho-Analysis, 1958, <https://www.pep-web.org/document.php?id=se.012.0000a>.

<sup>169</sup> "Analysis Terminable and Interminable," *ResearchGate*, accessed January 19, 2017, [https://www.researchgate.net/publication/19590597\\_Analysis\\_terminable\\_and\\_interminable](https://www.researchgate.net/publication/19590597_Analysis_terminable_and_interminable).

<sup>170</sup> Case 36345, Case notes (September 15, 1930).

suitability for hydrotherapy and occupational therapy, as well as any hereditary markers of mental illness, is carefully attended to in case discussions about suitability.

The plasticity with which Dooley and her colleagues at St. Elizabeths incorporated aspects of theories seen as hostile to the Freudian movement at that time is conspicuous. I posit that such flexibility was necessary in a setting in which psychoanalysis had to be more inclusive in order to be of service to the patients that the inpatient analysts were attempting to cure. In the hospital setting, the 'talking cure' had a place, but it was not seen as a panacea for all that ailed its residents. The physicians at St. Elizabeths acknowledged failures readily, alongside treatment successes. One such an example of a treatment failure is documented in a conference report presented on February 14, 1920, a case in which psychoanalysis had been unsuccessfully attempted. The patient was a 20-year-old educated male with a diagnosis of dementia praecox. He experienced auditory hallucinations for a few days after admission, and when these disappeared, he was referred for psychoanalysis for a period of approximately five weeks. His case was conceptualized as follows:

...the strain of being at the front in the war was very severe on him. He has regressed to a childish level...has fantasies of re-entering his mother to be reborn, has conscious sister incest wishes, has homosexual impulses which he tries to suppress...He is attempting a religious sublimation of his sexual instinct in his worship of the 'Creator' whom he calls on for help when fighting off fear caused by his improper sexual wishes."<sup>171</sup>

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<sup>171</sup> Case 27244, Case notes (April 1920).

Psychoanalytic treatment was attempted with two different psychoanalysts, and both treatments not only failed, but the physicians admit during case conference that the young man “has actually gone downhill considerably.” This treatment failure is explained primarily as the result of a lack of insight, as well as what is described as “...a very strong sexual conflict of some sort...he guarded his fantasies very carefully,” as well as lack of motivation, as the patient “was not anxious to leave.” Psychoanalysis was discontinued, and the patient was referred for occupational therapy prior to discharge. Psychoanalysis evolved through the very ill, and also through those patients who improved, as well as those who did not. Dementia praecox provides a vantage point from which to observe psychoanalysis in action.

#### *Dementia praecox in the wards*

White described dementia praecox as “the most important of all the psychoses because it supplies the greatest number.”<sup>172</sup> In 1912, Jung visited St. Elizabeths Hospital with the specific intent to study African American patients. White hosted Jung during this visit when Jung met with approximately fifteen patients. In his personal notes, he stated that more than a dozen patients in this group met criteria for dementia praecox. Jung’s particular interest in this diagnosis is reflected in his documentation of the dreams of these patients at St. Elizabeths. He documented religious themes, references to the patient’s race and cultural practices, for example, voodoo. In his notes related to this visit, Jung observes that dream material is often the only accessible medium with

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<sup>172</sup> William Alanson White, *Lectures in Psychiatry*, 1st ed. (New York: Nervous and Mental Disease Publishing Company, 1928), 132.

which to observe the psyche in these patients, as other forms of psychological material in praecox is not accessible.<sup>173</sup>

An elderly 69-year old patient diagnosed with dementia praecox had written letters to White between 1911, the year of her first admission, and 1930, when she was readmitted to St. Elizabeths. When a concerned friend of the patient asked White whether he thought this patient suffered from delusions, White's reply that "we all have them more or less" made such an impression on the attending physician that he documented this exchange in the case file.<sup>174</sup> The diagnosis of dementia praecox, later known as schizophrenia, was by far the most diagnosed, and arguably also one of the most vexing of the mental disorders treated at St. Elizabeths. In 1937, the final year of White's tenure, half of those hospitalized, 5700 patients, had been diagnosed with some variant of schizophrenia.<sup>175</sup> Dementia praecox was defined as "a disease which is typically a dementia from beginning to end, and that upon this groundwork of dementia various psychotic symptoms may be engrafted."<sup>176</sup> In *Outlines*, White emphasizes the hereditary basis of dementia praecox, stating that this disease is often found in families.<sup>177</sup> Biological influences—for example, infections, severe hemorrhages, old age, glandular dysfunction, and toxicity—are all offered as potential contributing factors. White, however, takes a developmental stance and makes the case that adolescence is a particularly vulnerable period for the onset of dementia praecox, and he argues that there is a developmental arrest during this time of life in which the individual becomes

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<sup>173</sup> Personal notes taken by C. G. Jung while visiting St. Elizabeths Hospital in 1912. Unpublished. Made available with permission from Professor Sonu Shamdasani.

<sup>174</sup> Case 36344, Clinical notes (July 3, 1930).

<sup>175</sup> United States Department of the Interior, "Annual Report of the Department of the Interior" (Washington, DC: St. Elizabeth's Hospital, 1937).

<sup>176</sup> White, *Outlines of Psychiatry*, 143.

<sup>177</sup> White, *Outlines of Psychiatry*.

trapped in the course of the disease. Given this biological predisposition, White argues, it becomes even more pivotal to consider other influences that may affect the development and maintenance of praecox. In this vein, White and his staff were also adherents to Meyer's view of social maladjustment as one of the primary etiological factors, and he also emphasized the role of "severe shocks, both physical and mental" as risk factors.<sup>178</sup> The symptoms of this disease are well documented by White, and he categorizes symptoms in terms of deterioration in memory, attention, emotion, thought content, and physical condition.<sup>179</sup> He also outlines the different subtypes of dementia praecox, identifying simple dementia (heboidophrenia), hebephrenia, catatonia, and the paranoid form of praecox.<sup>180</sup>

*Simple dementia* is described by White in the first instance in terms of symptoms. He describes a cluster of symptoms that develop over time, characterized by insomnia, headaches, lethargy, irritability, and melancholia. Delusions and hallucinations occur intermittently in a transient manner. *Hebephrenia* is distinct from simple dementia insofar as the onset is more abrupt. Confusion, melancholia, and delusions are more pronounced and frequent, and suicide attempts are common. Loose mental associations, flight of ideas, and a poverty of ideas are further characteristics. Manic and peculiar mannerisms, listlessness and apathy, and incoherent speech characterized by word salad are further features of the disease.

The *catatonic* type of dementia is also sudden in onset, characterized by mild depression and hysterical attacks, with irregular catatonic episodes. In more extreme cases, stupor, negativism, and muscular tension occur within and outside the context of

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<sup>178</sup> Ibid., 143.

<sup>179</sup> White, *Outlines of Psychiatry*.

<sup>180</sup> Ibid.

mutism and bodily rigidity. On the other extreme, White describes a bodily posture that is overly flexible in a condition known as “flexibilitas cerae,” directly translated as “waxy flexibility.”<sup>181</sup> As opposed to the negativism that can characterize this condition, the opposite state of command automatism is found in some patient presentations. In these cases, suggestibility, echolalia (repetitions of words), and echopraxia (repetitive gestures) are not uncommon. Catatonic excitement marked by increased psychomotor agitation reminiscent of manic states, yet of a more peculiar quality, are further characteristics of this subtype of catatonia. Incoherence, impulsivity, and the violence that may occur during such episodes is described by White in a cautionary manner. As to the etiology of this state, White makes it clear that the patient will not be able to provide a rationale for this behavior, because patients in this state are almost always inaccessible. He grapples with his own perplexing observations in *Outlines* when he writes that

The patient is inaccessible to a degree and either gives some senseless reply to the questions asked, a puerile reason, perhaps, or retires behind an “I don't know” or complete silence. These attacks come out of the clear sky, cannot be foreseen, and make these patients at times very dangerous.<sup>182</sup>

Finally, White distinguishes simple dementia praecox from the catatonic subtype in terms of physical characteristics. In the latter, physical symptom presentations are

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<sup>181</sup> Ibid., 154.

<sup>182</sup> Ibid., 157.

marked and severe, and include weight loss, mydriasis, and Pilz, as well as exaggerated tendon reflexes.

The final form of praecox delineated by White is the *paranoid* form. White acknowledges that the definition of what constitutes this subtype of the disease has not been settled and eludes simple classification. He states that the definition of what constitutes paranoia had been poorly defined by psychiatry, and accordingly, having a designation of paranoid forms of praecox is problematic. Nonetheless, White includes in his definition of the paranoid form of praecox delusions of grandeur and persecution, sometimes of a systematized type, emotional depression during the prodromal phase, and in other cases, acute onset. The differential diagnosis as to when the condition is psychosis and when it becomes praecox is not always clear. White, however, attempts to clarify a decision point as to when the condition is most likely to be dementia praecox. He argues that when the case history shows acute onset, insomnia, depression, loss of appetite, and emaciation, and when these symptoms occur within the context of what he refers to as a “loosely organized delusional system,” it is no longer only paranoia. Furthermore, when these delusions are “numerous, fantastic, and often changeable, associated with numerous fleeting hallucinations,” a diagnosis of praecox can be made with some confidence.<sup>183</sup>

White wrote about the psychoses within the context of case studies. He draws extensively upon the case of the female patient, discussed above, who frequently experienced “coffin dreams,” and who suffered the delusion that she had had an abortion. By singling out the following events from the patient’s past as relevant to her

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<sup>183</sup> Ibid., 158.

praecox, White shows how this patient's traumatic case history furthered these delusions related to death. When the patient was five years old, she became aware of the fact that skeletal remains of infants had been found in between the walls of a convent that had burnt down in her hometown of New Orleans. This led to the fear that she would be caught and thrown between the walls. Second, she experienced the trauma of seeing three former schoolmates drown, and one of these drowning incidents occurred one week prior to her only miscarriage. Third, she witnessed two separate incidents during which a crowd of men were preparing to lynch a Negro man. In a continuation of the theme of death, this patient recounted how she had had tea at the home of a Mrs. O, who had subsequently died in her bed that night, and, in an unrelated incident, the patient discovered that she had been on a railway journey while a friend's body was being transported on the same train. In addition to these events, White opined that the patient's complicated relationship with her mother added to her symptom constellation, as the patient's mother had a "depressing influence" on her.<sup>184</sup> This manifested in the mother's communicating to the patient about a spate of suicides in their inner circle, and lamenting to the patient, from the age of 8, that she wondered "what's the use of life?"<sup>185</sup> She also received a telegram from a friend a day after the friend's death, and she recounted another instance in which a male friend was murdered in a brothel. A particularly distressing incident occurred after she refused the marriage proposal of a young man and he committed suicide by shooting himself in the head outside her home. After this incident, she experienced a mental breakdown that lasted several weeks. In making sense of these events within the context of the patient's

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<sup>184</sup> White, *Mental Mechanisms*, 42.

<sup>185</sup> *Ibid.*, 43.

delusions, White, while acknowledging that there were other contributing factors to the delusion of death, conceptualized the position of death in the patient's delusion in the following way.

...[T]he subject of death was held before her mind very prominently throughout her entire life; that her life must have been distinctly colored by these numerous, often highly emotional experiences, and that later on it was a matter of comparative ease, an issue that might almost have been expected, for the psychosis to take up this material and use it in weaving a delusional system.<sup>186</sup>

He goes on to argue that the delusion was the starting point, and that through the process of free association, the analyst was able to access and reconstruct the "over-determined idea, an over-valued idea, a hyper-quantivalent idea or a dream thought continued in the waking state."<sup>187</sup> White concludes that the realm of the mind is the place where every idea, desire, impulse and action can be located within the context of psychic determinism. The view that intrapsychic factors, accessible with psychoanalytic treatment, could potentially relieve the suffering of these patients thus finds expression in the ability of the analyst to unravel, and then reconstitute, even the most baffling delusional systems.

The contribution of patients afflicted by this condition to the evolution of psychoanalysis in the hospital setting has been neglected in the history of

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<sup>186</sup> Ibid., 44.

<sup>187</sup> Ibid., 45.

psychoanalysis. It is for this reason that I place the patient front and center in the complex cases where they become both the protagonists, and also often the confounding variables, in a multilayered analytic method. It is, however, precisely this complexity that contributed to continual psychoanalytic formulations that extended the language, theory, and practice of psychoanalysis beyond the confines of the ‘perfect’ analytic patient—the neurotic level hysteric in the throes of an unresolved Oedipal conflict. White’s conceptions of the nature of dementia praecox remained firmly rooted within the frame of psychobiology. He viewed this diagnosis both as biological in origin and as bound to intrapsychic dynamics.

In White’s conceptualization, praecox, from the purely psychological level, is a “regression psychosis.”<sup>188</sup> In 1921, he explores this in *Some Considerations Bearing on the Diagnosis and Treatment of Dementia Praecox*.<sup>189</sup> After acknowledging that there is consensus around the pivotal role of regression in this diagnosis, White raises what he regards as fundamental questions in an attempt to make sense of the often confounding course and diagnostic presentation in praecox. He states that

Regression, however, is such an all-comprehensive term, it includes so many symptoms that do not even suggest malignancy or praecox, that to have said that dementia praecox is a regression psychosis is to have said very little. If regression is the only fundamental character, when does it become praecox? And if it is not the only fundamental mechanism at work, what are the other mechanisms?<sup>190</sup>

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<sup>188</sup> W. A. White, “Some Considerations Bearing on the Diagnosis and Treatment of Dementia Praecox,” 417.

<sup>189</sup> *Ibid.*, 416.

<sup>190</sup> *Ibid.*, 417.

White argues that the etiology of the regression, and the factors that maintain the regression, and accordingly, the praecox, should be considered on a case by case basis. He focuses instead on the factors that might account for the depth of the regression. White suggests that the degree of regression may be measured by a consideration of two factors: first, the patient's personal history and, second, phylogenetic material, including hereditary traits or biological markers gleaned from family history. Here White relies upon C. G. Jung's conception of the important influence of phylogenetic factors in the etiology and maintenance of mental disorder.<sup>191</sup> Shamdasani points out that Jung's conception of the phylogenetic, in terms of how it relates to the unconscious, had convergence with Hall's conception of the phylogenetic.<sup>192</sup> Both Hall's and Jung's incorporation of the phylogenetic allowed for a historicized body, and for a multifaceted consideration, made in light of evolutionary history, of the question of how the mind and the body relate. The place of evolution could now be considered within the study of the human psyche and could be harnessed in the development of psychotherapeutic technique. Both Jelliffe and White utilized these phylogenetic contributions in their writing. The way in which White integrated the psychological, the biological, and the environmental influences, taking into account the phylogenetic, finds particular expression in his conception of dementia praecox. From the intrapsychic perspective, there is a regression to the oral and anal stages of development, which often manifests in accompanying biological symptoms, for example, biting (oral), or disorders of secretion (anal). White also references regression that is so deep that it is reflective of the "history of the race," and when the individual's

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<sup>191</sup> C. G. Jung, *Psychological Types*, trans R. F. C. Hull and H. G. Baynes (1921; repr. New York: Routledge, 2014).

<sup>192</sup> Shamdasani, *Jung and the Making of Modern Psychology*, 11.

psychological development is not well integrated with what he refers to as the “archaic,” the regression is particularly pronounced. White acknowledges that he is unable to clearly define what constitutes the “archaic,” but nonetheless, he is convinced that the collective biological history of the human race plays a part:

Every psychological state must have an aspect due to the personal experiences of the individual, but must also have an aspect which is contributed by the experience of the race, and the two, while fusing, must be different. The gill arches of the human embryo, for example, belong to the developmental history of the individual, they also have an aspect which allies them with the early ancestors of the race.<sup>193</sup>

White argues that the regression observed in acute psychosis occurs simultaneously at the psychological and the biological level, but that it is rooted in the latter. In his view, both of these severe types of regression occur pre-verbally and can be located within the phylogenetic, archaic levels. White steers clear of offering a definition of what is deemed “archaic”; instead, he offers examples of manifestations of archaic regression. These include delusions related to bodily excretions, delusional content connected to food, air, and sounds, material that indicates bodily invasion, including impregnation, symptoms of water, fire, or cannibalism, and delusions surrounding heavenly bodies. When regression occurs at these levels, and remains there, the material contained in these realms of the unconscious remains inaccessible to

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<sup>193</sup> White, “Some Considerations Bearing on the Diagnosis and Treatment of Dementia Præcox,” 419.

psychoanalysis.<sup>194</sup> He summarizes the role of psychobiology in this particular type of psychosis as follows:

The regression here is so deep that it had touched the very sources of energy which are ultimately to weave themselves into the psychic integration even at their organic points of origin, so to speak.<sup>195</sup>

In White's conceptualization, praecox was not only a regression psychosis, but also conflict based. He argues that "the psychosis, so far as the mental symptoms are concerned, is an expression of a conflict in the individual's mind between desire on the one hand and attainment on the other." For White, psychosis follows a specific formula that includes failure to resolve intrapsychic conflict, within the context of compensatory and defense mechanisms.<sup>196</sup> White furthermore makes the case that, if the analyst is to understand the patient, each symptom presented will be found to have a *raison d'être* that is not accidental but has a particular meaning. In order to illustrate this, White presents the case of middle-aged woman who developed a praecox reaction. In this case, the praecox contained what White categorizes as a "loosely organized system of delusions of marked sexual coloring."<sup>197</sup> White again does not provide a lot of detail in discussing this case, but formulates the psychosis as imbued with logic by providing the following details. The patient is a virtuous woman who wished for a child; she develops the delusion that she is married and becomes impregnated. When no child is born, she develops the delusion that she had an abortion, which is in conflict with her religious beliefs. In order to manage this internal conflict, the patient develops another delusion, namely, that the abortion was performed,

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<sup>194</sup> White, "Some Considerations Bearing on the Diagnosis and Treatment of Dementia Præcox," 416.

<sup>195</sup> Ibid., 418.

<sup>196</sup> White, *Mental Mechanisms*, 41.

<sup>197</sup> Ibid., 42.

without her knowledge, while she was asleep.<sup>198</sup> White provides additional examples in which the delusions that so often characterize the psychotic states may be seen as logical. He summarizes his thoughts on this by stating that “no idea, no desire, no impulse, no action of any sort whatever but what has its sufficient cause.”<sup>199</sup>

The organic and the psychological were always connected in praecox, and this recognition in the hospital setting in particular, allowed for the analytic method to be practiced alongside hydrotherapy and occupational therapy in patients who did not remain in a state of continual regression. In keeping with White’s philosophy of the ‘organism as a whole’ these methods could enhance one another, as opposed to being mutually exclusive. The success of analytic treatment was often measured in terms of, for example, a patient’s increased ability to perform work, or to respond with reduced excitation to hydrotherapy treatments.

The diagnosis of dementia praecox existed along a continuum of severity. Gambino makes the important point that White and his staff were instrumental in refining the continuum along which this disease could be located.<sup>200</sup> Evidence for this fine-tuning of Kraepelin’s original classification system is found in the case files. White and his staff not only diagnosed patient with a particular type of praecox, they also attempted to “determine how much original defect there is.” One such a case was that of a male soldier born in Illinois who was thought to have suffered from a “simple praecox.” Case notes indicate that the medical team thought that the degree to which

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<sup>198</sup> Ibid.

<sup>199</sup> Ibid., 45.

<sup>200</sup> Gambino, “Mental Health and Ideals of Citizenship,” 183.

the patient was compromised should be investigated further through the use of the clinical interview, the patient's history, and psychometric testing.<sup>201</sup>

The perplexing nature of dementia praecox was highlighted by Edward Kempf in 1919 in a case report published in *The Psychoanalytic Review*.<sup>202</sup> Kempf opens his case discussion by lamenting what he deems to be a clumsy attempt at defining this complex diagnosis. Kempf appears to regard the term "dementia praecox" as a compromise that is satisfactory to the legal system, but woefully deficient in psychiatric practice. He writes that

...the absence of definite etiological factors, has reduced the psychiatrist to the sad plight of having to define what is meant by dementia praecox in terms of the symptoms which he has grouped under the name. This circular method of reasoning from *symptoms* to *name* and from *name* to *symptoms*, while it satisfies the court's and jury's demand for logic and the custodial psychiatrist's need for short, convenient names in order to pigeon-hole his cases, is diverting the major part of psychiatric curiosity from its task of working out the particular pathology of each individual.<sup>203</sup>

Kempf and White were critical of what they viewed as a bluntness in diagnosis that took into account only the symptom presentation in dementia praecox. White was also pragmatic in terms of the value of Kraepelin's classification system. He acknowledged that

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<sup>201</sup> Case 36324, Clinical notes (September 12, 1930).

<sup>202</sup> E. J. Kempf, "The Psychoanalytic Treatment of Dementia Præcox: Report of a Case," *Psychoanal. Rev.* 6 (1919): 15–58.

<sup>203</sup> *Ibid.*, 15.

Kraepelin gave a masterly grouping and description of symptoms which, on the whole, has an unfavorable course and which we have agreed in a general sort of way to designate as dementia praecox.<sup>204</sup>

White, however, joined Kempf in advocating for a more “individual, analytic” approach that would emphasize etiology and “psychopathological mechanisms” on a case by case basis.<sup>205</sup> Kempf shared White’s holistic view of the origin of mental disease. In his guidelines as to what should be contained in a patient case history, Kempf includes the environment alongside intrapsychic processes. The general areas that Kempf emphasizes in constructing a thorough case history, that goes well beyond symptom presentation, can be broken down as follows:

1. A description of the environmental setting that the individual has been a part of;
2. the individual’s developmentally based adaptation to these environmental demands in the areas of intellectual, social, economic, vocational, and “esthetic-moral” development;<sup>206</sup>
3. the psychopathological processes that are pertinent to the case;
4. the “nature of affective repression”, with a specifier as to the acuity and frequency of the repression as it relates in particular to love, hate, fear, shame, and sorrow;
5. the extent to which the patient has shown affective regression, again, broken down in developmental phases that begin at the intrauterine stage;

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<sup>204</sup> White, “Some Considerations Bearing on the Diagnosis and Treatment of Dementia Præcox,” 417.

<sup>205</sup> Kempf, “The Psychoanalytic Treatment of Dementia Præcox,” 15; cited and discussed in White, *Mental Mechanisms*, 44.

<sup>206</sup> Kempf, “The Psychoanalytic Treatment of Dementia Præcox,” 16.

6. an examination of what Kempf refers to as “affective dissociation”, grouped into how recently or frequently such episodes have occurred;
7. A detailed breakdown of how affective dissociation manifests in terms of obsessions, hallucinations, delusions, delirium, and compulsions;
8. Functional simulations or eliminations that include kinesthetic or other bodily symptoms, such as anesthetics;
9. The patient’s capacity for insight into their attempts at wish fulfillment;
10. Autonomic reactions particular to the patient’s presentation (e.g., glandular activity, muscle tone, postural tension)

Kempf makes the case that if these guidelines for constructing a comprehensive picture of the patient are followed, the diagnosis of dementia praecox actually becomes an “obstacle” to the ability to capture the complexity of the clinical picture.<sup>207</sup>

Kempf was well aware of the critique that cases of dementia praecox were not deemed analyzable. He preempts this criticism when he introduces this case of dementia praecox seen at St. Elizabeths by stating that

...the unexpected reverse and regression that occurred in the ninth week, was at first thought...to be a result of trying to psychoanalyze a “dementia praecox case”. This opinion was dogmatically suggested by critics of psychoanalysis and conservatively accepted as possibly being true because no experience or teaching was available to discredit it. I may now report, after four years of more or less exhaustive analyses of a large variety of cases...that psychoanalysis is as progressively beneficial as it is complete so long as the

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<sup>207</sup> Ibid., 18.

desire for the analysis is *spontaneous* upon the part of the patient and the *influence of the transfer* upon the physician and the patient is controlled. The transfer must not become negativistic, or the mean of satisfying personal curiosities, ambitions, or sensuous pleasures. It must remain altruistic.<sup>208</sup>

Despite Kempf's thorough guidelines for taking a case history, and his conviction that severe cases could undergo successful psychoanalysis, the meticulously detailed course of analytic treatment described in the case of a female patient diagnosed with dementia praecox, and analyzed by Kempf at St. Elizabeths, reveals a very challenging clinical picture. Kempf provides detailed "character studies" of the patient's closest personal influences in order to contextualize what he terms the "biological struggle and collapse" of this particular patient.<sup>209</sup> Kempf makes it clear, however, that the thorough case history was ultimately constructed not through direct questioning of the patient, but through the process of psychoanalysis. While a full exposition of this case is not possible, Kempf ultimately identified the three protagonists in the patient's psychosis as her mother, father, and husband. Some of the main features of this case include an authoritarian father who tabooed any reference to sexual content, and a mother who suffered from nervousness and who raised her two daughters to be overly independent. The patient was the youngest child, and her mother regarded the patient's sister as the favorite. Kempf notes that the patient's mother had died six months prior to the onset of the patient's psychosis. The patient's husband is described as finding her unattractive, he was dismissive of their only child, and he spent long periods of time away from home. All were, by Kempf's description, unusually critical of the patient's child-rearing practices. During the course of analysis, Kempf analyzed a number of her dreams, uncovered sexual

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<sup>208</sup> Ibid., 20.

<sup>209</sup> Ibid.

fantasies related to prostitution, which he interpreted as wish-fulfillment, and was able to help the patient gain insight into the content of her delusions, her tendencies to regress, and her “affective cravings.”<sup>210</sup> She was discharged as improved, and continued to attend psychoanalytic sessions with Kempf at St. Elizabeths. He does not specify how frequently these sessions occurred, except to state that it occurred several times a week. At the conclusion of Kempf’s case study, he seamlessly blends the biological and the analytical, in keeping with White’s philosophy of “organism as a whole,”<sup>211</sup> as he explains the patient’s successful recovery as follows:

Her psychosis may be regarded as an episode of confusion in her biological struggle.... her recovery and *insight* I believe [were] entirely due to the psychoanalysis, which, in turn, was dependent fundamentally upon the nature of the *transfer* she required.<sup>212</sup>

In Kempf’s view, the transference remains central in a successful psychoanalysis. He warns that the only successful intervention in the face of an affective regression to the lower levels of development integration, as was understood to be the case in dementia praecox, is located here. According to Kempf, “*nothing* but an adequate *transfer* of affection can prevent it.”<sup>213</sup> He contrasts the aforementioned case, in which the patient recovered, with two other cases of patients admitted with dementia praecox.<sup>214</sup> In both of these cases, the patient’s conflicts, situated at the infantile level, and accompanied by a significant affective regression were too severe to allow for the possibility of a benign and altruistically based transference.

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<sup>210</sup> Ibid., 50.

<sup>211</sup> White, *Lectures in Psychiatry*, 7.

<sup>212</sup> Kempf, “The Psychoanalytic Treatment of Dementia Praecox,” 54.

<sup>213</sup> Ibid.

<sup>214</sup> These are cases 16075 and 21896 from RG 418, NA.

While Kempf acknowledges the role of biological maladaptation, repression, and social and familial influences in the etiology and maintenance of psychosis in these cases, he maintains that if the patient's condition cannot allow for the development of positive transference, psychoanalytic treatment will not be successful. In all cases of affective regression that involves autoerotic pernicious regression, he recommends the principles of mental hygiene as adjunctive to psychoanalysis. In doing so, Kempf, by including "vigorous, playful exercises and simple, interesting handicrafts" as treatment methods, confirms that the psychoanalysis of the institutional setting saw no conflict between the practice of psychoanalysis, and the simultaneous inclusion of other measures such as occupational therapy. His final recommendation in the treatment of these cases is that "it is most helpful to the psychoanalysis to have these constructive measures in use as much as possible."<sup>215</sup>

Given the non-unitary nature of this disease, case files indicate a range of pathology, with varying degrees of success in treatment outcomes. One such an example was a 25-year old young woman from the South, who was diagnosed with a "praecox episode of a paranoid type" and experienced delusions that those around her each had two identities. It appears as though the accompanying diagnosis of "an acute benign repression neurosis with dissociative features," as well as the patient's ability to recall her dreams were viewed as mitigating factors, which led the medical team to consider psychoanalytic treatment as a viable option.<sup>216</sup> She stated during one of her admission interviews that not only did she dream frequently, but that she thought that her dreams often came true. Dr. Dooley, at the intake stage, documented this patient's dream:

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<sup>215</sup> Kempf, "The Psychoanalytic Treatment of Dementia Praecox," 58.

<sup>216</sup> Case 27211, Clinical notes (January 19, 1920).

Two years ago I dreamed I kissed everybody goodbye and went away and saw nobody any more, and at Chevy Chase I kissed everyone and they all went away and then I was sure I was dead. Have had crazy dreams since I have been here. Dreamed I was Louis XIV and played Joan of Arc—her martyrdom and everything.<sup>217</sup>

The course of psychoanalytic treatment for this patient was variable. On January 4, two days after admission, she is described as being in a weak and frail state, and when she met with White for a consultation later that same day, she is described as trembling violently. She was neither oriented to time or place nor was she able to identify the calendar year accurately. Despite this initial presentation, on January 6, the patient was referred for “special psycho-analytic treatment under the care of Dr. Dooley.” Nine days later, on January 15, the patient was transferred to another building, as she was deemed to be disturbed. Nonetheless, psychoanalysis continued, and on January 19, a team of four physicians, including Dooley, all concurred that she was to remain in psychoanalytic treatment. It is interesting to note that this patient’s active delusions were well documented. The next day, January 20, the case notes state that the patient still believed that she had telepathic powers. While it would have been rare for the psychoanalyst in private practice to take on this type of patient, the analysts in the hospital setting did treat patients who were disoriented, diagnosed with dementia praecox, and actively psychotic, decades before Melanie Klein made the case. Another well-detailed case in which acute psychosis and a diagnosis of praecox did not immediately disqualify a patient from being referred for psychoanalysis is that of a 28-

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<sup>217</sup> Case 27211, Clinical notes (January 2, 1920).

year old naval cadet who was admitted with acute persecutory delusions. He was, however, able to articulate the nature of his delusions in detail, and his account of his dreams about his mother and his resulting guilt about forcing her to search the house for money, were considerations that were taken into account in the treatment referral. Furthermore, he is described as having “considerable insight and is very cooperative.”<sup>218</sup> Unfortunately the patient committed suicide by swallowing foreign objects before psychoanalytic treatment could commence.<sup>219</sup> Individuals diagnosed with praecox who were ultimately not deemed suitable for psychoanalysis were asked equally about their dreams during the admissions interviews. This could be interpreted as illustrating the central role that the ability to recall dreams appears to have held both in the determination of analyzability, but also in attempts to understand these complex cases from a psychological perspective. One such an example is found on September 12, 1930. A male patient who was unable to successfully answer questions related to recent events, whose intelligence was noted as “poor” (he was “unable to do simple calculations”), and who was experiencing “imaginary” ideas, was nonetheless asked about his dreams later during the same interview. He stated that “he dreams of angels, sisters, priests...and that the other night he dreamt he was married and had some children” before continuing on to relate the sexual nature of many of his other dreams. In the case summary that follows the admission note, his hallucinations, his history, and the content of his dreams are conceptually framed as “sexual conflicts over repressed

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<sup>218</sup> Case 36313, Clinical notes (February 5, 1931).

<sup>219</sup> Ibid.

homosexual desires” and concerns about accusations against him with a religious content.<sup>220</sup>

A little more than a month later, on February 27, Dooley indicates that she has persevered in the treatment of this patient despite obvious challenges when she writes

This patient will seldom submit to analysis but when an interview is obtained reveals his difficulty over auto-eroticism, sexual inferiority and the inferiority of his family. His mother is the powerful personality for him.<sup>221</sup>

Another month later, Dooley updated the case record, stating that there are moments when the patient adjusts well to his environment, yet at other times, he presents as impulsive and destructive. She describes the patient as suffering from hallucinations and loose associations, but, in a departure from her treatment of the cases during the 1903–1910 time period, Dooley offers a psychoanalytic explanation for the origin of the hallucinations. She theorizes that the patient is experiencing internal conflict about a sexual experience that has led him into a state of dissociation, and she describes the accompanying hallucination as characterized by a self-critical internal dialogue. While the ultimate outcome of the case upon discharge is favorable, it is unclear what role the analysis with Dooley played in his recovery, but the ward notes in April indicate a great improvement in the patient. The nurse on the ward describes this patient as being more amiable, and less irritable. Although the patient still experiences moments of anger, he is not disruptive, and engages in reading for long periods of time.

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<sup>220</sup> Case 3625, Clinical notes (January 10, 1931).

<sup>221</sup> Case 27211, Clinical notes (February 27, 1920).

At the time of discharge, the patient was designated as “recovered” and went to live with his sister.

By 1920, diagnoses such as “alcoholic psychoses” are also framed psychologically. This represents a clear example of the shift that came about with the introduction of psychoanalysis, because the physicians at St. Elizabeths had been treating this type of difficulty for many decades prior. In a conference report on March 4, 1920, a patient who did not receive psychoanalysis is nonetheless discussed as follows:

*Dr. Dooley:* I agree with the diagnosis. From a psychological standpoint there seems to be a repression neurosis, with periodic compensatory outbreaks.

*Dr. Sheetz:* I agree with the diagnosis although I imagine he is more or less of a defective, praecox personality, and alcoholism is only a symptom.<sup>222</sup>

In one case, a patient who tried to physically assault Dr. White, and was diagnosed with “Dementia praecox, paranoid trend,” was nonetheless referred for psychoanalysis by the treatment team, who determined that “this man certainly needs psychoanalysis now, if he is going to have it, as it appears that he is suffering from a severe emotional upset.”<sup>223</sup> His general negative demeanor is explained in part as a consequence of praecox, and in part potentially the result of “a paranoid projection as a result of conflict.” The outcome of his analysis, if it did take place, was unfortunately not documented, but the patient’s status as discharged was marked as “improved.”<sup>224</sup>

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<sup>222</sup> Case 27246, Clinical notes (March 4, 1920).

<sup>223</sup> Case 27247, Case notes (March 5, 1920).

<sup>224</sup> Case 27247, Case notes (August 20, 1927).

Similarly, a 30-year old male who was diagnosed with dementia praecox, paranoid type, homicidal and suicidal at admission, convinced that his coffee was poisoned and who “often hears God’s voice talking to him,” was also referred for psychoanalytic treatment on March 16, 1920. Three days later, the case file indicates that the patient escaped from the institution, before treatment could commence.<sup>225</sup>

Even in cases of advanced dementia praecox where treatment did not commence, the language of psychoanalysis functioned seamlessly alongside occupational therapy and other non-psychological treatments. In the case files, particularly between 1925 and 1935, the physiological and psychological appear assimilated to a degree not found prior to this time. A case conference on August 5, 1931, embodies this consolidation. A male patient suffering from dementia praecox, paranoid type, who had been hospitalized at St. Elizabeths for 28 years was discussed at a case conference. This patient had an active and ongoing delusion that Dr. White had robbed him, and the patient had never been deemed a candidate for psychoanalysis. An unidentified member of the medical staff noted the following:

Is able to converse intelligently although his paranoid system is intimately wrapped up with the skin condition of his hands. He is a good worker on the ward. Gives no trouble. Very clean in his habits and person.<sup>226</sup>

In this description the patient’s mental capacity, delusions, physical condition, response to occupational therapy, overall disposition, and character is folded together

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<sup>225</sup> Case 27288, Case notes (May 20, 1920).

<sup>226</sup> Case 15175, Case notes (August 5, 1931).

seamlessly. This is significant, because it is one of those rare files in the archives that is complete in terms of records where the patient's history from admission in 1905, to discharge in 1933, is documented. The influence of psychoanalysis gradually enters into the case notes. In 1909, "excitement" is noted as a trigger for his "delusions to come to the surface,"<sup>227</sup> and in 1910, his delusions are for the first time described in more detail as sexualized.<sup>228</sup> This is not a case that would have come to the attention of Dooley or Kempf, and, in a surprising case note, the physician discharging him writes that "everybody has made notes but no one will remember him because there is nothing very outstanding about him."<sup>229</sup> As unfortunate a comment as this is, it does illustrate that by 1933 when this so-called insignificant patient was finally discharged, psychoanalysis had become an integral part of the broader vernacular at St. Elizabeths.

#### *Neuroses in the wards*

Most of the case files in the archives document patients who were diagnosed with dementia praecox or general paresis. There are, however, instances where other types of psychoneuroses are documented. The treatment recommendations of hydrotherapy, occupational therapy, and, occasionally, psychoanalysis, remained the same, as was the case for patients with dementia praecox. It is interesting to note that in cases of neuroses the case files are more likely to contain descriptive psychoanalytic language than is the case with schizophrenia or neurosyphilis. In some cases, it is surprising that patients did not receive psychoanalysis. The reason is not clear, but it most likely was a matter of resources. One such a case involved a 36-year old male Eastern European

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<sup>227</sup> Case 15175, Case notes (April 5, 1909).

<sup>228</sup> Case 15175, Case notes (September 27, 1910).

<sup>229</sup> Case 15175, Case notes (February 28, 1933).

immigrant who experienced guilt-filled ruminations with religious overtones. The conference report states that “the case is essentially an acute benign repression neurosis with many compensation features.” The patient improved and was granted ground parole, but did not appear to have received analysis.<sup>230</sup> Case conference reports also document instances when the medical staff are not able to settle on a clearly defined final diagnosis. A 23-year old educated male from the Midwest was admitted for a “mental breakdown.” While a diagnosis of praecox was given, with syphilis being ruled out, case notes indicate depression in the absence of psychotic symptoms. This patient was referred for psychoanalysis to “improve his insight” prior to discharge.<sup>231</sup> In a conference report dated March 2, 1920, clinical staff is again unable to settle comfortably on a final diagnosis in the case of a former soldier who “couldn't concentrate his mind; couldn't do his work properly.” The patient described himself as “nervously unstrung” and felt that he could no longer compete with others and became increasingly withdrawn. The case team concluded that “we can go no further than to say undifferentiated psychosis.” The recommendation was that this patient receive psychoanalysis due to what was viewed as “an acute benign suppression neurosis,” and the outcome appears to have been successful, as the patient was released with an “improved” status marked in the record.<sup>232</sup> On January 23, 1920, a female patient was re-admitted after frequent crying spells, incoherent speech, and fervently addressing envelopes. Case notes indicate that the diagnosis was “cross-indexed under Manic Depressive Psychosis and Dementia Praecox.” The admission interview noted intelligence, good insight into her condition, and an active dream life characterized by

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<sup>230</sup> Case 27254, Clinical notes (July 26, 1920).

<sup>231</sup> Case 27260, Clinical notes (March 5, 1920).

<sup>232</sup> Case 26261, Clinical notes (March 26, 1920).

amnesia except for themes of “something burning.” She also talked about her “attachment to her father.” Shortly after admission, she was referred for psychoanalysis, and Lucille Dooley reported slow progress due to the patient’s “strong guard.” Two months later, Dooley documents the difficulties with the analysis.

The patient has been disturbed and inaccessible to analysis...when interviewed she has appeared to be absorbed in sexual phantasies, indicated by suggestive gestures and her brief remarks. For a week past she has refused to speak to the analyst, covering herself up in bed, turning her head away and closing her eyes when approached.<sup>233</sup>

Dooley then documents an interruption in the attempts to engage this patient in psychoanalysis, mostly as a result of the patient’s violent behavior on the ward. On July 1, 1920, Dooley reports a change in the patient. According to Dooley, the patient appears interested in relationships and conversation. Dooley concludes that , despite the patient’s admission that she would like to kill her own sister, “her attitude, however, suggests that she really desires analysis in spite of her active resistance.” A month later, analysis restarts. Dooley states that the patient is willing to engage in the treatment, but that “she has involuntarily repressed a large part of her difficulty, and it is very hard to get at it.” During the month of August, Dooley saw the patient in twice weekly analysis, after which the patient decided to terminate the treatment as she felt that she had resolved her conflicts related to her sister. Dooley, however, admits that the origin of the patient’s mania was never identified. The patient was designated as “recovered”

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<sup>233</sup> Case 26267, Clinical notes (March 31, 1920).

upon discharge, with the final diagnosis being that of “manic-depressive psychosis” because she did not deteriorate during psychoanalysis.<sup>234</sup>

Psychoanalysis practiced in the institutional setting opened up avenues of inquiry and formulation that were not possible in the private practice setting. It would have been highly unlikely for the solitary analyst to suspend treatment for a few months as a result of a patient’s violent behavior, and then to continue twice weekly treatment, as was documented by Dooley. White’s humanitarian stance brought psychoanalysis to individuals who would not have been regarded as suitable candidates for this treatment. There are too many instances of patients at St. Elizabeths who benefitted from either psychoanalytic case conceptualization, or treatment, or both, to document here. The principles of psychobiology and the optimism of the Progressive Era permeated the attempts to cure, albeit with varying levels of success. General paresis, discussed in the following section, further embodied the early twentieth-century hope that progressive treatment methods could alleviate mental suffering.

### *General paresis*

Outside of dementia praecox, *general paresis*, a form of neurosyphilis, was the single-most-treated condition at St. Elizabeths. Although this diagnosis did not lend itself to psychoanalytic formulations to the degree that even hydrotherapy or occupational therapy did, the volume in which patients were admitted, and the accompanying psychiatric symptoms displayed during the course of this disease, warrants its inclusion.

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<sup>234</sup> Case 26267, Clinical notes (August 3, 1925).

One of the hallmarks of the clinical presentation of the paretic patient was grandiosity, characterized by expansive delusions and visual and auditory hallucinations. White did consider psychoanalytic explanations for what was first and foremost an organic disease. The principles of psychobiology legitimized this approach, despite the fact that the treatment for general paresis was never psychoanalytic. General paresis was perhaps of particular concern because it extended beyond the boundaries of class. It afflicted the wealthy, the respected, and those of higher social classes in equal measure to the destitute. In most cases a diagnosis of general paresis was terminal. In some cases the disease became manifest decades after the person first contracted it, with an average lag of time between five and twenty years.<sup>235</sup>

Both White and Meyer acknowledged the biological basis of this condition, but neither accepted the physiological explanation as representative of the totality of the disease. While Meyer's emphasis was mostly on the influence of life events in the course of the disease, White included what he viewed as the psychoanalytic influences that bear upon symptom presentation. In keeping with his views on psychobiology, White explained the mutual influence of the psychological and the biological, as well as the content of the grandiose delusions in *Outlines of Psychiatry* when he writes that

The destructive luetic process produces as it advances an ever increasing mental inefficiency which is compensated for in the only possible way because of its organic basis, namely fantasy.<sup>236</sup>

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<sup>235</sup> See Emil Kraepelin, *General Paresis*, trans. J. W. Moore (New York: Nervous and Mental Disease Publishing Company, 1913; repr., Cornell University Library, 2009).

<sup>236</sup> White, *Outlines of Psychiatry*, 151.

In White's view, the patient resorted to fantasy as a compensatory mechanism in the face of a progressively weakened state. White was not the only psychiatrist who considered the psychological as relevant to the physiological in general paresis. In 1927, Hollós and Ferenczi published a monograph titled *Psychoanalysis and the Psychic Disorder of General Paresis*. One of the main arguments presented was that the luetic infection was not dissimilar to traumatic neuroses. The grandiosity of the delusions were viewed as the result of a destabilization of a narcissistically organized libido, with the affected brain, now compromised, being the main seat of ego organization.<sup>237</sup> Despite psychoanalytic conceptions of general paresis, the degree to which White ascribed to these theories is unclear. Malarial fever therapy, instituted by White, remained the first line of treatment at St. Elizabeths until the 1950s, and case files attest to the biological emphasis. Psychiatrists, through inoculation, could induce and then terminate fevers with quinine.<sup>238</sup> The mortality rate of administering this treatment at St. Elizabeths was reported to be approximately 4.3 percent.<sup>239</sup> Given the high mortality rate from the disease itself, and its inhumane course, the conclusion was utilitarian in that it was a calculated risk in service of the greater good. The ideal outcome for a patient diagnosed with general paresis was documented as a "social recovery." Social recovery was defined as a patient's ability to return to society, to earn a living, and to work in either the occupation held prior to the illness, or another.<sup>240</sup> Social recovery was different from a complete recovery, and often patients were left with lifelong impairments in judgment or residual physical symptoms. In one such a case, a male patient who had presented

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<sup>237</sup> Stefan Hollós and S. Ferenczi, *Psychoanalysis and the Psychic Disorder of General Paresis*, 1st ed. (New York: Nervous and Mental Disease Publishing Company, 1925).

<sup>238</sup> White, *Outlines of Psychiatry*, 124.

<sup>239</sup> Gambino, "Mental Health and Ideals of Citizenship," 231.

<sup>240</sup> *Report of the St. Elizabeths Hospital to the Secretary of the Interior for the Fiscal Year Ended 1921*.

with psychotic symptoms and diagnosed with paresis was discharged as a social recovery. His case notes, however, indicate that “he shows some residuals as far as organic disease is concerned but I suppose we could call him a social recovery.”<sup>241</sup> White’s refusal to use blood from one paretic patient to inoculate another paretic, was controversial. His restraint and caution led to the Wasserman strain of malaria not always being readily available, resulting in wait lists of patients who were expecting treatment.<sup>242</sup> White was fiercely criticized for this by members of his staff, but he refused to compromise on this protocol for what he regarded as safety reasons. When Overholser became superintendent, he modified the inoculation procedures to include the transfer of blood between paretics.<sup>243</sup>

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<sup>241</sup> Case 36345, Case notes (August 16, 1933).

<sup>242</sup> Gambino, “These Strangers within Our Gates,” 388.

<sup>243</sup> United States Department of the Interior, *Annual Report of the Department of the Interior* (U.S. Government Printing Office, 1849).

## Chapter 4

### White's Views on the Nature of Therapeutic Action

White's views on fundamental psychoanalytic concepts as these relate to treatment shaped the practice of psychoanalysis in the hospital setting. His views on *transference*, the *unconscious*, *symbolism and language*, *defense mechanisms*, and the overall role of psychoanalysis not only in healing the individual, but its place also in healing society, found expression in the day to day practice of psychoanalysis at St. Elizabeths. The principal vehicle for the analytic method, however, is language. In White's view, psychopathology, and the psychoanalytic theory used to make sense of the psychic determinism inherent in mental content and actions deemed aberrant, cannot be understood without examining the role of language. White emphasizes that language, while being the principal and most essential vehicle of translating thoughts into understandable terms, is not sufficient to capture the complexity and scope of mental contents. He argues that, just as synonyms drawn from a dictionary all capture a slightly different meaning and nuance, in the spoken and written language of individuals, this variation becomes even more pronounced. Definitions and meanings differ significantly among different cultures, and among people of the same culture. Events are experienced differently, until the only conclusion can be that the word itself becomes a symbol. In *Foundations of Psychiatry*, White explores this problem in some detail, concluding that

...the word, when it is examined as symbol, is seen to have very little of the definiteness, that concreteness, that finality which is ordinarily attributed to it. Its meaning lacks definiteness, it lacks fixidity, but on the contrary seems to be in a state of unstable equilibrium constantly

changing under the influence of the as constantly changing circumstances which influences it.<sup>1</sup>

Here White returns to his conviction of the pivotal importance of the reciprocal relationship and mutual influence between individual and environment. In a nod to the Bergsonian philosophical underpinnings that White ascribed to, he regards symbolism itself as the result of an upwardly developmental trajectory wherein complexity is the result of an evolutionary process. Words are adaptive as expressions that capture symbolic development. The optimism of the Progressive Era permeates much of White's writing, and the connection between language, symbolism, and the utility of this pairing in service of the analytic method is no exception. Language is what enables this method, and he refers to speech as "wonderfully responsive and so wonderfully expressive," referring to the possibilities for further evolution as "limitless."<sup>2</sup>

### **White on Transference**

It was not only White's clinical staff who were acutely aware of the importance of transference. White viewed transference as central to the analytic process. In his presidential address to the American Psychoanalytic Association in Boston in May 1917, White referred to transference as "the most important problem in psychoanalysis,"<sup>3</sup> and while he praises Freud's emphasis on this construct, he critiques the broader psychoanalytic literature for not paying enough attention to this dynamic between patient and analyst.<sup>4</sup> Transference in White's view is not, however, a strictly intrapsychic process. It encompasses the individual's

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<sup>1</sup> White, *Foundations of Psychiatry*, 76.

<sup>2</sup> *Ibid.*, 77.

<sup>3</sup> W. A. White, "The Mechanism of Transference," *Psychoanal. Rev.* 4 (1917): 373.

<sup>4</sup> White, "The Mechanism of Transference."

capacity to engage with and adjust to environmental demands at the level of the psychological. He describes transference as a dynamic process, expressed by the patient through the directionality of attention and interest, and predominantly guided by libidinal wishes. The transference develops when the patient is able to shift these libidinal wishes onto the analyst. For White, “the transference phenomenon is the most valuable force within the physician’s control for helping the patient. In fact it is *the* force with which the physician must work.”<sup>5</sup> The transference provides a bridge between the patient’s inner world, where the libido can be located, and external reality.<sup>6</sup> White extends the centrality of the transference process to include all areas of medical practice, and he makes the argument that transference occurs in every doctor-patient relationship, with the only difference being that for the analyst, the transference is not unconscious, and accordingly, it can be addressed in service of the treatment. Characteristic of his egalitarian views, in which respect for the patient is paramount, he emphasizes the responsibility that accompanies the “enormous authority and influence” on the part of the physician.<sup>7</sup> White, however, acknowledges that working in the transference can be very taxing on the part of the analyst, in particular, the requirement that “the physician should keep his personality as far removed as may be from the problem at hand”.<sup>8</sup> The analyst should be aware of the power and role of transference and should conduct analysis from the vantage point of what is in the best interests of the patient, regardless of the power differential. The analyst must also keep in check his or her own personality dynamics. When these requirements are met, the transference will be allowed to develop to the point that the patient will bring dreams to the analytic process, thereby allowing for the analysis of resistance.

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<sup>5</sup> Ibid., 376.

<sup>6</sup> White, “The Mechanism of Transference.”

<sup>7</sup> Ibid., 376.

<sup>8</sup> Ibid., 378.

White describes a case that he treated wherein the transference toward him had developed to the point that the patient brought in very interesting dream content. He acknowledges that he was “seduced” by the interesting content of the patient’s dreams to the extent that he offered too many interpretations. In this case, the patient’s dream content placed White in the role of an illusionist, capable of clever trickery. He concludes that this dream was more indicative of his “showing my own prowess than of attempting to do something for the patient,”<sup>9</sup> and served as a re-orientation where the patient, not White as the analyst, once again became the focus of treatment. In his concluding remarks, White addresses the importance of the dissolution of the transference, stating that allowing the transference to develop is as important as allowing the transference to dissolve when appropriate. He returns to the centrality of the role of the libido in navigating the internal and the external when he states that

Freedom of the libido means youth, life; fixation means old age, death...the way in which the transfer is handled, the final result as expressed in the transference mechanism...is the measure of success or failure of the analysis.<sup>10</sup>

White understood the pivotal role of the unconscious as it related to transference in analytic theory and practice, but he also had a broader understanding of its centrality despite the fact that he was able to simultaneously hold the important role of environmental influences in making sense of pathology.

### **White’s Views on the Unconscious**

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<sup>9</sup> Ibid., 379.

<sup>10</sup> Ibid., 380.

White outlines his views on the unconscious with a caution that it should not be seen as occupying a specific spatial relationship. In other words, the attempt to define, for example, where consciousness ends and the unconscious begins is not a useful exercise, because there is a discontinuity. Mental contents move between the conscious and the unconscious without necessarily compromising the mental integrity of the individual. There is also a physiological aspect that harkens back to psychobiology. The example that White provides is the temporary suspension of consciousness during a fainting spell, after which the individual is able to resume the same state of consciousness that preceded the period of being unconscious.

White points out that there are many examples of mental content that can be voluntarily recalled, but that are not always the focus of attention. These ideas are classified as being a part of the fore-consciousness. In other words, what constitutes mental life is not equivalent to consciousness, because consciousness encompasses only that of which we are aware. Most of the motivations for our conduct, however, lie outside of our awareness. Drawing upon the prominent psychologist, G. Stanley Hall's iceberg representation,<sup>11</sup> White concurs with the general notion that only one tenth of the iceberg representing mental contents is visible, while the remainder is located beneath the surface. He returns to the concepts of adaptation and integration as it relates to consciousness, and states that it is a process of adjustment and adaptation at the psychological level. It is also an evolutionary process that involves choice. This choice may often be accompanied by moments of internal conflict, and it is in part organically based, for example, when an individual has to consider which fork in the

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<sup>11</sup> G. Stanley Hall, "Some Aspects of the Early Sense of Self," *The American Journal of Psychology* 9, no. 3 (1898): 351–95, <https://doi.org/10.2307/1411300>. Hall was the first president of the American Psychological Association and the first president of Clark University in Massachusetts.

road to take. It is therefore an active process in which the person reaches out to the environment in an attempt to mold the external realities to be better aligned with individual wishes and desires.<sup>12</sup>

White expands upon the notion of conflict within the context of the unconscious. Taking a Bergsonian stance, he forcefully makes the argument for its importance when he states that it is “the very root and source of life”;<sup>13</sup> however, White somewhat confusingly does not offer a clear definition of the term ‘conflict’. He goes as far as stating “call it what you will,”<sup>14</sup> and refers to conflict alternately as a “great creative energy,”<sup>15</sup> an “*élan vital*,”<sup>16</sup> quoting Bergson, “*hormé*,”<sup>17</sup> utilizing Jungian terms, or the libido. The main point for White, beyond offering a strict definition, is that conflict is a catalyst for adjustment.

Out of the conflict, if the battle is won, come new adjustments on a higher plane; if the battle is lost there comes failure – the sinking to a lower a plane of activity. The conflict, however, does not cease. Each new vantage won becomes but the battleground for new problems, and like the conflict that Bergson describes, forces always trying to free itself from its material prison, so the libido is ever trying to break away from its limitations.<sup>18</sup>

By contrast, White adopts a distinctly Freudian view when defining the *unconscious*, and he states that Freud’s contribution here should be regarded as the most valuable.

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<sup>12</sup> White, *Mental Mechanisms*, 123.

<sup>13</sup> White, *Mechanisms of Character Formation*, 42.

<sup>14</sup> *Ibid.*, 42.

<sup>15</sup> *Ibid.*, 42.

<sup>16</sup> *Ibid.*, 42.

<sup>17</sup> *Ibid.*

<sup>18</sup> *Ibid.*, 43.

Nonetheless, White, in his definition of the unconscious, retains elements of development and adaptation, alongside the Freudian concepts.

It is that portion of the psyche which has been built up and organized in the process of development and upon which reality plays in the form of new and hitherto unreacted to situations, and in the friction resulting strikes forth the spark of consciousness.<sup>19</sup>

The emphasis on adaptation to reality and its relationship to the unconscious is framed in evolutionary terms in *Mechanisms*. White argues that, as man's reality has increasing become more civilized over time, it requires the ability to delay and postpone desire. This reality is often at odds with the unconscious, which, according to White, is predominantly constituted of wishes. However,

reality is always knocking at the door, always demanding recognition but always being met by a tendency to fixation which prevents progress. The conflict between the demands of reality for a more accurate adjustment is always being met by the drag back of a desire that prefers lack of exertion, the sense of protection and finality that comes by remaining in the region of the known rather than continuous effort and constant projection into the great world of the unknown.<sup>20</sup>

White differentiates the *foreconscious* from the *unconscious* principally in terms of the foreconscious being more immediately accessible as the resistances to this

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<sup>19</sup> Ibid.

<sup>20</sup> Ibid., 51.

accessibility are quite easily overcome, including by the individual him or herself. By contrast, the unconscious is not easily accessible. Another difference is in terms of content. While the content in the foreconscious, once conscious, seems familiar, unconscious content made conscious is often experienced as alien, uncomfortable and unfamiliar. It is only after a careful analysis that the true meaning of this unconscious content, quite different from the original manifestation of the material, is revealed. Symbolism is at work here, disguised under a wish and a fear. White provides an explanation as follows:

Under a fear a wish will be found hidden, the idea of a ruler will be found to hide the image of the father, right and left may mean right and wrong...In other words they are highly symbolic.<sup>21</sup>

Even in the midst of the explanation of intrapsychic conflict, White never moves away from including the concept of conduct. He utilizes Freud's concepts of *lustprinzip*, the pleasure principle, and the reality motive, *realitätsprinzip* in explaining how these principles are often at odds, giving rise to a conflict between the emotional (pleasure principle) and the intellectual (reality principle), and how this conflict in turn can affect conduct. White also makes the point that the language of emotions is underdeveloped.

We can feel, but we cannot put our feelings into words. And so when these feelings, which are the reverberations of past experiences, come to attempt needs to do so symbolically for clear consciousness implies a situation intellectually controlled.<sup>22</sup>

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<sup>21</sup> Ibid., 55.

<sup>22</sup> White, *Mechanisms of Character Formation*, 56.

At first glance, White's views on emotions appear confusing. He differentiates between emotions and emotional states, or content. White does not believe that emotions exist per se. He argues that mental states, including bodily reactions, can be viewed through the lens of both intellectual or emotional states. What White refers to as the "characteristics of emotions" take on a psychosomatic form.<sup>23</sup> From the standpoint of the psychological, pathological bodily states are the result of a failure of integration. Mental states, unlike emotional states, are further removed from immediate bodily states, and are less reactive, from a pathophysiological perspective. This is especially so in the case of mental disturbances, in which the physiology of the patient is heavily involved. White's view is that emotion dominates thinking, positing that "man is a feeling being before he is a thinking being."<sup>24</sup> Accuracy in the perception of reality however, is found principally within the latter, the intellectual realm. During psychoanalysis, childhood experiences are recalled in an overwhelmingly affective manner, and thus the language of consciousness is the filter through which the unconscious is channeled by the adult patient. Accordingly, the analyst listens not only for facts, which can be elusive in this context. Rather, the analyst attends to the symbolic as the sign of past conflicts imbued with highly affective content that has not become a part of the patient and the patient's history. This leads White to conclude that "the unconscious is our historical past."<sup>25</sup> He likens it to the tail of a kite, simultaneously providing stability, yet holding back the individual from either self-destruction or progress. It shapes the development of the individual, is the path that every individual has partaken in, and finds expression in the symbolic. For White, the unconscious is psychological, not neurological. He again emphasizes the power of the environment, most

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<sup>23</sup> Ibid., 52.

<sup>24</sup> Ibid., 56.

<sup>25</sup> Ibid., 59.

especially a less than ideal environment, in creating fixations and regressions that may be revisited years later. In terms of the more severe forms of pathology, most notably dementia praecox, White is of the view that conduct cannot always be understood or explained in this mental condition. Consciousness itself cannot be understood fully in praecox as this can occur only in an analysis of the individual. Instead, White argues that *race consciousness* needs to be taken into account. He explains the importance of this expanded view of consciousness as follows:

Many reactions, especially in praecox, are so primitive in type that we must seek their explanation, not in the individual consciousness, but in the *race consciousness*...many of the reactions of the mentally diseased can only reach their full explanation when we have studied the mind in its stages of development in the race and see the analogies with savage and infantile ways of thinking.<sup>26</sup>

This is illustrative of White's belief that the individual's unconscious is a part of a greater whole, and that both the individual and a larger, shared environmental past contribute to shaping a particular symptom presentation, or conduct. One of the characteristics of both the individual and the culturally constituted environmental milieu is the presence of symbolism.

### *Symbolism*

White often refers to the importance of symbolism in his writing, and he dedicates an entire chapter in *Mechanisms* to this concept. He begins his discussion by

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<sup>26</sup> Ibid., 60.

pointing toward the presence and necessity of symbolism in human language, and the diversity as well as the universality found in symbolism across cultures. White makes the point that the psychologist cannot know the meaning of any particular symptom for any particular patient, because of the idiosyncratic meaning and significance it holds for the individual person and circumstance. He argues that the choice of symbol is limited by the content of the patient's mind, and that the meaning of the symbolism can change over time. Concreteness in thinking is antithetical to symbolism. The relationship between symbolism and consciousness varies according to where on the continuum between the unconscious and the conscious the symbolism is located. Symbolism in the foreconscious can be interpreted more easily than the symbolism found in the unconscious, because in the latter, a defensive process often works against the discomfort represented by the real meaning symbolized. It is often only through psychoanalysis that the symbol can be extricated and made sense of, and accordingly, the symbolism located specifically within the unconscious is of primary interest to the psychoanalyst. Unconscious content that is antisocial in nature can become conscious only under the guise of symbolism. In this way, symbolism in consciousness represents the individual's adaption to external reality, and in doing so, symbolism becomes a defense that protects the individual from unacceptable unconscious wishes. From a developmental perspective, the further the distance from the primitive instincts, the deeper and more voluminous the symbolic world becomes, and accordingly, the deeper the analysis has to be to decode the symbols. The unconscious, being primarily infantile and affective in nature, does not prioritize a critical way of examination. Instead it makes possible substitutions, allows for obstructions to dissolve, and facilitates the

energy-based movement of the libido within the world of the symbolic.<sup>27</sup> The primary and most essential function of the symbol is its ability to transmit energy from a lower level, from the unconscious, the libidinal, the instinctive, to the higher levels of development. Symbolism is therefore subject to developmental lines. Not all symbols are equally useful as carriers of energy, capable of transforming the primitive to progressively higher levels of meaning and usefulness. White provides the example of the evolution of God as symbol:

This same symbol has been able to follow along with the development of man's religious consciousness ever remaining delicately attuned to his stage of development and servicing to express him in his reactions. Herein we see the most important function, the greatest value of the symbol. It is not only a transmitter of energy but it is capable of transmitting energy from a lower to a higher level. In the evolution of this concept God the same symbol has been continuously employed but the energy has been employed at progressively higher and higher levels.<sup>28</sup>

He also offers a brief case example of the evolution of the God symbol in a case treated by Edward Kempf. Here the patient transferred early libidinal wishes toward her father to what White argues is a higher form of symbolism. This transformation allowed the patient to rid herself of the incestuous wishes toward her father expressed in her psychosis, and instead found sublimation in forming a symbolic relationship with a Heavenly Father.

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<sup>27</sup> White, *Mechanisms of Character Formation*.

<sup>28</sup> White, *Mechanisms of Character Formation*, 113.

The developmental trajectory that White charts for symbolism has, at its most undeveloped end, the bodily, including the physical, the chemical, and reflex nervous reactions. The symbol can be considered only at the conscious levels, representative of a higher plane of development. In this sense, the symbol takes the place of the bodily representations as a carrier of energy. Mind and body are thus connected through energy, with symbolism representing the psychological, as much as the body can be an expression of the psychological. The psyche is composed of a bodily history, a psychological history, and a symbolic history. As it represents the patient's intrapsychic world, it becomes a part of the work of the psychoanalyst, and the degree of adaptation to external reality is explored during treatment.<sup>29</sup> Central to the idea of adaptation is the defense mechanism.

### **White's Views on Defense Mechanisms**

The psychoanalytic concept of defense mechanisms is entirely compatible with White's conception of the mind as "a complex of adjustive mechanisms."<sup>30</sup> White views defense mechanisms as action-oriented compensatory devices. He equates the psychological with the physical by drawing an analogy between psychological defense mechanisms and the physiological reactions that the body puts in place in response to, for example, bacterial infection or malignant pathological changes. White states that consciousness itself is a means of adaptation that enables the individual, as a biological unit, to adapt to the environment. The function of the mind, according to White, is to enable the individual to relate to the social environment in particular. This is not a

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<sup>29</sup> White, *Mechanisms of Character Formation*.

<sup>30</sup> White, *Mental Mechanisms*, 19.

passive process wherein only the environment shapes the individual; rather, psychological health involves the individual's capacity to shape the environment. In this reciprocal dynamic of action and reaction, conflict is inevitable. Based upon these premises, White defines defense mechanisms more broadly than just a feature of the intrapsychic:

It is at these points of conflict between the individual and forces either from within or without inimical or destructive in tendency that there arise the types of reactions...and which correspond to the defense and compensatory reactions in the realm of the physical functions.<sup>31</sup>

The first defense reaction to which White attends is the phenomenon of forgetting. He argues that the process of forgetting is not simple but complex. It is not the act of omission, as it may at first appear, but rather an active process. The proactive nature of it can be located in the action of selecting the unpleasant or painful experience that is to be avoided. These events that tend to be forgotten become what White refers to as "circumscribed amnesias."<sup>32</sup> The event itself, over time, may become surrounded by danger signals that warn the mind about the perils of remembering. In a cumulative sense, a defensive wall may be constructed around this mental content to the degree that the memory becomes almost completely inaccessible. This type of inaccessibility is especially pertinent in the more severe forms of pathology. White provides three case examples as illustrative of the lengths the mind may go to in order to defend, but also communicate, necessary and adaptive content.

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<sup>31</sup> White, *Mental Mechanisms*, 21.

<sup>32</sup> *Ibid.*

In the first case, White was the analyst. The patient experienced the hallucination of a fatherly voice telling him to convert to Catholicism. The father voice communicated to the patient that if he did so, he would have a priest who could fulfill the role of a father. This was of special import because the patient's father had died, and the patient had been abusing alcohol and had not been attentive to his spiritual life in the way that he had been while his father was alive. White also refers to one of Carl Jung's cases. In this case, a Russian Jew converted to Christianity against the wishes of his own conscience. The patient had a dream during which his mother admonished him and threatened to choke him if he completed this conversion. The patient then decided to listen to what he referred to as "the still small voice" and retained his Judaism.<sup>33</sup> In the third case, White summarizes a particular incident described by Théodore Flournoy, professor of psychology at the University of Geneva, who investigated spiritism through his studies on mediums and the phenomena of suggestion and telepathy. The degree to which White was relying upon Jung's usage of Flournoy's 1908 paper on anti-suicidal teleological automatism is not clear. White, like Jung, read and drew upon Flournoy's work to argue for the teleological significance in the conceptualization and treatment of cases, and in reconsidering the role of the unconscious within the clinical context.<sup>34</sup> In this particular instance, White writes about a suicidal female patient walking to the waters' edge. Just as she was about to throw herself into the water, she is able to visualize her treating physician, whom she trusted. She has an image of him rising from the water, taking her by the arm, and leading her home while speaking to her in a soothing manner. White regards the defense mechanisms in these three cases as

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<sup>33</sup> White, *Mental Mechanisms*, 23. Here White quotes Jung's case detailed in *Über die Psychologie der Dementia Praecox*.

<sup>34</sup> C. G. Jung, *Psychology of the Unconscious*, trans. Beatrice M. Hinkle (1916; repr. Mineola, N.Y.: Dover Publications, 2003).

essential to the continued functioning and adaptation of the person, both from the standpoint of the intrapsychic, and also in terms of the external. His adherence to the ideals of the Progressive Era, in which the highest ideals of civilization are borne out—and psychoanalysis represents one path to such ideals—is illustrated quite clearly when he states that these defenses “serve to keep the individual to the right path and even in the last case actually to save a person from destruction.”<sup>35</sup>

Defense mechanisms, however, can fail. White identifies the experience of extreme psychic pain as the condition under which such a failure is most likely. White offers the following statement with regards to defensive failures

...in serious conditions when the pain is very great they do not succeed. No matter how thick or how high they build their wall the pain is still within and has to be reckoned with. Some compromise is now sought. Some compensation that will enable the person to bear his burden.<sup>36</sup>

This defensive failure therefore necessitates a compromise, with the aim of finding a solution to the inner conflict experienced. This compromise is so powerful that it has the ability to influence and shape the person’s entire character formation. White provides the example of the quick-witted person who also often experiences deep inner sadness. These inner conflicts, the discrepancy between that which is longed for and the possibility of the fulfillment of the desire, provide much of the energy required for the sublimatory activities that human beings engage in. When the defensive process of sublimation is successful, the result is often impressive and to the benefit of the

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<sup>35</sup> White, *Mental Mechanisms*, 24.

<sup>36</sup> *Ibid.*

individual and society. This is the case in, for example, the creation of art, or in the lives and works of the great writers. However, in the case of individuals who are poorly organized in their defensive structures, these conflicts can “literally tear the individual apart and make only too often nervous invalids or even result in chronic deteriorating psychoses.”<sup>37</sup> White acknowledges that there are many other types of defenses, although he does not explore these in detail. He includes sleep, dreams, and the defense of justification, which he states he often sees in the case of criminals who show no remorse. Ultimately, defenses, while subject to broader categories, such as sublimation, are individual to the person being analyzed. Each individual mind is engaged in a constant struggle of offense and defense, success and failure, and eventually culminates in a compromise that may be constructive or destructive to the individual and society.<sup>38</sup> Closely related to the functioning of the defensive structures, is the *complex*, which White explores in depth.

### **White’s Views on the Psychoanalytic “Complex”**

White acknowledges that the theoretical concept of a “complex” was originally used to denote dissociative states. However, by 1911, he argues that such a definition is outdated. In *Mental Mechanisms*, White posits that the term more accurately refers to adaptation—more specifically, to the hereunto undervalued ability of the human mind to adapt to external sensory stimuli and to then utilize adaptive mechanisms to negotiate with the internal world. White explains that attention to the external world is

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<sup>37</sup> White, *Mental Mechanisms*, 25.

<sup>38</sup> White, *Mental Mechanisms*.

not equally distributed, but is in part a function of the internal mental processes and the external realities of the whole organism, the whole individual. He states that

The fact for us to consider is that the individual reacts to external conditions not simply from a physiological or from a mental basis but that he reacts as a whole—as a biological unit—and in this reaction are both physiological or mental elements, sometimes one, and sometimes the other, dominating the picture.<sup>39</sup>

Complexes, therefore, are adaptive, and this adaptation occurs in part through the grouping of ideas, often connected to a single event or to related events, and cemented together by painful emotion. When the complex spurs in the individual a reaction that occurs outside of the patient's awareness, it is referred to as a *dormant* complex. The mind, in its attempts at adaptation, guards itself against threatening influences and, according to White, can be as powerful as physiological bodily responses that guard against infection. He outlines three primary types of "complex reactions," namely, *forgetting*, *compensatory*, and *mental attitudes, moods, and character*.

*Forgetting* as a type of 'complex reaction', according to White, is the most commonly seen, and the most pronounced subtype. When experience is painful, the mind, in the attempt to protect against painful realities and the accompanying feeling states, engages in what White refers to as "the limbo of the forgotten."<sup>40</sup> He offers a case

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<sup>39</sup> White, *Mental Mechanisms*, 52.

<sup>40</sup> *Ibid.*, 55.

described by Carl Jung in which the spurned suitor is not able to remember his rival's name in future business dealings.

The second 'complex reaction' that White describes is *compensatory*. By way of introduction, White poetically describes 'compensating' as "for the sadness and sorrow, the blasted hopes and disappointments, the trials and tribulations, the mind again comes to the rescue."<sup>41</sup>

Manifestations of compensatory behaviors include, for example, the young woman disappointed in love entering a convent, or the woman who becomes a nurse when maternal instincts are frustrated. He also references the fatalism that he sees in religion and in Nietzsche's philosophy as further examples of compensatory mechanisms. Wish-fulfillment in the form of dreams or deliria are further examples of the compensation complex. In the psychiatric population, White observes that compensatory dreams are commonly seen in those suffering from profound melancholia: "the misery of the day often finds relief in the visions of the night."<sup>42</sup> White frames this as a defense reaction. In severe cases, the compensatory system can become a psychotic process, as was the case with a young woman who developed a "wish-fulfilling delirium" after being abandoned at the altar.<sup>43</sup>

*Mental attitudes, moods, and character* constitute the third type of complex. White connects mood states with complexes by arguing that moods are frequently "conditioned by dormant, submerged complexes."<sup>44</sup> He includes here witticisms and other forms of humor, as well as puns, as potential indicators that painful emotion is being dealt with defensively. Complexes not only dominate attitudes and mood in the

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<sup>41</sup> Ibid.

<sup>42</sup> Ibid., 40.

<sup>43</sup> White, *Mental Mechanisms*.

<sup>44</sup> Ibid., 57.

person suffering from, for example, long-standing melancholia, but can crystallize to the point that they form a part of the fabric of the personality as manifested in prominent traits. White singles out complexes with a sexual underlay that is connected with painful emotion as particularly challenging.

The ways in which the complex becomes manifest can often be located within the behaviors of the patient, in what White refers to as “modes of expression.”<sup>45</sup> Here again White draws upon case material to illustrate his point. He explains how, in a case that he treated, he was able to locate the presence of a complex through the patient’s narrative. This patient, a young girl, witnessed a suicide. While she had no memory of having witnessed the suicide, she experienced a great deal of anxiety every time she saw the color red. When she was running an errand at the hospital, and had to walk over a red carpet, she returned to White in a state of acute anxiety, but despite her crying and trembling, she was not able to articulate why she was afraid. For White, however, these reactions are not only mental, but also bodily. He reminds the reader that the physiological is always connected to the psychological, and he cites cases treated by Janet and Sidis to make this point. In both these cases, the patients experienced what White refers to as “hysterical seizures” with the accompanying mental symptoms. Complexes become defense constellations in this conceptualization.

We have already seen that with emotional experiences there always go along certain physiological disturbances. In these cases the physical appears in the foreground and the mental, while it exists, is not apparent on the surface...the whole affair is a defense reaction, a protective device

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<sup>45</sup> Ibid., 59.

for repressing the complex, for keeping painful mental facts out of consciousness.<sup>46</sup>

White then shifts to an energy-based explanation for the often acute physiological manifestations observed within the context of mental conditions. He likens it to an episode of epilepsy, but the episodic emotion-based manifestations can be explained to be in part the result of significant emotional content being repressed and dissociated, until a critical mass of accumulated energy results in the complex taking on a “dynamogenic” character to the point that an inevitable explosion occurs.<sup>47</sup> This newly released energy follows the path of least resistance, and the “psychomotor channels” represent these paths by providing a relatively easy outlet.<sup>48</sup> These convulsions seen in psychogenic seizures, according to White, constitute conversion symptoms. Sensory type reactions are often connected to prior traumatic experiences. One case example he offers is that of a patient who had collapsed on a stage with a green carpet. Subsequent to this event, the patient was particularly prone to seizures when in the presence of the color green.<sup>49</sup>

The symbolic level at which complexes can occur, however, poses particular challenges. In one case example, White recounts a patient he treated who, during the course of a delirium, used a strange sounding word that he later identified as being from a foreign language. During the course of treatment, White discovered that the word translated meant ‘cigarette’, and that the patient had bet on a horse with that name, and subsequently bought an expensive cigarette with the money that he had won.

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<sup>46</sup> White, *Mental Mechanisms*, 60.

<sup>47</sup> *Ibid.*, 61.

<sup>48</sup> *Ibid.*

<sup>49</sup> *Ibid.*

According to White, defensive processes that are a part of complexes can become characterological, and can be identified by paying attention to the role of symbolism in a patient's life, or in the recollection of dreams. This is the case too with *displacement*. The example he offers is that of the childless woman who displays inordinate affection toward a pet. The animal of choice becomes symbolic for a displaced wish to have a child. He offers a case treated by Freud as an example of the important place of symbolism in dreams. In this instance, the patient's dream of a horse who gallops away after breaking out of restraint, symbolized the ability of the patient to do the dream work. The fact that the horse was not killed symbolized the resilience of the patient to deal with challenges.<sup>50</sup>

*Contextualizing the "complex" in the interior life of the patient*

The argument could be made that, unlike Freud and his followers, White did not view psychoanalysis as a cure-all. He was not afraid to acknowledge when the analytic theory and method was not able to provide explanations or cures for some the most perplexing psychiatric problems of his time. In *Mechanisms*, when writing his summative thoughts on the problem of the 'complex', he acknowledges that the complexity with which displacements, conversions, and symbolisms coincide and intermingle makes it virtually impossible to unravel the complicated etiology and symptom presentations seen in some patients. However, he maintains that even in the most complex of cases, often seen in patients suffering from paranoid forms of dementia praecox, the most incomprehensible of symptoms make sense insofar as it represents

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<sup>50</sup> White, *Mental Mechanisms*.

the mind's best attempt to adjust to external pressures. White makes the argument as follows:

We see, too, how, when disease has pulled the mental superstructure to pieces and it comes tumbling down in ruins, the same effort at adjustment continues, but it is, of course, expressed in a much more imperfect and incomplete way.<sup>51</sup>

According to White, the notion of the 'complex' provides an avenue with which to approach confounding cases through intelligent and patient observation, which may eventually yield a clearer picture of the patient's psyche. White makes the point that patients often do not regard their mental aberrations as anomalous, and he explains that part of the reason for this is that the patient has found a way to group mental content, regardless of how irrational it may seem to the observer. If the analyst is to truly understand the patient, there has to be a readiness to enter into the most incoherent and incomprehensible mental content and symptom constellations. Mental facts can be understood only within their idiosyncratic mental settings. Given the presentations of patients hospitalized in the asylum, White, by necessity, revisited the practice of psychoanalytic psychotherapy in the institutional setting.

### **White's Views on the Role of Psychoanalysis in the Hospital**

In *Mental Mechanisms*, White grapples with the definition of what constitutes psychotherapy. He balks at the criticism from those in the medical community who regard the therapeutic method as nothing more than suggestion. He regards this

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<sup>51</sup> White, *Mental Mechanisms*, 64.

conception as overly simplistic, and not reflective of the complexities that characterize human consciousness. He offers the following case that he treated to illustrate that suggestion alone cannot be effective as a treatment method and, accordingly, cannot possibly constitute the entirety of the definition of what constitutes psychotherapy. In this case, the patient had a phobia of the color red, and despite hypnotic suggestion, the phobia remained. The phobia was also tied to suicidal ideation. White's attempts at substituting the suicidal thought with the ideas of a cat or a bright flash of light worked for a short time before losing their potency, leading to a return of the patient's self-destructive thoughts and depressive symptoms. The failure of hypnotic suggestion to address these symptoms adequately signifies for White that the "fundamental, underlying conditions are not reached by suggestion."<sup>52</sup> White argues that the suggestion accepted by the patient in and of itself becomes an expression of the underlying symptomatology. In this conception, all of the "psychoneurotic" symptoms are expressions of a primary condition.<sup>53</sup> He remains very critical of suggestion as a method of treatment, and he advocates for psychoanalysis when he states the following:

...the psychoneurotic symptom is an end-product only and that it may be varied to any extent, even removed, without affecting the underlying condition out of which it grew, and which made it possible. Just as the old psychiatrists sought patiently in the autopsy-room for the solution of the insanity riddle without appreciating that they were dealing only with end-results, so the psychotherapists have for long been using

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<sup>52</sup> White, *Mental Mechanisms*, 121.

<sup>53</sup> *Ibid.*

suggestion without appreciating the necessity of going deeper than the surface in attacking the problem.<sup>54</sup>

According to White, psychoanalysis goes to the source of the symptomatology, avoiding what White deems to be the superficiality of the method of suggestion. Psychoanalysis is able to get to the root of the mechanisms of consciousness and examine the character of abnormal mental reactions. Consciousness, that which is observable, is contained within a relatively restricted range compared to that which is outside of awareness, and the latter directs the majority of mental acts and behavior. During times of conflict, when the individual has to adjust to external reality, conscious content becomes clearer and more crystallized. The alternative is that the mind, "in self-defense pushes aside painful memories and experiences into the obscure region of unconsciousness outside of the focus of the bright light of attention."<sup>55</sup> This, to White, is the essence of repression. It comes at a cost, because the material that has been pushed out of consciousness is now unavailable for synthesis with the rest of the personality. When these aspects of mental content become split off and start functioning in a quasi-independent manner, they often become organized in the form of submerged complexes. The individual, unaware of the submerged complex, cannot control its manifestations, and, accordingly, neurotic symptoms arise.<sup>56</sup> White was, however, aware of the necessity to translate theoretical tenets into usable techniques, in particular as a result of the high volume of patients entering St. Elizabeths. In addition to specific

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<sup>54</sup> White, *Mental Mechanisms*, 121.

<sup>55</sup> *Ibid.*, 122.

<sup>56</sup> White, *Mental Mechanisms*.

instructions for dream analysis and word association, he also provided stringent guidance to physicians in the form of the mental examination.

*The practicalities of the mental examination*

White was pragmatic in his approach to hospital psychiatry. In the midst of the problems of definition seen in psychoanalysis, and the often perplexing issues around the diagnosis and etiology of the symptoms with which patients presented, he remained steadfast in his approach to what he regarded as the fundamentals of psychiatry.<sup>57</sup> He emphasizes the importance of the physical as well as the mental, as well as the premorbid level of functioning. In his instructions to medical residents in *Outlines*, he states the following:

In no department of medicine is a complete examination of the patient more important than in the department of psychiatry. This examination must not only include the symptoms that the patient may present when seen, but must also include the most detailed obtainable anamnesis...In order, therefore, to understand a particular case it is of the highest importance to have, as fully as possible, a conception of the individual before he became afflicted, so that we may understand the symptoms which are an expression of this reaction...Mental Disorders at best are obscure phenomena and no pains should be spared to illuminate them from every quarter.<sup>58</sup>

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<sup>57</sup> White, *Mental Mechanisms*. See also *Outlines of Psychiatry*.

<sup>58</sup> White, *Outlines of Psychiatry*, 258.

The thorough physical examination is followed by a thorough mental examination.

White outlines the following broad categories, pointing out that the first three categories are at least in part subject to the patient's recall of events.

*Table 4.1: White's recommendations based upon principles and methods for the examination of a patient*

I	<b>HISTORY OF THE FAMILY</b>	<ul style="list-style-type: none"> <li>▪ Parents</li> <li>▪ Mental characteristics of mother and father</li> <li>▪ Nervous and mental disorders</li> <li>▪ Other diseases</li> <li>▪ Alcohol</li> <li>▪ Crime and suicide</li> <li>▪ Defects of siblings</li> <li>▪ Grandparents</li> <li>▪ Siblings of patient</li> </ul>
II	<b>HISTORY OF THE PATIENT</b>	<ul style="list-style-type: none"> <li>▪ Biographical information</li> <li>▪ Occupation</li> <li>▪ Early childhood</li> <li>▪ School</li> <li>▪ Injuries and diseases in later life</li> <li>▪ Alcohol</li> </ul>

		<ul style="list-style-type: none"> <li>▪ Other habits</li> <li>▪ Marriage and children</li> <li>▪ Previous attacks</li> </ul>
III	<b>HISTORY OF THE PRESENT ILLNESS</b>	<ul style="list-style-type: none"> <li>▪ Cause and onset</li> <li>▪ General physical and mental challenges</li> <li>▪ Emotional condition</li> <li>▪ Hallucinations and delusions</li> <li>▪ Suicide and homicide</li> <li>▪ Intellectual and memory defects</li> <li>▪ Moral and legal laxness</li> <li>▪ Insight</li> </ul>
IV	<b>GENERAL OBSERVATION OF THE PATIENT</b>	<ul style="list-style-type: none"> <li>▪ Is the patient in bed, active in the ward, or on parole?</li> <li>▪ Facial expression</li> <li>▪ Movements</li> <li>▪ Appearance and demeanor</li> <li>▪ Mental observations</li> </ul>

V	<b>SPECIAL EXAMINATION OF THE PATIENT</b>	<p>A. PHYSICAL</p> <ul style="list-style-type: none"> <li>▪ Status corporis</li> </ul> <p>B. NEUROLOGICAL</p> <ul style="list-style-type: none"> <li>▪ Sensation</li> <li>▪ Movement</li> <li>▪ Cranial nerves</li> </ul> <p>C. MENTAL</p> <ul style="list-style-type: none"> <li>▪ <i>General memory and orientation</i> <ul style="list-style-type: none"> <li>▪ General understanding and insight</li> <li>▪ Special memory and insight into the present condition</li> <li>▪ Bodily/emotional</li> <li>▪ Auditory and visual hallucinations</li> <li>▪ Memory/attention/thinking/capability/sleep</li> <li>▪ Dreams</li> </ul> </li> <li>▪ <i>Special tests</i> <ul style="list-style-type: none"> <li>▪ Speech</li> <li>▪ Apprehension and apperception</li> <li>▪ Attention</li> </ul> </li> </ul>
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		<ul style="list-style-type: none"> <li>▪ Memory</li> <li>▪ Association</li> <li>▪ Determination of submerged complexes</li> </ul>
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The 'special tests' recommendations include methods designed to elucidate unconscious content designated as 'submerged complexes'. This material becomes accessible through probing about the patient's dream content and through the mechanism of word associations. Tests of memory, thinking, and overall psychological functioning became especially relevant during times when St. Elizabeths accommodated military patients. As the largest public institution in the United States, the hospital became an integral part of the war effort. In the following section, the significant impact that the war had upon the day to day functioning of the hospital is outlined. Military case studies are offered to further demonstrate that the psychoanalytic method was utilized with patients who would not ordinarily have had access to, or have been deemed suitable candidates to undergo, this type of treatment method.

## Chapter 5

### Psychiatry and Psychoanalysis during the Great War

The First World War had an undeniable and significant impact upon the daily operations at the Government Hospital for the Insane, and it also influenced White's thinking about some of the central concepts of psychiatric practice. The logistics of running a large scale institution became an immediate priority as a result of rapidly dwindling manpower. The War also raised questions from a clinical perspective about the ways in which patients were treated. In this chapter, the philosophical stance White took in thinking about the societal and intrapsychic impact of war is explored. The practice of psychiatry at St. Elizabeths during the Great War is examined next from the perspective of case files of military personnel who were referred to St. Elizabeths. A particular focus is on the absence of the diagnosis of "war neurosis" or "bomb shock" in the case files.

#### St. Elizabeths: Receptacle of War

In White's *Autobiography of a Purpose*, he references the impact of the Great War when he laments the fact that many of the pivotal staff members, including machinists and mechanics responsible for the day to day operations of the hospital, were drafted in the war. The juxtaposition between lower staff resources and an escalating rate of admissions caused a significant systemic disruption.<sup>1</sup>

The effect of the World War upon the hospital was terrible...We were left with only a handful of experienced individuals to run an institution, the

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<sup>1</sup> White, *William Alanson White*, 45.

admission rate of which had more than doubled, because in that war year we received patients almost by the trainload, nearly two thousand altogether.<sup>2</sup>

On a practical level, the hospital had to start conserving food for its patients during the War. Large swaths of lawns and sports fields were converted into agricultural grounds that were capable of producing crops on a scale that could sustain the institution.<sup>3</sup> The First World War also had a long-term impact on the institution during White's tenure long after the War ended. Veterans continued to be hospitalized after the conclusion of the War, and, in response to this continued need, White approved the presence of charitable organizations on the grounds to assist with the needs of veterans. The Red Cross opened a field office adjacent to Hitchcock Hall (depicted below in figure 5.1) in 1920.



*Figure 5.1 Red Cross House interior at St. Elizabeths Hospital.  
(National Archives RG 418-P-233).*

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<sup>2</sup> Ibid., 106.

<sup>3</sup> Otto, "St. Elizabeths Hospital: A History," 49-53.

Services offered were adjunctive to hospital operations and emphasized social services, which were in line with White's philosophy of patient care, which emphasized the importance of individual adjustment to the social environment. Services included entertainment programs and facilities, and the presence of psychiatric social workers who assisted in locating missing relatives, filing pension requests, writing letters on behalf of patients at the hospital, and ensuring that patients had access to creature comforts such as reading material or tobacco.<sup>4</sup> White also sanctioned the Catholic-affiliated fraternal order, the Knights of Columbus, who erected a temporary building for activities in 1919. Patients were trained in carpentry and other forms of woodworking, not only with the aim of donating items manufactured there, but also to teach patients skills with which to make a living upon discharge from the hospital. The "toy school" accommodated twelve to fourteen patients every day, who participated in what was classified as a form of occupational therapy.<sup>5</sup> A number of other charitable organizations, such as the American Legion and Veterans of Foreign Wars, rounded out the network of social support specifically provided to veterans.<sup>6</sup> This approach to holistic patient care was very much in keeping with White's humanitarian stance, his belief in the idea of "organism as a whole,"<sup>7</sup> and his conviction that the an exclusive focus on the internal world of the patient is not sufficient for healing on an either individual or societal level. The challenges in the adjustment between military life, treatment in a hospital setting, and return to civilian life was ever present in White's thinking, as is evident in his main work on the War, *Thoughts of a Psychiatrist on the*

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<sup>4</sup> Otto, "St. Elizabeths Hospital: A History," 63.

<sup>5</sup> Ibid., 64.

<sup>6</sup> Ibid., 65.

<sup>7</sup> White, *William Alanson White*, 11.

*War and After*.<sup>8</sup> Gambino argues that military patients hospitalized at St. Elizabeths experienced what he refers to as a form of “civic alienation,” a term that expresses the contrast between being able to function independently in an honorable capacity, only to then be confined in a hospital setting. White appears to have been keenly aware of this contrast, as he emphasizes the complexities inherent in adjusting to a different social environment away from the front lines. Furthermore, not all patients from the military ranks presented with mental health issues; in fact, the majority were admitted for physical injuries and illness. Lantern slides from the First World War era, for example, illustrate the extent to which the pathology laboratory at St. Elizabeths diagnosed infections and parasitic diseases, including the widely prevalent Trench fever.<sup>10</sup>

In addition to the day-to-day practicalities of managing a large institution with limited resources, White also saw the need for reflecting upon the impact of this cataclysmic event on a more personal and philosophical level. In *Thoughts of a Psychiatrist on the War and After*,<sup>11</sup> he devoted an entire volume to the implications for the individual and for society, and he examines the role of psychology and philosophy in the formation of character on both the individual and the group levels. While it can be argued that there is not much new in White’s thinking in terms of psychoanalysis or philosophy, his stance on the impact of War elucidates and solidifies further his identity as a humanitarian and progressive thinker, and also as a psychoanalytic theoretician who diverged from the classical Freudian school. For White, the individual has a

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<sup>8</sup> William A. White, *Thoughts of a Psychiatrist on the War and After* (New York : P.B. Hoeber, 1919), <http://archive.org/details/b29817432>.

<sup>9</sup> Gambino, “Mental Health and Ideals of Citizenship’,” 80.

<sup>10</sup> Amanda Quinn, “Lantern Slides Reveal the Impact of World War I on St. Elizabeths Hospital,” *Military Medicine* 182, no. 5–6 (May 1, 2017): 1570–71, <https://doi.org/10.7205/MILMED-D-17-00056>.

<sup>11</sup> White, *Thoughts of a Psychiatrist on the War and After* (New York: Hoeber, 1919).

responsibility to improve society. Intrapsychic dynamics, including defenses, ultimately have to be in service of the utilitarian principle of the betterment of the social structure.

His organism-as-a-whole view therefore extends into society-as-a-whole.

Psychoanalytic principles, in order to be truly useful, have to be translated beyond the individual. The intrapsychic and the societal represent two recurring themes in White's writings on the Great War.<sup>12</sup> An examination of these ideas provide insight into his thinking about the place of psychoanalytic mechanisms on both an individual and a societal level.

### **The Psychology of the Individual: Intrapsychic Considerations during a Time of War**

For White, an understanding of “man’s struggle with himself... from savagery to civilization” is pivotal to making sense of the etiology of war.<sup>13</sup> White identifies the *instincts*,<sup>14</sup> as well as the *defenses* of repression, regression, and sublimation as pivotal psychoanalytic concepts in understanding the psychological mechanisms that underlie human conduct during mass conflict. He also singles out the importance of understanding the analytic construct of *omnipotence* within the context of war.

#### *The instincts*

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<sup>12</sup> Ibid.

<sup>13</sup> Ibid., 9.

<sup>14</sup> White, *Thoughts of a Psychiatrist on the War and After*, 11. For White, the fundamentals of the experimental method, objective observation, experimental verification of that which is observed in the laboratory, and the place of physiology as it relates to the human mind, not dissimilar to animal instincts, are central in an understanding of the formation of human instincts. He refers to psychology in its early developmental phases as a type of physiology connected to the sense organs. The defenses of sublimation and repression are in constant battle with the instincts.

The concept of instincts is important in how White frames his understanding of the psychology of conflict. He classifies instincts into two basic categories, namely the self-preservation instinct (hunger) and the race preservation instinct (sexuality). He elaborates by adding the idea of tendencies, distinguishing between acquisitive tendencies that manifest in the effort to acquire the object (love), and avertive tendencies that manifest in the effort to destroy or avoid. The latter can in turn find expression in hate, anger, and fear. Although these instincts have commonalities with behavior found in animals, in humans, the defenses of sublimation and repression represent a pivotal evolution from “savagery to civilization.”<sup>15</sup> It is these defensive processes that enable individuals to progressively move away from the primitive nature of the instincts. Instincts are always present in the human mind and conduct, but the psychologically healthy individual can be recognized as a “well-rounded, integrated individual...in whom all of the instincts operate, but in service of the needs of the whole individual.”<sup>16</sup> If any one instinct gains dominance, it leads to illness. For example, gluttony is the result of the dominance of the hunger instinct, or instinct domination of acquisitive tendencies manifest in theft or miserly behavior. Instincts, however, do not have implications only on the individual level, but have the potential to affect society. Society becomes ill if any one group of a profession, for example, lawyers or doctors, become too prominent at the expense of other contributing members. The idea of integration and balance therefore extends from the individual into society, with the ultimate aim being that of the overall well-being of everyone. In White’s view, a lack of

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<sup>15</sup> White, *Thoughts of a Psychiatrist on the War and After*, 16.

<sup>16</sup> *Ibid.*, 22.

integration and balance is indicative of a deficient developmental process, both for the individual and on a broader societal level. He makes the argument as follows:

It is only when all work together for the common good of the whole that the society is adequately integrated and so healthy...integration is in itself a process of development, and failure of integration is, therefore, an indication of lack of development or of relative immaturity.<sup>17</sup>

In the face of such developmental arrest, what White refers to as the “herd critique” functions as a control, both positively and negatively. Society can aid in repressing the instinct to kill in a savage manner, or it can sanction it in the form of war, which would enable the soldier to sublimate that same instinct. The developmental process offered by a evolved society therefore aids in sublimation in the case of war. In White’s writing, he simultaneously holds both the individual and society. He goes as far as stating that it is immature, and a failing, to focus only on the individual. He advocates for a “broader outlook,” especially during times of war, because of the risk that emotion may cloud a particular state of mind, characterized by hate. It is only by analyzing the individual’s failure to adapt or integrate the psychological, relative to societal demands, that one can come to understand the societal and individual mechanisms at play in mass conflict.<sup>18</sup>

*Sublimation, regression and repression*

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<sup>17</sup> Ibid., 26–27.

<sup>18</sup> White, *Thoughts of a Psychiatrist on the War and After*.

White identifies the defensive processes of sublimation, regression, and repression as the three pivotal mechanisms relevant to human conduct during a time of war.<sup>19</sup> It is regression, and the failure to sublimate instincts that help the psychoanalyst conceptualize aggression on such a scale. The instincts also appear to be tied to emotion, and, in White's writing, conduct fueled by emotion is potentially destructive. The emotions that emerge when defenses fail disrupt the equilibrium needed to modulate human conduct. White argues that when reason is compromised by emotion, it becomes hazardous on both an individual and a societal level as it affects human conduct. Violence occurs when reason has been "temporarily dethroned and pure feeling, emotion takes its place".<sup>20</sup> Formulated in this manner, the conflict between emotion and rationality is a pivotal process with implications for human existence on a global scale. During times of war, higher intellectual processes are renounced, and instinct expression, followed by what White refers to as "lower levels of emotion," become the basis upon which war is justified. Nowhere else in White's writing does he so clearly articulate the dangers inherent in emotion's becoming dominant in human functioning. He refers to a process of negotiation between emotion and rationality as a battleground: "the long battle for the control of the emotions, of instinct, by the intelligence, seems to have been lost and man slips back to be again dominated by his feelings."<sup>21</sup> The key to maintaining balance on both an individual and a societal level lies in sublimation. For White, the defensive process of sublimation is an essential component of a civil society. When the individual is able to engage in sublimation, the ability to delay immediate gratification makes available socially useful activities.

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<sup>19</sup> Ibid.

<sup>20</sup> Ibid., 63.

<sup>21</sup> Ibid.

Regression is inversely related to the ability to sublimate, and when regression occurs, primitive reactions of “hate, cruelty and deceit” become manifest in behaviors such as “killing, looting, burning, rape, and all manner of bloodshed and violence, such as bring about the general feeling of the collapse of civilization.”<sup>22</sup> Here the link between regression on the individual level is clearly translated into implications for greater society. White thus ties regression specifically to the emotion of hate. The other emotion that he associates explicitly with regression is fear. Both these emotions arise from the unconscious and become manifest during times of regression. Fear in a time of war emerges as cowardice, which in turn puts the war effort at risk if individuals are not able to control their conduct. In White’s view, war is a threat to an individual’s capacity for repression in part because it legitimizes conflict. He states that

The social conventions, the customs, forms, and institutions which he has built up in the path of his cultural progress represent so much energy in the service of repression. Repression represents continuous effort, while a state of war permits a relaxation of this effort and therefore relief.<sup>23</sup>

White’s emphasis remains on the failure in balancing individual needs with societal needs. The individual psychology, unsublimated, contributes to “the problems of the herd,” wherein the individual remains undifferentiated and regressed, and where the good of society falls by the wayside. This lack of balance leads to cataclysmic large-scale events such as the First World War.

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<sup>22</sup> *Ibid.*, 60.

<sup>23</sup> White, *Thoughts of a Psychiatrist on the War and After*, 36.

War, however, also offers opportunities for what White refers to as “altruistic tendencies,” that is, the opportunity for acts of service and self-sacrifice. In the later chapters of *Thoughts of a Psychiatrist on the War and After*, he also frames war as constructive and in service of a developmental process, a recalibration of society. He argues that it represents the opportunity to make a start along new lines of progress, and that it is a “precondition for development along new lines of necessity...and the first stage of a constructive process.”<sup>24</sup> He goes as far as to argue that war is necessary under certain circumstances. The complexity involved in understanding the place of war in society, and of what it requires of the individual, is captured quite poignantly by White in his reflections on the psychological effects of war:

War is an example of ambivalency on the grandest scale. That is, it is at once potent for the greatest good and the greatest evil: in the very midst of death it calls for the most intense living; in the face of the greatest renunciation it offers the greatest premium; for the maximum of freedom it demands the utmost giving of oneself; in order to live at one’s best it demands the giving of life itself...In this sense the great creative force, love, and the supreme negation, death, become one.<sup>25</sup>

### *Omnipotence*

The beginnings of the unconscious need for omnipotence is during infancy. For White, the human need for omnipotence can be located during this early period as it manifests as an attempt to recreate the feeling of safety that infants crave. He states that

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<sup>24</sup> Ibid., 85.

<sup>25</sup> Ibid., 85–86.

...deep in the unconscious of man there always lurks that desire for omnipotence which we once knew when we still believed our thoughts brought things to pass, as they do nowadays in dreams, and for that feeling of safety we once knew as children.<sup>26</sup>

According to White, the wish for omnipotence that continues into adulthood represents an important part of the mechanism that underlies human aggression. During times of regression, two types of emotion arise from the unconscious, take control of our conduct, and culminate in hate and fear. These affects he later ties explicitly to an attachment to unresolved past wishes and, in this context, the wish for omnipotence.<sup>27</sup> Whereas physiologically based sensation once represented the basic psychological unit, the wish has come replace it. The wish as substitute for the now defunct sensation denotes a more evolved view of the mind. In White's words, the wish has "the effect of humanizing the science of mind."<sup>28</sup> Science, the experimental method, and physiology, though necessary in understanding human functioning, are no longer sufficient in the field of psychology, because the scientific method alone does not capture human experience. In White's writing on the psychology of conflict, he makes the argument that

Psychology can no longer be content to deal with abstract scientific concepts, but it must deal with actual, living human material, with men as

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<sup>26</sup> White, *Thoughts of a Psychiatrist on the War and After*, 67.

<sup>27</sup> *Ibid.*, 68.

<sup>28</sup> *Ibid.*, 14.

they are, with their aspirations and disappointments, their hopes, their fears, their loves and hates. Psychology has become humanized.<sup>29</sup>

*Adaptation and the societal context during a time of war*

In White's view, the concept of insanity is insufficient to explain what he refers to as "imbalances of the personality make-up."<sup>30</sup> Rather, he posits that mental disorders are the result of "defects in the capacity for adjustment" to the social environment.<sup>31</sup> The individual and society function in a mutually interdependent manner, and intrapsychic dynamics are always accompanied by what he refers to as "social values." White however, does not clearly define what exactly these social values are, other than to make a broad statement that it is the task of the psychiatrist to "fit all sorts of unusual types of personality into some sort of social usefulness."<sup>32</sup> Personal freedom finds expression only within what White refers to as a "milieu in which it can be safely exercised and brought to its fullest possible fruition." The individual functions most fully within the larger context of association in groups, and has a social obligation toward society, an obligation that provides the organizational and communal scaffolding for work, the accumulation of wealth, and social change.<sup>33</sup> With regard to the change mechanisms provided by the social environment, White singles out the women's movement. In an activist tone, reflective of his egalitarian stance, he connects the advent of the War with the acceleration of women's rights when he states that the war has

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<sup>29</sup> White, *Thoughts of a Psychiatrist on the War and After*, 14.

<sup>30</sup> *Ibid.*, vii.

<sup>31</sup> *Ibid.*

<sup>32</sup> *Ibid.*, ix.

<sup>33</sup> White's socialist views on wealth include a very clear articulation of the role of money. He argues that that the accumulation of wealth comes with social obligations, because it is the existence of the structure of society that allows for the individual to accumulate wealth. Hence, the individual needs to return wealth to society in mutually beneficial way.

hastened this movement as nothing else could, because it has demonstrated beyond argument that woman can do all the things that man can do and do them quite as well. The necessities of the warring nations have given her an opportunity to show her ability in almost every walk of life, and she has stood the trial successfully.<sup>34</sup>

War is a great equalizer in White's view, not only in terms of women's rights, but in a broader sense that addresses the inequities in society. He acknowledges that some individuals are more advantaged than others, whether materially, in terms of social class, of physical handicaps, or of constitution. However, White, in keeping with his progressive views, argues that many of these inequities can be overcome, and that both society and the individual have a role to play in making this possible. The particular role of war is that it brings those from disparate backgrounds together, transcending the barriers of class and the mistrust that he argues are often the result of ignorance and a lack of social contact between classes.

Living together, facing danger together, tends to wipe out such distrust built upon lack of acquaintance and respect, and helps to weld the individual members of the social group into a more sympathetic and understanding union.<sup>35</sup>

White's egalitarian views can be further located when he makes the case that war has the ability to bring in closer proximity those "of different races, nationality, religious creeds, political persuasions."<sup>36</sup>

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<sup>34</sup> White, *Thoughts of a Psychiatrist on the War and After*, 93.

<sup>35</sup> White, *Thoughts of a Psychiatrist on the War and After*, 101.

<sup>36</sup> *Ibid.*, 102. White's views on race here seem disconnected from what Gambino argues about hospital policies that were racially discriminatory toward African American patients (see Gambino, "These Strangers within Our

According to White, the Great War illuminates the undeniable reality of the impact of the social environment on the mental state of the individual. He argues that the actuality of having loved ones in constant danger, the disruption to home life, and the difficulties in adapting to this reality make undeniable the case for the mutuality between the inner world of the individual and environmental forces. While he acknowledges that social upheaval has always been a part of human existence, he singles out the sheer scale of the Great War in particular when he states that

Individuals have always had the tragedy of frustrated lives to face with the necessity for radical readjustment ...but never before has the whole world been so put to it. It is the scale of which the present situation is drawn that destroys our perspective rather than the nature of the problems that are involved...therefore, we cannot escape a personal reckoning with the results...with that feeling of anxiety which grips in the face of overwhelming forces that push us irresistibly into the very midst of the great unknown.<sup>37</sup>

*For the greater good*

The constant tension between the intrapsychic world of the individual on the one hand, and the need for adaptation to the social environment on the other, is an ever present theme in White's writing specific to the Great War. His utilitarian approach does not

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Gates"). It is not clear to what degree these practices were institutionalized prior to White's arrival, and to what degree White continued these practices.

<sup>37</sup> White, *Thoughts of a Psychiatrist on the War and After*, 4.

allow for what he refers to as “selfish aims” or individual recognition,<sup>38</sup> but rather he emphasizes the commonalities inherent in the human condition. White argues that

when men can realize that they all are after the same things, that growth is in the same general direction for all, they will come to realize that they can better effect their several purposes by pooling their interests than by insisting too strongly upon individual recognition. Devotion to selfish ends makes enemies, consecration to service invariably commands a following.<sup>39</sup>

### **Military Patients at St. Elizabeths: Diagnostics and Treatment**

While the Civil War introduced the idea of a distinct group of symptoms related to the experience of combat, it was the magnitude of the First World War, and the transatlantic collaboration between European, British, and American physicians that re-introduced the questions of diagnosis and treatment in systematized manner.<sup>40</sup> The popular term ‘shell shock’, however, proved too ambiguous, and psychiatrists could not agree on a unified definition of the symptom presentations that they were observing in soldiers returning from war. While there was some discussion about treatment, scholars of military medicine concur that most of the debate was centered on prevention and causation, mostly because of the enormous cost in manpower and finances incurred by warring nations.<sup>41</sup> Susan Epting makes the important point that

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<sup>38</sup> Ibid., 123.

<sup>39</sup> Ibid., 125.

<sup>40</sup> Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Cambridge, Mass.: Harvard University Press, 2003), 36-64.

<sup>41</sup> Stefanie Caroline Linden and Edgar Jones, “‘Shell Shock’ Revisited: An Examination of the Case Records of the National Hospital in London,” *Medical History* 58, no. 4 (October 2014): 519–45, <https://doi.org/10.1017/mdh.2014.51>.

during the 1910s and 20s, and also during the First World War itself, there was no standardized protocol for the treatment of war neuroses.<sup>42</sup> Case registers between 1907 and 1937 at St. Elizabeths support this. First, records do not show any diagnoses of “shell shock” or “war neuroses” for military patients admitted to St. Elizabeths, despite the fact that term first appeared in the medical journal *The Lancet* in February 1915,<sup>43</sup> six months after the start of the First World War. Second, treatment records also show no specialized treatment regimens that differ from the treatment protocols that non-military patients received. This is in line with Hans Pols’s argument that, while the term had been in existence prior to 1939, psychiatrists in the United States introduced systematic treatment methods specific to this diagnosis only during the Second World War<sup>44</sup>.

A review of military case files between 1903 and 1937 show that a combination of occupational therapy, hydrotherapy, and, increasingly, psychotherapy was the treatment of choice. The determination as to which patient was to receive which treatment, or combination of treatments, was very similar to the ways in which treatment decisions for civilian patients were made. Factors such as level of intelligence, the capacity to recall dreams, level of education, willingness to engage in occupational therapy, and the severity and duration of symptomatology were taken into account when treatment regimens were determined. Just as Linden and Jones found during

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<sup>42</sup> See Susan Epting, “Casualties of the Spirit: The Development of Military Psychology and Psychiatry in the United States, Great Britain, and Germany, 1914--1945” (PhD diss., University of Pennsylvania, 2012), ProQuest, AAI3508998.

<sup>43</sup> Charles S. Myers, “A Contribution to the Study of Shell Shock: Being an Account of Three Cases of Loss of Memory, Vision, Smell, and Taste,” *The Lancet* 185, no. 4772 (February 13, 1915): 316–20, [https://doi.org/10.1016/S0140-6736\(00\)52916-X](https://doi.org/10.1016/S0140-6736(00)52916-X).

<sup>44</sup> Hans Pols, “Waking up to Shell Shock: Psychiatry in the US Military during World War II,” *Endeavour* 30, (no. 4) 2006: 144–49.

their review of the case records of the National Hospital in London between 1914 and 1919,<sup>45</sup> military patients at St. Elizabeths frequently presented with anxiety, depressive mood, and physical symptoms deemed to be psychosomatic. Many soldiers also suffered from delusions and hallucinations connected to military themes. It is important to note that the treatment location of war neuroses or “shell shock” shifted based upon the recommendation from Dr. Thomas William Salmon, a major in the US Army Reserve who was dispatched to the United Kingdom to study the phenomenon of war neurosis. Salmon’s conclusion that soldiers suffering from “shell shock” should be treated as close as possible to the front lines of battle, or to their assigned posting, arguably had an impact upon the type of military patient admitted to stateside asylums. The first line of treatment was therefore not at hospitals like St. Elizabeths. It was only after treatment failed at military hospitals, both at home and abroad, that patients were to be transferred to non-military institutions. Salmon’s recommendation based upon his observations in Britain was as follows:

The lesson to be learned from the British results seem clear—that treatment by medical officers with special training in psychiatry should be made available just as near the front as military exigency will permit and that patients who cannot be reached at this point should be treated in special firing lines. As soon as this fact is established military needs and humanitarian ends coincide. Patients should then be sent home as soon as possible. The military commander may have the satisfaction of knowing that food need not be brought across to feed a soldier who can render no useful military service, and the military officer may feel that his patient

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<sup>45</sup> Linden and Jones, “‘Shell Shock’ Revisited.” 19-31.

will have what he most needs for his recovery—home and safety and an environment in which he can readjust.<sup>46</sup>

Case files bear out the fact that a great number of military patients were transferred from other hospitals prior to admission to St. Elizabeths. Unfortunately, referral records are sparsely populated and provide very little detail about case history or course of illness. At the National Hospital, the term “shell shock” was briefly embraced before being re-categorized as a functional disorder or hysteria; however, prior to the Second World War this term was not used in the case notes at St. Elizabeths, despite being cemented into the lexicon of popular culture. By 1917, the term “shell shock” was banned in Britain when the British War Office stated that the connection between direct artillery exposure and nervous mental affliction could not be established. Moreover, there were concerns about the amount of money that the British government would have to pay if this diagnosis was formalized in institutional settings.<sup>47</sup>

Based upon White’s correspondence with family members of military personnel hospitalized, as well as notes in case files, and Kempf’s writings, it appears as though, similar to their British counterparts, psychiatrists at St. Elizabeths could not agree on the fundamental nature of what constituted “shell shock”<sup>48</sup> (nor would they, until the next World War). Kempf, one of the principal providers of psychoanalysis at St. Elizabeths, wrote the following about the place of war neurosis:

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<sup>46</sup> Thomas W. Salmon, *War Neuroses* (Mental Hygiene War Work Committee of The National Committee for Mental Hygiene, 1919), 42.

<sup>47</sup> Shephard, *A War of Nerves*, 58

<sup>48</sup> Edward John Kempf, *Psychopathology* (St. Louis, MO: C. V. Mosby Company, 1920).

The suppression neuroses are characterized by the individual being, clearly to vaguely, conscious of the nature and effect upon himself of his ingratiating cravings. Similar autonomic distresses may be caused by the loss of the love-object, through its inaccessibility, as death, indifference, infidelity, or the perverseness that is craved, or through the individual's becoming disgraced and unfit for the love-object, as imprisoned, exiled, ostracized, etc.; or the inability to escape from one cause of fear because of a more dangerous cause, such as the battlefield versus court-martial for desertion. For this reason it is utterly unsatisfactory to use such terms as "situation psychoses," "war neuroses," or "shell shock." They are no more scientific and practical than the diagnosis of "automobile fracture," "fall fracture," "jump dislocation," "elevator sprain," or "railway spine."<sup>49</sup>

Moreover, the associated symptom presentations outlined in the case files appear to have had enough overlap with what was seen in patients who had not experienced combat that a separate diagnosis did not appear to be useful and did not significantly alter the types of treatment that could be offered.

A full exposition of the history of the concept of "war neurosis" or "shell shock" is outside the scope of this chapter, but the case files and notes of military personnel hospitalized provide support for the notion that these patients' symptom presentations were followed carefully, examined for connections with the patient's past, viewed as treatable in some cases, and, arguably, paved the way for a shift in treatment and

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<sup>49</sup> Ibid., 195.

diagnosis of the conditions with which soldiers presented during the Second World War. As is the case with all patient records, the files of military personnel became more detailed with the establishment of psychotherapy as a treatment modality, and they provide additional insight into the history and treatment of military patients.<sup>50</sup>

### *Military case studies*

There is an inevitable emphasis on the perspective of the physician and clinical staff in the case files at St. Elizabeths. This “source-bias” is not unique to the archival material examined here.<sup>51</sup> In recognition of this phenomenon, so often found in medical records and case files, first person accounts by soldier patients are provided whenever possible. Symptom presentations included somatization, which often overlapped with sensorimotor symptoms and psychological symptoms, often manifesting in mood dysregulation that included depressive, manic-depressive, and anxiety presentations, frequently referred to as “nervousness”. In the psychological category, patients also reported delusions and hallucinations with content that was at times connected with a history of military service.

It is also important to note that not all military patients saw combat. Case files show that the stresses of military life appear to have affected a number of patients hospitalized at St. Elizabeths between the First and Second World Wars. This premise is supported by an analysis of the Office of Medical History affiliated with the US Army medical department, which concluded that

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<sup>50</sup> Despite the fact the term “shell shock” was not used as a diagnosis in case files, in 1920 the local Park View Community Center hosted a series of banquets for victims of “shell shock,” which indicates that the term had found a place in American culture.

<sup>51</sup> See Ben Shephard, *A War of Nerves*, 21.

Among the reasons adduced for the excessive prevalence of insanity among soldiers, the peculiar kind of stress which military life imposes upon psychopathic individuals was considered the most important.<sup>52</sup>

Case files at times bear out the degree to which the treatment team directly connected the pressures of military service with symptom presentation. One such an example was that of a technical sergeant in the Army who had successfully completed fourteen years of service. The conference report at discharge concluded that the diagnosis of dementia praecox, from which the patient had successfully recovered, was most likely triggered by work pressure and the patient's fear that "his work was overpowering him."<sup>53</sup> A very similar precipitating event was cited as the reason for the mental deterioration of a 21-year old military recruit stationed in Puget Sound in Washington State. According to the case history, this patient started experiencing brief psychotic episodes while working in the ship's kitchen, ultimately leading to a three-month psychiatric confinement in an asylum prior to his transfer to St. Elizabeths. The patient attributed his self-described "nervous breakdown" to "difficult work." The treatment team in Washington, DC, diagnosed him with dementia praecox shortly after admission. His subsequent release seventeen months later designated his condition as a "social recovery," and the consensus was that a combination of constitutional factors and the stress of adjusting to the military represented important features of his illness.<sup>54</sup>

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<sup>52</sup> Frankwood E. Williams, introduction to Section 1 of *The Medical Department of the United States Army in the World War*, vol. 10, *Neuropsychiatry*, ed. M. W. Ireland (Washington, DC: U.S. Government Printing Office, 1929), 1. <https://history.amedd.army.mil/booksdocs/wwi/Neuropsychiatry/section1introduction.htm>.

<sup>53</sup> Case 36358.

<sup>54</sup> Case 36359.

A particularly detailed case history of a second class naval seaman diagnosed with delusions shows the importance to the patient of coming from a military family. In this case, the patient's father had been an admiral in the Navy, and one of his brothers attended West Point. The patient in part recognized the family's frequent relocation, a result of his father's military service, as a contributing factor to his mental difficulties. He stated that he joined the Navy in part "to follow in his father's footsteps" and he hoped to "work himself up to what his father wanted him to be—a naval officer." He presented with sexual conflicts, and was referred for occupational therapy, hydrotherapy, and psychotherapy in an attempt to treat the significant suicidal thoughts with which he presented. Treatment was, however, unsuccessful, and the patient died by suicide thirteen months after initial admission<sup>55</sup>. Occupational therapy remained a treatment mainstay, even in severe cases. A 22-year old Navy cadet who served on a battleship arrived at St. Elizabeths and stated during the interview that "I just couldn't get along in the Navy." He was diagnosed with dementia praecox characterized by persecutory delusions. The patient displayed significant mental and emotional apathy, accompanied by worsening mood symptoms. Progress notes include a statement that the patient is not making adequate use of occupational therapy, and attributes part of this patient's difficulties to not following the recommended treatment protocol, noting that "he shows quite a tendency to sit about doing nothing and apparently has no ambition."<sup>56</sup> In another case, a 22-year old soldier admitted as a US Army case presented with delusions after going AWOL. His ideas of reference were connected to a superior

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<sup>55</sup> Case 36313, from RG 418, NA: E66.

<sup>56</sup> Case 36314

who forced additional duties upon him, and which he felt were beyond his capabilities. Occupational therapy was recommended as the treatment of choice for this patient.<sup>57</sup>

It was not unusual for patients to blame their military service for their difficulties. A 29-year old army soldier admitted in September, 1930, stated during the intake interview that he believed that he was experiencing, in his own words, “a nervous breakdown due to army routine.” He also lamented that the level of responsibility that he had as an acting corporal was too much for him, and that he would have preferred to remain a private.<sup>58</sup>

Delusions connected to war and the military structure were quite common. One soldier’s paranoid delusions were directed toward the army leadership, whom he was convinced was trying to “stop my release and hold up my diploma.” This patient received the diagnosis of dementia praecox based upon his symptom presentation and underwent occupational therapy and hydrotherapy with minimal improvement.<sup>59</sup> Another example of delusional content related to military service was that of a 31-year old US Army recruit who had hallucinations that he had fought in a war between Spain and Egypt, and also that he was being persecuted by the German army. He was convinced that the US Army was attempting to poison him. He stated that his enemy was the Army. “It was the army’s fault. They put poison in my food to make me talk. It was all the army’s fault.”<sup>60</sup> A former soldier who was diagnosed with general paresis, presented with delusions, hallucinations, euphoria, and what the patient himself refers to as “nervous trouble” that manifests in “chills and fever.” In moments of lucidity, the patient was able to access his past, for example stating that “I’m going home out of here

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<sup>57</sup> Case 36324

<sup>58</sup> Case 36353

<sup>59</sup> Case 36327

<sup>60</sup> Case 36352

tomorrow. I came from the Veterans' Bureau."<sup>61</sup> A 25-year old seaman in the Navy started experiencing paranoid delusions on the U.S.S. Mahan in Boston. His delusions included the conviction that his fellow shipmates were attempting to poison him. In this case, both occupational therapy and psychoanalytic treatment were recommended in an attempt to treat the diagnosis of dementia praecox that he was given. The patient was discharged after a four month stay designated as "much improved" and a "social recovery."<sup>62</sup>

In very few instances did the treatment team directly connect the threat of war to a patient's psychosis. One exception found in the archival records occurred in the case of a soldier admitted in 1920. The diagnosis of "psychoneurosis conversion hysteria" was confirmed after a second opinion by a specialist physician outside of St. Elizabeths confirmed that there was no physiological explanation for the patient's paralysis. The conference report additionally offers the hypothetical diagnosis of "War Risk Psychosis."<sup>63</sup> Unfortunately the treatment team offers no elaboration on this term, so it is unclear whether it refers to the possibility of malingering, or whether the patient's neurosis might be connected to the fear of being drafted into combat situations in the future.<sup>64</sup>

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<sup>61</sup> Case 36311, from RG 418, NA: E66.

<sup>62</sup> Case 27504

<sup>63</sup> It is very likely that the treatment team had in mind the War Risk Insurance Act approved by the US Congress on October 6, 1917. This bill allowed for the support of the families of enlisted military personnel, monetary compensation for death and disability while enlisted, provision for retraining the disabled and offered voluntary government administered insurance at low rates.

<sup>64</sup> Case 26248

In cases in which military personnel did experience combat, they at times refused to talk about it, or the impact of their military experience on their current symptom presentation was unclear. This was the case of an elderly patient who had fought in the Civil War, but would say nothing further of his experience other than to state the fact that he had been in combat.<sup>65</sup>

Another patient who had been a prisoner of war in a German camp for three years during the First World War, and who had experienced significant adversity, presented with delusions that he had electricity running through him. A review of his case history shows periods during which he was able to function at quite a high level. Admission and discharge notes confirmed that he speaks five languages, and also includes an unverified statement that he had been a part of Charles Lindbergh's refueling team. In this case, the discharge team makes no connection between the patient's prior military experience and the diagnosis of dementia praecox that he was given. The patient was discharged as improved and harmless, but with the acknowledgement that he was not cured from his psychosis.<sup>66</sup>

While a formal diagnosis of "war neurosis" does not appear in the case files at St Elizabeths, the symptom presentation of what would qualify under such a definition is found in some cases. One such an example occurs in the case of a 29-year-old soldier who was deployed in France during the Great War. His case history notes that he had no prior history of mental or physical illness prior to the war. His symptoms developed in France and included that he "felt as if he were completely upset. Couldn't concentrate his mind; couldn't do his work properly," while the treatment team later states that he

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<sup>65</sup> Case 36356

<sup>66</sup> Case 36357

would “occasionally feel depressed—unable to concentrate his mind and do his work as he did before he went into the Army.” Case notes furthermore describe the patient as “nervously unstrung” and suffering from significant anxiety. One of this patient’s main concerns centered around his fear that “he may not be able to get well again and thus prevent his marriage on which he planned before he left for Europe.” In this case, the patient was referred for psychotherapy along with occupational therapy, recovered from his “nervous upset,” and was discharged as “not insane” after a four-month stay at St. Elizabeths.<sup>67</sup>

Another example of a patient who was deployed in the First World War in France, and who was discharged after significant improvement in his mental state, is that of an enlisted man who was admitted with a diagnosis of dementia praecox. His delusions upon admission included that he needed an officer’s uniform to reflect his true rank, the fear that he “was to be killed by one of the chief petty officers in charge,” and visions of his family “visiting him in the garb of angels commanding that he return to France.” The case history describes him as “tense”, “markedly suspicious”, “intensely nervous and trembling,” and with speech “in a stuttering manner.” Over time his persecutory delusions abated, and his general functioning was greatly improved upon discharge.<sup>68</sup>

What is notable in both these cases is the absence of any reference to war neurosis as an etiological factor. It is possible that military psychiatrists had ruled out this as a diagnosis prior to the patients’ referral to St. Elizabeths. It is also likely that the prevailing understanding of the place of war neurosis, or “bomb shock,” in the field of

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<sup>67</sup> Case 26261

<sup>68</sup> Case 27241

psychiatry, as was outlined earlier in this discussion, contributed to its omission in the case files. The connection between military service and psychopathology is referenced in an inconsistent manner in the case files. One of the rare direct references occurs in a case conference report in 1916 during the evaluation of an infantry soldier with a history of insubordination. In this particular case it appears as though the military specifically requested a determination of whether the patient had a long-standing and pre-existing mental disorder, or whether his symptoms emerged during his military service. This 33-year old private was transferred to St. Elizabeths as a result of auditory hallucinations identified during the line of duty. The psychiatrists John Lind and Edward Kempf determined that the diagnosis was “dementia praecox on a defective basis—not in the line of duty.”<sup>69</sup>

Scholars such as Epting and Shay regard the First World War as representative of the first “psychological casualties” that were studied in a systematized manner.<sup>70</sup> While the case files at St. Elizabeths are not solely focused upon the diagnosis of “bomb shock” or “war neurosis,” the detailed case histories and close attention to the role of any type of military service in case histories provide evidence for the seminal role that the First World War had in the evolution of psychiatric care. The staff at St. Elizabeths were acutely aware of the challenges inherent in adjusting to post-war, post-hospital life, and the case disposition conferences are often focused on the future adjustment of the patient upon discharge. This is very much in line with White’s philosophical stance and his conviction that it is the segue between the internal and external, between society

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<sup>69</sup> Case 22898

<sup>70</sup> See Epting, “Casualties of the Spirit,” 7, and Jonathan Shay, *Achilles in Vietnam: Combat Trauma and the Undoing of Character* (New York: Simon & Schuster, 1995).

and the individual, between that which is intrapsychic and that which is environmental, that denotes not only a healthy individual, but that also makes for a well-functioning society.

## **Conclusion**

White's commitment to psychoanalytic treatment was evident not only in his scholarship, professional affiliations, and philosophical and personal views, but also in the treatment of patients at St. Elizabeths Hospital. He was involved in grand rounds and was often consulted on more complex cases. Case files and journals document his presence at discharge conferences, his clinic meetings with patients and staff on a weekly basis, and his involvement in training psychiatric residents. While he delegated much of his correspondence to his clinical directors, many records exist in the case files that attest to his ongoing efforts to remain involved in patient care. The degree of his involvement in the day-to-day functioning of the hospital can also be located in the consciousness of the patients, some of whom continued to write to him after discharge. Case notes often document White's presence in the dreams of patients, in their transference neuroses (as a father figure), and, on at least two documented occasions, in physical attacks directed at him. The archives that document the evolution of psychoanalysis and White's role in it are incomplete, providing only a partial account of this history. In the following chapter, I examine White's lifelong friendship and professional relationship with Eli Smith Jelliffe. This association represents another perspective that can be utilized to construct a more cohesive narrative.

## Chapter 6

### White and Jelliffe: A Lifelong Collaboration

I have no one to talk such matters over with intimately since Dr. White died and I need must let it go forward without his kindly critique. If some time you feel you have a word for or about the *Psychoanalytic Review* I trust you will favor me with it. During Dr. White's illness, for he had been sick a year or more, the *Review* suffered from a lack of attention...But I too am not as young as I would like to be and find it increasingly difficult to edit and finance all by myself.<sup>1</sup>

White's death in 1937 had a profound effect on Jelliffe on both a professional and a personal level. Evidence for the fact that White and Jelliffe's relationship was as much a formative friendship as it was a professional collaboration is found throughout their correspondence. The degree to which the professional and the personal was intertwined is directly expressed a year after White's passing in this letter from Jelliffe to Freud on August 16, 1938. Jelliffe's letter begins with a communication to Freud that the editor of the *American Journal of Sociology* asked him to write a paper about Freud's contributions to, and place in, psychiatry. In this letter, Jelliffe deals with administrative matters, such as sending Freud reprints and galleys of his article. Jelliffe's letter, however, then takes an unexpected turn when Jelliffe acknowledges, on a very personal level, his attachment to White. This is especially striking in light of the contentious relationship that had existed between White and Freud, and also when seen in the

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<sup>1</sup> Typewritten letter, signed; from the Sigmund Freud Collection, Library of Congress.

context of Jelliffe's at times arduous entrance to the inner circles of the traditional Freudian analysts. In this chapter, I attempt to provide a fuller picture of the relationship between White and Jelliffe by examining their personal correspondence and professional collaborations. While the personal and the professional had extensive mutual influence, for the sake of organizational structure, I attempt to delineate these areas in this chapter. In addition, there appear to be two distinct time periods with regards to the different trajectories that their careers followed: The period prior to 1924, and from 1924 until White's death in 1937. I argue that while it is well known that Jelliffe and White were lifelong collaborators and friends, the historiography, including the primary scholarly work examining Jelliffe's life and work, *Jelliffe, American Psychoanalyst and Physician* by John Burnham,<sup>2</sup> omits the extensive correspondence between White and Jelliffe. When White does come up, it is almost exclusively within the context of Jelliffe's correspondence with Freud and Jung. The relationship between White and Jelliffe, both the personal and the professional, provides an important lens through which to view the history of psychoanalysis in the United States.

### **White and Jelliffe: Personal Correspondence and Connection**

There are some historians, notably David Tanner, who argue that White was unexpressive and emotionally restrained in character. Tanner points to several indicators of restraint in White's character: his "familiar role as consummate politician" who worked behind the scenes, his focus on minor details with regard to financial matters, his penchant for seeking to maintain control of the journals that he oversaw in a cordial manner while avoiding conflict, and his very cautious approach to new treatment methods.<sup>1</sup> But this

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<sup>2</sup> Burnham and McGuire, *Jelliffe*.

narrative is challenged when we read White's correspondence with Jelliffe. On March 3, 1916, White writes to Jelliffe the following in response to the death of Jelliffe's first wife, Helena Leeming Jelliffe:

Have just this minute hung up the phone. I was inexpressibly shaken by what you told me and cried and could not find words to speak my feelings as I felt also that you could not for I caught the tremor in your voice. I know that this will mean a very great readjustment for you in all sorts of ways...It is the children I am thinking of. She really was such a fountain of wisdom for them.<sup>3</sup>

White again writes to Jelliffe on March 6 to express his shock at her untimely death, and states that "she had come to occupy a 'taken-for-granted' position in my life." Three days later, on March 9, White continues his correspondence, assuring Jelliffe of his support and suggesting ways in which Jelliffe can take care of himself.

Jelliffe's home at Lake George was a refuge not only for him but for White also. White spent many summers at Lake George with Jelliffe, times during which both their friendship and their professional collaboration were solidified. The degree of closeness between the two men is reflected in a letter dated September 29, 1926, wherein White, his dry humor on display, writes to Jelliffe the following:

Let me know as soon as you get back as I have a little envelope to send you by registered mail that will help tide you over the period of readjustment which I have watched over throughout the years following

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<sup>3</sup> W. A. W. to Jelliffe, March 3, 1916. Personal Correspondence, NARA, RG 418.

your vacation, during which you are convinced that your business is ruined and that you never will get any patients and when you look forward to winter expecting that the world will come to an end. I trust this will be a therapeutic effort that will prove successful, although, as usual, your contribution to the success of the business has been very feeble.<sup>4</sup>

This type of interaction between White and Jelliffe challenges the narrative that neither White nor Jelliffe was particularly capable of close relationships. Karl Menninger, in a tribute to Jelliffe, wrote: "Although he was extremely sociable, he was not gifted in the establishment of warm interpersonal relationships. He was really more concerned with knowledge than with people."<sup>5</sup> A review of their correspondence, and consideration of the documented, long-standing friendship between White and Jelliffe, indicate that they were capable of shedding their public personas.

For ten summers, Lake George provided a platform for literary collaborations, intellectual debates, and also for the blending of the personal and the professional in their reciprocal roles of psychoanalysts for each other.<sup>6</sup> While White and Jelliffe shared a commitment to psychoanalytic theory and practice, the way in which it manifested in their respective careers was quite different. White's principal role throughout his life remained that of the steward of St. Elizabeths. He demonstrated the ability to curate and implement novel ideas, for example, by his appointment of Kempf as psychotherapist, and by hiring Lucille Dooley in her role as psychoanalyst, and by

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<sup>4</sup> W. A. W. to Jelliffe, September 29, 1926, NARA, RG 418.

<sup>5</sup> Karl Menninger and George Devereux, "Smith Ely Jelliffe--Father of Psychosomatic Medicine in America," State Archives, Kansas Historical Society, 358, <http://www.kshs.org/archives/298742>.

<sup>6</sup> Smith Ely Jelliffe, "Glimpses of a Freudian Odyssey," 328–31.

implementing group therapy. Equally, he rejected ideas that he judged as too extreme, for example lobotomies or, initially at least, malarial therapy. White did not travel to Europe after World War I, and he did not actively engage with the world of psychiatry and psychoanalysis in the world's prominent cities beyond Washington, DC. His correspondence files are filled with invitations that he did not accept. This isolationist stance was tempered only by his writing, but arguably did not serve to advance his ideas within the closed elite psychoanalytic circles during the early twentieth century, when theories very much tied to powerful European figures and to their loyal followers.

Tanner asks what it was that sustained White and Jelliffe's lifelong friendship and professional collaboration. This is a particularly salient question, given that Jelliffe was very much in the world of psychoanalysis, while White drew lines that confined him to a particular parameter, mostly within the broader field of psychoanalytic psychiatry, as opposed to the more traditional version of psychoanalysis. While the answer will most likely never be certain, the private correspondence between these two men indicates an ease of expression and an undaunted confidence that the requirement for collaboration and mutual respect was not tied to interminable agreement. What White and Jelliffe had in common was that neither was a conformist, and both had a high tolerance for not continuously being a part of the Vienna inner circle, now displaced to New York.

When Jelliffe eventually did situate himself firmly within the American school during the early 1920s, he does not appear to have arrived there principally based upon the desire to be a part of an elite coterie. While there can be little doubt that Jelliffe was beguiled by Freud's affirmation of him, he did not define his professional identity as exclusively that of a psychoanalyst in the purest sense. Jelliffe is widely regarded as one

of the fathers of psychosomatic medicine,<sup>7</sup> and an examination of his writing illustrates that this was as much a part of his identity as was adherence to the classical form of psychoanalysis.<sup>8</sup> Tanner makes the argument that White's and Jelliffe's increasingly divergent paths in terms of their respective places within the American School was partly a reflection of the tensions within the greater American psychoanalytic community.<sup>9</sup> Extending this argument, I posit that the idea of depth (the calling card of psychoanalysis) versus breadth (the perceived hallmark of the hospital psychiatry in which White found himself immersed) contributed to a schism in definition. The discipline of psychoanalysis was attempting to define itself, and part of that definition manifested itself in exclusion. It became as much a question of what was *not* psychoanalysis, and who was *not* a true psychoanalyst, in order to define what and who was.<sup>10</sup>

White did not appear to conform to the widely held norms held by the inner circles of the members of the American school. First, he did not analyze many patients, and, second, his view of the theory of psychoanalysis and etiology of psychopathology was not exclusively intrapsychic, as he emphasized the impact of the societal forces. The field of mental hygiene was far more forgiving. It allowed for an integration of the intrapsychic and the environment, the internal and unconscious with the external and

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<sup>7</sup> Menninger and Devereux, "Smith Ely Jelliffe—Father of Psychosomatic Medicine in America," State Archives, Kansas Historical Society.

<sup>8</sup> Smith Ely Jelliffe, "Sketches in Psychosomatic Medicine," *Journal of the American Medical Association* 114, no. 26 (June 29, 1940): 2591, <https://doi.org/10.1001/jama.1940.02810260077035>.

<sup>9</sup> Tanner, *Symbols of Conduct*, 114.

<sup>10</sup> In many ways, this debate remains today as analytic institutes not belonging to the American Psychoanalytic are often viewed with mistrust, and as psychoanalysts grapple with whether or not an analysis that occurs three times a week is as valid as that which occurs five times a week, or whether only training analysts should be able to analyze candidates.

the behavioral manifestations expressed on both the individual and societal levels. White's version of psychoanalysis incorporated the principles of the mental hygiene movement, and, by extension, one could argue that he was a "social psychoanalyst" as opposed to a "classical psychoanalyst." There is accordingly a strong argument to be made that, during his lifetime, there was not enough scope for the former definition within the exclusive circles of the gatekeepers that defined what psychoanalysis was to become in the United States during the twentieth century. Accordingly, White's credibility as a psychoanalyst was called into question, not only by his peers, but also subsequently in the historiography of psychoanalysis.

In the following section, I examine the place that White and Jelliffe occupied within the context of early-twentieth-century psychiatry and psychoanalysis. I argue that they did not remain "psychiatric twins,"<sup>11</sup> as Tanner asserts, but that enough commonalities remained to sustain a lifelong friendship and collaboration.

### **White, Jelliffe, and the Travails of the Analytic Method**

White and Jelliffe were lifelong collaborators with regard to psychoanalytic theory, but they did always share the same views. Their academic partnership can be divided roughly into two periods: 1907 to 1924, and 1925 until White's death in 1937. The watershed year of 1924 denotes a formal schism in their approaches to the politics and theory of psychoanalysis; this occurred when Brill reinstated Jelliffe, through an orchestrated campaign within the American Psychoanalytic Association membership ranks. This is significant not only because of the way in which it defined Jelliffe's

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<sup>11</sup> Tanner, *Symbols of Conduct*, 93.

theoretical allegiance, away from Jung and towards Freud and his followers. It also signifies that Jelliffe had crossed over in the political sense, and that he was now, with Freud and his adherents, on the opposite side of the line in the sand that had been drawn between Freud and White. Jelliffe and White increasingly came to give different weight to certain philosophical and psychological concepts. White gravitated toward the social and the psychoanalysis practiced within the social psychiatry setting of the hospital, while Jelliffe gravitated toward the intrapsychic, and the traditional form of psychoanalysis practiced within the private consulting rooms of Manhattan.

*White and Jelliffe: 1907–1924*

In 1907, White and Jelliffe decided to launch a monograph series, based upon a mutual conviction for the need to bring previously untranslated European works to the United States in the English language. The monograph series followed shortly after White and Jelliffe travelled to Europe. Jelliffe writes that this 1907 trip represented his “first personal contact with psychoanalysis. We met Jung and Maeder and Riklin in Zurich.”<sup>12</sup> In 1912, Jelliffe was instrumental in inviting Jung to lecture at Fordham University, and as a co-founders of the *Psychoanalytic Review* one year later, Jelliffe and White still shared an analytic understanding that incorporated the teachings of both Freud and Jung. Jung’s influence persisted for both White and Jelliffe in their technique of dream analysis. Both favored the Jungian emphasis on dream interpretation that focused on how the content of dream surfaces were connected to the problems of everyday life experienced by the dreamer.

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<sup>12</sup> Jelliffe. “Glimpses of a Freudian Odyssey,” 23.

During this early time period, White and Jelliffe also shared the Bergsonian idea of life force, and they incorporated this into their theories related to energy transformations.<sup>13</sup> Jung's conception of libido was closely connected to the idea of energy, and, unlike Freud, he did not associate it primarily with sexual impulses. In 1912, Jung offered an energy-based definition of libido:

All psychological phenomena can be considered as manifestations of energy, in the same way that all physical phenomena have been understood as energetic manifestations ever since Robert Mayer discovered the law of the conservation of energy. Subjectively and psychologically, this energy is conceived as desire. I call it *libido*, using the word in its original sense, which is by no means only sexual.<sup>14</sup>

During this period, White and Jelliffe shared the view that Freud's emphasis on infantile wish fulfillment was too narrow, and they gravitated to Jung and Maeder's interpretations that incorporated life goals in their conceptualizations. The Bergsonian optimism and the idealism that permeated twentieth-century American psychiatry, shared by White and Jelliffe, arguably rendered Jung's emphasis on the patient's wish for growth, often disguised in the dream, as appealing. In addition, Freud's opposing view, skewed toward pathology and unfulfilled wishes, was likely less appealing, not only theoretically, but on a pragmatic level within the confines of the psychiatric ward, which was filled not only with the milder forms of neuroses but with conditions that

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<sup>13</sup> Smith Ely Jelliffe, *The Technique of Psychoanalysis* (New York: Nervous and Mental Disease Publishing Company, 1918).

<sup>14</sup> C. G. Jung, "Psychoanalysis and Neurosis," in *Collected Works of C.G. Jung, Volume 4: Freud & Psychoanalysis*, Course Book, trans. Gerhard Adler and R. F. C. Hull (1916; repr. Princeton, N.J.: Princeton University Press, 2014), 22, <https://doi.org/10.1515/9781400850938.243>.

frequently appeared quite hopeless. It was not long before Jelliffe drew upon Rank's desexualized theory and focused on ego strivings. The movement was forward, toward growth and change. Rank drew on Freudian theory, and, accordingly, adherence to his work would be palatable to the Freudian analysts.<sup>15</sup> More problematic, however, was the fact that White and Jelliffe also found Adler's work appealing. Adler and his work were unacceptable within traditional Freudian circles.<sup>16</sup> The combination of Jelliffe's training as a neurologist, his eclectic consideration of theories, and his lifelong interest in physiology and psychosomatic medicine nonetheless predisposed him to Adler's work regardless of the politics in analytic circles. White similarly admired Adler's work, but he did so more specifically for Adler's views on the individual's task of adapting to environment and social context, the task of striving in a future-oriented manner, and his focus on self-determination and the ultimate importance of social context. Both White and Jelliffe were willing to engage with theories that they thought had merit.

The notion that White and Jelliffe were independent thinkers, not 'joiners' led to their being alternately admired, mostly in the circles of psychiatry, and ostracized at times in the analytic cliques of New York and Vienna. During the early years of White and Jelliffe's academic collaboration, what Tanner refers to as their "eclectic synthesis," further solidified their life-long friendship.<sup>17</sup> They shared a belief in the "organism-as-a-whole," the importance of adaptation to the environment, the important role of symbolization, and the early twentieth-century hallmark of psychological health, which could be located within proper conduct. It is perhaps here that White and Jelliffe's

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<sup>15</sup> Otto Rank, *The Trauma of Birth* (New York: Brunner, 1952); first published in German in 1924.

<sup>16</sup> Tanner, *Symbols of Conduct*, 293.

<sup>17</sup> *Ibid.*

departure from classical Freudian theory is most immediately obvious: The unconscious, while central and worthy of exploration and analysis, had to become manifest in a way that would lead to the capacity for the organism to adapt to an impinging environment. What was intrapsychic could not remain so, but had to find expression in the external world of the individual. In White's daily clinical environment, where the lives of patients were filled with destitution and hardship, this seems particularly important.<sup>18</sup>

Another significant event that could explain Jelliffe's shift to a more individual emphasis in his understanding of psychoanalytic theory occurred in 1917, when Jelliffe resigned from medical school teaching and terminated his hospital appointments. This was a significant departure from White's world, which was dominated by St. Elizabeths. That same year, Jelliffe published an article in the *American Journal of the Medical Sciences* that cemented his place in psychosomatic medicine. In line with his holistic understanding of pathology, Jelliffe argued that

To neglect this, the study of man's psyche, in the production of disease, is to neglect the most important part of man's functions. To include it is to follow out the Hippocratic injunction to 'study the whole of man.'<sup>19</sup>

While Jelliffe thus entered private practice in 1917, White remained steeped in the hospital setting, where social psychiatry and what can be viewed as a non-

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<sup>18</sup> A review of the case files illustrates that White's contact with the often-brutal environmental demands that encroached quite heavily on his patients in part shaped his theoretical preferences. See, for example, Cases 36344, 27247, 36389, and 27290.

<sup>19</sup> Smith Ely Jelliffe, "The Vegetative Nervous System and Dementia Praecox," *New York Medical Journal* 105 (1917): 969.

traditional method of practicing psychoanalysis remained, in part perhaps by necessity, the prevalent treatment approach. The historiography does not pay may much attention to this development, but the fact that Jelliffe and White were now practicing in two vastly different settings brought the split between hospital psychoanalysis and private practice psychoanalysis into their long standing collaboration in a tangible way. By the time Jelliffe met Freud for first time, in 1921, his practice and his theoretical orientation were primed for a more complete shift to the more traditional circles of classical analysis. While Jelliffe continued to develop and refine his interests in the field of psychosomatic medicine, he appears to have increasingly done so within the context of the traditional psychoanalysis of the early to mid-twentieth century. For Jelliffe, psychosomatic medicine became increasingly compatible with classical psychoanalytic theory. In 1919, utilizing Freud's psychosexual stages of development, he wrote about tuberculosis and argued for the role of psychoanalysis in the recovery stages of this disease. Recovery from disease was thus both physiological and psychological. For Jelliffe, neuroses could inhibit the physiological recovery from disease, and in such cases psychoanalysis was indicated. In a later seminal 1920 paper titled "The Mentality of the Alcoholic," Jelliffe solidified this view when he definitively integrated the tenets of psychobiology with Freudian concepts. In a shift away from the individual-environment view, he argued that "man's enemy lies only in himself."<sup>20</sup> White appears to have shared this view. An illustration of this is found in his personal correspondence, in 1919, with an ardent lay supporter of the psychiatric community, Mrs. Dummer. White's personal correspondence file contains numerous pages outlining this communication, which involved her struggles and questions related to pulmonary tuberculosis. The detailed

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<sup>20</sup> S. E. Jelliffe, "The Mentality of the Alcoholic," 635.

and thoughtful way in which White responded to this inquiry about a potential mental connection to the disease, illustrates the importance of both the intellectual challenge of the symptoms described, but also White's personal desire to be helpful.

From this correspondence, it becomes clear that White, though he was not a pioneer of psychosomatic medicine, shared Jelliffe's views in this area. Mrs. Dummer expressed her concern to White that her persistent cough, after what she had regarded as a recovery, had a neurotic basis. White responded, affirming her initial impression that pointed to an unresolved unconscious conflict that he located within Freud's anal erotic structures. He also referenced the respiratory libido as connected to hate. He gently encouraged Mrs. Dummer to search her "inner self and find out whether any of these symptoms, so to speak, are present."<sup>21</sup> While the correspondence between White and Mrs. Dummer does not contain detailed information about the treatment that she received for her condition, she did conclude one of her letters to White by stating that "psychoanalysis is illuminating human behavior to me, and seems to offer scientific basis for the ethics of the old and new testaments." The moralistic emphasis on conduct and behavior so characteristic of the early twentieth century United States can be located here. Jelliffe and White were both products of the idealistic Progressive Era, wherein science and reason could be harnessed to tame id impulses and libidinal drives. It is perhaps for this reason that psychosomatic medicine appealed to Jelliffe, and to White. It provided another avenue through which to sublimate the basic drives and to make sense of human action. In this context it makes sense then that while Jelliffe referenced many of Freud's other works throughout his career, he never mentioned

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<sup>21</sup> W. A. W., Personal Correspondence, RG 418, NARA.

*Civilization and its Discontents*,<sup>22</sup> arguably one of Freud's most dystopian works. Jelliffe's understanding of the mutuality between the human person and society was not based only upon the tension that Freud emphasized. It also included within it a more hopeful narrative of adaptation and compromise in service of building a civil society within which individuals could find not only conflict, but also consolation.

*Libido as battleground: White, Jelliffe, and the analysts*

A concept central to Jelliffe's integration of psychoanalytic theory and psychosomatic medicine is found in the libido, and Jelliffe's conceptualization of the libido encapsulates the way in which he was caught in the fray between the Freudians and Zurich during the early part of the 1920s. Jelliffe emphasized the tendency for intrapsychic conflict, regression, and fixation in the libido, in line with the Freudian School, but he also incorporated elements of Jung's definition of the libido as not being exclusively sexual but principally defined by psychic energy and containing within it symbolic representations. Jelliffe argued that every organ was a potential source of libidinal attachment, that it was imbued with a past, a motivation, a function, that it was connected to emotion, and, perhaps most controversial in terms of classical theory, that it had a forward-looking developmental trajectory. This blend of Freudian concepts and Jungian principles did not endear Jelliffe to either camp. In 1921, Brill, in response to *Technique of Psychoanalysis*, wrote to Jelliffe:

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<sup>22</sup> Sigmund Freud, *Civilization and Its Discontents*, 1930, ed. and trans. James Strachey, 1961; reprint edition (New York: W. W. Norton & Company, 2010).

“I assume that you realize that your whole mode of approach is more of the Jung Anschauung than Freud’s,” while Jung in turn took exception to Jelliffe’s inclusion of the sexualized libido by stating that

I think it is a fundamental mistake when the creative libido is called sexual...It looks to me as if sexuality were a subdivision of the creative energy...I can’t help it, I am quite unable to appreciate such reductive and monotonous explanations as Freud’s sexualism...I am convinced that it is a most unscientific encroachment, when the Psyche becomes subordinate to the sexual instinct. ... I hope you will not mind my opposition.<sup>23</sup>

In contrast to Jelliffe, who incorporated both Freudian and Jungian elements in his understanding of the libido, White preferred the Jungian conception of the libido as opposed to Freud’s more narrow version. The Bergsonian undertones are unmistakable when White describes the libido as a biological force that is “always striving to attain higher levels of adjustment.” White added the concept of will power to argue that the libido can be harnessed to negotiate the realities of the environment. White did acknowledge the Freudian pleasure principle of unconscious conflict, but he viewed the successful resolution and sublimation of this conflict as finding ultimate expression in the ability to resolve the individual-society encounter. Similar to Jelliffe, White incorporated symbolism and energy transformation, both concepts that were characteristic of Jungian analytic theory. White, however, gravitated toward Adler and Jung in his final analysis of the place of biology and psychic energy connected to

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<sup>23</sup> C.G. Jung, “Jung to Jelliffe,” Handwritten letter, signed, April 2, 1920, Smith Ely Jelliffe Letters, Library of Congress.

erotogenic zones. For White, the libido was connected to the biology of the organism as a whole, not exclusively to the erotogenic zones. White and Jelliffe both referred to bodily zones outside of the erotic zones designated by Freud, for example the eye libido, ear libido, and the libido connected to the digestive system, to name a few.

### *Ego and adaptation*

In line with his Bergsonian philosophical views, White drew upon biological laws of adaptation in line with the organismic biology expressed by Henderson and Ritter. He emphasized the principles of organization, the organism's forward struggle for cohesion, and the constant goal of regulation and homeostasis. He furthermore retained a retrospective understanding of the psyche, which he referred to as the "law of recapitulation" which further implied that the human psyche and mind together contained within them "the totality of instincts and archetypes of apprehension".<sup>24</sup> In 1925, White reiterated this when he wrote to Karl Menninger that "from my point of view and that of the biologists everything living has a psychological aspect."<sup>25</sup> Freud's bodily ego became far more specific in White and Jelliffe's conception, as conflict arose when a specific organ stood in an inferior position in relation to the cohesive nature of the organism as a whole. In order to compensate for this inadequacy, the individual would turn passive into active, in other words, by acting as if the inferiority did not exist. This compensatory mechanism could work in quite a powerful manner, for example, an individual who suffers from a deep seated fear of public speaking becomes a powerful figure who frequently delivers public addresses. However, in the great many

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<sup>24</sup> William Alanson White, *Medical Psychology: The Mental Factor in Disease* (Nervous and Mental Disease Pub. Co., 1931), 54.

<sup>25</sup> William Alanson White to Menninger, Typewritten Letter, April 4, 1925, William Alanson White Papers, National Archives.

instances where such a conflict is not overcome, neurosis ensues. Adler's work in this area appealed to White in particular because of Adler's emphasis on the role of the social environment, and how this can in turn affect the psychological. White viewed Adler's theory of inferiority compensation as further bolstering his own philosophical stance and his psychological understanding that emphasized the human potential for self-preservation and striving for integration. While White did appear to recognize the place of Freud's pansexualism,<sup>26</sup> his conclusion about the ability of the human organism to overcome the conflicts that resided within the entire body, not only the conflicts within the erogenous zones, imbued his theory with a more hopeful view of intrapsychic dynamics and the individual's ability to traverse environmental challenges. It is therefore not surprising that the first psychotherapist White appointed at St. Elizabeths, Dr. Edward Kempf, shared White's enthusiasm for the capacity of the organism to strive toward the intrapsychic cohesion of constituent psychological parts, and also drew upon Adler by emphasizing "social esteem" when assessing the mental health of the individual. Tanner correctly surmises that White, Jelliffe, and Kempf shared an eclectic view of the available psychoanalytic theory of the time, combined with an emphasis on psychobiological synthesis that incorporated the disciplines of physiology, psychology, sociology, and, I would add, philosophy.<sup>27</sup> At the center here remained, in opposition to Freud, the Jungian concept of symbolism and representation as it pertained to psychobiology. Here Meyer and White saw eye to eye, because symbolization provided the bridge that connected disparate parts not only of biology, but also of past, present, and future, and of movement between dysregulation and

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<sup>26</sup> Tanner, *Symbols of Conduct*, [[page?]].

<sup>27</sup> *Ibid.*, [[page?]]

homeostasis, between that which is unconscious and that which can be accessed consciously. Symbolization became a central tenet in the treatment of neuroses. For White, the symbol was a tool that could be utilized in service of mobilizing and transforming energy.

Contrary to a somewhat blunt narrative put forward by Freud, White did not reject Freudian principles outright, but he incorporated enough of Adler's and Jung's theories to designate him an outsider. He accepted that symbolization is present in dreams, he incorporated the idea of the mind and body in conflict, and he found much use in the Freudian idea of sublimation. White, however, never bought into the classical Freudian conception of the absolute centrality of the sexual instinct. Disease, in White's conception, was never only intrapsychic and never exclusively social, but was a failure to successfully negotiate between the two, and up until the early 20s, Jelliffe shared this view. This "symbolic neurology" that Jelliffe developed over time came to hold wide appeal within the ranks of the New York psychoanalytic circles.

#### *White and Jelliffe, 1924–1937*

In correspondence with James S. Van Teslaar in 1924,<sup>28</sup> Jelliffe singled out the journal he had founded with White, the *Psychoanalytic Review*, as well as the 1915 publication of the book, *Diseases of the Nervous System* (also with White), as important milestones in his career. Despite acknowledging these collaborations, a shift in theoretical views between White and Jelliffe became increasingly apparent. While White

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<sup>28</sup> Jelliffe to Van Teslaar, March 6, 1924. Smith Ely Jelliffe Papers, Library of Congress. Van Teslaar was a Boston based physician and psychotherapist.

remained firmly rooted within social psychiatry, Jelliffe gravitated to the American school and its emphasis on depth psychology, incorporating this into his psychosomatic medicine specialization. By 1925, Jelliffe was firmly situated on this divergent path, and he joined the ranks of those in the analytic community who lobbied for a more controlled definition of what constitutes psychoanalysis. Jelliffe increasingly conformed to the New York and International Analytic Associations, which were strong proponents of what can be viewed as a protectionist stance regarding what it is that constitutes psychoanalysis. Tanner rightly points out that this path chosen by Jelliffe was essentially a microcosm of what was taking place within the larger analytic community. The American was increasingly on a different trajectory than the New York and the International Analytic Associations.<sup>29</sup> This tension appears to have spilled over into White and Jelliffe's collaboration on the *Review* and also into their monograph series. While Jelliffe's correspondence with Freud increased, White maintained a stance of disallowing certain articles, and allowing for the publication of others which were frowned upon by the traditional analytic establishment. This no doubt caused some difficulties for Jelliffe, even after he was reinstated as a member of the New York Psychoanalytic Society in 1925, after Frink's mental breakdown. One article in particular, "Freud's Complex of the Overestimation of the Male" by the London psychiatrist, Paul Bousfield,<sup>30</sup> constituted a direct attack on the New York analysts. While Bousfield's main thesis pertained to his argument that women were subjugated to men, he also stated that "all analysts, whether of the Freudian school or not, possess complexes in spite of their endeavors to free themselves." He furthermore argued that

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<sup>29</sup> Tanner, *Symbols of Conduct*, 128.

<sup>30</sup> Paul Bousfield, "Freud's Complex of the Overestimation of the Male" *Psychoanalytic Review*, 12, no. 2. (1925): 127-50.

Freud and, by proxy, his followers, suffered from “repressed narcissism, impotence and inferiority” that culminated in rancor against women. Bousfield’s scathing critique of Freud and his followers, published by White in the *Review*, occurred the same year that Jelliffe was reinstated. The timing could hardly have been worse for Jelliffe. He took immediate exception to White’s decision to print the article, and in a strongly worded letter to White he wrote that “nearly all the New York men can’t understand” why White allowed for such a “puerile” and “misinformed” article to be published.<sup>31</sup>

White’s insensitivity to Jelliffe’s arc within the New York analytic circles is quite striking, all the more so given that, two years prior, Jelliffe’s entreaties to White to strike a more conciliatory tone with the International Analytic Association were soundly rejected. In 1923, White referred to any collaboration with the International Psychoanalytic Association and Jones as “alliances with my enemies.”<sup>32</sup> By December of 1925, Jelliffe and White experienced what Jelliffe later referred to as their first true conflict.<sup>33</sup> This major disagreement centered around White’s stubborn refusal to publish a third edition of the wildly successful *Technique*. While the reason for White’s resistance is not clear, it is doubtful that this decision was based purely upon the economic concerns cited by White. The theoretical and political schism that occurred between Jelliffe and White in 1924 no doubt had influenced White’s stance. Any revision of *Technique* would most likely have included Jelliffe’s decidedly Freudian influence, and there can be little doubt that White must have been aware of this possibility. During this time of tension between Jelliffe and White, Jelliffe and Freud’s relationship, in contrast,

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<sup>31</sup> Jelliffe to White, April 21, 1925, Box 20 of the Smith Ely Jelliffe Papers, Library of Congress.

<sup>32</sup> White to Jelliffe, May 1, 1923, Box 19 of the Smith Ely Jelliffe Papers, Library of Congress.

<sup>33</sup> Jelliffe to Ives Hendrick, December 13, 1929, Box 8 of the Smith Ely Jelliffe Papers, Library of Congress.

continued to improve. By the end of 1925, Jelliffe referred to Freud as “Father Imago,” and throughout the following year the bond with Freud continued to strengthen.<sup>34</sup> To Jelliffe’s credit, he does not appear to have been wholly seduced by Freud’s stature. He defended the *Review* by arguing that the United States analytic community was large enough to allow for the pluralism embodied by this publication. Jelliffe was able to become a full-fledged member of the New York analytic community, but remained above the fray politically. He agreed with the traditional analytic notion that quacks and lay analysts were to be strictly sanctioned, and that only analysts who were medically trained should be allowed to practice psychoanalysis. White, as President of the American Psychoanalytic Association, endorsed this view also, but appears to have been conflicted. In 1928, White’s presidential address included a nod to those competent practitioners who fell outside of this narrow definition. Jelliffe and White had another disagreement about the publication of a paper in the *Review* in 1929 involving a lay analyst from the American school named Dr. Schmalhausen. Jelliffe was adamant that this article was not to be published, and, after a testy exchange with White and a disclaimer to Freud that he had no involvement with any decision to do so, Jelliffe ultimately prevailed.

Despite White and Jelliffe’s disagreements about how to navigate the world of early-twentieth-century psychoanalytic politics, they remained close friends. The bedrock of their relationship, based upon mutual respect and admiration, absorbed the tensions that characterized the development of the definition of psychoanalysis in the 1920s. White remained the social reformer, the purveyor of the wide applicability of

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<sup>34</sup> Jelliffe to Sigmund Freud, December 19, 1925, Smith Ely Jelliffe Papers, Library of Congress.

psychoanalysis within the hospital and as a change agent for society as a whole. Jelliffe, by contrast, viewed psychoanalysis as increasingly more narrow and individualistic in its application. Jelliffe's view of human impulses also became darker over time, more focused on destructive potential. The argument that White remained the antithesis of this—the enlightened advocate for human potential—is, however, oversimplistic. Tanner's and D'Amore's tributes to White have made this argument,<sup>35</sup> but it belies what is found in White's personal correspondence. White was well aware that many patients, especially those suffering from praecox, were not cured, that the social circumstances of the indigent was unlikely to change much after discharge, and that the ideals of science and progress at times fell short in terms of having a direct impact on mental affliction and upward mobility. Perhaps a result of the heavy burden that he carried in the hospital setting, surrounded by the destitute and the chronically ill, by those for whom psychoanalysis did not bring about the therapeutic benefit hoped for, he at times privately grappled with the disconnect between the analytic cure, the progressive ideals that he believed in, and the reality of the human condition.

#### *A matter of definition*

White and Jelliffe increasingly came to occupy very different places under the evolving definition of what exactly psychoanalysis was during this time in American history. Jelliffe moved with the tide of the New York and the international institutes, while White mostly remained sequestered within the theoretical ebb and flow of the trends in hospital psychiatry and the unique version of what can be viewed as applied psychoanalysis. This remained so seven years prior to White's death, when Jelliffe was

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<sup>35</sup> See Tanner, *Symbols of Conduct*, and D'Amore, *William Alanson White: The Washington Years*.

elected as vice president of the New York Society at the age of 64. During his tenure, the first American analytic training institute was established in New York, followed by equivalents in Chicago, Boston, Washington DC, and other cities across the United States. Training and personal analyses were standardized as much as possible in order to ensure quality control. Jelliffe resigned from this position three years later as a result of progressive hearing impairment. The fate of the *Review* changed only after White's death, as Jelliffe's uncompromising approach to including what White appears to have viewed as dangerous contaminants from the strictly Freudian camp never abated. After White's passing, the *Review* took on a distinctly different, more traditional character that involved a far larger editorial board. Jelliffe, similar to White, retained the belief in "organism as a whole" but blended it with Freudian psychoanalysis, applied on a more individual level. Perhaps the fact that White and Jelliffe inhabited such different worlds within psychoanalysis, and its possible definitions, contributed to the preservation of their lifelong friendship and collaboration. These men on a very personal level understood perhaps what the larger political landscape could not—that there never was only one definition of American psychoanalysis, but rather different versions suited to distinctive clinical environments. White found applications for psychoanalytic principles across a diverse range of settings, including within the criminal justice system, as discussed in the following chapter.

## Chapter 7

### William Alanson White and the Criminal Justice System

#### White's Views on the Nature of Crime

White frames the starting point for crime as a conflict between individual needs and societal needs. This is in line with his developmental views on the advancement of society within the context of the Progressive Era. The individual has to be contained and held accountable by the group, for the greater good of society. Natural tendencies and motivations on the individual level correspond to what White refers to as an “innate primitive way of reacting to injury resulting from the acts of others.”<sup>1</sup> It is the individual’s “natural tendency,” similar to that of other animals, that directs behavior toward avenging personal slights and injuries in a persecutory way, with the aim to attack and destroy the enemy. White furthermore points out that this aggression may be misdirected but the behavior may continue because it satisfies the need for vengeance and retaliation. The vicarious object upon which the aggression is carried out becomes a substitute and outlet for the pent-up aggressive wishes. Every individual possesses, mostly at the unconscious level, an element of the desire for vengeance. When development and adjustment fails, these tendencies emerge. White relates this not only to the reasons a criminal may commit a crime, but also to the ways in which society may wish to punish the criminal. Criminal behavior stirs up that which has been repressed in the normal population. In punishing the criminal, those individuals

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<sup>1</sup> William A. White, *Insanity and the Criminal Law* (New York: Macmillan, 1923), 11.

identified with civilization and culture find a mechanism to rid themselves of the destructive impulses of which they have some awareness.

In punishing the criminal...he is not only trying to get rid of sin in the abstract, that is his rationalization for his action, but he is trying to get rid of that sin which he feels resident within himself. The criminal thus becomes the handy scapegoat upon which he can transfer his feeling of his own tendency to sinfulness and thus by punishing the criminal he deludes himself into a feeling of righteous indignation...both to restrain himself from like indulgences and to keep himself upon the path of cultural progress.<sup>2</sup>

These practices of “private vengeance” are antithetical to the development of a mature and highly functioning society. The desire for vengeance, especially as it relates to criminal behavior, represents the regression and degeneration of both the individual and, in turn, society. In his detailed examination of the concept of ‘degeneration’, Daniel Pick makes the point that advances in the medical profession through science came to be viewed as antidotes to degeneration.<sup>3</sup> The scientific would address the social. In the United States, at the turn of the century, White, too, held this optimistic view. More specifically, a scientific psychiatry could be harnessed to interrupt regressive tendencies in the individual, and thus ensure the continued upward trajectory of societal development. It is therefore important to understand the way in which the individual’s psychology contributes to this type of regression.

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<sup>2</sup> Ibid., 13.

<sup>3</sup> Daniel Pick, *Faces of Degeneration: A European Disorder, c.1848–c.1918* (1989; repr. Cambridge: Cambridge University Press, 1993).

*The intrapsychic in relation to criminal acts*

White argues that it is crucial to understand the individual psychology of the offender, in part because the intrapsychic interacts with the environment. The human mind, according to White, is potentially more complex than the human body. It is “the most complexly organized and intricate system in the universe.”<sup>4</sup> White emphasizes a number of components of the intrapsychic machination of the individual specific to “dealing with instinctual tendencies,” which often underlie conduct antithetical to the greater good of society.<sup>5</sup> White’s starting point is emphasizing the role and structure of the conscience, and he does so by outlining the principle functions of the Ego, Id, and Superego psychic system. The ego, the ‘I’, mediates between the instinctual strivings of the id on the one hand, and the internalized ideals of the social milieu within which an individual is socialized, on the other. These internalized ideals, drawn from the world within which in the individual is born, form the basis of conscience. When the moral prohibitions that are set by the social environment are violated, the individual has to suffer punishment, either from the superego of the self or from the collective superego of the other. Either way, the conscience and its mechanisms come into play. White also explores the role of the psychoanalytic concept of *determinism* as it relates to the psychic structure. All psychological phenomena have antecedents that can be traced through the patient’s history by the analyst. The attempt of the mind to navigate and balance the needs of the individual may predispose a person to criminal conduct, in part, through environmental deprivation. The example that White offers is that of the

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<sup>4</sup> William Alanson White, *Crimes and Criminals* (New York: Farrar & Rinehart, 1933), 19.

<sup>5</sup> *Ibid.*, 20.

child who is raised in an environment of inadequate material and emotional resources. In this case, the child, sensing that he or she is unwanted and a burden, may compensate for the deprivation by stealing toys or money in order to maintain an equilibrium within the self, and within society. A second example that White offers as a potential antecedent to criminality is the child who experiences hate towards one of the parents, typically within a highly conflictual parent-child relationship. The child may then engage in behaviors designed to reflect poorly on the parent. For example, a child from a wealthy family might steal a car, even though the family already owns several. The point here is that criminal acts that may, on the surface, appear to make no sense, according to the principle of psychic determinism will be found to contain a certain logic. This form of determinism, according to White, should always be considered, and most especially so in cases where the individual has engaged in criminality.<sup>6</sup>

The role of *emotion* in criminal behavior is of pivotal importance. White makes the argument that many of those criminally accused do not suffer from mental defects, and are quite high functioning and capable of rational decision making. He concludes that a psychoanalysis will confirm the fact that emotion, rather than intellectual deficit, is central to criminal behavior. White writes that

When the more profound methods of study of psychoanalysis were applied to these individuals it was discovered that the disorder lay primarily and fundamentally in the emotional sphere and that disturbances of emotion were at the root of the disturbances in conduct which were under consideration.<sup>7</sup>

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<sup>6</sup> White, *Crimes and Criminals*.

<sup>7</sup> White, *Crimes and Criminals*, 30.

According to White, all forms of criminality can be viewed from this perspective, not only the so-called 'crimes of passion'. Criminal acts have at their root the aim to satisfy emotional needs. All human beings are always striving to meet emotional needs. The only difference between the sane and the insane person, between the normal and the criminal, is the matter of degree, and the balance found in the intrapsychic negotiation of these needs. An acknowledgement of the importance of emotional genesis does away with the notion that criminal conduct is always voluntary, intelligently planned, and intentional.

*The unconscious, intrapsychic conflict, and psychogenesis in the context of criminality*

White argues that it is of particular importance to understand the role of the *unconscious* as it pertains to criminality. The basic definition holds that there are actions and words that at first glance appear to have little connection to conscious meaning. However, these mental events should be reframed in psychological language, and when this reframing occurs, unconscious content becomes accessible. In this way, criminal acts cannot be taken at face value, because a sole focus on the action itself does not capture the complexity and deeper meaning underlying the motivating forces of the unconscious. Moreover, White frames the role of the unconscious not only in terms of the individual, but also in terms of the transmission of a historical past that belongs to a particular society. In this way, a nation can have an unconscious psyche that is

intergenerationally transmitted, and that can contain content related to traditions of crime and punishment.<sup>8</sup>

The notion of *conflict* is framed by White as related to the unconscious but as extending beyond the conflict of the tripartite structural system of id, ego, and superego. It is analogous to the physical world, where action and reaction are in constant divergence, equally powerful, but drawn in opposite directions, and therefore, perpetually in motion. When applied to the world of emotions, paired emotional states are in antithetical struggle. Love and hate, fear and anger, good and evil, while opposite, can also *become* its antithesis. In this line of thinking, fierce love, for example, may be transformed into fierce hate, as is the case in crimes of passion. Conflict, White argues, is therefore “at the very basis of life itself and represents an ultimate, fundamental character of everything psychological.”<sup>9</sup> As much as conflict is an integral part of life, so are the mind’s attempts at finding equilibrium. One particular attempt at reaching an equilibrium is the mechanism of *over-compensation*. This unconscious process is employed most often when the individual has a particularly significant conflict that needs to be addressed. An understanding of the role of the unconscious, and its attempts to resolve intrapsychic conflict, is essential when considering the *psychogenesis* of what constitutes abnormal behavior and mental processes, such as is often the case in criminal behavior and tendencies.

White’s starting point for psychogenesis is to point out that the explanations for conduct and mental events have shifted, from the exclusive starting point of the somatic, to include the psychological. This represents a revolutionary new way of

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<sup>8</sup> White, *Crimes and Criminals*.

<sup>9</sup> *Ibid.*, 41.

viewing the genesis and pivotal importance of mental events. In a similar way, according to White, the field of criminology at the turn of the century had been expanded greatly through the understanding that a sole focus on the criminal act itself was very limiting. The addition of the individual as actor, of the criminal as an individual with varying capacities, mental or psychological, entered the criminal justice system. This addition contributed significantly to a more inclusive and sophisticated understanding of aberrant behavior and was instrumental in the establishment of juvenile courts. It forced the judiciary to reconsider the long-held notion that individuals either had free will or were completely neutral in their capacities for decision making. Criminology's taking into account psychogenesis also contributed to a redefinition of what constitutes psychopathology. White argues that this redefining not only extends to the intrapsychic, where what was once seen as abnormal may make sense in the context of a psychoanalytic process, but also includes the individual's relationship with the environment. He states that an action can be deemed pathological only if it is reconsidered within the context of this relational world within which the individual functions. Specifically addressing criminal conduct, White emphasizes the "instinctual core of the ego" as the origin of both intrapsychic conflicts and the failure to mediate the demands of the environment.<sup>10</sup> This instinctual core, according to White, is "primitive and selfish" and is oriented to finding the shortest possible path to satisfying wishes, which in turn sets up a conflict between individual desires and social obligations.<sup>11</sup> The ego ideal functions as gate keeper of the instinctual core. White argues that it becomes redundant to distinguish between the normal and the abnormal, and

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<sup>10</sup> Ibid., 49.

<sup>11</sup> Ibid., 48.

that ultimately the abnormal can be defined as behavior and mental content that has not been subjugated by the superego, both intrapsychically and also by the beliefs, customs, and traditions that constitute a well-functioning society. Conduct, and, by extension, the superego, therefore evolves through historical time. White frames this evolutionary development as follows:

Such conduct, which results from the escape from control of that which has been repressed through the ages, is therefore not in this sense abnormal in itself... but simply conduct which is out of place, which might have been perfectly proper at one time, a million years ago, but which today in the present order of things is intolerable.<sup>12</sup>

White identifies two critical developmental periods from which mental disease and disorder, and criminal conduct, are most likely to originate. He regards *adolescence* as one of these critical periods. It is during this time that the individual is in the midst of a monumental struggle to control the destructive and self-oriented instinctive tendencies. Failure to do so results in the failure to meet the demands of the social environment, which in turn predisposes the individual not only to mental illness, but also to criminal tendencies and behavior. The second critical period that White identifies is *involution*, defined as periods of particular stress. During these times, the individual's overall ego functioning is compromised, defensive structures are weakened, and the entire intrapsychic system becomes more vulnerable to the possibility that instinctual tendencies will dominate.<sup>13</sup>

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<sup>12</sup> White, *Crimes and Criminals*, 49.

<sup>13</sup> William Alanson White, *Crimes and Criminals*.

### *The emotions*

The major emotions that White identifies in understanding the way in which the intrapsychic engages with criminal acts are *love*, *hate*, and *guilt*. He ties these emotions to instinctive drives. These drives in turn have the aim of either preserving the race as a whole (“race-preservative tendencies”<sup>14</sup>), or the preservation of the self (“self-preservative tendencies”<sup>15</sup>).

The emotion of *love* is constructive, and sympathetic towards the group. Here White includes the biological—signified by procreation, the care of children, and the relationality required for building families—as well as the organization of society more broadly. He states that love “feels with,” as opposed to “feels against,” and that the concept of love encompasses a creative element of collaboration, and also serves as a mechanism of sublimation.<sup>16</sup> Love, sublimated, is not only constructive and creative to the individual, but also to society, and finds its highest expression in the spiritual. White, however does not define what constitutes the spiritual, except to state that it involves higher levels of expression.

The emotion of *hate* is framed as the antithesis of love. It is destructive, antisocial, aggressive, and includes exploitation of others, as well as predatory tendencies. Hate, according to White, explains cruelty not only on an individual basis, but also within society more broadly. Here he includes acts of sadism, ranging from physical acts of extreme cruelty such as bodily torture, but also socially deleterious actions, for

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<sup>14</sup> *Ibid.*, 90.

<sup>15</sup> *Ibid.*, 90.

<sup>16</sup> *Ibid.*, 23.

example, sarcasm or verbal cruelty, typically delivered by those in positions of power who have the advantage over others. White, however, argues that aggression is also necessary for a functioning society. It provides the impetus for taking action against hate. In line with the optimistic stance of the Progressive Era and the capacity of society to remain on an upward trajectory, White argues that the constructive and creative forces in society and in the individual outweigh the destructive. Love ultimately dominates hate, but not without struggle. He summarized this struggle between love and hate in service of a continually evolving society as follows:

At least we live in that faith and we prefer to think that what happens in the course of the history of the human race is on the whole properly designated by such terms as development, evolution and progress...we are assured a continual going forward, although, to be sure, progress is distressingly slow...real progress could not be otherwise than slow because it is only by overcoming difficulties that this progress is effected and the greatest difficulties of all are those that reside within us.<sup>17</sup>

With regards to *guilt*, White refers broadly, and without providing a citation, to Ernest Jones's general formula that love leads to hate, and hate leads to guilt. Love, in its purest form, extends continuously and indefinitely. Human beings, however, are not capable of this type of love, as a result of the constant internal conflict within the self. This conflict described by White is between the higher aspirations held on the one hand, and the more "concrete, instinctual tendencies" on the other.<sup>18</sup> The impetus for this

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<sup>17</sup> White, *Crimes and Criminals*, 95–96.

<sup>18</sup> *Ibid.*, 97.

constant conflict is the love object, which triggers both love and hate simultaneously. This oscillation gives rise to guilt. White provides the example of the Oedipal conflict. The child, in loving the one parent, is in turn frustrated by the other, which gives rise to the opposite emotion and leads to guilt for experiencing these emotions. Guilt finds its manifestation in either being projected onto the other, or being turned on the self. This may explain, in part, cruelty to others. It is also connected to the need for punishment. In this way, guilt may therefore be assuaged by a certain amount of suffering, inflicted either upon the self or upon the other. In the case of the latter, this need for punishment becomes particularly relevant in relation to the criminal justice system, where criminal acts carry societal repercussions. On an individual basis, the need for punishment takes on not only a sadistic character when directed to the other, but also a distinctly masochistic form when directed at the self. Masochism as described by White entails self-punishment, followed by suffering, and the subsequent repetition of situations and interactions in which this cycle of discomfort and pain is assured of being repeated. While White provides examples of masochism on the individual level that ranges from the intrapsychic (for example, constant self-recrimination) to the physical (for example, bodily self-harm), he also points out that the need for punishment does not occur only on the individual level. It takes on communal form in which the individual is exposed to the vengeance of the community. The mechanism by which the community utilizes projection is described as follows:

In order to satisfy this need for punishment the individual exposes himself to the vengeance of the community. The satisfaction of this vengeance in the various sadistic ways that punishment offers permits the community to purge itself of its guilt feelings by projection, so that

there is a reciprocal relation between the individual and the community...<sup>19</sup>

*The defenses in relation to criminality*

In addition to the mechanisms of *projection* and *sublimation*, White discusses other defense mechanisms specifically in relation to criminal conduct. White argues that, because the underlying causes for conduct can be located within the realm of emotions, reason and logic are required to temper these affective states. The defensive response here is frequently *rationalization*. Rationalization, as is the case with other defenses, is an unconscious response that influences thought and action. According to White, rationalization is “the automatic tendency to find logical reasons for whatever [he] thinks and does.”<sup>20</sup> Rationalization may therefore appear logical, but it is quite often an unconsciously based form of self-deception. Within the context of criminal conduct, this phenomenon can be observed in false confessions, wherein individuals may be convinced of their own guilt in the absence of evidence.

Another defense mechanism White references within the context of criminology is *displacement*. Here the emotional emphasis is shifted away from a pivotal element to a less important aspect, and it is particularly relevant to the motivation underlying a criminal act. The defense of *projection* within this context, wherein blame is shifted entirely, can be observed in the failure on the part of a criminal to take responsibility for the adverse action taken.

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<sup>19</sup> White, *Crimes and Criminals*, 103.

<sup>20</sup> *Ibid.*, 52.

*Symbolization* involves the utilization of a symbol, accompanied by ideas and emotions that at first glance may seem disconnected but that are in fact very much a part of the symbolic meaning of the action or object. The example offered here, by way of explanation, is the significance of symbolism in kleptomania. The object, or the act of stealing, is seldom directly connected to ostensible need. It is only through a careful examination of the perpetrators' interior life that the significance of the symbolism is revealed.

The overall function of defenses within the context of criminality is therefore as distorting mechanisms, disguising the instinctual needs and the unmodulated emotional life of the individual, as expressed in the various forms of criminal acts that the individual may engage in.<sup>21</sup>

#### *The alienist in the court room*

White is widely credited for his advocacy of individuals moving through the criminal justice system. He was a sought-after expert witness, with his most well-known testimony being during the Leopold Loeb trial, which will be described in more detail below. He was also interviewed after the abduction of the Lindbergh baby, with regard to the mental status of the kidnapper. White was famously quoted as stating that while he could not speak to whether or not the abductor was insane, he did say that "he was a damn fool—he picked the wrong baby."<sup>22</sup> While a detailed exposition of the Leopold Loeb trial falls beyond the scope of this discussion, the trial does provide a lens through which to observe the ways in which White utilized, within the criminal justice context,

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<sup>21</sup> William Alanson White, *Crimes and Criminals*.

<sup>22</sup> "Dr. White Asserts Kidnapper Is 'Fool,'" *The Washington Post*, March 3, 1932.

psychological theory and the methods of inquiry typical of the case histories taken at St. Elizabeths. In this high-profile case, the defendants, Richard Loeb and Nathan Leopold, were two affluent Caucasian college students from the University of Chicago. They were accused and subsequently found guilty of the abduction and murder of 14-year old Bobby Franks, who was the son of a wealthy Chicago businessman, and also Loeb's second cousin. The high-profile murder victim and defendants, combined with a public fascination with the individuals involved, resulted in months of press coverage, and the involvement of the most prominent attorneys and psychiatrists in the United States. The trial lasted for thirty-two days after the lead attorney, Darrow, decided on a guilty plea with the aim of avoiding the death penalty. Referred to as the "crime of the century" in the press, White, in his capacity as superintendent of St. Elizabeths and an authority on the criminal mind and psychoanalysis, was asked to testify for the defense.



*Figure 7.1 William Alanson White, defense attorney Darrow and Kentucky senator, Augustus Stanley, circa 1925 (Library of Congress, DIG-npcc 26880)*

When White, in his role as an expert witness during the Loeb trial, was asked to evaluate Richard Loeb, he emphasized certain categories from his recommendations for a patient examination (shown above, in table 4.1), including the defendant's family

history, history of the present illness, as well as the mental aspects of the special examination, in his testimony. This included the role of Loeb's nanny, who was described by White as having "pushed him tremendously in his school work...pushed him ahead, further than he would have gone without that sort of stimulus." Loeb's response to this pressure from his social environment was to develop a persistent pattern of lying that continued throughout his life to the point that reality and fantasy converged to a degree that Loeb was unable to distinguish one from the other.<sup>23</sup>

White also utilized these pivotal parts of the recommended examination of the patient to structure a conceptualization of Nathan Leopold, which he offered during trial. The following excerpt from White's testimony shows the way in which he integrates the defendant's history in order to explain his current personality constellation.

Nathan's pathology had begun early in childhood. His classmates at the Douglas School has teased him relentlessly; his estrangement from his peers had begun when he was seven or eight years old and had continued through his time at the Harvard School and into present. Nathan had always been a lonely, unhappy child, ever the outsider; and to protect himself from further pain and hurt, he had retreated into an inner world where emotion counted for nothing and intellect was all.<sup>24</sup>

Later during the testimony, with regard to Richard Loeb, White takes a developmental stance based upon case history. He argues that Loeb was the receptacle

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<sup>23</sup> Charles River Editors, *Leopold and Loeb: The History and Legacy of One of 20th Century America's Most Notorious Crimes and Trials* (Charles River Editors, 2015).

<sup>24</sup> "Psychiatric Testimony in the Leopold and Loeb Trial," <http://law2.umkc.edu/faculty/projects/ftrials/leoploeb/psychiatrictestimony.html>.

of antisocial tendencies since childhood, and that his infantile make-up persisted into adulthood, hardening the developmental lines in parallel. His superior mental capacity was at odds with the infantile hallmarks of his emotional life, giving rise to poorly developed defenses on the narcissistic spectrum.<sup>25</sup> White's testimony in the Leopold-Loeb trial is very much in line with his own guidelines for the evaluation of patients, as found in *Outlines* and *Mental Mechanisms*, and also reflective of his writing on the criminal justice system in *Insanity and the Criminal Law*.

With regard to the insanity defense generally, White was an advocate for the role of the alienist in the courtroom. He argues that psychiatric testimony, particularly as it pertains to the insanity defense, has been misrepresented. White holds that alienists in the courtroom, contrary to popular public opinion, are not responsible for the abuse of the insanity defense in convincing juries to exonerate the guilty. He makes the argument quite forcefully in *Insanity and the Criminal Law* when he states that "I have never known a criminal to escape conviction on the plea of 'insanity' where the evidence did not warrant such a verdict."<sup>26</sup> He locates part of the problem in the widespread presence of mental illness, specifically mental deficiency or psychosis, diagnosed in over fifty percent of the forensic population. A second issue, according to White, pertains to the language used in the courtroom. The method of cross examination on the part of the judiciary, and the difficulties in translating complex psychological concepts and phenomena in a jury trial, may lead to misinterpretation, and give rise to verdicts deficient in logic. White cites a case treated at St. Elizabeths as illustrative of the dire consequences that can ensue when the alienist is not trusted to make an accurate

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<sup>25</sup> Ibid.

<sup>26</sup> White, *Insanity and the Criminal Law*, 4.

diagnosis and is instead overridden by the jury. In this case, a 49-year-old male army sergeant was found to be in a paranoid state, and was hospitalized. A hearing was arranged so that a guardian could be appointed. During this hearing, four alienists attested to the mental deficiency and paranoid ideas exhibited by the patient. The patient, upon taking the stand however, denied that he suffered from delusions, and claimed that any delusions that he suffered from were in the past. Upon his release, he identified someone on the street as his “enemy,” and he proceeded to shoot the person in the back. White laments the fact that the alienists were, in his view, treated as partisan, and thus were prone to being viewed as making use of what he refers to as the so-called “the insanity dodge.”<sup>27</sup> The mistrust between the jury, the lawyers, and the alienists contributes, in White’s view, to the dysfunction in the legal system, and is often to the disadvantage of the accused. He argues there is a systemic issue in that the legal system has not adequately taken advantage of the advances in the medical sciences. The field of psychiatry has much to offer in terms of understanding human conduct and, in particular, criminal behavior.

*White’s recommendations for a humane approach to criminality*

White did not merely emphasize the intrapsychic and societal forces that shape criminal behavior. He remained pragmatic in his approach and had very definite recommendations for penal reform that were consistent with his humanitarian stance and his continued belief in the ideals of the Progressive Era. An upward trajectory in the evolution of society should be reflected in the treatment of those in the midst of the criminal justice system. First and foremost, White was vehemently against capital

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<sup>27</sup> Ibid., 8.

punishment. He viewed it as nothing more than a rationalization in order to meet the instinctual need for vengeance, and he did not believe that the death penalty was a deterrent against crime. White was also opposed to the form and function of imprisonment as it operated in the United States during the early to mid 1900s. He viewed prisoners as the embodiment of social problems. The approach of locking away those whom society deems unsuitable, without regard for the potential value of the person, or without assessing the potential value of the act of imprisonment, was very problematic in his view. He regarded this approach as overly simplistic and inadequate in the attempt to construct a better-functioning society. White argues that no evidence exists to indicate that the prison system yields positive outcomes, and he points out that the opposite is more likely to be true. First offenders, imprisoned alongside repeat offenders, show little personal improvement, and become a far greater risk for society. White concedes that there are those with antisocial tendencies who pose a real danger to those around them, and, while he makes the exception for the confinement of these individuals, he settles on the conclusion that, relative to those who remain imprisoned for nonviolent crime, the truly dangerous offenders constitute a very small percentage. He distinguishes between those who possess “vicious tendencies,”<sup>28</sup> and the majority, who are criminals as a result of “weakness of character, inability to stand temptation, lack of real initiative and resourcefulness.”<sup>29</sup> White argues that the prison system is built upon the presentation of the minority, who are violent and subject to the more vicious tendencies. The overly punitive architecture of heavily barred cells with sparse light and the strict rules involving silence and control of movement are designed for this

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<sup>28</sup> White, *Crimes and Criminals*, 220.

<sup>29</sup> *Ibid.*, 221.

minority. Such restrictions do not take into account the makeup of the typical prisoner, whom he describes as “rather helpless and inadequate individuals, often boys and decrepit old men.”<sup>30</sup> White uses these arguments to make the case for different types of institutions for different types of crimes and populations. His philosophical stance on the mutuality between the individual and society finds expression within this particular context when he urges for a realization that

...every individual represents an investment of society...and presents certain assets...and certain liabilities...when for one reason or another he has drifted into the prison it becomes an obvious opportunity to the state to endeavor to develop the good and suppress the evil so that in the end he may become a good citizen, his value to the state enhanced thereby and his capacity for individual happiness correspondingly increased.<sup>31</sup>

White believes that the state can contribute to the well-being of society by recognizing what he regarded as essential existential truths about the individual. He is highly critical of the state’s engagement with the individual within the penal system, because he regards the mechanisms of punishment that characterize the prison system as ill-considered, with no direct connection to the individual person. For White, the issue becomes systemic because the crime itself is overshadowed by the overall impact on society. It has no bearing on the future improvement of society. White advocates for the principles of mental hygiene in medicine to be translated into a mental hygiene movement within the realm of psychiatry and the criminal justice system. As opposed to

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<sup>30</sup> Ibid., 222.

<sup>31</sup> White, *Crimes and Criminals*, 223.

the field of medicine, where the object is to heal and to isolate the individual from others until there is a restoration to health, the state's approach, in White's view, is downright destructive:

Now the object of the state in dealing with the criminal is to punish irrespective of anything else, even though the punishment may destroy the offender, even though it may destroy the family; and it is because the state acts in this way that we have a right to say that it is the spirit of vengeance that controls, and that it is not the wish to prevent like offenses that is the controlling principle.<sup>32</sup>

White's argument here is that societal needs are prioritized in a zero-sum way where the individual is subjugated to the illusion of the greater good. This is antithetical to his conviction that it is the individual *and* societal needs that should be balanced, not one at the expense of the other. True adaptation, and authentic societal change in a perpetually upward direction, will necessarily involve a constant renegotiation between competing needs. In an attempt to make the argument for prison reform that takes into account both individual and societal needs, White references models of incarceration in other countries. He is complimentary of Germany, where newly arrived prisoners are studied carefully for a period of time, and then assigned to an industrial occupation based upon the results of what was observed. The prisoner earns, through good behavior and service, increasing levels of privilege and living quarters, before being assigned to a job outside of the prison, while still using the prison living quarters. White rails against the US prison system, by contrast, summarizing the situation as one in

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<sup>32</sup> White, *Crimes and Criminals*, 226.

which the prisoner upon release “is given a cheap suit of clothes and a five-dollar bill and goes out with the stigma of the prison.”<sup>33</sup> His view is that prisoners should have access to meaningful work, and this is especially relevant in light of his views on occupational therapy as curative in the hospital setting. He states that

...while under confinement such individuals should be utilized in constructive and productive labor both for their own good and for the good of everybody else, as a part of their education and as a part of their contribution to society.<sup>34</sup>

From a philosophical perspective, White applied the principles of mental hygiene across the array of difficulties faced by society. Whether the subjects be the mentally ill or the incarcerated, these principles are to be applied in service of the upward trajectory of continual improvement of the individual, and of society. While outside the orbit of classical psychoanalysis, White’s legacy includes an acknowledgement of the important reforms that he championed in relation to the way in which criminal behavior was understood, and subsequently approached in the criminal justice system.

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<sup>33</sup> Ibid., 228.

<sup>34</sup> White, *Crimes and Criminals*, 233.

## Chapter 8

### Conclusion: William Alanson White's Public Persona and Legacy

White found himself in public life throughout his career. The numerous congressional hearings of which he was a part, his advocacy for the reform of criminal law, and his role as expert witness in the Leopold Loeb trial stand out as events that received significant press coverage. When White died, his legacy was written about in numerous publications, and offers another window through which to view his impact.

The *Washington Post* of December 19, 1937, reported on the formation of the then newly founded Washington School of Psychiatry. This was described as “a memorial to the late Dr. William A. White”: the purpose was that it become a post-graduate training foundation, a place where the science and studies of “human living—mental, moral and physical—may grow,” and that it would continue on in scope and size in a way that would serve White’s “accomplishments and ideals forever.”<sup>1</sup> Two years later, Henry Stack Sullivan, in his position as professor of psychiatry at Georgetown University Medical School, delivered the first in a series of the “William Alanson White Lectures” under the auspices of the William Alanson White Psychiatric Foundation. Sullivan, who spoke in front of an audience of five hundred, was quoted in the *Washington Post* as follows:

At the start of the century, he said, three great men appeared in the field of psychiatry. These were Sigmund Freud, who posited the relationship between past experience and present activity; Adolf Meyer, of Johns

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<sup>1</sup> “School Started as Memorial to Dr. W.A. White,” *The Washington Post*, December 19, 1937.

Hopkins, who taught that every thought or act of behavior was a result of a huge number of processes going on within the individual, and Dr. White, late superintendent of St. Elizabeths Hospital, who developed the concept that psychiatry should deal with all relationships of men and not only mental illnesses.<sup>2</sup>

The contrast between Sullivan's view of White as in the same category of Freud, and White's subsequent fading legacy within the field of psychoanalysis is striking. This again highlights the division between the psychoanalytic conceptions and practices affiliated with the psychiatry of the hospital setting, and what those in Freud's circles appear to have regarded as a 'purer' form psychoanalysis in the private consulting rooms, a form that placed far less emphasis on environmental influence and social impact.

White, ill for less than a week, succumbed to pneumonia. In a very personal account of his final moment, the *Washington Post* reported that, after initially showing remarkable improvement, White's night nurse summoned his personal physician, Dr. William Mallory. Mallory arrived at White's home at 5 am and found him a state of rapid deterioration. Four other physicians came to assist, and White is reported to have been conscious until the time of his death. He was described as "cheerful and exerted every effort to respond to Dr. Mallory's treatment."<sup>3</sup> His wife, Lola (figure 8.2), and M. Sanger, who was his administrative assistant for thirty years, were by his side.

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<sup>2</sup> Sullivan, *Conceptions of Modern Psychiatry*, 15.

<sup>3</sup> "Dr. White, St. Elizabeth Chief, Dead," *The Washington Post*, March 8, 1937.



Jelliffe, upon hearing about White’s condition, hurriedly left New York for Washington, DC. At least one newspaper reported that Jelliffe was at White’s bedside when he died; however, reports on this are inconsistent. In the *Washington Herald*, Jelliffe described White as a regular child who “loved to swim and was interested in bugs, botany and peculiar people.” Jelliffe also described the response that White had had to being selected as superintendent of St. Elizabeths. This little-known interaction, as well as White’s tenure at Binghampton, is described by Jelliffe, who was also on staff at Binghampton at the time:

He came back to Binghampton, ran around the place like a thunderbolt. Never had seen a man so happy, so proud. He had a headful of ideas and

couldn't wait to put them into practice. Everyone at Binghampton loved him, hated to see him go.<sup>4</sup>

Jelliffe furthermore disclosed that White was a very talented piccolo and flute player, and he led the hospital band that played for the patients. He also sang in a Gilbert and Sullivan opera at the hospital, described by others as a “smash hit.”<sup>5</sup> White’s obituaries provide a vision of someone who held wide appeal, both on professional and personal levels. The editorial in the *Washington Herald* of March 9, 1937, introduced White as someone who “was always trying to chart pathways through private worlds lost in the midst of insanity,” and later, “it will be years before the world realizes how important, how vital his pioneering has been. He never rested in all his 67 years, and the force of his presence will be manifest long after these sad days.”<sup>6</sup> White was generally described as congenial, gentle in manner, and in a lesser-known professional attribute, a prolific speaker. Dr. William Mercer Sprigg, president of the District Medical Society, referred to White as “one of the most delightful and fluent speakers I have ever heard.”<sup>7</sup>

The outpouring of affection for White posthumously is evident through the press and, in some instances, is very personal. In one prominent publication, he is referred to as “the Louis Pasteur of psychiatry,”<sup>8</sup> in part because he removed methods of restraint from the psychiatric ward at St. Elizabeths, and in part for his approval of malarial

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<sup>4</sup> “Jelliffe Here, Mourns Death of Dr. White,” *Washington Herald*, March 8, 1937.

<sup>5</sup> “Jelliffe Here, Mourns Death of Dr. White,” *Washington Herald*, March 8, 1937.

<sup>6</sup> “A Great Man Passes,” *Washington Herald*, March 9, 1937, Editorial edition.

<sup>7</sup> “Dr. White, St. Elizabeth Chief, Dead,” *The Washington Post*, March 8, 1937.

<sup>8</sup> “Head of St. Elizabeths, Dr. Wm. White, Is Dead,” *Washington Daily News*, March 8, 1937.

treatment for general paresis. Generally seen as “forward looking” and a scientist, White was framed as a pioneer in all these areas, simultaneously “a poet, a philosopher and evangelist” who straddled the worlds of Washington politics and the politics of American psychiatry and psychoanalysis. Emil Kraepelin’s visit to St. Elizabeths is also mentioned as a part of White’s legacy.<sup>9</sup> The *Washington Times* reported on Kraepelin’s visit as follows:

When the famous Prof. Emil Kraepelin of Munich, known as ‘The Master’ in mental science, visited this country some years ago, he spent two weeks at St. Elizabeths. Upon leaving, Prof. Kraepelin said: ‘This is the finest institution I have ever been in. In my estimation, Dr. White is to be ranked with the great scientists of our time’.<sup>10</sup>

It is perhaps the contrast between the hopeful optimism of the Progressive Era, juxtaposed with the confined, dark, cramped quarters in which those suffering from mental illness were often kept in confinement, that contributed to White’s legacy as an enlightened scientist and humanitarian. White embodied the Progressive Era by changing these conditions in very measurable ways. The editorial in the *Washington News* on March 8, 1937, encapsulates this juxtaposition of which White became a part:

There was a time when the fumbling and groping idiot was dressed up in cap and bells, to be the butt for the horseplay of his ‘saner’ brothers.

There was a time when those bereft of reason, those who stumbled down dark corridors of incoherent fear, were hidden in attic corners and

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<sup>9</sup> Eric J Engstrom and Ivan Crozier, “Race, Alcohol and General Paralysis: Emil Kraepelin’s Comparative Psychiatry and His Trips to Java (1904) and North America (1925),” *History of Psychiatry* 29, no. 3 (September 1, 2018): 263–81, <https://doi.org/10.1177/0957154X18770601>.

<sup>10</sup> “White’s Death Is Mourned by Nation,” *Washington Times*, March 8, 1937.

forgotten, or were beaten and starved in filthy bedlam cells. There was a time, even, when those in whose deranged minds imaginary voices sounded, were burned to death by men who called themselves reasonable. That such unfortunates received gentler treatment nowadays is due to the unremitting educational efforts of those physicians who insisted that madness in all its forms was not sin or disgrace, but sickness; who searched for treatment and who then fought to have it applied. Dr. William Alanson White of St. Elizabeths Hospital, whose death is mourned today, belonged to that gallant and humane group of men.<sup>11</sup>

In the “Stars, Men and Atoms” column, the science writer Thomas Henry wrote about White’s passing on March 9, and again a week later, on March 16, 1937.<sup>12</sup> In both these instances, he emphasizes the humanitarian impact that White’s life and work had on the well-being of the mentally ill. While Henry emphasized White’s adherence to scientific rigor and precise style of hospital administration, he makes the point that this is not White’s only, and perhaps not even his most important, legacy. Henry points out that White entered the field of psychiatry at a time when the “current theories of the psychoses and neuroses were not far from superstitions.”<sup>13</sup> He credits White with being a synthesizer between the diverse schools of thought that emerged related to the etiology and treatment of mental illness, and between the scientists who “demolished each other’s thought structures.”<sup>14</sup> In order to be such a synthesizer, Henry argues, a

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<sup>11</sup> “A Healer Dies,” *Washington News*, March 8, 1937.

<sup>12</sup> Thomas R. Henry was a prominent science writer and journalist for the *Washington Evening Star*. He was also the press writer for the Smithsonian Institution from 1931 until the mid-1960s.

<sup>13</sup> Thomas R. Henry, “Stars, Men and Atoms,” *The Evening Star*, March 9, 1937.

<sup>14</sup> Thomas R. Henry, “Stars, Men and Atoms,” *The Evening Star*, March 9, 1937.

certain practical philosophy was required, and White was such a “practical philosopher” who could straddle the scientific, the poetic, and the philosophical. It was, however, not only the science writers and highly qualified medical professionals who wrote about White’s impact. In a letter to the editor of *The Evening Star*, printed on March 20, 1937, a self-described staff member in a “subordinate position” wrote that he felt compelled to write because he wanted to communicate the following:

[H]e was father to a vast multitude—employees and patients alike, whose troubles and perplexities were laid at his feet, and in his kindly eyes were revealed friendship and love, beaming forth as a light in a troubled sea of darkness and despondency. To those unfortunates that were committed to his care and keeping, he labored long and tirelessly to reach into the remote mysticisms of their lives and repair the frayed and broken light of a new day and awaken a clearer concept of human understanding and life.<sup>15</sup>

While not every article juxtaposes to this degree White’s reforms at St. Elizabeths with the prior treatment of the insane, almost all of the press articles related to White posthumously credit him with improving the conditions of the insane. At least some of these reforms are attributed to his personal qualities. His “common sense,” “devotion,” “good humor,” “judgment,” and “undiscouraged optimism,”<sup>16</sup> as well as his

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<sup>15</sup> Thomas R. Henry, “Stars, Men and Atoms,” *The Evening Star*, March 16, 1937.

<sup>16</sup> Editorial, *The Evening Star*, March 8, 1937.

being “kindly” and possessing “authority,” “eloquence,” and “poetic vision” are qualities that are connected to his reforms at the hospital.<sup>17</sup>

Returning to the question posed at the beginning of this exploration of the life and work of William Alanson White as to the degree to which St. Elizabeths’ history is White’s history, and vice versa, the answer has emerged that it is a simultaneous history. White’s legacy was St. Elizabeths Hospital, the countless staff who trained and worked there, and the patients who improved, and equally those who did not. The history of psychiatry and the history of psychoanalysis were living, through White’s presence, in the wards. This history found form in the trial-and-error approach constituted by the methods of the mental hygiene movement. When White removed the forcible restraints of confinement, a new framework within the psychiatric hospital in the United States became possible. The at times trial-and-error approach, tailored to each individual patient, of hydrotherapy, occupational therapy, and, for some, psychotherapy, embodied the hoped-for ideals of the Progressive Era. Scientific enquiry and systematic treatment planning promised a final movement away from the unenlightened methods of restraint and blanket pathologizing. Psychoanalysis promised a new and ordered way of approaching the human mind. The complex relationship between mind and body, the role of psychobiology, and the skirmishes between biological psychiatry and talk therapy, however, all remain ongoing, and fraught with politics. White’s own legacy did not appear to escape the politics of his time. His skirmishes with the Freudians, and the tension with Freud himself, undoubtedly affected how he was perceived in psychoanalytic circles. While the history of psychiatry has been far kinder, the history of psychoanalysis has all but omitted

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<sup>17</sup> Thomas R. Henry, “Stars, Men and Atoms,” *The Evening Star*, March 9, 1937.

White. Unlike the classical analysts, he was simultaneously outward- and inward-looking in locating psychogenesis. His lifelong belief in the mutual interaction between the individual and society, his views on the equal importance of the intrapsychic and the environmental, and his understanding of the necessity of, and potentially dire consequences of the failure to adapt to, external demands, positioned him outside the inner circle of Freud and his followers. This is ironic, given that White and his staff at St. Elizabeths provided psychoanalysis, used psychoanalytic concepts *en masse*, and most likely treated thousands more patients than were treated in the private practices. White and his staff were also instrumental in bringing psychotherapy to patients who would not have been deemed good candidates for the analytic method, given the severity of the pathology and the pre-Oedipal conflicts with which they often presented in the inpatient setting. In the history of psychoanalysis, White has at times been dismissed as a popularizer and an administrator. It appears as though Sullivan, his protégé, and founder of interpersonal psychoanalysis, was better able to operationalize White's positions, and re-entered the fold of analytic circles, utilizing many of White's original ideas. White was an adherent to Bergsonian ideals and the progressive optimism in the capacity of science to cure. He was, however, also tempered by the magnitude of the suffering that he encountered on a daily basis. His academic writing at times appears disconnected from his personal papers. The former often appeared more optimistic in terms of what the practice of psychiatry and psychoanalysis could offer within an optimistic philosophical frame, while the latter provides a glimpse of the harsher realities inherent in early-twentieth-century psychiatry-in-the-making. White, however, was very connected to the mission of treating the mentally ill, and of advocating for the disenfranchised, the destitute, and the criminal. St. Elizabeths was the conduit for much

of his work, a laboratory that was as much social as scientific, and that came to closely embody the principles to which White ascribed. It is therefore virtually impossible to disentangle White from the institution that he built up over almost four decades. Shortly after White's death, his closest colleague and lifelong friend, Eli Smith Jelliffe, confirmed this view in the *Washington Herald* on March 8, 1937, when he was quoted as saying the following:

“His life was St. Elizabeths Hospital. He ate with it and slept with it. And there can be no greater monument to Dr. White than his institution, the greatest of its kind in the world today. He took it when it was nothing. He made it. He loved it.”<sup>18</sup>

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<sup>18</sup> “Jelliffe Here, Mourns Death of Dr. White,” *Washington Herald*, March 8, 1937.

## Appendix: White's

### Word Association List

	To swim:	To despise:
Head:	Journey:	Teeth:
Green:	Blue:	Correct:
Water:	Bread:	Crowd:
To prick:	To threaten:	Book:
Angel:	Rich:	Unjust:
Long:	Lamp:	Frog:
Ship:	Tree:	To cut:
To plough:	To sing:	Hunger:
Wool:	Sympathy:	White:
Friendly:	Yellow:	Ring:
Table:	Mountain:	To listen:
To carry:	To play:	Pencil:
Insolent:	Sail:	Woods:
To dance:	New:	Apple:
Lake:	Custom;	To meet:
Sick:	To ride:	Law:
Proud:	Wall:	Love:
To boil:	Stupid;	Glass:
Ink:	Volume:	To quarrel:
Angry:	Potato:	Goat:
Needle:	To paint:	Large:
		Part:
		Old:

Flower:	Dog:	Wagon:
To strike:	To talk:	Judge:
Box:	Carriage:	Night: <sup>671</sup>
Wild:	Sky:	
Bright:	Straw:	
Family:	Baby:	
To wash:	Anxiety:	
Cow:	To kiss:	
Stranger:	To lie:	
Luck:	Fire:	
To tell:		
Hesitation:	Blood:	
Narrow:	Duty:	
Brother:	Bed:	
To harm:	To rent:	
Stork:	Sorrow:	
Dirty:	Mirror:	
Door:	Prison:	
To choose:	Knee:	
Hay:	To live:	
Quiet:	Change:	
Scorn:	Barn:	
To sleep:	Snake:	
Month:	To uncover:	
Colored:	Policeman:	

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<sup>671</sup> White, *Outlines*

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