The rise of psychoanalysis in US hospitals: William Alanson White at St. Elizabeths, 1903-1937

El auge del psicoanálisis en los hospitales de EEUU: William Alanson White en St. Elizabeths, 1903-1937

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Abstract

William Alanson White's views on the function and conceptualization of psychoanalysis shaped the practice of the analytic method in the hospital setting in the United States. Here I explore White's original work and maintain that his understanding of transference, the unconscious, symbolism, language, and defense mechanisms were rooted in both traditional intrapsychic and individualistically oriented conceptions and influenced by his orientation toward social psychiatry. In line with Progressive Era ideals, White considered the new science of psychoanalysis important for healing both the individual as well as society; this mutual influence helped shape the evolution of psychoanalytic principles and informed the treatment of patients undergoing psychoanalysis at St. Elizabeths Hospital.

Keywords: history; transference; unconscious; language; defense mechanisms.

Resumen

Las opiniones de William Alanson White sobre la función y la conceptualización del psicoanálisis dieron forma a la práctica del método analítico en el ámbito hospitalario de los EEUU. Aquí exploro el trabajo original de White y sostengo que su comprensión de la transferencia, el inconsciente, el simbolismo, el lenguaje y los mecanismos de defensa estaban enraizados tanto en las concepciones intrapsíquicas tradicionales como en las de orientación individualista e influenciadas por su orientación hacia la psiquiatría social. Conforme con los ideales de la Era Progresista, White consideró que la nueva ciencia del psicoanálisis era importante para curar tanto al individuo como a la sociedad; esta influencia mutua ayudó a dar forma a la evolución de los principios psicoanalíticos y mostró el tratamiento de los pacientes sometidos a psicoanálisis en el Hospital St. Elizabeths.

Palabras clave: historia; transferencia; inconsciente; lenguaje; mecanismos de defensa.

William Alanson White's (1870-1937) influential position as superintendent of St. Elizabeths, the largest hospital in the United States between 1903 and 1937, had a significant impact on the practice of psychiatry and the solidification of the technique and language of the psychoanalytic method in the asylum setting. White was a product of the Progressive Era who embodied an optimism in which the principles of scientific inquiry and the emphasis on the importance of environmental adaptation stood alongside the psychoanalytic method (D'Amore, 1976). For White, these ideas were not in opposition, but rather co-existed in the inpatient ward. I argue that twentieth-century American psychiatry and psychoanalysis was practiced in parallel tributaries, in private consulting rooms as well as the hospital setting. White's psychiatry and his views on the analytic method were informed mostly by the challenges and opportunities of the latter, and included modifications to allow for his belief in the centrality of environmental influences on intrapsychic functioning. Related to this context within St. Elizabeths, a comparative study in the contrasts between the views of Freud, Jung, and White on psychoanalytic concepts is complicated; not only were these terms in the evolution of psychoanalysis in flux, constantly being refined and revised, but there was additionally a fluidity in the techniques, definition, and language of psychoanalysis within St. Elizabeths itself. Psychoanalysis was only introduced in this hospital in 1915, and it was practiced with a certain degree of trial and error. This is illustrated by case files showing that the understanding of what constitutes a patient's capacity to undergo analysis changes over time, and in relation to constantly evolving environmental demands, as well as adherence to what White and his followers believed was an emerging science.

Situating White within American psychoanalysis: 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, but also looked increasingly towards the interaction between individual and environmental demands that impinged upon function. While Hale (1971, p.43) 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, not all scholars agree 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 which was filled by psychobiology and psychoanalysis. 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. To Caplan (1998), there was no "crisis:" this author argues that cultural forces and shifts in the legal landscape (including growing emphasis on environmental influences) contributed to the shift away from the organic. 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 effects on the nervous system. Noll and Kendler (2016) 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 this country

where psychiatric research was conducted. The aim was to attempt to emulate what was viewed as the scientific rigor of European (and more specifically German) laboratory practices as they pertained to psychiatry. Between 1898 and 1902, Boris Sidis utilized the methods of suggestion and other hypnoid states in his investigations of the subconscious, thus solidifying the role of the psychological as an investigative method. Sidis (1908), Ukrainian immigrant to the United States, 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. White was very impressed with Sidis's work and was instantly drawn to the psychological method, perhaps partly 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.

Any discussion about White inevitably raises questions 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 treating patients at Phipps (Lamb, 2014). 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 neuron 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 (Menninger, Nemiah, 2008). He also strongly advocated for clinical observation as a method, rejected the Kraepelian approach as too reductionistic, and incorporated William 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 their response to adverse environmental influences, this set the stage for discerning the early stages of disease and responding accordingly (Hale, 1971). While there was mutual influence between Meyer and White – for example, Meyer's views on the removal of restraints at Phipps appear to have been influenced by White's recommendations – they rarely collaborated directly. A comprehensive biography on Meyer by Susan Lamb (2014) mentions White, very briefly, on only two occasions, affirming the view that they practiced psychiatry in what appear to be separate fiefdoms.

By the early 1900s American psychiatrists had acknowledged the role of early childhood experiences in forming the adult character. But 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 (Hale, 1995).

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. But within four years things had rapidly shifted, and psychoanalysis emerged as a method for studying the psychological. Freud's conception of the primacy of the psychological at the expense of the 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 to explain pathology, the door was left wide open for the psychological, and more specifically, psychoanalysis, to enter as the primary method of inquiry.

White began his work at St. Elizabeths firmly situated within this newfound enthusiasm for the potential of the scientific method of psychoanalysis that permeated American psychiatry. In 1909, he wrote enthusiastically about the analytic method, expressing hope that it would provide a new and coherent way to make sense of the mind and of pathology. By 1914, when he attended the Annual Meeting of the American Medico-Psychological Association, he retained this initial enthusiasm, although clearly the analytic method had not yet provided all the answers he was seeking. In an impassioned defense of the theory of psychoanalysis, he statedstated: "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" (D'Amore, 1976, p.71).

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 (White, June 1914). But it was not long before White's willingness to incorporate the theories of Jung and Adler theories relegated him to the very edges of 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, Freud's followers). His relationship with Freud remained problematic throughout his life, despite Jelliffe's attempts at mediation (Burnham, 1983).

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 (Tanner, 1981). This made his methodology more palatable to the world of psychiatry, and less so to classical analysts. His approach therefore held a wider appeal to physicians and those outside the field of psychoanalysis than within traditional analytic circles. It is important to consider that precisely this departure from classical theory may have allowed the analytic method to become part of the fabric of the hospital treatment setting. When White died in 1937, psychoanalytically informed psychiatry and the accompanying language for

operationalizing patient care was firmly ensconced at the largest asylum in the United States. His contributions to this solidification of analytic theory and practice can be located in the areas of language, transference, the unconscious, symbolism, defense mechanisms, and the psychoanalytic complex.

The role of language

White ascribed to the idea that the principal vehicle for the analytic method is language. In his 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 emphasized that language, although 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 argued that just like synonyms plucked 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, while events are experienced differently, until the only remaining conclusion is that the word itself becomes a symbol. In *Foundations of psychiatry*, White (1921, p.76) explored this problem in 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 constantly changing circumstances which influences it."

Here White returned 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 he ascribed to, White (1911) regarded symbolism itself as the result of an upwardly developmental trajectory in which 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," thereby harnessing the possibilities for further evolution and elaboration on the part of both the patient and the analyst (White, 1921, p.77). The pivotal concept of transference is central to this mutuality in language.

White on transference

White viewed transference as fundamental to the analytic process. In his presidential address to the American Psychoanalytic Association in Boston in May 1917, he referred to transference as "the most important problem in psychoanalysis" (White, 1917, p.373). While he praised Freud's emphasis on this construct, he critiqued the broader psychoanalytic

literature for not paying sufficient attention to this dynamic between patient and analyst (White, 1917). In keeping with his views on the symbiotic relationship between individual and environment, transference in White's view was not, however, a strictly intrapsychic process: it also encompassed the individual's capacity to engage with and adjust to environmental demands at the level of the psychological. He described 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 (1917, p.367), "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" (emphasis added). The transference provides a bridge between the patient's inner world, where the libido can be located, and external reality. White extended the centrality of the transference process to include all areas of medical practice, and argued that transference occurs in every doctor-patient relationship. The main difference, however, is that for the analyst, the transference is not unconscious, and can be addressed accordingly during treatment. Characteristic of his egalitarian views in which respect for the patient was paramount, he emphasized the responsibility that accompanies the "enormous authority and influence" (White, 1917, p.367) on the part of the physician. But he also acknowledged that working on the transference can be very taxing for the analyst, particularly the requirement that "the physician should keep his personality as far removed as may be from the problem at hand" (p.378). The analyst should be aware of the power and role of transference and should conduct analysis in accordance with the best interests of the patient, regardless of the power differential. The analyst must also keep their own personality dynamics in check. 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 permitting analysis of the resistance (White, 1917).

White described a case he treated in which the transference toward him had developed to the point that the patient brought in very interesting dream content. He acknowledged 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 concluded that this dream was more indicative of his "showing my own prowess than of attempting to do something for the patient" (White, 1917, p.379), 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 addressed the importance of dissolving the transference, stating that allowing the transference to develop is as important as allowing the transference to dissolve when appropriate. He returned to the central role of the libido in navigating the internal and the external in stating 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" (p.380).

White thus understood the pivotal role of the unconscious as it related to transference in analytic theory and practice. He also had a broader understanding of its centrality, while simultaneously recognizing the important role of environmental influences in making sense of pathology.

White's views on the unconscious

White outlined his views on the unconscious with the caution that it should not be seen as occupying a specific spatial relationship. In other words, an attempt to define where consciousness ends and the unconscious begins, for example, 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 (1907) 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 pointed out that there are many examples of mental content that can be voluntarily recalled but are not always the focus of attention. These ideas are classified as part of the fore-consciousness. In other words, what constitutes mental life is not equivalent to consciousness, because consciousness only encompasses what we are aware of, while most of the motivations for our conduct lie outside of our awareness. Drawing upon the prominent psychologist G. Stanley Hall's (1898) iceberg metaphor, White concurred 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 returned to the concepts of adaptation and integration as they relate to consciousness, stating 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 is partly organically based, for example when an individual has to consider which fork in the 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 (White, 1911).

White expanded upon the notion of conflict within the context of the unconscious. Taking a Bergsonian stance, he forcefully argued for its importance when stating that it is "the very root and source of life" (White, 1916, p.42), although he does not offer a clear definition of the term conflict, creating some confusion. He alternately referred to conflict as a "great creative energy," an *élan vital*, quoting Bergson, *hormé* (p.43), utilizing Jungian terms, or the libido. The main point for White, beyond offering a strict definition, was 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 (White, 1916, p.42).

In contrast, White adopted a distinctly Freudian view when defining the unconscious, stating that Freud's contribution here should be regarded as the most valuable. Nonetheless, White's definition of the unconscious retains elements of development and adaptation, alongside the Freudian concepts. He explained this as follows: "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" (White, 1916, p.44).

The emphasis on adaptation to reality and its relationship to the unconscious is framed in evolutionary terms in *Mechanisms* (White, 1911). White argued that as humankind's reality has become increasingly civilized over time, it requires the ability to delay and postpone desire. This reality is often at odds with the unconscious, which in his opinion is predominantly comprised of wishes. But he adds:

> 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 (White, 1916, p.51).

White differentiated the foreconscious from the unconscious principally in terms of the foreconscious being more immediately accessible as resistances to this accessibility are quite easily overcome, including by the individual him- or herself. The unconscious, in contrast, is not easily accessible. Another difference involves 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 careful analysis that the true meaning of this unconscious content, which is quite different from the original manifestation of the material, can be revealed. Symbolism is at work here, disguised under a wish and a fear. White (1916, p.55) provided the following explanation: "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."

Even among explanations of intrapsychic conflict, White never moved away from including the concept of conduct. He utilized Freud's concepts of *Lustprinzip* (the pleasure principle) and *Realitätsprinzip* (the reality motive) to explain how these principles are often at odds, giving rise to a conflict between the emotional (pleasure) and the intellectual (reality), and how this conflict can consequently affect conduct. White also noted that the language of emotions is underdeveloped, pointing out that "we can feel, but we cannot put our feelings into words. And so when these feelings, which are the reverberations of past experiences … [it] needs to do so symbolically for clear consciousness implies a situation intellectually controlled" (White, 1916, p.56).

At first glance, White's views on emotions appear confusing. He differentiated between emotions and emotional states, or content. White did not believe that emotions exist *per se*. He argued that mental states, including bodily reactions, can be viewed through the lens of both intellectual and emotional states, referring to the latter as the characteristics of emotions that take on a psychosomatic form. From a psychological standpoint, pathological bodily states are the result of a failure of integration. Mental states, unlike emotional states, are farther removed from immediate bodily states, and are less reactive from a pathophysiological perspective. This is especially true in the case of mental disturbances,

in which the physiology of the patient is heavily involved. White's (1916, p.56) view was that emotion dominates thinking, positing that "man is a feeling being before he is a thinking being." Accurate perception of reality, however, is found principally within the latter 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, and instead is attentive to the symbolic as a sign of past conflicts imbued with highly affective content that has not become a part of the patient or the patient's history. This led White (1916, p.59) to conclude that "the unconscious is our historical past, likening it to the tail of a kite, simultaneously providing stability yet holding the individual back 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 was psychological, not neurological. He again emphasized the power of the environment, most especially how less-than-ideal environments can create fixations and regressions that may be revisited years later. In terms of the more severe forms of pathology, most notably dementia praecox, White maintained that conduct cannot always be understood or explained in this mental condition. Consciousness itself cannot be understood fully in praecox, for example. He argued that this can occur only in an analysis of the individual. Instead, White (1916, p.60) argues that race consciousness must be taken into account, explaining 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." This illustrates 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 (1911) often referred to the importance of symbolism in his writing, and dedicated an entire chapter in *Mechanisms* to this concept. He began his discussion with a nod to the presence and necessity of symbolism in human language, and the diversity as well as universality found in symbolism across cultures. White noted that psychologists cannot know the meaning of any particular symptom for any particular patient, because of the idiosyncratic meaning and significance it holds for each individual person and circumstance. He argued 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, and the relationship between symbolism and consciousness varies according to where the symbolism is located on the continuum between the unconscious and the conscious. Symbolism in the foreconscious can be interpreted more

easily than symbolism found in the unconscious, because in the latter case 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 as a result 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 adaptation 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 consequently 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 (White, 1916). 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 (1916, p.113) provided 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.

White also offered 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 argued 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 (White, 1916).

The developmental trajectory that White charted 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 (White, 1916). 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 (1911, p.19) conception of the mind as "a complex of adjustive mechanisms." White viewed defense mechanisms as action-oriented compensatory devices, equating the psychological with the physical by drawing an analogy between psychological defense mechanisms and the physiological reactions of the body in response to bacterial infection or malignant pathological changes, for example. White stated 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 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 (1911, p.21) defined 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."

The first defense reaction described by White attends is the phenomenon of forgetting. He argued that the process of forgetting is complex, rather than simple. It is not the act of omission, as it may at first appear, but rather an active process. Its proactive nature 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 (1911, p. 21) referred to as "circumscribed amnesias." Over time, the event itself 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 provided three case examples to illustrate the lengths the mind may go to in order to defend, but also communicate, necessary and adaptive content.

In the first case, White was the analyst. The patient experienced the hallucination of a fatherly voice telling him to convert to Catholicism, saying that if he did so, he would have access to a priest who could fulfill the role of a father. This was especially important because the patient's father had died, and the patient had been abusing alcohol and neglected his spiritual life in comparison to his practices while his father was alive. White also referred to one of Carl Jung's cases, a Russian Jew who converted to Christianity against the wishes of his own conscience. This patient dreamed that his mother admonished him and threatened to choke him if he completed his conversion. The patient then decided to listen to what he referred to as "the still small voice" (White, 1911, p.23) and retained his Judaism. In the third case, White summarized a particular incident described by Théodore Flournoy, a 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 relied on Jung's usage of Flournoy's 1908 paper on anti-suicidal

teleological automatisms 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 (Jung, 1916). In this particular instance, White described a suicidal female patient walking to the water's edge. Just as she was about to throw herself into the water, she was able to visualize her treating physician, whom she trusted. She saw 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 regarded the defense mechanisms in these three cases as 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 were borne out (with psychoanalysis representing one path to such ideals) is illustrated quite clearly when he stated 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" (White, 1911, p.24). Defense mechanisms can fail, however. White (1911, p.26) identified the experience of extreme psychic pain as the condition under which such a failure is most likely, offering 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."

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 provided an example of a 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 individual and society. This is the case in artistic endeavors, for example, or the lives and works of the great writers. But for 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" (White, 1911, p.25). White acknowledged that there are many other types of defenses, although he did not explore these in detail. He included sleep, dreams, and the defense of justification, which he stated he often saw in the case of criminals who showed 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. 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 acknowledged that the theoretical concept of a "complex" was originally used to denote dissociative states. But by 1911 he argued that such a definition was outdated. In *Mental mechanisms*, White (1911) posited 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 then utilize adaptive mechanisms to negotiate with the internal world. White explained that attention to the external world is not equally distributed, but is partly a function of the internal mental processes and the external realities of the entire organism, the whole individual. He argued 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 in this reaction are both physiological or mental elements, sometimes one, and sometimes the other, dominating the picture" (White, 1911, p.52).

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 a reaction in the individual that occurs outside 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 outlined three primary types of "complex reactions:" forgetting, compensatory, and mental attitudes, moods, and character (White, 1911).

Forgetting as a type of "complex reaction," according to White, is the most commonly seen and most pronounced subtype. When an experience is painful, the mind (in an attempt to protect against painful realities and the accompanying feeling states) engages in what White (1911, p.55) referred to as "the limbo of the forgotten." The second "complex reaction" described by White is compensatory. By way of introduction, White (1911, p.55) poetically described "compensating" as "for the sadness and sorrow, the blasted hopes and disappointments, the trials and tribulations, the mind again comes to the rescue." Manifestations of compensatory behaviors include, a young woman disappointed in love entering a convent, for example, or a woman who becomes a nurse when her maternal instincts are frustrated. He also referenced the fatalism he viewed in religion and in Nietzsche's philosophy as further examples of compensatory mechanisms. Wish-fulfillment in the form of dreams or deliria offer additional examples of the compensation complex. In the psychiatric population, White (1911, p.40) observed 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." White (1911, p.41) framed this as a defense reaction; in severe cases, the compensatory system can become a psychotic process, as in the case of a young woman who developed a "wish-fulfilling delirium" after being abandoned at the altar. Mental attitudes, moods, and character constitute the third type of complex. White connected mood states with complexes by arguing that moods are frequently conditioned by dormant, submerged complexes. Here he included 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 person suffering from long-standing melancholia, for example, but can crystallize to the point that they form a part of the fabric of the personality as manifested in prominent traits. White (1911) singled out complexes with a sexual undertone that is connected with painful emotion as particularly challenging.

The ways in which the complex becomes manifest can often be located within the patient's behaviors, in what White (1911, p.59) referred to as "modes of expression." Here again White drew upon case material to illustrate his point: in one case, 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 this event, she experienced significant anxiety every time she saw the color red. When she was running an errand at the hospital and had to step 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. In White's conceptualization, these reactions are not only mental, but also bodily. He reminded the reader that the physiological is always connected to the psychological, citing cases treated by Janet and Sidis to make this point. In both these cases, the patients experienced what White (1911, p.59) referred 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 for repressing the complex, for keeping painful mental facts out of consciousness (White, 1911, p.60).

White then shifted to an energy-based explanation for the often acute physiological manifestations observed within the context of mental conditions. He likened it to an episode of epilepsy, but episodic emotion-based manifestations can be explained as partly the result of significant emotional content being repressed and dissociated. At its peak, a critical mass of accumulated energy results in the complex taking on a "dynamogenic character" (White, 1911, p.61) to the point that an inevitable explosion occurs. This newly released energy follows the path of least resistance, and the psychomotor channels represent these paths by providing a relatively easy outlet. These convulsions seen in psychogenic seizures, according to White, constitute conversion symptoms. Sensory-type reactions are often connected to prior traumatic experiences. One example offered by White is a patient who collapsed on a stage with a green carpet. Afterward, this patient was particularly prone to seizures when in the presence of the color green (White, 1911).

The symbolic level at which complexes can occur, however, poses particular challenges. In one case example, White described a patient he treated who used a strange sounding word during a delirium that he later identified as being from a foreign language. During the course of treatment, White discovered that the word translated to "cigarette," and that the patient had bet on a horse with that name and subsequently bought an expensive cigarette with the money that he won. 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 also the case with displacement. White offered an example 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 also described a case treated by Freud as an example of the important place of symbolism in dreams. In this instance, a patient's dream of a horse that breaks free and gallops away symbolized the patient's ability to do the dream work. The fact that the horse was not killed symbolized the patient's resilience in deal with challenges (White, 1911).

Contextualizing the "complex" in the interior life of the patient

It can be argued 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 were not able to provide explanations or cures for some the most perplexing psychiatric problems of his time. In *Mechanisms*, summarizing his thinking on the problem of the "complex," White (1911) acknowledged 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 maintained 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 they represent the mind's best attempt to adjust to external pressures. White (1911, p.64) stated: "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."

White's (7 Oct. 1909, 1911) advancement of the notion of the complex" provides an avenue with which to approach confounding cases through intelligent and persevering observation, which may eventually yield a clearer picture of the patient's psyche. White noted that patients often do not regard their mental aberrations as anomalous, explaining 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, he or she must be ready 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 (1911) grappled with defining what constitutes psychotherapy. He balked at criticism from figures in the medical community who regarded the therapeutic method as nothing more than suggestion. In White's opinion, this was an overly simplistic understanding that did not reflect the complexities that characterize human consciousness. He offered the following case he treated to illustrate that suggestion alone cannot be effective

as a treatment method, and accordingly cannot possibly embody the entire definition of what constitutes psychotherapy. White's patient had a phobia of the color red, which remained despite hypnotic suggestion. The phobia was also tied to suicidal ideation. White's attempts to substituting the suicidal thoughts with ideas of a cat or a bright flash of light worked briefly before losing their effect, which in turn caused the patient's self-destructive thoughts and depressive symptoms to return. To White, the hypnotic suggestion's failure to address these symptoms adequately signified that the fundamental, underlying conditions are not reached by suggestion. He argued 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" (White, 1911, p.121) symptoms are expressions of a primary condition. He remained very critical of suggestion as a method of treatment, and advocated psychoanalysis in stating:

> 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 psychotherapeutists have for long been using suggestion without appreciating the necessity of going deeper than the surface in attacking the problem (White, 1911, p.121).

According to White, psychoanalysis goes to the source of the symptomatology, avoiding what he deemed 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 lies outside 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" (White, 1911. p.123). This, to White, was 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 neurotic symptoms arise accordingly (White, 1921). This intrapsychically situated complex in turn interacts with the external environment, shaping the individual's conduct, albeit only partially conscious.

Final considerations

William Alanson White was simultaneously outward- and inward-looking in locating psychogenesis. His understandings of transference, the unconscious, symbolism, language, and defense mechanisms were shaped by 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 need for adaptation to external demands, along with potentially dire consequences of failing to do so. This paper presents White's explanations and conceptions of these psychoanalytic concepts, situating the language of psychoanalysis firmly within the hospital setting. White's emphasis on the social utility of psychiatry and psychoanalysis considered the realities of patients who were often released into challenging environmental circumstances, and consequently required an approach to psychoanalysis that was pragmatic, translatable, and oriented toward the well-being of the individual and the overall advancement of a civil society, in keeping with the idealistic aims of the Progressive Era. The hospital setting allowed the theory, practice, and language of psychoanalysis to be applied in a wide variety of cases that would not have otherwise been possible in private practice. This treatment milieu required a rigorous yet flexible stance on psychoanalysis, one that was also integrated into real environmental demands of patients' lives. This engagement did not endear him to traditional analytic circles, and his application of analytic terms and concepts to case conceptualization at times involved a certain quality of trial and error. But ultimately, White made psychoanalysis accessible to large numbers of patients and hospital staff because of his willingness to engage with theory in a pragmatic, idealistic, and flexible manner. In doing so, he became one of the most pivotal psychoanalytic figures within the field of psychiatry in the United States.

REFERENCES

CAPLAN, Eric. *Mind games: American culture and the birth of psychotherapy*. Berkeley: University of California Press, 1998.

BURNHAM, John. *Jelliffe: American psychoanalyst and physician and his correspondence with Sigmund Freud and C.G. Jung*. Chicago: University of Chicago Press, 1983.

D'AMORE, Arcangelo R.T. *William Alanson White: the Washington Years, 1903-1937. The contributions to psychiatry, psychoanalysis and mental health by dr. White while superintendent of Saint Elizabeths Hospital*. Washington: National Institute of Mental Health, 1976.

HALE, Nathan. *The rise and crisis of psychoanalysis in the United States: Freud and the Americans, 1917-1985*. Oxford: Oxford University Press, 1995.

HALE, Nathan. *Freud and the Americans: the beginnings of psychoanalysis in the United States, 1876-1917*. Oxford: Oxford University Press, 1971.

HALL, Stanley G. Some aspects of the early sense of Self. *The American Journal of Psychology,* v.9, n.3, p.351-395, 1898.

JUNG, Carl. G. *Psychology of the unconscious*. New York: Moffat and Yard, 1916.

LAMB, Susan D. *Pathologist of the mind: Adolf Meyer and the origins of American psychiatry*. Baltimore: Johns Hopkins University Press, 2014.

MENNINGER, Roy W.; NEMIAH, John C. *American psychiatry after World War II (1944-1994)*. Washington: American Psychiatric Press, 2008.

NOLL, Richard; KENDLER, Kenneth. Edward Cowles (1837-1919). *American Journal of Psychiatry*, v.173, n.10, p.967-968, 2016.

SIDIS, Boris. The doctrine of primary and secondary sensory elements. *Psychological Review,* v.15, n.2, p.106-121, 1908.

TANNER, David. E. *Symbols of conduct: psychiatry and American culture, 1900-1935*. Austin: University of Texas at Austin, 1981.

WHITE, William A. *Foundations of psychiatry*. New York: The Journal of Nervous and Mental Disease Publishing Company, 1921.

WHITE, William. A. The mechanism of transference. *Psychoanalytic Review*, v.4, p.373-381, 1917.

WHITE, William A. *Mechanisms of character formation: an introduction to psychoanalysis*. New York: McMillan, 1916.

WHITE, William A. Letter from W.A. White to Karolinsky Institute. William Alanson White Papers. Records of St. Elizabeths Hospital. Personal Correspondence. Record Group 418 (National Archives, Washington, DC). June 1914.

WHITE, William A. *Mental mechanisms*. [S.l.]: University of California Libraries, 1911.

WHITE, William A. Forty-third opening exercises of the Howard University School of Medicine. *Howard University Journal*, v.3, n.4, p.4, 7 Oct. 1909.

WHITE, William A. *Outlines of psychiatry*. New York: The Journal of Nervous and Mental Disease Publishing Company, 1907.