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A Reassessment of Middle Class Demand as an Explanation for the Rise of Psychoanalysis in America

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ABSTRACT

Historians often claim that psychoanalysis grew in America in the early twentieth century because of a middle class demand. This article refutes such a claim and shows that it masks the true history of psychoanalysis. Psychoanalysis was largely an upper class phenomenon and the market metaphor of supply and demand is inapplicable to an understanding of psychoanalysis. This article traces the economic context of psychoanalysis in the first half of the twentieth century. Evidence shows that psychoanalysis benefited from very wealthy patients, from the largess of the grand bourgeois – particularly through private foundations, and from state support.

INTRODUCTION

There is a prevalent fantasy that America is a middle class society. The fantasy that a significant majority -- or for that matter a simple majority -- of Americans are part of the middle class is a myth. Relatedly, popular and academic discourse today would have us believe the working class is far smaller than it actually is. Indeed, the working class appears to have been eviscerated in

these discourses. Yet the working class continues to be quite large, much larger than the image portrayed -- as large or larger than the middle class, and the middle class is far smaller than many would have us believe (Perrucci and Wysong, 1999). These fantasies serve a number of interests. For example, politicians surely are wise to pander to the working class desires to believe themselves to be of a higher class than they really are, i.e., to be of the middle class, by repeatedly calling them the latter rather than the former. People tend to like those who flatter them.

There is perhaps a more insidious problem with such mislabeling. It blinds us, as Marx has said of ideology, to class conflicts present in society. When this myth of a middle class society is extended back in time, it helps obfuscate the origins of the theory and practices found in the social service and mental health fields. This essay shows how psychoanalysis, a theory and set of practices that dominated the field of social work and psychiatry for much of the last century, has its roots in the upper class and not in the middle class as is often claimed by historians. Psychoanalysis trickled down to the middle classes only after World War Two. Furthermore, while the poor and working class could not afford classic psychoanalysis, members of these groups were subjected to a psychoanalytic ideology being imposed upon them by psychiatrists and social workers, who framed their understanding of problems in psychoanalytic terms, in clinical settings ostensibly meant to help members of these groups.

Psychoanalysis (or analysis), at least in the first half of the twentieth century, was a branch of psychiatry, and psychiatry is and was a branch of medicine. Psychoanalysis emerged within the field of psychiatry through the works of Freud and his followers in the early years of the twentieth century. By the 1930s psychoanalysis became the dominant theory and practice within psychiatry and it retained this dominance through the 1960s. Psychoanalysts (or analysts)

gained control over all facets of the profession of psychiatry and at least until the 1950s had exclusive control over the training of future psychoanalysts. Potential competitors such as social workers and clinical psychologists did not embrace the theory and practice of psychoanalysis to any appreciable extent until the 1950s and 1960s. As such, the history of psychoanalysis in the early twentieth century is the history of medical psychoanalysis.

Marx's famous claim that "religion is the opium of the people" is applicable to the understanding of how psychoanalysis grew as the result not of the middle class but of actions related to the upper and lower classes. Perhaps psychoanalysis was in some convoluted way one form of the opium of the people? Psychoanalysis, an apolitical theory that locates the source of social problems -- or maladjustments -- in intrapsychic, individual dynamics is bent upon mollifying social discontent by urging people to look inward for the true source of their problems. It is the individual, not the social that is the problem. This is not to deny that psychoanalysts tended on the whole to be more liberal than their non-analytic colleagues. Similarly, it is not to deny that a number of analysts embraced a more radical view of society (Hale, 1995). It is only to suggest that the theory and practice helped prevent any significant social activism on the part of psychiatrists who called the existing class relations into question.

The misunderstanding of which classes were instrumental to the rise of psychoanalysis is not the only problem for historians. Cultural historians have also suggested that psychoanalysis grew as the result of market forces of supply and demand. Psychoanalysis, it is claimed, grew as the result of a middle and upper class demand (Hale, 1971, 1995; Shorter, 1997, Burnham, 1967). For example, Hale (1971, 1995) argues that psychoanalysis was able to expand in America because it appealed to the cultural sentiments of middle class American patients and

psychiatrists. However, the market assumptions of supply and demand are inappropriate to explain this history. Psychiatric theories and practices rise and fall for complex professional and institutional reasons, many of which reveal the market assumption to be faulty.

SOCIAL CLASS IN EARLY TWENTIETH CENTURY AMERICA

Social scientists define social class in countless ways. Some even argue the concept is void of meaning (Kingston 2000). Most definitions incorporate income, occupation, and/or education, and most social scientists would recognize the existence of four social classes in America: The grand bourgeoisie, the middle class, the working class, and the poor (cf. Perrucci and Wysong, 1999; Gilbert 1997). The grand bourgeoisie, or upper class, is the wealthy capitalist class who owns vast sums of money and controls major facets of the economy. Their primary incomes are derived from investment capital or ownership over large capitalist enterprises. The middle class consists of white collar, educated professionals and administrators as well as middle level managers. Doctors, lawyers, and middle and upper level administrators are in the middle class. The working class consists of blue collar workers, both skilled and unskilled, and those who work in the lower end of the service sector, i.e. service work that requires limited education and offers limited benefits and security. The poor consist of the unemployed, the underemployed and the working poor.

The middle class was relatively small in the first half of the twentieth century, and the working class was relatively large. Janowitz (1978) describes the class composition in America as well as the changes in the American work force over much of the twentieth century. He identifies three “occupational groups”: White collar (professional, technical, managers, officials, proprietors and sales persons), blue collar (craftsmen, foremen, operatives, services workers,

laborers), and farmers. The white collar group is comparable to what is here called the middle class. The blue collar group is comparable to the working class. Janowitz notes that 17.6 percent of jobs in 1900 were white collar or middle class, and 40.8 percent were blue collar or working class. In 1920, 20.2 percent were white collar and 45 percent were blue collar. (Robert and Helen Lynd (1929) in their famous Middletown study found that 29.4 percent of the workers in Middletown in 1920 were in the business class. The business class is comparable to Janowitz's white collar class. They also found that 70.6 percent of the population in 1920 was in the working class.) Janowitz traces the changes in class composition from 1900 through 1975 and finds that white collar jobs steadily increased from 1920 through 1975, when they constituted 41.2 percent of the work force. The blue collar jobs also steadily increased throughout this period, though at a much slower pace. They grew to 20.4 percent of the work force by 1975. The major area of decline that accounted for these increases was in farming, which fell dramatically through this period.

SOCIAL CLASS AND PSYCHOANALYSIS

Psychoanalysis expanded dramatically in size and influence both within American psychiatry and within American society at large in the first half of the twentieth century (Hale 1971). Not only was the practice of psychoanalysis as a form of psychotherapy embraced, but psychoanalysts also came to dominate the field of psychiatry. For example, by the 1940s the president of the American Psychiatric Association was routinely a psychoanalyst. Also, psychoanalysis became influential in many facets of American culture, such as literature, film, as well as within the universities.

What caused this expansion and specifically what caused the expansion of

psychoanalysis within psychiatry? Hale (1971) would have us believe it was largely the result of changes in middle class sentiment. Actually, he is quite ambiguous about the role of social class in the history of psychoanalysis. At times he suggests it was a middle and upper class phenomenon. At other times he suggests it was an upper class product. Still at others he implies that it was simply a middle class phenomenon. The following discussion assumes the most accurate reading of Hale and other cultural historians such as Burnham is that they believe by and large that psychoanalysis was indeed centered around the middle class. Their tendency to invoke the middle class far more than any other class suggests this is so.

The changing beliefs or values of the middle class, i.e., the "repeal of reticence," Hale says, prompted this class to seek out psychoanalytic services -- at least in the first few decades of the twentieth century. Yet such an explanation does not seem to account for the growth of analysis. The middle class was too small and could not afford psychoanalysis. This problem became even more acute during the Great Depression, a time when psychoanalysis grew significantly. A review of the economics of the clinical practice of psychoanalysis and of the public's income during the Great Depression suggests that only a very small percentage of persons could afford psychoanalysis, a percentage so small and wealthy as to render meaningless the designation of this group as middle class.

The analyst Lawrence Kubie (1950) estimated the average fee per session for analysis in New York City in 1936 was under ten dollars. Others have made similar claims. Kessel and Hyman (1933) say fees were "rarely less than \$3 an hour and frequently exceeded \$10 an hour" (p. 1613). Hyman (1936), critical of the huge expense, uses these figures to calculate the yearly cost of psychoanalysis in 1936. In classic analysis patients were expected to meet with their

analyst four or five times each week for up to a year and a half or more. At 250 to 270 sessions a year, the annual cost averages from \$2,500 to \$3,000. Further, "an analysis is rarely terminated sooner than ... eighteen months [to two years]" and as such "the total fee for the analysis may be estimated to average between \$5,000 and \$6,000" (p. 327).

However, Hale (1995) has challenged the \$10 per session estimate. He uses a letter sent by Smith Ely Jelliffe to Ernest Jones to claim the average fee in New York in the 1930s "was well under \$10" (p. 118). Hale says "the \$20 to \$25-an-hour patient was becoming rare and social workers were paying around \$2.00. How many analysts drew a clientele paying \$2,750 a year is impossible to tell" (p. 118). Kubie (1950), too, was careful to say the fees charged by analysts varied greatly from patient to patient.

In any event, it seems likely that the cost of analysis in the 1930s was quite prohibitive for the vast majority of citizens, including most if not all of the middle class. When the cost is compared to the average income of people in the United States, it becomes evident that privately funded psychoanalysis was strictly for the wealthy. Indeed, it appears that analysis was reserved for the very wealthy. The average annual income for Americans in 1933 in the midst of the Depression was a measly \$950 to \$1,500, depending upon where one lived (Mendershausen, 1946). The average income had declined anywhere from 25 percent to 45 percent from only a few years earlier, i.e., in 1929 before the market crashed. Only between five to eight percent of the total population had family incomes in excess of \$3,000 (Mendershausen, 1946).

There is a surprising lack of unequivocal information about the incomes of psychoanalysts in the 1930s. Nevertheless, what information there is suggests that analysts' salaries during the Great Depression were growing relative to other fields of medicine. Analysts

were doing quite well financially. Psychoanalysis is a subfield of psychiatry and there are more data on the income of psychiatrists generally. It is possible to compare the relative incomes of the analysts and psychiatrists. When this is done, it appears that analysts were making more than psychiatrists and that this gap was expanding.

R. G. Leland (1931), the Director of the Bureau of Medical Economics of the American Medical Association, conducted a survey of salaries from medical practice in various specialties and found the income for "neurology-psychiatry" in 1928 (at the time the disciplinary boundaries between psychiatry and neurology were somewhat blurred) was approximately \$7,300. Of the 21 specialties listed by income neurology-psychiatry ranked near the bottom at 15. Fields like surgery and internal medicine were the most prosperous. Neurology-psychiatry ranked only slightly ahead of specialties like physical therapy and industrial medicine. The historian Gerald Grob (1983), referring to a study done by the Committee on the Costs of Medical Care, also says psychiatrists were earning far less than was the average of all medical specialties in the early 1930s. Persons in the "neuropsychiatry" field ranked near the bottom of the specialties with an annual income of \$10,008. This contrasts to the \$16,304, which was the average for persons in all specialties.

Hale (1995) tries to estimate the income for psychoanalysts. He relies upon comments made by the analysts Kubie and Jelliffe to estimate that a person working as a full-time analyst in New York in the early to mid 1930s would probably have made between \$12,000 and \$15,000. Hale further notes that the overall average income for physicians -- and not the average of only specialists as Grob describes -- was \$7,020 in 1936. It appears that psychoanalysis, at least if practiced on a full-time basis, was indeed a relatively lucrative enterprise by the mid

1930s and that it was one that provided a strong "economic incentive to practice it" (Hale, 1995, p. 118).

Analysts often complained about the relative lack of income and the financial hardships involved in practicing psychoanalysis in the early decades of this century. Yet despite the incomplete income data from the 1930s, it seems they were indeed making substantially more than other physicians. And this disparity continued into the post-World War Two era. Their salaries on the average in the decade following the war were approximately a third higher than other fields of medicine (Hale, 1995).

The large and growing incomes of the analysts in the 1930s and beyond suggest that their patients were also wealthy. Of course, one might argue that psychoanalysts charged their patients on a sliding fee scale and that as such analysis might indeed have been made affordable to others besides the extreme rich. That is, the high analytic income might be the result of analysts seeing a range of patients, some wealthy, some middle class, and perhaps some poor or working class. But this would be wrong. Computations of salaries and expenses show that the sliding fee scales could not have been used very much to allow poorer patients into analysis, otherwise salaries would not have been so high.

Kubie (1950) notes that most psychoanalysts had a sliding fee scale; persons were charged according to their presumed ability to pay. The results of a 1948-1949 survey conducted by him shows that fees charged, at least in the 1940s, did indeed vary greatly from patient to patient. The median fee was \$14.50 per hour but the fees ranged from 0 to \$50.00 per hour. Approximately 90 percent of all the patients seen by the analysts responding to the survey paid at least \$10 per session. Kubie's findings show that there was a variation in charges but that the

variations seem far greater on the more expensive side of the median than on the less expensive side. In other words, less wealthy patients may have been charged less, but their numbers were quite small. If we can extrapolate from these findings and assume that analysts in the 1930s also used a sliding fee schedule somewhat comparable to that noted by Kubie, then we might wonder whether the sliding fee scale actually allowed very many non-wealthy persons to see analysts. It does not appear to be the case.

It is uncertain how many psychoanalytic patients in the 1930s paid "well under ten dollars." However, if we rely upon the annual salaries stated above, we can estimate how much the analysts did tend to charge their patients. Analysts, as noted, earned between \$12,000 and \$15,000 per year. If we assume \$13,500 is a reasonable average and if we assume that analysts charged on average \$10 per visit, then they would have to meet with patients for approximately 28 clinical hours a week, assuming the analysts took a few weeks off each year. This is a significant case load. As such, if they had considerably more patients paying less, i.e., if they had more middle class patients, then their incomes would not have been as have been reported. They would have been much less.

The precise caseload for analysts in the 1930s is impossible to determine. However, data from more recent decades suggest that analysts did not maintain such a high number of patients. Arnold Rogow (1970), for example, conducted a survey of psychiatrists and psychoanalysts in the 1960s and found that the analysts in his small and non-random survey by and large did not see more than 26 patients a week. "Of the analysts in the study group 41 percent see between 11 and 20 patients per week, and 28 percent see between 1 and 10 patients per week. Nineteen percent see between 21 and 30 patients, and only 6 percent see between 31 and 40 patients" (p.

77). This study suggests that analysts may not have had as many middle class patients as would have been needed to legitimately claim they constituted the bulk of the analysts' patients.

The middle class assumption is also questionable when one considers the size and constitution of the patient population in the 1930s. If we assume that all of 68 members of the APsA in 1931 practiced on a full-time basis, a highly questionable assumption, then there were only a few hundred analytic patients in the early 1930s. This hardly seems to warrant claims about middle class sentiments. Such a small and select group cannot be thought to be reflective of the American middle class in any sense. A number of characteristics of the early patient population make them distinctive from the WASP American middle class.

Historians such as Hale (1971, 1995) suggest that the middle class is not only defined by a common level of income but also by a shared ethos or world view, and this shared view, it is claimed, fostered a demand for psychoanalysis. But it seems quite plausible that different ethnic groups constituting the middle class may not have such a shared world view. There is a long history in sociology, perhaps most classically seen in Max Weber's The Protestant Ethic and the Spirit of Capitalism, that argues that groups have meaningful differences in their orientations toward the world.

Whereas for the most part the middle class in the early years of this century seemed to embody a rural protestant ethos, the patients and supporters of psychoanalysis were principally urban, and a significant percentage were Jewish. Despite Hale's claim that Jews and Gentiles both embraced a "civilized morality," it would not be unreasonable to think the cultural and religious traditions of the Jewish Americans differed enough from those of the Protestant and Catholic Americans to render sweeping generalization about a unified middle class inoperative.

(Similarly, one could question whether Protestants and Catholics had such a shared ethos.) In addition, many of the early patients, Jews and Gentiles, were involved with the bohemian arts culture of places like Greenwich Village. Such people hardly reflected common middle class values, i.e. a rural Protestant ethos.

In short, historians such as Hale inappropriately conflate the cultural sentiments of different groups such as Jews and WASPS and middle class and upper class and then construct a cultural interpretation for the rise of psychoanalysis based upon such homogenized grouping. This is not the only problem. An equally, if not more severe, problem lies in his failure to appreciate the role played by the poor and working classes in the expansion of psychoanalysis. These classes clearly did not constitute a large percentage of the clinical office practice of psychoanalysts. They did however fill the rolls of patients and clients seen by analysts in a range of institutional settings, and in this way these classes were instrumental to the expansion of psychoanalysis.

INSTITUTIONS, THE POOR AND WORKING CLASSES, AND PSYCHOANALYSIS

Cultural historians have misinterpreted the history of psychoanalysis partly as the result of a failure to appreciate the role played by the institutional contexts within which analysts worked. Certainly, many analysts worked with a number of middle class patients in private clinical practice, but analysts also often worked at least part-time in institutional settings directly or indirectly with poorer patients or with patients who did not embody middle class sentiments -- for example with children, prisoners, and juvenile delinquents. The work in such settings provided income for analysts so that they could maintain and propagate their ideas.

Both the patient population and the financing of the work done in these institutional

settings render assumptions about middle class demand questionable. Not only were these patients oftentimes not from the middle classes, the psychoanalysts working in these settings were often not being paid by the patients themselves, but by the institutions. Often the funding was derived from the state or from philanthropic organizations. As such, to the degree that analysts worked in these settings, the assumptions that the middle class market demand facilitated the expansion must be challenged. Such demand was absent in these sites.

It was generally recognized that psychotherapeutic activities, be they Freudian, Meyerian, or a combination of both, were practiced in a wide range of settings. As George Kirby (1934), the President of the American Psychiatric Association [APA] in 1934, notes: "The mere enumeration of the various agencies and activities, outside of hospital and medical clinics, where the problems of treatment are approached mainly if not exclusively from the psychotherapeutic standpoint [i.e. Freudian and Meyerian] makes an impressive list." He goes on to list some of the "more important sites." These include places like child guidance clinics "and other agencies dealing with the child-parent relationships," schools and colleges, welfare and relief organizations, court clinics, churches, and industry (p. 10).

Places like these provided occupational anchors that allowed analysts to maintain their beliefs even if the positions did not permit the full-time practice of clinical psychoanalysis. The positions often consisted of such things as consultation, teaching, supervision, and administration. Frequently the analysts worked in such locations on a part-time basis, and this allowed them to conduct some orthodox analyses with wealthy private paying patients while their institutional work provided income to sustain themselves.

The career of one psychoanalyst, Clarence Oberndorf (1882-1954), perhaps illustrates the

range of position they held (Lehrman, 1954). Oberndorf was one of the founders of the APsA. He was born into a Jewish family in Alabama and attended Cornell University. After receiving analytic training in Berlin, he settled in New York. There he joined the staff of the Manhattan State Hospital on Ward's Island, where he met Adolf Meyer who was then the director of the New York State Pathologic Institute, also on Ward's Island. Although Meyer quickly rejected the dogmatic claims of psychoanalysis, he did teach analytic ideas there (Lewin, 1962). After an initial flirtation with psychoanalysis, Meyer quickly found it to be too rigid and dogmatic. He said it was "unfortunately too denominational" (Meyer, 1928, p. 24).

Ward's Island, and particularly the Pathological Institute (renamed the New York State Psychiatric Institute when it was moved uptown to Washington Heights, Manhattan in 1929), in the first few decades of this century proved to be important to the development of psychoanalysis in the first few decades of this century in America (Hamilton, 1934). A number of important psychiatrists and analysts, including: Macfie Campbell, David Henderson, Trigant Burrow, George Kirby, Clarence Cheney, and A.A. Brill, worked there.

Oberndorf occupied a number of positions throughout his career. In addition to maintaining a private practice, he was employed in academic and consulting positions. He was also involved in professional organizations and in the creation of hospitals and clinics (Lehrman, 1954). He was the clinical instructor in neurology at Cornell Medical College for several years. He served as consultant in an investigation involving the Hebrew Sheltering Guardian Society and helped create the "Resident Child Guidance Service," which evolved into the Jewish Child Care Association, a social service and referral agency for troubled children and families (Oberndorf, 1953). He helped create the Hastings Hillside Hospital and served as a consultant to

the psychiatry department at Mount Sinai Hospital.

The extent to which psychoanalytic psychiatrists found work outside of clinical office practice is evident in the number of positions created and filled in the 1920s and 1930s in various institutional settings. These positions provided opportunities for both analytic and non-analytic psychiatrists, and as such contributed to the expansion of both. Psychiatrists for example managed to assume leadership positions in the correctional field. The National Committee for Mental Hygiene, the influential organization founded largely through the initiative of Clifford Beers with help from such people as Adolf Meyer and William James, conducted a national survey in 1928 on the extent of psychiatric employment in criminal courts and in prisons. Of the 259 public institutions responding to the survey, 35.9 percent employed psychiatrists "on either a full-time or part-time basis," and fifty percent of the institutions referred suspected cases of "mental abnormality" to private physicians for examination (Proceedings, 1928). More specifically, one hundred and ten courts in the United States, constituting 9.4 percent of the total number of courts, "report[ed] themselves to be served regularly by a psychiatrist, either employed by the court on a full-time or part-time basis, or furnished by some other public agency" (Menninger, 1930, p. 434).

Psychiatrists often found work in administrative positions in places like prisons and related correctional settings. The New York Department of Corrections, for example, which was responsible for the prisons and reformatories, was placed under the direction of a psychiatrist in 1927. Psychiatrists were also employed at various prisons such as Sing Sing to examine and classify inmates (Brown, 1928).

The rise of psychiatrists within the correctional system was inspired in part by funding

from the Rockefeller Foundation, which ten years earlier had paid Bernard Glueck, an analytically inclined psychiatrist, to develop a plan for psychiatric classification of the inmates at Sing Sing (McCartney, 1934). Glueck produced a report that championed the involvement of psychiatrists in this field. He was one of the founding members of the New York Psychoanalytic Institute and was a follower of Adler's Individual Psychology, an offshoot of Freudian psychoanalysis (Atkin, 1962). This is indicative of the influence of the grand bourgeoisie, through philanthropic foundations, on the development of psychoanalysis.

Psychiatrists, a number of whom were analysts, could be found in diverse extramural, i.e., non-asylum, settings working with criminals and delinquents within the courts, in prisons and in reform schools (Nelson, 1933). Psychiatric work increased in these settings through the 1930s. Chicago in the late 1930s provides a nice example. Chicago established a psychiatric assessment "institute" as part of the municipal court system as early as 1914. The psychiatric institute saw more cases in 1937 than in any previous year since its creation. In that year the assessment institute saw over two thousand people. Chicago psychiatrists in 1937 evaluated persons referred from the courts and made recommendations. Seven hundred and one patients were "certified to the psychopathic hospital as insane" in 1937. One hundred and seventeen were adjudged feeble-minded; these were then sent to various institutes in the state. Another 314 patients were "sent to the psychiatric clinic of the university medical schools" (Medical News, 1938, p. 516).

Perhaps the clearest example of the range of institutional positions that analysts and non-analytic psychiatrists filled can be seen in the expansion of the child guidance clinics. These clinics grew in the 1920s, and analysts and non-analytic psychiatrists often could be found

working there. Numerous clinics were opened that required their services. The Department of Mental Hygiene in the State of New York in the mid 1930s, for example, controlled over one hundred child guidance clinics, each of which required the services of a psychiatrist (Cheney, 1936). The number of child mental health clinics, as well as the number of child psychiatrists, many of whom were analysts, in the United States "increased steadily in the 1920s and 1930s. By 1936 there were over 230 child guidance programs," including the "demonstration" guidance clinics as well as other types of programs such as "traveling clinics" ... "and [each was staffed] with a psychiatrists, a psychologist, and social workers" (Jones, 1988, p. 79; Harvey and Abrams, 1986).

The psychoanalytic presence is clearly seen in the child guidance clinics. Analysts could be found either working in or directing many of these programs. From David Levy and Bernard Glueck at the Institute to Child Guidance in New York, to William Healy's work in Chicago, to C. Macfie Campbell at the Boston Psychopathic Hospital, analysts and sympathizers found ready work in child guidance programs (Horn, 1989).

Historians also have noted the prevalence of psychoanalytic ideas in the guidance clinics. Jones (1988), for example, says the psychiatrists in the clinics focused upon such things as family dynamics and, in particular, the role of the mother in the child's problem. Further, the "theoretical foundations" for the psychiatric response to these problems "was found in the teachings of Sigmund Freud" (Jones, p. 286).

In addition to child guidance clinics, the courts and the prisons, analysts found work in other institutional settings. These included such places as psychopathic hospitals, general hospitals, universities and psychoanalytic training institutes. The training institutes in particular

that began to emerge in the 1930s provided work for a number of analysts in the 1930s. Some analysts greatly prospered in these settings. The influential analyst Franz Alexander, for example, is reported to have had an income of \$21,600 in 1935 as director of the Chicago Psychoanalytic Institute. This was a substantial sum for that time (Brown, 1979). Similarly, Smith Ely Jelliffe became quite financially secure in the 1910s and 1920s largely as the result of his work as editor and founder of a number of important journals, including the Journal of Nervous and Mental Disease and the Psychoanalytic Review. His income was further aided by his affiliation with universities in the New York City area. He initially worked at Columbia University then moved to Fordham University's medical school, which has since closed. He also worked as a consultant to several state hospitals (Burnham, 1983). The wealth of Jelliffe and Alexander was not derived mostly from the private practice of psychoanalysis and from the pockets of middle class patients.

Analysts clearly drew their incomes from a number of different positions in addition to, or instead of, strictly clinical office practice. The range of positions within which psychoanalysts worked suggests also that their patient population was not solely, nor predominantly, from the middle class. The existence of a patient population consisting of children in the clinics and persons in prisons hardly supports the contention that middle class demand fostered the growth of psychoanalysis.

BOURGEOIS SUPPORT FOR PSYCHOANALYSIS

Evidence for more complex social class dynamics in the expansion of psychoanalysis than that which has been offered by cultural historians can be found in the ways in which various aspects of psychoanalysis were funded. Analysts drew their incomes from a wide range of

sources besides private paying patients. A wide range of organizations provided incomes. Importantly, analysts often were the direct or indirect beneficiaries of the largesse of very wealthy Americans through foundations established by the latter. As such, the role of the grand bourgeoisie should not be ignored.

Groups such as the Rockefeller Foundation, the Commonwealth Fund, the Josiah Macy Jr. Foundation, and the Hofheimer Foundation contributed sums to various projects that facilitated the growth of psychoanalysis. These philanthropic organizations were created and controlled, at least initially, by extremely wealthy individuals who sought to contribute to "the welfare of mankind"; and though such foundations gradually assumed more of a corporate and less of a personal quality to them, the influence of individuals of great wealth is evident in the work of the foundations in the decades prior to World War Two.

The Rockefeller Foundation's principal mission was not specifically geared towards psychoanalysis. Instead, its goal was the improvement of various aspects of medicine such as medical education and training. It contributed more than \$161 million towards that end by 1940 (Brown, 1979). Nevertheless, the Foundation did indeed give much money to psychiatric projects that indirectly supported psychoanalysis, and to a lesser extent it gave money directly to analytic causes.

The Rockefeller Foundation gave around \$16 million to psychiatry from 1930 through the 1950s; nearly two-thirds of this money went to decidedly non-analytic projects related to things like neurology, neurochemistry, and psychology (Morrison, 1964). Psychiatry and psychoanalysis nevertheless benefited from Foundation grants. Though the sum of \$16 million may appear small, one must keep in mind that psychoanalysis was a very small subdiscipline of

psychiatry in the 1930s with only a few hundred adherents.

The Foundation funded one of the more important analytic training centers, the Chicago Psychoanalytic Institute. The Foundation was only one of several that supported this Institute. The Macy Foundation as well as the Rosenwald Foundation did so as well (Brown, 1987; Pollock, 1977; Powell, 1974). The Rockefeller Foundation gave the Institute grants of several hundred thousand dollars in the mid to late 1930s (Medical News, 1938; Morrison, 1964). By the late 1930s, however, the Foundation was becoming reluctant to fund the Institute any further. It had given the Institute money because Alan Gregg, the Foundation's chief administrator overseeing medical funding, had been reluctantly convinced that Franz Alexander, the Institute's director, was indeed committed to establishing a research program in psychosomatic psychoanalytic medicine, one that would bridge the gap between biological and psychoanalytic medicine by utilizing accepted scientific research methods. By the end of the decade, Foundation leaders were complaining that this had not occurred and were increasingly becoming reluctant to fund this organization (Brown, 1987; Medical News, 1938).

The Rockefeller Foundation also gave significant sums to a number of universities, including Yale, Washington University in St. Louis, McGill, the University of Pennsylvania, Duke, and perhaps most notably the University of Chicago, to create or expand psychiatric departments within medical schools. Analysts often found work in these departments (Morrison, 1940; Brown, 1935). The Foundation also provided money for the training of psychiatrists in general, and often this money was used by future psychoanalysts in their medical training. For example, Lawrence Kubie, who went on to become an important analyst in the middle decades of the twentieth century, received a Rockefeller Foundation fellowship when he was twenty-six

that allowed him to study neuropsychiatry in Europe (Kubie, 1950). This grant did not provide for psychoanalytic training, but it did facilitate Kubie's training in psychiatry, and this paved the way for his subsequent training in that field. Kubie's experience was not unique. Many who subsequently became analysts were provided money by the Rockefeller Foundation for their psychiatric training. The Foundation also gave money to psychiatrists for their analytic training itself. For example, Henry Brosin, one time President of the APA, with the help of a Rockefeller Foundation grant, completed training at the Chicago Psychoanalytic Institute in 1940 (Branch, 1968).

The Commonwealth Fund also facilitated the expansion of psychoanalysis through its backing of programs such as the child guidance clinics within which analysts often worked. The Fund also provided money for the education of psychiatrists. The Fund was created in 1918 by Anna Harkness, the widow of a man who made his money investing in Rockefeller's Standard Oil Company when it was first created (Harvey and Abrams, 1986). The initial goal of the fund was quite vague, but by 1921 the Director, Max Farrand, announced the creation of two programs. One dealt with the prevention of delinquency and the other dealt with children's health (Horn, 1989). It was the "primary donor to child guidance" in the 1920s and 1930s and provided seed money to develop the extensive network of child guidance clinics referred to earlier (Horn, 1989, p. 5; Harvey and Abrams, 1986; Jones, 1988). It gave significant sums, for example, to the National Committee for Mental Hygiene beginning in the 1920s to create a series of "demonstration" child guidance clinics in various cities (Horn, 1989; Pratt, 1930).

The focus of the Fund shifted at the end of the 1920s when it became more interested research and the training of mental health professionals. Towards this end it provided numerous

fellowships in psychiatry and in psychiatric social work (Harvey and Abrams, 1986; Horn, 1989). None of these fellowships focused upon training in analysis. Instead, the teaching of psychoanalysis was only part of the larger program in which the participants engaged (Horn, 1989).

Fellows and others could readily get exposure to psychoanalysis in many of the sites financed by the Commonwealth Fund. For example, a number of psychiatrists received fellowships to train at the Boston Psychopathic Hospital. C. Macfie Campbell assumed the leadership of the Boston Psychopathic after Elmer Southard died in 1920 (Russell, 1937). Campbell's early involvement with psychoanalysis and his usage of various analytic conceptualizations throughout his career certainly paved the way for its greater reception by the training fellows at the Boston Psychopathic Hospital; although at the time of his appointment, and for the rest of his life, he was not a dogmatic believer in psychoanalysis. Instead he seemed to be favorably inclined towards Adolf Meyer's psychobiology. Ives Hendrick (1955), a prominent younger figure in the early years of the Boston psychoanalytic group, notes that Campbell, who along with others like Meyer and August Hoch, were charter members of the APsA and who later distanced themselves from psychoanalysis, actually was "influential in interesting most of our older American analysts in Freud" (p. 581).

The Fund provided money for a number of projects that contributed to the expansion of psychiatry and psychoanalysis. For example, it financed surveys on issues related to the extent and availability of mental health services (Medical News, 1931). It also paid for the creation of the Directories of Psychiatric Services, and it funded fellowships in "penal psychiatry" (Association and Hospital Notes and News, 1932; Editor's Notes, 1941). In addition, the Fund

gave many training fellowships to students in psychiatric social work that, then as now, were dominated by analytic ideas. Often these fellowships were given to students trained at schools of social work, like the one at Smith College, that came to be identified with psychoanalytic training (Harvey and Abrams, 1986). Later in the century, the Commonwealth Fund supported the influential Group for the Advancement for Psychiatry (GAP), which was in effect a group of psychoanalytic psychiatrists who organized to advance their agenda, though the ostensible goal of GAP was to improve the psychiatric profession (Harvey and Abrams, 1986).

CONCLUSION

Ideology has been defined in many different ways (Eagleton 1991). In this article, ideology is defined as a false belief system that serves to maintain a system of inequality that ultimately serves the interest of the ruling class. To claim that psychoanalysis is a scientific ideology is to claim that it is a false belief system. It is false in that it attempts to identify the essential, timeless and universal working and nature of the self, a self that many have argued does not exist. The roots of such an attempt can be traced back to the Enlightenment thinkers, but increasingly throughout the twentieth century scholars from Heidegger (1977) to Foucault (1970) have railed against the claims of an essentialist self. The psychiatric profession itself with its embrace of psychopharmacology, beginning in the 1950s and expanding through the present, has implicitly agreed with such critics. Psychiatry has seemingly abandoned the project of attempting to construct a universalistic theory of the self, such as that found in psychoanalysis, and instead has rallied around psychopharmacology, an approach that treats the person not as a subject, i.e. a self, but as an object.

Psychoanalysis also served to maintain the system of inequality in America and served

the interest of the ruling class in the process. While psychoanalysts in the early and mid-twentieth century were more liberal than their medical colleagues (Hale 1995), and while a number of European psychoanalysts (including those who did and did not immigrate to America) embraced Marxism or a fusion of psychoanalysis with Marxism, mainstream American psychoanalysis was not oriented toward social activism, particularly toward any social activism that would call for revolutionary rather than reformatory types of change. Psychoanalysts located the source of people's problems not in the organization of society but in the psyche of individuals or in the family dynamics of childhood.

Further, the patients and benefactors of psychoanalysis, i.e. the rich and the private foundations of the rich, embraced a theory and practice that would give them assurances, mostly implicitly, that the existing social order was as it should be. Any problem lies within the individual and not with the organization of society. Such thinking was carried forth into the society, and money and resources were deployed to expand and apply the theory, if not the practice, of psychoanalysis to various social problem populations, from troubled, disruptive children to criminals to the mentally ill.

It was not that orthodox clinical psychoanalysis was often practiced on such populations. It was prohibitively expensive to do so. Rather, it was that the psychoanalysts were very instrumental in shaping and running the types of programs, policies and practices that were put into place to treat such populations. Psychoanalysts brought with them a particular theory about the origins of social problems and they had solutions as well: Changing the individual and ignoring the social structural factors that may contribute to these problems.

This article also shows how ideologies operate within a complex social class dynamic.

While the initial growth of psychoanalysis can be traced to the actions of the rich and their relations to the poor and working classes, in the post-World War Two era, the middle class did indeed become more significant to the spread of psychoanalysis. As the middle class expanded in the 1940s and 1950s and as the fields of clinical psychology and clinical social work grew and increasingly entered the psychotherapeutic market – offering their services for much less than psychoanalytic psychiatrists, psychoanalysis, albeit in a diluted form, was dispersed over a broader swath of American classes. Psychoanalysis, in effect, trickled down to the American middle classes after World War Two and permeated much of American culture – from movies to literature to art – only after it was received and supported by the upper class.

Lastly, this essay shows how historical accounts of psychoanalysis are themselves ideological. Hale's depiction of psychoanalysis (1971) as rooted in a middle class demand obfuscates both the class dynamics in American history – by among other things denying the role of class conflicts – and the role of scientific ideologies in maintaining belief systems that are congruent and supportive of the existing system of inequality.

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