ample, he thought that the establishment of African churches was necessary. He also advocated the establishment of black agricultural communities. Rush's suggestion was in line with some of today's proposals for separation on the part of blacks. Rush wanted integration but obviously became disillusioned and compromised for separatism, much as some blacks have currently done. Consequently it appears that he was more a realist than an idealist in his dealings with free blacks, i.e., Rush's ideal society would have been completely integrated but he knew that for all practical purposes separatism was necessary to some extent in the 18th and 19th centuries.

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Problems of Black Psychiatric Residents in White Training Institutes

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The authors, who recently completed residencies in three predominantly white psychoanalytically oriented training programs, believe that such programs are failing to produce psychiatrists—black or white—who are prepared to address themselves to the mental health needs of the black community. They offer a number of recommendations for correcting this situation.

THIS PAPER is an outgrowth of the training experiences of five black psychiatrists, four of whom completed their training at the end of June 1969 and one in October 1967. The paper presents conclusions we have reached on the basis of our experiences

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in three predominantly white psychoanalytically oriented training programs in metropolitan areas of the East and Midwest. The issues raised and the experiences related sometimes reflect the experience of all the authors and in some instances only of one.

It is our thesis that predominantly white psychoanalytically oriented residency programs are failing to produce psychiatrists, black or white, who are motivated or prepared to address themselves to the mental health needs of the black community. Although there are many factors that have contributed to this failure, we believe a major one has been the ethnocentric white middle class, psychoanalytic orientation of these programs and their faculties. This can be subsumed under the heading of "white institutionalized racism"—covert in its design and insidious in its practice. We believe that during their training, residents tend to incorporate and identify with this orientation. Classical psychoanalytic theory teaches us that some forms of mental illness derive from insoluble intrapsychic conflicts that are unconscious and that represent inadequately resolved infantile conflicts. Other contributing factors such as persistent socio-environmental factors are largely ignored or minimized. We believe that this is a significant oversight when one tries to understand the developmental history of black patients and the interaction between patient and therapist when they are of different racial and ethnic backgrounds.

Today race is an emotionally charged subject. It is generally considered one of our major domestic issues, yet in our residency programs it was not mentioned except in the identifying data along with age, sex, and marital status. The distinctive difference made in a psychiatric illness because of race was rarely considered. Rarely was the question asked: How does race specifically affect the nature, dynamics, prognosis, and course of therapy?

It is our contention that white middle class, psychoanalytic values and biases significantly affect residency training programs by influencing resident and faculty selection, supervision and content of didactic courses, patient selection, assessment and treatment of individuals, and attention to community mental health needs. The institutional policies, values, and biases lead to an absence or scarcity of blacks at every level and in most roles. Although we cannot demonstrate that this is the purpose of the policies, the end result is the same and is in effect white institutionalized racism.

Relationships Among Residents, Peers, and Institutions

Blacks who are chosen to enter the system as patients, residents, or staff members must in some manner share these values and demonstrate that they will uphold, continue to support, and reaffirm the white institution's concept of itself as liberal, unbiased, and nondiscriminatory. Should their attitudes, actions, or views be perceived as challenging, threatening, or contrary they may be considered unsuitable for the system, or if they are accepted, they may be in for a difficult time.

The black resident chosen for these training programs must demonstrate a willingness to accept the institution's values and biases. Once chosen, however, he presents a problem for all concerned. In the early stages of his residency, attempts are frequently made to make him feel wanted. He is told that he isn't thought of as a Negro, that he really knows how to talk to white people, and that color doesn't matter. In one institution where all the residents in the same year are in group therapy together there was almost a "hallucinatory whitening" of the black resident in an attempt to assimilate him. When viewing a video tape of themselves the white residents' most common remark was that they had forgotten that the resident was black until he was seen on the screen. The black resident receives high praise for what would be considered ordinary achievement by other residents, and there is a reluctance to criticize him for his shortcomings. It would be nice to think that these statements and attitudes indicated that race was unimportant in these institutions, but we think they are more likely reactions to latent anti-black sentiment.

The black's unique feelings and difficulties are frequently overlooked, and others not infrequently find it difficult to empathize with him. The best example probably is the difficulty many whites had in understanding the impact of Dr. Martin Luther King's

death. The day following the assassination a white colleague asked one black resident why he appeared so despondent that day. In an abortive attempt to console the resident, he then said that he had seen a newsclip of Dr. King receiving the Nobel Peace Prize that reminded him of the black resident. When racial matters are discussed or situations occur that would stress black-white relations, the black resident is expected to display personal restraint and a stability of character rarely expected of others. If he fails to do this, he is labeled as hypersensitive about race. We may even say that when questions of racism come up the black resident is expected to deal with them as if he were himself white, lest he disturb the apparent peaceful black-white relations.

Patient Selection and Training Programs

In each of the three residency programs we have felt that a preselection process is operant that by design or otherwise limits the number of black patients initially seen and those ultimately treated. Part of this preselection process involves the referring person or agency, which is aware that the clinic is interested in "good" treatment cases. "Good" refers to young, motivated, introspective patients with few reality difficulties who are students, suburban housewives, upwardly striving junior executives, or others with whom it is relatively easy to identify. Thus the referring person is likely to send white middle class people who they feel can benefit from psychotherapy.

The psychiatric clinic is the other link in this selection process that makes it difficult for black people to be treated. Because of admission policies based on criteria that adhere primarily to training needs, research endeavors, and minimal service obligations the clinic looks for referrals that can be considered good treatment cases. They readily accept such cases. The chance that a black person would fit these criteria is minimal.

The impact of this selection process is graphically illustrated by a survey initiated by the psychiatric residents at one of our institutions located in a medical center surrounded by the black ghetto. They first examined the patients who applied for treatment to the psychiatry clinic and compared them to the patients who applied for treatment to the medical and surgical clinics. The first 50 patients applying for care on three randomly selected days to the psychiatry and to the medicine and surgery clinics were compared for diagnosis, race, home address, and disposition. The overwhelming majority of applicants at the medicine and surgery clinics were black, lived within a three-mile radius of the hospital, and were accepted for treatment. The overwhelming majority of applicants to the psychiatry clinic were white, lived in the suburbs, and were accepted for treatment.

The residents then studied the disposition of the black patients who were accepted for treatment by the psychiatry clinic. They first listed all the patients they were seeing in either individual or group psychotherapy; these totaled over 100. Of this group only five were black, and they all were seen as middle class. Of the total psychiatric clinic patient population, only ten percent were black; they were overwhelmingly assigned to the drug clinics, 15-minute clinics, or to programs with a rapid turnover of inexperienced therapists.

In each of the three institutions insight oriented psychotherapy is valued as the appropriate referral for "good" patients. Group psychotherapy is somewhat less valued and is on a par with family treatment. The supportive therapies, including drug clinics, 15-minute clinics, and medical student training programs are least valued. As the previous example indicated, there is a paucity of black patients in individual, group, and family therapy.

In one institution the number of black patients seen on the inpatient service was minimal before the assumption of chief resident duties by one of the black residents. After this the number of black patients on the ward increased due to the combined efforts of two other black residents and a resident from Southeast Asia. The resistances offered by the staff were all couched in language suggesting that these patients did not seem to be able to benefit from our kind of treatment, did not seem to be motivated, were not sufficiently introspective, etc. Some of the patients have turned out to be extremely good therapy cases. We are greatly con-

cerned about the process within and without the hospital that either resists admission of black people or shunts them to the least valued programs; we view this as a major problem area.

It is our feeling that too many intake workers in our psychiatric facilities approach the black person with a bias indicating that "a black person is not a good candidate for intensive psychotherapy." The intake worker then supports his point of view by using the theoretical assumptions evolved from psychoanalytic theory. This theory stresses that those people who will most benefit from intensive psychotherapy are those whose ego strengths of motivation, intelligence, introspection, delay of gratification, and repudiation of action in favor of thinking are rated highly. Invariably a black person is rated as having few of the desired ego strengths and is therefore not a good candidate for anything more than the supportive therapies. We feel that too many intake workers are not empathic enough to make accurate assessments of black patients because they are unable or unwilling to deal with the subtleties and nuances present in the material presented by these patients.

The diagnostic and initial treatment process requires sufficient empathy so that engagement occurs rather than a mutual decision that further involvement would be fruitless. A black being screened for admission to a psychiatric clinic by a white intake worker will probably respond to the white in the same way he has learned to respond to all other unknown whites. He will quickly try to assess this white person and his attitudes toward blacks; until convinced that the white is not anti-black he will be guarded, secretive, and reluctant to reveal himself. The intake worker may not recognize that this style is reserved for "whitey" only and conclude that the black person lacks the ability to relate in an intensive one-to-one relationship.

The major problem in this area is the loss to us, as well as to other residents and the institutions, of a chance to understand the black patient and the unique problems he may present. Such policies also prevent us from observing and understanding the strengths and methods of adaptation of a suppressed and oppressed minority.

Supervision

Supervision in each of the three programs is handled primarily by successful, white upper middle class psychiatrists whose training and background do not give them sufficient understanding of the special, and at times realistic, problems of the black patient. (At the time of this writing only one training institution had a black supervisor.) Many of these supervisors have never treated a black patient and too often minimize the influence and impact of sociological factors on personality development and the resulting intrapsychic process. Sufficient emphasis is not given to the adaptive point of view. One supervisor who has been in psychoanalytic practice for more than 15 years was able to state that he had an increased awareness of the difficulties that one of his black patients was experiencing after reading *Black Rage* (1). He not only increased his empathic understanding of the patient but felt that because of his own blind spots his previous treatment of this patient had left untouched many important areas.

Supervisors deal with us around the issue of our blackness in three characteristic ways: —avoidance, reaction formation, or confrontation. With some supervisors the issue of our blackness never comes up, and the supervisory process moves along as if they have never noticed we were black. With others there is the tendency to accept anything we offer as more than adequate: they are consequently less critical and less exacting with us than with white residents. It is as if any criticism concerning our work will be taken as evidence of racial bias or prejudice.

The supervisor who confronts us immediately with what he notices first and our patient notices first—our blackness—is the most helpful. This confrontation, which can immediately change the nature of the supervisory process, is an important influence on the treatment of the patient we are presenting to him, whether the patient is black or white. One of us had been in residency about 15 months before a new supervisor, in an initial session, stopped his routine presentation of a patient and said he wondered what the effect of the therapist's blackness had been up to this point on the treatment process. The author until this

day feels that this was one of his most useful and instructive supervisory experiences.

Supervision often fails to deal directly with our identity problems of being black and functioning in a white institution. The black resident brings to the residency program many of his own distortions concerning his "supposed" inferior training and second-class status. He also brings his misperceptions about the need to have the stamp of approval of the white institution for him to really "make it." The black resident, having lived in a society that says you are black and hence inferior, is likely to have in part accepted this distorted view of himself and made it an integral part of his concept of self. Seldom dealt with is the issue of our ambivalence in terms of what we feel is the pull of the institution toward the treatment of white middle class patients and away from the black patient. All of us have experienced a tendency for some supervisors to deal with us as if we were "special," "different," less like the masses of black people and more like the supervisor. This tendency to minimize the difference in race and to offer themselves as models with whom we should identify is strong and very seductive. The resulting ambivalence often interferes with the treatment of our patients; we feel it should be a concern of the supervisor and not dismissed as only important as part of our personal therapy.

Another factor in the supervisory process is the personal reaction of the resident and the supervisor to their differences in race, which may seriously interfere with a productive supervisory experience. Too often this issue is left as something unspoken and unresolved, which has the effect of creating a bland and superficial supervisory process.

As stated previously all of the supervisors in the three programs are white (with the exception of one institution) and we continually wonder where our black models are. Each of these residency programs is located in a large city; there is in three of the cities a minimum of nine practicing black psychiatrists, but none of them is on our supervisory lists. Black supervisors would be as useful to the white residents in our programs as to us in helping all of us consider the special contribution of racism and discrimination to the psyche of both white and black patients.

Recommendations

Patient Selection and Training Programs

1. The subtle selection process of each institution should be examined and more black patients should be sought out and treated in the training programs, particularly through individual, group, and family therapy, and in the inpatient service.

2. Intake workers should become aware of their blind spots in their work with black patients and be more aware of the fine line distinguishing pathology and adaptation. Perhaps a training course should be given to emphasize the special contributions of race to personality development.

3. The training programs should examine their white middle class orientation and their psychoanalytic bias in an effort to broaden the base of psychiatric knowledge to include those black patients they are currently excluding.

4. Each institution should do some soul searching and examine its institutional practices for subtle forms of racism manifested by acts of omission or commission.

Supervision

1. Black supervisors should be sought out and utilized as participants in the training of residents.

2. White supervisors should be more attuned to the identity problem that black residents may be experiencing in the training program and be willing to deal with this issue openly.

3. Direct confrontation about the issue of differences in race as it may involve the effectiveness of the supervisory process should be an integral part of supervision.

4. Bringing black professionals into the institution will be helpful but carries the danger that the rest of the faculty may use their presence to further segregate themselves from confronting their racism and class bias. It is therefore strongly urged that all supervisors and residents rotate through a treatment program located in and controlled by the local black community. This will enable the faculty and residents to learn about the community firsthand from persons who know the ghetto and respect the people in it.

General Recommendations

1. Lectures, seminars, and small group discussions should be utilized to disseminate current and relevant information from other disciplines such as sociology and anthropology. Autobiographical material should be used to understand what individual blacks believe have been significant influences in their lives.

2. Finally, a major commitment of resources should be made in institutions to generate new information about the special affect of race and racism on emotional health and illness.

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Beware of Whites Bearing Gifts

BY GERALD MELCHIODE, M.D., SAM C. GOULD, M.D., AND PAUL JAY FINK, M.D.

The authors describe their study of four black students who participated in a special 13th year of schooling in predominantly white private schools. They found that the students' difficulties in the program resulted in a loss of self-esteem and the precipitation of an identity crisis to which they were particularly vulnerable because of inadequate preparation and the lack of peer support. The authors present a set of recommendations for prevention of these difficulties in other programs.

IN RECENT TIMES the social conscience of this country has been stimulated to make reparation for past injustices to the black man. One of the most important rights denied him has been that of an adequate education. This paper deals with how four blacks were affected by the attempt to bestow this right through a special educational program. The effects in each case were paradoxical. We believe it is important to illustrate these cases and the unintended consequences of a program sponsored by a sincere and well-meaning social institution. We hope to obviate repetition of this pattern by alerting social and philanthropic institutions, as well as the psychiatric community, to certain pitfalls.

The four black students are patients at the Hahnemann Community Mental Health Center, a comprehensive mental health facility serving a Philadelphia inner city catchment area population of over 200,000. Sixty percent of this population is black, and another five percent is Puerto Rican.

Although each patient had individual problems, a common theme was noted. All were young black people from the ghetto who developed overt onset of symptomatology just before or during a special 13th year of education in predominantly white private high schools.

This case study will discuss the psychological and social stress placed on these individuals, the ways in which they tried to cope with the stress, and the mental health center's involvement in trying to help them.

In each case, the patient's charts were extensively reviewed and all contacts with therapists were investigated. All therapists were interviewed. One investigator conducted the patient interview; another investigator recorded the session. We were unable to contact one of the patients. There were numerous interviews with the social worker currently in charge of the 13th year program, and written reports of the program were studied in detail.

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At the time this paper was written, the authors were all with the department of psychiatry, Hahnemann Medical College and Hospital, 230 North Broad St., Philadelphia, Pa. 19102, where Dr. Melchiode is clinical instructor, Dr. Gould was a resident, and Dr. Fink is associate professor and director of education and training; Dr. Gould is now in the U.S. Army.