RACE UNCHRONICLED. A DISCOURSE OF PSYCHOANALYSIS IN MID-20th CENTURY UNITED STATES /
RAZA IGNORADA. UN DISCURSO DEL PSICOANÁLISIS EN LOS EEUU DE MEDIADOS DEL SIGLO XX

Elizabeth Ann DANTO (*)

Abstract: Effectively ending federal non-involvement in mental illness in the US, John F. Kennedy signed the Community Mental Health Care Act in October 1963. Some psychoanalysts took to the CMHC movement, some not, while others had been working in community-based services like the Lafargue clinic in Harlem since the 1950s. To what extent did America’s historical tendency to merge social class and race influence these psychoanalysts, their theories, their formal associations like APSaA? To understand the psychoanalytic profession’s construction of race and of white-black relations in the 1960s, this essay is not a history but rather a historiographic inquiry that explores how key players of the era itself understood the challenge. Based solely on materials written or spoken between 1958 and 1972, this is a narrative of power that interweaves the mid-century union of psychiatry and psychoanalysis, the residues of slavery, and the on-going white ambivalence about the emerging influence of a multi-ethnic, religiously diverse popular campaign for basic civil rights. With few exceptions, the psychoanalysts tended to idealize their own sense of democracy while remaining oblivious to the exclusionary nature of their enclaves. Ultimately, however, we find that American psychoanalysis was probably no more racist in the 1960s than other systems of thought, but no less either.

Keywords: Psychoanalysis in the United States, White on black racism, Viola Bernard, The Lafargue Clinic, John F. Kennedy, The 1963 Community Mental Health Act.

Resumen: Concluyendo de manera efectiva con el no involucramiento del gobierno federal de los Estados Unidos en temas vinculados a la enfermedad mental, el presidente John F. Kennedy promulgó en 1963 la Community Mental Health Care Act (CMHC). Algunos psicoanalistas se vincularon al movimiento de CMHC, otros no, mientras un tercer grupo había trabajado desde los años 1950 en servicios comunitarios tales como la clínica Lafargue de Harlem. ¿Hasta qué punto las tendencias históricas existentes en los EEUU que vinculaban clase social con raza influenciaron a estos psicoanalistas, a sus teorías, y a sus asociaciones formales? Este ensayo, que es una investigación historiográfica que explora como los actores clave de la era entendieron el desafío, intenta comprender la construcción que la profesión psicoanalítica realizó del concepto de raza y de las relaciones entre negros y blancos durante los años 1960s. Basado exclusivamente en materiales escritos o hablados entre 1958 y 1972, este artículo es una narrativa del poder que entrelaza los vínculos entre psicoanalistas y psiquiatras, los residuos de la esclavitud, y la ambivalencia de la población blanca acerca de la emergente influencia de una campaña popular de carácter multiétnico y religiosamente diverso por los derechos civiles básicos. Con pocas excepciones los psicoanalistas tendían a idealizar su propio sentido de democracia desentendiéndose, al mismo tiempo, del carácter excluyente de sus enclaves. En última instancia, sin embargo, encontramos que el psicoanálisis de los EEUU probablemente no era más racista que otros sistemas de pensamiento durante los años 1960, pero tampoco lo era menos.


Recibido: 18 de febrero de 2014 / Aceptado: 20 de mayo de 2014

(*) Hunter College – CUNY New York City. E-mail: edanto@hunter.cuny.edu
RACE UNCHRONICLED. A DISCOURSE OF PSYCHOANALYSIS IN MID-20\textsuperscript{th} CENTURY UNITED STATES

Elizabeth Ann DANTO

Introduction:

Is American psychoanalysis racist? The question has arisen periodically for at least eight decades. In the winter of 1966, Erik H. Erikson, an avowedly liberal man who wielded significant influence on American culture and psychoanalysis alike, attempted to deconstruct the effects of racism on both subject and object. “What before was a more unconscious mixture of guilt and fear on the white side, and a mixture of hate and fear on the other,” he said, “has now been replaced by the more conscious and yet not always more practical sentiments of remorse and mistrust…. I would not be surprised to find that our Negro colleagues and friends often sense a residue of species-wide colonialism in the ‘best’ of us.” (Erikson 1966, p. 166) Erikson was neither the first nor the last psychoanalyst to view his white colleagues’ ambivalent - arguably elitist but certainly colonialist - stance on race as a massive threat to all aspects of identity formation. From individual to collective, historical to cultural, gender to social class, racial identity was the omnipresent but seemingly indissoluble psychological node of the 1960s.

American psychoanalysis was probably no more racist in the 1960s than other systems of thought, but no less either. Similarly, psychoanalysis was no more to blame for American racism than social work was for poverty, though neither profession offered solutions deep enough to offset historical over-determination. Still, analysts of the 1960s may have laughed uncomfortably at The New Yorker’s latest cartoon of the bumbling Freud wannabe, but few questioned the position of psychoanalysis in the larger cultural narrative. The country’s mid-20\textsuperscript{th} century protest against racism occurred with psychoanalysis dominant in psychiatry, and with the psychoanalysts holding a majority position in (if not always in control of) mental health treatment.

The following essay explores the psychoanalytic literature of the era and finds that its efforts at social self-assessment started in about 1950 but rarely included the dimension of race
until the 1960s. The profession managed to feel it had overridden its own racism for at least two reasons. For one, the psychoanalytic movement’s original progressive agenda had found a home among a segment of American liberals who greeted Sigmund Freud’s 1909 Massachusetts speeches with a tremendous sense of relief. Emma Goldman, the American feminist and anarchist leader, saw in Freud the liberation of female sexuality and, one can assume, release from other oppressions as well. She said that Freud “gave one the feeling of being led out of a dark cellar into broad daylight.” (Goldman 1971, p. 173). The second reason stems from the psychoanalytic movement’s own experience with racial marginalization. “Because I was a Jew,” Freud explained in 1926, “I found myself free from many prejudices which restricted others in the use of their intellect; and as a Jew I was prepared to join the Opposition and to do without agreement with the ‘compact majority’.” (Freud 1926, p. 272) Through encounters with sundry scientists, novelists, patients, students, politicians and students, Freud assembled a compelling portrait of Jewish identity and the limits of anti-Semitism. The extent to which this tension between racial margin and center may, or may not, have shaped the trajectory of psychoanalysis, has been widely discussed (Gilman 1992 and Gay 1989, for example) and, like all social constructions, never settled.

In America of the 1960s, broadly bracketed, the psychoanalysts’ official approach to white-on-black racism (as to most concerns, clinical or not) was largely defined by the American Psychoanalytic Association’s (APSaA) position of empathic good will but little action. Determining whether the association was racist or not, depends on reading how the analysts thought and wrote about themselves, and on how others portrayed them as well. Arnold Rogow’s extensive 1970 membership survey of APSaA and the American Psychiatric Association, for example, shows that practicing clinicians considered analysis, along with its energizing effects, as providing individuals with ample opportunity for expressions of compassion, which is usually tolerant, and organizations for self-rule, which almost never is. The analysts were more left-wing in general outlook, in voting patterns, and in their belief that government should make greater efforts to eliminate poverty and to support entitlement programs such as Medicare than the psychiatrist. On closer review though, Rogow’s study tells a more ambiguous story: only one analyst, compared to eighty-three psychiatrists, had any blue-collar patients and many practitioners continued to show flagrant ethnocentrism and cultural biases in their assumption that the poor were “unreachable.” With few exceptions, the psychoanalysts had a tendency to idealize their own sense of democracy, while remaining as oblivious to the exclusionary nature of their enclaves as the South African
psychoanalytic society. To what extent did America’s historical tendency to merge social class and race influence these psychoanalysts, their theories, their formal associations like APSaA, and “alternative” or “radical” groups of the 1960s? To understand the psychoanalytic profession’s construction of race in the 1960s, this essay is less a history than a historiographic inquiry that explores how key players of the era itself understood the challenge. Their narrative of power interweaves the mid-century union of psychiatry and psychoanalysis, the residues of slavery, and the on-going white ambivalence about the era’s campaign to place black people in the same economic stratum as whites and give poor (or lower class) people the same social rights as the more affluent classes.

1. Psychoanalysis meets Jim Crow

When Freud’s breaking arguments with Carl Jung swept through the psychoanalytic movement in 1912, the latter had already advanced his theory of the American “Negro complex.” By this he basically meant that American culture is severely repressive, especially of sexuality, because the presence of blacks causes American whites to shore up their defensive systems. “The chivalry of the South,” Jung explained in The New York Times, “is a reaction against its instinctive desire to imitate the negro.” Two world wars later, the psychoanalysts of the 1950s faced something possibly more contentious: the covert racism Jung had articulated, however obnoxious, was as prevalent within their profession as American society at large. Having endured racial trauma and escaped Hitler’s ethnic genocide, the European émigré analysts (and the Americans they trained) seemed caught somewhere between Eisenhower conservatism and the progressive, if privileged, optimism of academia.

In the early 1950s, the same Lawrence S. Kubie who had spearheaded huge rescue efforts on behalf of the émigrés a decade earlier, now tried to capture APSaA’s emerging mood of introspection in a process arguably parallel to other largely white professional associations. “It is a striking and deplorable fact,” Kubie wrote (1950, p. 245), “that after fifty years of work by an increasing body of analysts, we do not know the incidence of even the simplest neurotic symptoms in any socio-economic or national or cultural group in the population… [or other] elementary psychosocial facts.” Kubie collected nationwide data from psychoanalysts’ self-reports on fees, patient ages and occupations, and individual income. The topic of race, however, is not given one single mention; presaging what the novelist Richard Wright would call the white “moral argument”
for this oversight, the study omits the category of race as though it never existed. Then, toward the end of the 1960s, Kubie visited the Southern Psychiatric Association in Asheville to give a paper and this time, he would not let race go unmentioned. “I gradually became aware of the absence of any Negroes at the meetings” he (Kubie, 1969) wrote to its director, James Asa Shield, in December 1969. “Of course the issue of membership is only part of the problem; the other is the question of whether the meetings are open and whether Negro psychiatrists would be welcome to attend.” When this assertion, bold as it was, remained unanswered for over two years, Kubie was galvanized.

Kubie was a handsome man who led clinical seminars wearing a double-breasted tweed suit and classic tortoise-rim glasses, and who held keenly to the pursuit of justice. He tangled with Francis Braceland, then editor of the Journal of the American Psychiatric Association, in an effort to take “the problem of black membership or exclusion” public: “Silence here is tantamount to being an accessory to their conspiracy of silent and unacknowledged segregation.” (Kubie, 1971) This defiant statement brought in Dr. Viola Wertheim Bernard, the psychiatrist who would become the voice of anti-racism in psychoanalysis over the next two decades. She had publicized the lack of black trainees in psychiatry and said that the ratio of three hundred blacks to seventeen thousand white psychiatrists in America in 1965 (Bernard 1972, p. 981) was not only unjust and unfair – it confirmed the existence of race-based structural inequality in the profession. Kubie was wise to engage her diplomacy. In the wake of her intervention in 1971, the Southern Psychiatric Association once and for all solicited and received applications for membership from five black psychiatrists by October (Holland, 1971).

In the decade following World War II, the exiled Viennese psychoanalyst Richard Sterba (1948) elaborated on one aspect of the Freudian canon, writing - just eight years after fleeing the Nazis - that white fear of the Negro disguises unconscious sibling rivalry and an underlying dread of the Oedipal father. Erikson’s celebrated Childhood and Society appeared around the same time, and his cliché-ridden chapter on “Black Identity” (“Negro babies receive … enough oral and sensory surplus for lifetime, as clearly betrayed in the way they move, laugh, talk, sing.”) merely reiterated the orthodoxy. Similarly Janet Kennedy’s influential if partial article from 1952 set out to explore the connections between memory, fear, and skin color; the result was an almost comic validation of the argument that the black patient’s aggression toward the white therapist results from prior experience of life in the United States. In other words, black patients must locate a non-
black ego ideal with whom they can work through their own angry or suspicious stereotypes of the white therapist before entering treatment with the white therapist. Finally, in a posh essay that’s as sturdy and proper as his native post-Civil War American South, Clarence Oberndorf (1954), said that interracial therapy (white therapist/black patient) was ineffective and that incompatible psychological bias was inevitable.

Not all analysts agreed. When Abram Kardiner and Lionel Ovesey published The Mark of Oppression (1951), they pointed to the power of white on black discrimination and intimidation as explanations of those “deviations in the Negro personality” evidenced by, for example, Rorschach tests. Published the year after Kenneth Clark’s influential study of children’s racial identifications, Kardiner and Ovesey put forth a dynamic sequence in which black adults’ low self-esteem results in an idealization of the white and frantic efforts to be white. Consequences of this unattainable ideal include hostility to whites, self-hatred and hatred of other black people. The book marked a curious bifurcation of thought. On the one hand, the idea of an individual “Negro personality” is described by low self-esteem, mistrust, self-hate, poor impulse control, and present-centeredness, perhaps as a compensatory accommodation to life under segregation and perhaps not. On the other hand, these so-called attributes suggest that personality characteristics of black people can be identified only in relation to white people.

Exposing how establishment psychiatrists, who had rejected the black population for decades, remained subtly offensive in their distaste for desegregated mental health care, the novelist Richard Wright wrote a watershed essay in 1946, ostensibly about the new Lafargue Clinic in New York, but more about how “idealism protecting corruption” had, thus far, precluded the development of a mental health clinic in Harlem and the training of black psychiatrists. The white so-called “moral” argument, Wright said, was six-fold: no clinic should open until trained black psychiatrists can staff it; “naturally irresponsible” blacks already fill the existing state and city hospitals; a clinic in Harlem only adds to the pattern of racial segregation; current institutions should be forced to serve blacks; singling out Harlem for special aid indicates over-sensitivity; and anyway many white psychiatrists treat black patients privately. The Lafargue Clinic opened nonetheless “to provide expert psychotherapy for those who need it and cannot get it” in the basement of St. Philip’s Episcopal Church parish house, propelled by Dr. Frederic Wertham and his intellectual allies, Richard Wright, Ralph Ellison and the journalist Earl Brown. The outpatient clinic had neither a budget nor any official social service agency or institutional affiliation, and while
it couldn’t attract funding, the clinic found many friends in the white liberal press. “Here’s Hope for Harlem!” exclaimed James Tuck (1947) in the *New York Herald Tribune*, followed by equally amazed and affirmative articles in *Time*, *Life*, the *New York Post*, the *Amsterdam News*, *Woman’s Home Companion*, and *The Humanist* (Doyle, 2008, 2009). The small mixed-race staff believed in “social psychiatry”: Wertham’s form of psychodynamic treatment where social work theory and practice played a central role. No clinical intervention could go forward without explicitly assessing the client’s own mix of intrapsychic dynamics and environmental factors. Perhaps the two biggest fictions that the Lafargue rewrote are that the inner lives of African Americans are not as emotionally complex as those of white people, and that they cannot benefit from insight-oriented psychotherapy. The unconscious has no social class, and neither social disadvantage nor economic discomfort precludes the capacity for – and right to – discerning mental health treatment.

2. **Identity by Negation**

The initial rhetoric of anti-racism in the early 1960s showed a promising white self-examination that anyone old enough to remember the Eisenhower era of racial conformity could not casually dismiss. An undeniable boldness seeped into the psychoanalysts’ sightlines: when it reached APSaA by way of a report issued by the association’s portentously-named Central Fact Gathering Committee in 1961 (Hamburg, 1967), members could read how just over eight hundred psychoanalysts had recorded their patients’ sex, age, marital status, occupation, number of weekly visits, length of treatment – and, this time, race. The results could not be clearer: “All patients in the sample were white.” Nathaniel Siegel, who had secured funding for the study, was sufficiently upset to repeat the statement in reverse, saying that “not one Negro patient was to be found in the sample,” (Siegel 1962, p. 156) and he raised some fundamental, if unanswered, questions: how does race influence an analysis? How many “Negro” professionals are in analytic training? Where are “Negroes” receiving psychoanalytic treatment? Few responses, if any, came from within the US.

Thus, by 1960, if organizers of the Greensboro sit-ins thought that the image of race segregation had been rendered for all to see, mainstream psychoanalysis showed limited engagement with the discourse on race and even fewer signs of anti-racism. Glimmers of a new rhetoric may have started to emanate from Washington DC, but research sponsored by the National Institute of Mental Health showed that the psychoanalysts still thought “desirable to
exclude… [people] in markedly adverse life situations.” (Knapp et al, 1960, p.461). The NIMH study tallied “cases” by sex, education, age, and social and class status – not race. In the same way, and even though Leo Rangell’s organizational work as president of APSaA had touched on social justice and the stubborn exclusion of non-whites from the profession, his autobiography (2004) fell into the unaffected habits of white privilege and unquestioningly replicated this exclusion in his narrative.

The larger point, however, was that America’s historic fusion of race and social class, which would be exploited by conservative policy makers in decades to come, had also consolidated within the mental health professions. From psychiatrists to psychologists and social workers, most had come to believe the elitist rhetoric that the so-called lower class patients were somehow not suited for insight-oriented psychotherapy (Brill and Storrow 1960, Hollingshead and Redlich 1958). Reproducing a white middle class ethic under the guise of objective science, everyday objects from waiting room pamphlets on mental health to Rorschach protocols upheld, explicitly or implicitly, conventional cultural norms (Gursslin et al 1960). With examiner bias as documented as it was pervasive, how could social class/race practitioner bias escape notice? Because, found Nancy Kurtz (1970) among others, of the highly significant correlation between level of authoritarianism and negative attitudes toward the lower-class patient. In other words, middle-class/white patients were considered neurotic/treatable whereas lower-class/black patients were judged psychotic/non-treatable. White practitioners had a lineage to uphold. “If his analyst can trace his treatment back to Freud through only one generation, he gains in social position much as the man who purchases a Stradivarius.” (Aronson & Weintraub, 1968 p. 97) That elitism surely signaled that the aura of social prestige which gripped American psychoanalysis had not run its course.

3. Hugh Butts and Erik Erikson

One man to question the subject of psychoanalysis and race (and race within psychoanalysis) was the psychiatrist and psychoanalyst Hugh F. Butts. Hugh Butts became interested in the relation between self-esteem and the perception of skin color among black children, while researching the nature of racial identification in the early 1960s. At the time, he was working at a New York state residential institution, the Hillcrest Center for Children in Bedford Hills. Adding psychoanalytic theory to Clark and Clark’s path-breaking investigations of the early 1950s, Butts demonstrated that black pre-adolescents whose self-esteem was already impaired, were
more vulnerable to racial self-doubt than children with higher self-esteem. He used Sandor Rado’s definition of self-esteem as concept of self. In light of Dale Meer’s concurrent explorations of children’s symptoms as ordinary adaptation to hostile environments, phenomena identified historically as “pseudodeflect, pseudoimbicility, and pseudodebility” would not be unthinkable (Meers 1970, p. 210). The institutionalized children’s concept of self was as “unlovable,” and they identified self-esteem with lighter or white skin color. Accordingly, the children’s transference to the largely white therapists exacerbated their already low racial self-esteem. But what if the therapist were black? While this theme would take over the psychoanalytic discourse on race later in the decade and throughout the 1970s, it was Hugh Butts (besides Viola Bernard) who actually confronted the question. In “White Psychiatrists’ Racism in Referral Practices to Black Psychiatrists” (1970) and its sequel, “Psychoanalysis, the Black Community and Mental Health” (1971) Butts gave a stark but still impassioned portrait of the white psychiatrist as an old racist – the doctor of good will, patronizing, unaware, and almost alarmingly bigoted. Based on responses to a mid-1960s survey sent to one hundred white psychoanalysts and psychiatrists in New York, Detroit and Chicago, the “referral” article, co-authored with Phyllis Harrison, investigates this collective contradiction: why 100% of the respondents “indicated a desire to end ‘racism’ once and for all” and still say, as one responded, “Of course I would tell a patient that the physician is black. I would tell them if he were fat, crippled, blind, or had a thick accent, or any other physical defect” (Harrison and Butts, 1970, p. 279). Free-roaming racism of this kind would startle most writers; for Butts, it was almost routine. The profession’s condescension masquerading as white liberal concern for black sensitivity was, for Butts, exactly the picture of intolerance that needed uncovering. He used the language of psychoanalysis to show how the confluence of countertransference and racial stereotypes can accelerate the treatment, and not always adversely (Schachter and Butts 1968). On an empirical level, he studied the low rate of referrals to black psychiatrists in urban hospitals; he found, for example, that the white doctors in the study listed “feelings that black psychiatrists are better able to treat children, hippies [and] working class patients, …[and] over-concern that racist attitudes from patients will ‘humiliate’ and ‘hurt’ the black psychiatrist” (Harrison and Butts, 1970, p. 281). Black patients paying lower fees would be suitable as well. Finally, in an interesting twist on the association between race and capital, Butts noted that low-fee or free clinics without religious affiliation seemed to find race irrelevant whereas racial distinction in selecting a therapist became more important as fees increased, or in private practice.
Enter Erik Erikson. While completing his psycho-historical study of Gandhi, in the early 1960s Erikson attempted to set down the process of identity formation in non-whites. If identity is not biological, is it all cultural? If yes, then the definition of identity would be strikingly different from the eight incremental psycho-social crises published in *Childhood and Society*. Erikson approached the question in a set of five dialectical categories, a series of humanist puzzles that could be solved either by the insights of psychoanalysis or not at all. Doing so was a puzzle in itself. “Identity… is something in the psychological core of the revolution of the colored races and nations who seek inner as well as outer emancipation from colonial rule and from the remnants of colonial patterns of thought,” Erikson writes. But then he says: “Power, or at least the power to choose, is vitally related to identity” (Erikson, 1966, 145-146.). The two statements seem to contradict each other, at least in ideology. The first is expansive, collective, liberationist; in contrast, the idea of “power to choose” is classic Western individualism, and also patriarchal. Erikson takes up this contradiction in “Individual and Communal,” the first of his reflections on identity and race. What William James had called mental and moral “character” is really identity, says Erikson, and he suggests that the absence of Jamesian character in the work of black writers like Baldwin and Ellison is a kind of “negative identity” marked by “invisibility, namelessness, facelessness” that could also be viewed as “positive” if it is “something to be liberated.” The theme of positive and negative identity recurs in Erikson’s next reflections on race. In “Conscious and Unconscious,” the straightforward use of Freudian terminology (which aspects of identity are preconscious and which unconscious?) is intermixed with the question of free will and a touch of nihilism: “[Because] the preoccupation with identity may be seen as a symptom of alienation… Negro writers have become the prophets of identity confusion” (p. 152). Of course, the layering of identity processes can’t be traced back to their precise origin. But Erikson did see that combining psychoanalysis with oppression theory might allow him to assemble a sort of map, both chronological and geographic, of the system by which a racial identity is ultimately constructed.

As Erikson’s conceptualization of racial identity began to shift away from classic individualism, his social awareness grew and his grasp of majority culture contrasted with psychoanalytic contemporaries like James Hamilton, Terry Rodger or Andrew Curry. To explain white on black aggression, for example, Rodger (1960) presented the symbolism of the Negro as the castrating father, while Hamilton (1966) applied the psychosexual metaphor of anality, chiefly...
the fear of filth and of contamination by touch. Discussing how racial group membership altered treatment, Waite (1968) speculated on black patients’ fantasies about the white therapist as a locus for resistance, and white therapists’ own countertransference resistances. In contrast, Andrew Curry’s 1964 essay offers up the controversial theme of black therapist/white patient. The black therapist is a novelty, a grasping interloper in the minds of white and black patient alike. Despite Curry’s initial and affecting boldness, this particular transference is mapped as a journey between archaic myths and fairy tales of “devils and darkness” where only “mystery” is left to elucidate the insight experience. Effectively portraying blacks as “others,” regardless of patient or professional status, writers like Curry, Hamilton and Rodger remain entrenched in the individualism of the 1950s unreached by the racial integration movements of the early 1960s. A few others, Erikson included, broadened their political thinking.

4. Community Mental Health?

Effectively ending over one hundred years of federal non-involvement in mental illness, John F. Kennedy signed the Community Mental Health Care Act in October 1963. Government-financed out-patient mental health centers began to expand into geographies virtually untouched by psychoanalysis until the CMHC Act became law. Psychiatrists were among the first onboard. “The [individual] model alone is inadequate,” the psychiatrist Robert Corney emphasized in 1967. "Another model must be used which permits the consideration of population units larger than the single patient." For Corney, the new model of community psychiatry represented non-alienating, comprehensive mental health care for all age groups, all psychiatric diagnoses and all socio-economic categories. He was pretty blunt: since the upper classes already had private access to treatment, their avoidance of a community clinic was immaterial. What was called for was a lowering of economic barriers so that everyone in need could use a mental health center, with or without an appointment. Corney (p. 143) called the ubiquitous “waiting list” a subtle example of covert exclusion. Even before de-institutionalization became a scandal-pressed reality in the 1970s, the CMHC aimed to move masses of psychiatric patients back from remote campuses and into the urban racially-mixed communities, often close to the patients’ home and families.

At the same time, the principally urban profession of psychoanalysis slowly cast off an identity as psychiatry’s sub-specialty (though the two had become nearly synonymous) all the while affirming its connection with the social sciences and the humanities – but not with community
psychiatry. Norman Zinberg, a lifelong believer in the merger of psychoanalytic theory with psychiatric practice, commented on the absorption of psychoanalysis into American popular and academic culture. “This degree of diffusion is almost unbelievable [since] in 1963, the American Psychoanalytic Association, for the first time in its history, included more than 1000 members.” (Zinberg 1963, p. 810) Still, except for those few analysts affiliated with community psychiatry, neither the increase in membership nor the cultural dispersion of psychoanalysis seemed to reflect the minimal awareness that most psychoanalysts held of race, spoken or unspoken. Adding to sheer racial discrimination, perhaps the barrier was built by the professions’ multiplicity of contradictions: housed in both the behavioral sciences and the humanities, aiming to relieve collective neurosis one person at a time, validating personal insight and social materialism at once. Kurt Eissler (1963) argued that, properly used and applied, psychoanalysis would assure the survival of the West. That belief may have been just the barrier to be dismantled.

The psychoanalysts’ basis for engagement with community mental health ranged from the evident (duration of treatment should not be correlated to social class, Hunt 1962), to the semantic (eliminate technical terms and ambiguous language that favored an educated class, Adams and McDonald 1968), to the radical (the mental health movement simply perpetuates a middle class ethic, Gursslin et al 1960). In other words, lower class patients received fewer clinical interviews; poorly educated people were not accepted for treatment as often as the better educated; and the so-called “poor risk” applicants were, for example, poor children with uninvolved parents.

Ultimately mental health professionals who saw racial difference as mere instances of individual counter/transference had more negative attitudes toward lower-class patients, and their lack of self-awareness would have disastrous consequences. Dr. Joe Yamamoto and a group of Los Angeles psychiatrists decided to investigate how to avoid this disaster. They measured the relationship of failed psychiatric clinic appointments to social class, therapy’s congruence with class-linked expectations, and in 1967, they asked “Is Race a determining factor in the selection of patients for psychiatric treatment?” The answer was an unequivocal Yes. “We were amazed,” they wrote, “It became apparent that the patients were being treated differentially depending on factors of race and that these differences were of dramatic proportions” (Yamamoto et al 1967, p. 84). The “difference” meant that nonwhite patients were discharged more often, or received less intensive therapy, than white patients. This conflict reached deep into the treatment session, even when two therapists purposely made use of co-therapy to mitigate its effects on transference (Brayboy and
Marks, 1968). Before long, two more studies found that patients who ranked highest in “similarity to the [white] therapist” also scored highest on “acceptability for treatment.” (Lowinger & Dobie 1968, p. 628) In other words, the racial composition of analytic patients barely changed in the full decade since Hollingshead and Redlich (1958) showed them drawn exclusively from the higher, whiter classes. As a white institution, APSaA could have been the poster organization for 1968 Kerner Report from the President’s Commission on Civil Disorders: “our nation is moving toward two societies, one black, one white – separate and unequal… What white Americans have never understood – but what the Negro can never forget – is that white society is deeply implicated in the ghetto. White institutions created it, and white society condones it.” The message was, if not uniquely, certainly salient in psychiatry. Though the American Psychiatric Association would soon issue a rational statement on racism, at the moment the white psychiatrist was challenged, in writing, “to become aware of how their everyday practices perpetuate institutional racism” (Sabshin, 1970).

Discussions of a political platform at the 1968 meeting of APSaA’s Committee on Social Problems were halfhearted and almost entirely defensive. The Committee on Social Problems then headed by Robert Dorn did not trust the federal legislation and questioned the APSaA’s involvement “in such an area” although, in fact, most of the psychoanalysts individually supported the idea of community psychiatry. For Dorn however, community psychiatry was a “specific problem,” and he said (twice) that the “vagueness of the concept” precluded any action more pointed than forming a separate liaison committee. Similarly, in his cringe-worthy and, at times, self-flattering reflections, Gerald Bychowski scorned the “so-called community psychiatry” and the expansion of psychoanalysis to family and group therapy (1970, p. 503). Still, as chance would have it, Charles Brenner, as a member of the executive council, was slightly more vigorous. He formulated a Resolution which expressed “positive support for the aims of community and social psychiatry” and charged the new committee with range of simple if patently noncommittal activities, to “consider the possibility of articles”, for example, under the umbrella of research. Given the polarizing shifts in fortune that community psychiatry endured, however, perhaps only Hugh Butts was adequately prepared to cope with this uncertainty – anxiety about the topic, hence reluctance to deal with it, he would say - and he released the question “What makes us so unique?” (Butts, 1971, p.150). He pointed to the American Psychiatric and the American Medical as associations with advocacy positions on social issues like abortion, and confronted his psychoanalytic
colleagues on their lack of opposition to an “archaic, anti-female, anti-black female, discriminatory law.” Indeed the trustees of the American Psychiatric Association had recently published their position on the training of minority psychiatrists. In line with the tenets of community psychiatry, the statement demanded that all residency training programs must make clinics available to the surrounding community; must train minority candidates; and must have a racially-balanced faculty to be certified. The problem, therefore, lay in the elitist structure of the American Psychoanalytic training programs’ lack of minority recruitment (in 1971, six of the twelve hundred members were black) and its aversion to the community mental health movement. The prospect of hearing about recruitment problems brought Hugh Butts to the office of Viola Bernard.

5. Social Psychoanalysis

Dr. Viola Wertheim Bernard worked where she lived for most of her life. Her office was situated at 930 Fifth Avenue, a twenty-four story classically elegant New York building with a marble lobby and an entrance on East 74th Street. It faced west directly on to Central Park, with a view of the boat pond and urban, defiantly lush trees. Wealthy, white and beautiful with light eyes and carefully bobbed hair, Bernard harnessed a combative streak and strong liberal views to apply “social psychoanalysis” in areas ranging from refugee settlement to foster care and adoption, school desegregation, and in particular, racism in psychiatry and psychoanalysis (Christy, 2000). In the late 1930s, she found medical school psychiatry so dull that she took courses in psychiatric social work. Two decades later, she had become a solid New York psychiatrist but also an activist psychoanalyst in the left-wing tradition of European émigré colleagues now practicing in institutes and social welfare agencies. By shaming, pleading and cajoling, Bernard almost single-handedly opened up the discourse on race and racism in psychoanalysis.

Bernard was particularly alert to the destructive power of a society where “racism is so insidiously pervasive and culturally ‘normal’” (Bernard 1972, p. 92) on analysts, patients, educators and students. Her “chronology,” as her 1970 self-report on her own anti-racist (including her fight against anti-Semitism and anti-Hispanism) activities in psychiatry was titled, was a covert record of sorts and, she admitted, “I should have made my work better known.” Arranging years of accumulated presentations, consultations and publications, she uncovered the starkest evidence yet of racial discrimination in psychoanalytic institutes: with 17 of 25 institutes across the country reporting on the racial composition of their faculties in the late 1960s, she noted, for example, 1
black male (and 4 Hispanic males) to 581 white male instructors, and 2 black females to 78 white female instructors. Three institutes offered courses in community psychiatry. Of the 664 candidates in training, 9 were black (and only in the Northeast) and 18 Hispanic. From these statistical and narrative details, Bernard outlined the clearest yet profile of psychoanalytic institutes: white, male, and indifferent to community psychiatry. “Recruitment of Negroes into psychiatry has been a longstanding interest since 1938,” she wrote to Dr. Lawrence Kolb then forming a departmental committee to explore this very issue at Columbia’s Psychiatric Institute in 1970. Interest yes, but impact? As she said from her vantage point as faculty in psychiatry and psychoanalysis at the same university, “the persistent one-sidedness in interracial practice – i.e. white therapist-black patient” did not decrease because, due to “institutionalized racism their number is still disproportionately small” (1972, p. 97).

Viola Bernard never gave in to her white colleagues’ characteristic, if generally unspoken, ambivalence about racial difference. She demanded of them “a unique degree of responsibility in the nonabuse of power” (1953, p. 265). From 1953 onward her writings became the mainstay of psychoanalytic race criticism, and also stood at the midpoint of American civil rights within organized psychoanalysis. The racialized counter-transference described in white therapist-black patient pairings in “Psychoanalysis and Members of Minority Groups” (1953) and institutional racism’s long-term harm to children in “School Desegregation: Some “Psychiatric Implications” (1958) are matched by the fervent demand for change in “Composite Remedies for Psychosocial Problems” (1971) and dejection at seemingly intractable white racism in “Interracial Practice in the Midst of Change” (1972). In contrast to the establishment’s appeasers like Brenner and the mediators like Rangell, Bernard issued dictums and confronted her colleagues racism with a writing style governed more by intellect than instinct. White “analysts perpetuate a new kind of racial stereotype – the psychoanalytic stereotype,” she wrote in 1953 (p. 260). “Some seem compelled to overemphasize the effects of being Negro on the patient’s difficulties [while] others have an apparent need to deny and sidestep such effects altogether.” Harsh yes, but Bernard was determined to see her profession join the CMHC movement.

Free-ranging criticism of this kind would be startling in most professions; with Bernard, they were almost routine. She confronted the psychoanalysts’ fine-tuned defensive clinicism, and she seemed eager to advance a social justice legacy, taking on a slew of slew of individual and organizational responsibilities and adding her racial awareness to each event. Reforming structural
racism in psychiatry (as elsewhere) was daunting at all levels, and so she mentored a few individual analysts equal to the task. Among them was Margaret Morgan Lawrence, the first black person to be certified in psychoanalysis at Columbia, and also the first black person to complete a residency at the N.Y. Psychiatric Institute. The difficulties of translating interracial relationships into political change and of coalition-building even between seemingly natural allies, became apparent. “When I said [to you that] I had an ‘identity problem,’” Lawrence confided to Bernard many years later, “it was said by and large lightly but it had some deep connotations. Coming to Miami as a psychiatrist I was co-opted into being a black psychiatrist. In a way I like it, take my stand as a conservative black psychiatrist (in relation to militancy) and forge ahead, I hope, in the service of mankind” (Lawrence 1969). One could recoil in aversion at the humbled tone and seeming illogic of this letter, at the fact that one of the great black female pioneers in psychiatry would assume a stigmatized stance - at least outwardly – and the pliancy of a compromised racial identity. Is the tone regretful or ironic, or even cheerful? Lawrence alludes to the struggle which seems, at this point, more sadly existential than incriminating. Even as Lawrence and Bernard cheer their persona interracial triumph, they begin to wonder whether integration (or in truth, individual success) can offer a solution to the state of painful segregation that they inhabit.

Like her students, Viola Bernard straddled two worlds: she was both an individual mentor and a transformer of organizations. As chair of APSaA’s Committee on Community Psychiatry in 1969, she sought out the Committee for Societies and Institutes to form a kind of collaborative clearinghouse on the psychoanalysts’ experience with the CMHC, to understand, train and then promote mental health programs in terms of community process and community control (APSaA Bulletin, 1970). Messy as the reform plans are, they could still dramatically transform the system for the good. Even in the 1970s, her colleagues still approached race with circumspection, mirroring the massive white resistance to racial equality. Bernard hovered in the background, time and again presenting a starkly urgent picture of her white colleagues’ racial countertransference reactions as “return of the repressed,” unconscious fears reaching from primitive savagery to slave rebellion. Even cross-racial treatment “is bound to suffer, no matter how subtly” she wrote (1972, p. 96) “from the ubiquitous racist premise of unequal human worth between doctor and patient.”

Beyond Bernard, the question of whether racial transference/countertransference helps or hurts the therapeutic relationship hovers over the clinical literature of the early 1970s. Until later in the decade, the configuration still privileges the white therapist over the black patient, and subtly points
to the ongoing challenge of maintaining a “classical” analytic stance in the face of countertransference, cultural bias and race prejudice. With Ira Halper (1970, p. 176), we reread the theme of white therapist in “danger of being too sympathetic [or seeing the black patient] as a representative of a social problem,” and the black therapist who “may overidentify with his Negro patient.” For Newell Fischer (1971), the lesson in interracial analysis (black/white) is that no one can escape the serious hazards of either overestimating or ignoring the unconscious meanings of race to both participants. With regard to countertransference, Fischer observed that white analysts’ denial of patient skin color wards off their own repressed sexual and aggressive fantasies. Similarly, as Eugene Goldberg (1974) would later conclude, self-scrutiny of countertransference responses is key to a productive interracial analysis – though reasons why the process is any more or any less significant to interracial, as opposed to same race, analysis remain elusive. In an arguably more Kohutian vein, Ticho (1971) described how her own negative countertransference feelings inhibited her ability to empathize with a black patient, to which the profession’s dogged overseer Viola Bernard responded in 1972: “Some white therapists could never treat black patients effectively because they feel too intimidated or apologetic.” In the hands of the venerable observer of race in mental health practice, what would ordinarily be a platitude - that overtly racialized countertransference accelerates treatment - assumes the kind of conviction that Hugh Butts (1972) could deliver. Finally, “White Therapist” is the bluntly titled 1972 essay by Clifford Sager and his associates who highlight (perhaps to the tune of Wilhelm Reich’s “Listen Little Man!”) the damaging impact of widespread political and social racism, even in the consulting room.

Fifty years later, the Community Mental Health Act lies largely forgotten and buried under the current health and mental health care debates. More important, at the time it marked a fundamental shift the U.S political history; in the decades since the CMHC, all manner of policy issues have been recast as matters of privilege and oppression: unfair, unequal, and intractable. The cost of health and mental health care is paramount today in the media, among providers (psychotherapists, psychoanalysts, physicians) and social policy makers. The universal dimension of access to health care - and of the place of mental health services within a universal framework - is being debated on every level of government today. The press for affordability - for adequate, effective and equitable treatment - is an increasingly dominant political issue within the psychoanalytic institutes and other organized providers of mental health services. Do American citizens have a social right to mental health care regardless of their ability to pay? Regardless of
race? During the nineteen-fifties and sixties, a number of psychoanalysts fought to drag their profession out of racism, both in the training of analysts and in patient treatment. Today, the American Psychoanalytic Association highlights its advocacy efforts and is led by a social worker. Is the association headed for racial equality? In a sense, echoing Freud’s 1927 concept of the role of social work in psychoanalysis, Richard Wright (1946, p. 58) had a similar vision for race-blind mental health treatment in Harlem: “Maybe one day somebody with millions of dollars, prompted by a benign vanity which the Lafargue Clinic surely would diagnose as utterly normal, will come forward, thereby helping this social experiment in psychiatry and tear ‘idealism’ away from corruption and weld it to human need.”

Bibliography


Association for Psychoanalytic Medicine/APM (1955), “Resolution” Papers of Dr. Viola Bernard. Series 9, box 224, folder 18 “APA Annual Mtg 1956, Dallas” Archives and Special Collections, A.C. Long Health Sciences Library, Columbia University Medical Center, New York


Special Collections, A.C. Long Health Sciences Library, Columbia University Medical Center, New York.


