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Of Being and Becoming: Psychoanalysis, Race and Class in an Urban ER

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ABSTRACT

Psychoanalysis in the United States has traditionally been a practice of long-term, individual therapy conducted within the safe and comfortable surroundings of a consulting room. Through my work as a white man with a largely African American, low-income patient population in a hospital emergency room, I learned it can also be used in that fast-paced, crisis environment. Doing so, I learned, required a full engagement with my biases, cultural history, memories and personal traumas. It required understanding how structural racism is embedded in the work, the role it plays in defining my patients' reality coming into the ER, and their options once there.

Although the first priority is to determine safety: Is the person in danger of harming themselves or another, if one broadens the scope of one's attention, as an analyst does, to the full person, do one's perspective, role and opportunities shift? I learned that I could do more than provide a descriptive diagnosis and disposition; I could actually begin the healing process. I learned I could better understand myself and my patients. The process was healing to both of us.

KEYWORDS

Emergency room; ER; racism; countertransference; socioeconomic class

At the core of the medical field are a number of dicta. One is, "Physician, heal thyself."

At the core of psychoanalysis there are also a few dicta. One is, "Know thyself."

Knowledge doesn't come all at once, however.

When I was in my mid-20s, I suffered excruciating lower back pain following a running injury. My internist diagnosed a pulled muscle of little consequence. But when the pain continued, he referred me to a rheumatologist. In the course of the interview, the rheumatologist said to me that 50% of lower back pain is psychogenic. After a 20-minute consultation, he made the acute observation, "You have trouble finishing things." And in fact, the running injury had stirred up old fears and angers from an injury I had incurred in childhood. When I was six, a neighbor backed her car into me, fracturing my pelvis – and cutting me off from finishing a tower, fraught with personal meaning, that I was building in a pile of sand by the roadside. Desire, fear, and anger had coalesced with that traumatic scene, and, unthought and unresolved, had remained dangerous to feel into my adulthood. For years, when I felt compelled to stop a task before completion, I experienced intense anxiety as I was faced with feelings wrapped up in the memory of that trauma. A few days after the visit with the rheumatologist, the severe pain resolved. And as I worked in my

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own psychoanalysis, emotionally connecting those dots, the remaining lower back pain disappeared. It has never returned.

I work in the emergency room of an urban hospital, evaluating people in psychological crisis. Are they a danger to themselves or others? Are they suicidal? Homicidal? Are they safe? Should they be admitted to an inpatient psychiatric unit? This is a simple understanding of what I do; it is also a rigorous understanding of what I do. As I learned the ropes, I worked with restless anxiety. So much at stake for my patients, so much dread I might be mistaken. It took three years for the needed knowledge to distill, for me to be comfortable making these decisions.

Those three years were also years I sharpened my skills as a psychoanalytically oriented psychotherapist in private practice. Working psychodynamically over time allows emotions and defenses to repeat and evolve; a patient can reach, observe, and change fundamental patterns and metaphors of their life. In my private practice, a patient and I would create an intense, complex relationship over months or years. In the ER, on the other hand, every interaction is an intense, complex phenomenon with multiple moving parts. It happens fast. While the essential task is to protect life, within the stillness of an interview there is opportunity to connect, to understand, to heal.

Today, decades later, I remember the exact encounter with my rheumatologist: his office, his desk, his request as he said goodbye: "Could I keep your list of symptoms?" For I had written out a day's timeline of shifting somatic pains that were expressions of the intrapsychic conflict. His wish to use it for teaching was apparent. I was reluctant to let go, but equally, I saw I could contribute. I am struck still by his quick and ready understanding of my plight. Unhurried yet efficient, he had, using his knowledge of psychodynamic processes and principles, uncovered a moment of childhood developmental crisis living on in present time, a moment of the mind expressing itself through the body. And by making the unconscious conscious with new meaning, he helped heal me.

As I write this essay, I seek to connect that encounter to my present work in the ER and to explore how, broadened and deepened, it shapes a means to work with, help, and even, at times, heal the largely impoverished and working-class patients I see. For them, current practice, available resources, and the historical assumptions of psychoanalysis say "no." For my African American patients, historical events embedded in cultural memory and historical misapprehension of the psychological underpinnings and potential of African Americans add weight to that "no." Grappling now with my patients' needs requires that I work to understand the psychological effects on them of class and, notably in the healthcare system, of structural racism. Writing this essay requires that I tease out and confront my own experiences of race and class and the professional role I play in the social and economic system. Yet the journey seems promising.

Alliance and a psychoanalytic approach

A white, middle-aged man was admitted to our emergency room. He said he was suicidal and homicidal. He told the triage nurse and the attending physician he was hearing voices telling him to kill himself. I approached him and gently asked where he was living, whether he had friends, did he speak with his family? I asked him if he were safe now. He answered yes. I asked if he would be safe if he went home. He looked up at me from where he was lying flat on the hallway stretcher, his blanket pulled up to his chin, and

said quietly, "Yes." So I asked what had brought him to the hospital. He said, "I'm lonely."

How was it that the answers I got were so different from those he had given moments before? How was it that he could now tolerate his loneliness enough to return home? I believe it was because he felt heard. He felt heard because I had engaged him fully as a person, so he could trust himself and me with his emotions. He had come to the ER with a plan: to be admitted to an inpatient psychiatric unit. Most likely, the physician or nurse asked him questions from a mental checklist: Are you hearing voices? Do you want to hurt yourself? Have you ever been an inpatient before? Do you use alcohol? Cocaine? Heroin? How much? Last time? Questions he knew how to answer to get an inpatient admission. Questions that were a wall with no door to his actual experiences and true wishes: I want to be around caring people. It's cold outside. I can't stand the fighting at home.

Trust and connection are essential to my work in the ER. For a patient to lower the drawbridge and allow passage to-and-fro, they must feel that an inner world, often betrayed, violated, or in multiple other ways damaged, is safe. An intense African American girl in middle school said, in response to my soft voice, "I can't hear you." I laughed and said, "Well, we don't want that." She replied quickly, "But it makes me want to talk to you." A white student at a public school, terrified of her inner world, spoke for the first time, in fits and starts, with guilt and shame, of voices telling her to kill her lab partner. She was relieved that a hospital stay would happen. Yet other times, distrust is palpable. A six-year-old African American boy sat on the white sheet of his hospital bed, feet dangling, and stared directly at me. His eyes, black, round, and frightened, shielded by street smarts beyond his years, dared me: "You want to find me out? I do not want to be here, and I will tell you nothing that might keep me here."

Few children and adolescents wish for an inpatient admission. Young children especially fear being separated from their families. Adolescents, even those who say they are lonely, resist separation from friends and social media. To both, being hospitalized speaks of punishment, and to adolescents concerned with acceptance by their friends, it reeks of stigma. Patients may, on feeling safe, tell me of suicidal impulses and plans but deny them as soon as they realize it means being admitted to a hospital psychiatric unit. Yet some adolescents, on speaking of previously unvoiced secrets and painful experiences and seeing that they are heard, find their agitation settle or their sorrow lift. Hope that their anger, suffering, or chaotic feelings might end, and ambivalence about suicide, lead them to an acceptance of an inpatient stay.

A parent or legal guardian must sign paperwork to admit a child or adolescent into a psychiatric unit. A vein of distrust, though, runs through the African American community, especially among those with fewer resources, who rely on the ER for medical care. White people thought Black people, being less than human, could not feel pain, physical or psychological. Further, and this is a view once prevalent in psychoanalysis, African Americans did not have the psychological strength or social and cultural resources to sustain challenging treatment. These currents colluded with a view in the African American community – perhaps a defensive reaction to being devalued – that mental health care is for white people, the "worried well." And there is risk: Mental health workers (along with the police) can commit you. They can take your children, your freedom. So psychological difficulties, denied and untreated, build until an ER admission becomes

unavoidable. Feeling threatened by The System and devalued through cultural beliefs and by history, African American families with fewer resources often carry into the ER encounter a tension born of deep distrust of people who say, "We can help you."

In the interview that I hope will lead to help for my patient – Black or white, mostly working class or poor, often homeless – I often must overcome their uncertainty, suspicion, or anxiety to form an alliance. My understanding of my patient's developmental age shapes that process. My youngest patient ever was five; my oldest, in her 90s. One evening, a white man in his 80s came to the ER. He had mild dementia and was living alone, simply, on a limited income. He had become tearful, depressed, unable to fix meals, and detached from the caring neighbor who had brought him to the ER. He could not tell her what troubled him except that he was old. With that starting point, I engaged him in a life history of memory and reminiscence. I learned about his son, who had died prematurely. I learned about his life working in the market stalls that no longer existed in the city. It soon became apparent that he had been traumatized by numerous losses – both of people and of a way of life – and that he had not yet been able to mourn. He hadn't developed the resilience in early life to absorb the buffeting of his later life. His loss of mind and function had been the tripwire to his withdrawal. As I listened with curiosity and empathy, he told his story with deepening emotion. As he spoke, he heard the echo of loss succeeding loss and began to mourn.

I had become a guide to his underworld of suffering. Personally and professionally I was engaged, but I also had to be detached. I had to use my own internal, unconscious universe of feeling, experience, wish, and imagination: being shaken by a lost love, an opportunity mourned, being of an age when one starts to look back as well as forward and acknowledge, with joy or pain, what has been and is no longer. Sitting there, an ache went through me. Yet my alliance with my patient also had to navigate differences – not only the circumstances, developmental and otherwise, of his life, but also those of age, class, and occupation. I had a quiet but deep-seated drive in that moment to know. By knowing myself, I could know him by our similarities; by knowing myself, I could recognize our differences. As I was able to be curious about and tolerate our differences, he had space for dignity in his separate and unique grieving. I was so intent on his world, I forgot about the neighbor sitting a few feet away. When the man and I emerged, she spoke: "I never knew this about him."

To unearth the metaphors and patterns of a particular life may take years of dedicated work with a therapist, but when a patient is in crisis, the story is often there in the moment to be noted, respected, and cherished. A young, white freshman woman transitioning to college life came to our ER, suicidal, brought in by her brother. She told me, tentatively, of having gone that evening to a crowded student party where she knew only a few people. She told me of a boyfriend who had left her when he went to another state to go to school. She still longed for him and, when she happened to learn at the party that he had a new girlfriend, had become anxious and agitated. Blaming herself afresh – without cause, I thought – for the breakup, she felt lacerating guilt. All was futile, and she turned an unrecognized jealousy against herself. She had intended to kill herself. Fortunately, her brother had read between the lines of a text message and rushed to pick her up.

As I took a brief history, she spoke of a father who criticized her choices at each turn of the road; of a father who divorced her mother, with whom she then lived and identified; of how she could never be a good enough student or friend; that she would never be good enough for anyone. As I listened, guiding her recollections gently, she caught glimpses of

the painful pattern of recurring guilt built on ambivalent love, hostility, and identification as successive developmental crises interacted with her world and, like struck tuning forks, resonated with each other. With churning emotions, from those of a toddler to those of an emerging adult, she surprised herself by saying, "I caused my parents' divorce." The suicidal impulses began to subside.

Sometimes, I would relax a little when a patient was white and middle class, or on or past a certain trajectory of four-year college and a professional career. I would experience a feeling of familiarity – and shame. Shame because despite my upbringing leavened with ideas of color-blind equality and my discomfort with the wealth of my neighborhood, I had succumbed to my privilege. Yet to see this young woman's suffering, I had to recognize and deflect this homogenizing myth of liberal, upper-middle-class whiteness, a myth I knew had once caused and defended against the pain of my own early inadequacies in school. Having done so, I could look into the way her world was fractured, her future uncertain. I could see myself, I could see her, and I could, with deeper imagination and fuller humanity, experience the aspirations of some of my adolescent, African American patients who wanted a college education but whose desires were impeded by family conflict and structural racism.

In my second year working in the ER, an African American girl in high school was admitted one evening with chest pain. The attending physician found no physical cause, yet the patient remained terrified she was dying. So, the attending referred her to Psychiatry for an evaluation. Reviewing the girl's chart, I noticed she had been an ER patient eight or ten times over recent years: chest pain, abdominal pain, headache, and so forth. Sometimes the doctor prescribed medication, but the diagnoses were always inconclusive. The doctor would discharge her, but she would return two or six or ten months later with a different complaint.

Reflecting on her checkered history with the ER, I remembered my own back pain. I wondered if there might be a relationship or trauma in my ER patient's life that could be causing a similar displacement of suffering. As I took a history, following her emotions, I inquired about trauma in her life. She said that some years earlier, a great-uncle who had helped raise her, and with whom she had spoken about intimate feelings and problems, had suddenly had a brain aneurysm burst. He died in front of her. Today's ER admission was occurring on an anniversary associated with this relative. It became clear to us both that the ER visits and her fear of dying repeated her terror, uncertainty, and confusion when her uncle died. As she realized this, her slumped body straightened. Facing her trauma and her loss, she could begin her slow journey absorbing into consciousness and accepting the trauma of her great-uncle's death and loss, with its full meaning. In the intimacy of the moment, with our intersecting histories, despite our difference in age by two generations and our differences of race and class, we connected deeply.

Racial differences in the ER

One White therapist's response to Blackness

A s I reflect on my experiences as a white clinician with patients who are primarily Black, I forage for memories and tags of my being white and others being Black in my youth. I was brought up in the white suburbs of Washington, DC, where houses and yards were large,

and doors were left unlocked. There were sailing lessons and vacations at white beaches. Children were expected to go to college, and most did. I had the privilege of education, aspiration, and opportunity. Unconsciously, I had the privilege of power. To be Black was to be Katie, a maid to whom my mother was close, or the picture framer at Brooks Photographers, where I took out the trash in the afternoon; it was the March on Washington, civil rights in the newspapers, and the neighborhoods along U Street and New Jersey Avenue that I thought of as poor and deprived as I looked, with a bit of anxiety, out my crosstown bus window on my way to an internship on Capitol Hill.

When I turned 20, I emphatically chose to leave behind the all-white suburb in which I was raised for the city, to live in housing on the ragged edge of the racial divide. Although I lived many of my adult years in urban communities that were diverse and often majority African American, I did not visit in my neighbors' kitchens or go to their churches. In many of those years, I kept to myself. I had little knowledge of the psychological forces driving me. I knew little of the psychological implications of the structural racism that divides white and Black in housing, education, employment, and health care. Yet that diversity of race and class drew me, enlivened me, made me feel true to myself.

To understand my patients in the ER, I needed to listen closely, drawing from my knowledge of myself and the rich, if fragmented, puzzle of my own years living in the diverse neighborhoods of downtown Washington, DC. At work in the ER of an urban community hospital, as I entered the room of a child or adolescent patient, meeting a parent or guardian, possibly with a sibling, grandmother, or social worker also present, I would be attentive but holding back, aware of my role and unsure of my audience. At times I wondered, "How do they hear *me*?"

While I was aware that many impoverished Black families lacked fathers in the household, I also knew that for some whites that fact had morphed into a belief that *all* urban Black men were unemployed, unfaithful, and irresponsible. The racism behind this belief made me uneasy, and I asked myself, "Did my white skin make my adolescent patients think *I* believed that?" How was I to be comfortable, how was I to make my patients comfortable, when what I often needed to ask was, "Tell me about your father."

A middle-school girl I worked with told me about her father with pain she could not numb. He had been shot in the head and killed when she was five, an age when little girls have very intense feelings for their fathers. Her mother remarried. A few years later, her stepfather was stabbed to death. When I saw her in the ER, she was severely depressed. I responded to her anguish deeply; a door had cracked open to a world barely touched by crime-blotter newspaper stories tinged with racial difference. That she had allowed me to know her sadness plunged a bucket into a deep well for me.

The depth of darkness into which I plunged was not one of gun violence, it was one of abandonment. At age two and a half, having fallen from a second story window, alone in early dawn, I was carefully watched throughout the day at home. Then, taken to the city hospital for a head x-ray and overnight observation, my father had left me to the care of nurses–abandoned me, as I could best then understand. Along with this young girl, backed into her pillows, who had twice had fathers ripped from her life, I had feelings of profound isolation and father abandonment.

As my Black patients see me

Race can unsettle us, throwing up roadblocks to listening and being heard. How I am heard by my patient can be very different from how I imagine myself speaking. When I do not recognize that I am crossing the divides of race, class, and power, there can be consequences. Early in my ER career, an African American patient who was homeless would come in frequently. She could afford housing – she had a disability income that she husbanded throughout the month – but she was particular. And entitled. She repeatedly rejected housing possibilities offered by a nonprofit organization because they did not meet her standards. So, she would come to the ER, say she was suicidal, get a meal and a night's sleep in a warm bed – and in the morning, deny she was suicidal and leave. Frustrated at the waste of health-care dollars, one evening I said to her, as she lay on a stretcher, "Ms. X, this is not a hotel." She spun around, lifted herself on her elbow, and shouted, "You fucking white overseer!" Her furious, racially loaded insult, in response to what I thought was a mild scold, set me back on my heels. I was stung, angry, unsure how to respond. Her reminder of the trauma of slavery, condensed into a symbol of her pain and flung as a weapon, hit home.

We came to an understanding after that: She would not tell me she was suicidal, and I would say to her, "Would you like a meal before you leave?" It was an accommodation that gave us a balance of power. Each of us had come to a deeper respect for the other. Yet when she showed up in the ER, I used at times a defense of bemused outrage with my colleagues. It hid what I now know was the deep pain and personal memory that drove my side of the accommodation.

My mother's Texas roots were as much a part of my identity as the assimilated New York Jewish household my father had been brought up in. But there were stories my mother told, stories with a whitewashed subtext of race. At the outbreak of the Civil War, four brothers – I am a direct descendant of one – had gone to Sam Houston and asked, "Should we fight?" He reputedly said, "I do not support this war, but I support my State." The brothers signed up and fought in the West for the Confederacy. It is a story of privilege and power, a dark and brutal reality I had avoided confronting for years: Members of my family had fought to defend chattel slavery. Not only that, but an ancestor on the other side of my mother's family owned nine Black human beings. Since memory is represented in and used by the present, I wonder how I might have understood my patient, what depths of hurt in her I might have been able to reach, had I then felt not only the anguish I now feel, but also the culpability I had tolerated well into adulthood by being blind to the reality of my mother's story.

It is with open eyes that I continue to navigate the distinctly different religious histories my parents brought to their marriage. In the ER, I wondered about the implications for my patients. The Christian church is a nurturing presence that for over two centuries has helped sustain the Black community through its suffering. The rituals and manner of worship are infused with African traditions, including ideas and practices of the healing arts. How, then, am I, a white man who practices a rather odd form of treatment, with personal and methodological roots in Western Europe, perceived by my patients? How am I, a man whose lineage is half Jewish (some say it is apparent in my features), perceived, given the troubled historical relationship, filtered through distortion, falsehood, stereotype, and myth, of Jewish shopkeepers and Jewish numbers runners in Black communities? I have

spent many years working for therapeutic institutions with Jewish affiliations serving an African American community, and yet only a handful of times has a patient spoken to me of these tricky currents. Once, while I was working for a clinic, an African American patient let slip, with a raw edge in her tone, that her friends didn't trust that "Jew hospital" in their community. I was shocked; I wanted to know more. She clammed up, and even though I would work with the woman for many more years, she never again allowed me entry to that corner of her world.

In my private practice, I am a psychotherapist; in the hospital, my title is psychiatric evaluator. But by license, I am a clinical social worker. In the African American, urban community surrounding my ER, I belong to the social service system; I am known as a worker. Once I became more familiar with the community, for a while I would appropriate it to myself, imagining myself into belonging to the community of my patients. But I pulled up short and never said it out loud, for the sword has a double edge. The worker is a vital member of the impoverished community served by an urban ER, but one held in ambivalent regard, often derogated with an assignment of lesser value than that to which I assigned myself. The worker represents The System. And I am white. What were the outlines of trust and distrust that defined my work?

Patients with mental illness often resist treatment. Any of their many defenses may lead them to turn away help, to deny the reality of their illness. Those with severe and persistent mental illness – bipolar, schizoaffective, or schizophrenic disorders – may have cognitive limitations contributing to their psychological resistances. But in fact, African Americans with a mood disorder are more likely than whites to be misdiagnosed with the more severe schizophrenia, and research shows that, if psychotic, they are, on average, prescribed higher doses of antipsychotic medications. Further, African Americans have an especially difficult legacy to deal with: Throughout slavery and on to incidents as recent as the 1980s, their community has been used, because of its impoverished, dependent status, as a laboratory for medical research. The Tuskegee syphilis study, James Marion Sims's gynecological research, the lead paint studies by Johns Hopkins University researchers are but examples. The poor and the Black were considered expendable. That legacy combines with a continuous reality of substandard care to produce a high level of distrust of the health-care establishment.

Although most of my interactions with patients and their families were polite and respectful, sometimes I could taste the distrust. A tense African American man admitted to the ER for a psychiatric consultation looked at me with suspicion. He had requested a medication refill. Until now, he had received his medication from a clinic across town. Propped on his elbows on his bed in the half-dark he had requested, he told me that the white clinic doctor, believing the medication had not been working, had changed his doses and added a new pill. My patient had become mistrustful of all of his prescriptions and quit taking his medicine entirely, saying to me, "I don't know what's in that pill." I wondered if he felt, as other patients occasionally had said when I spoke with them: "Don't experiment on me." Soon after he quit taking his medicine, the voices he heard in his head, which had been quieted, returned with a roar. Disturbed by the voices and mistrusting the clinic he felt had not taken his suspicions and concerns seriously, he now wanted to return to a medication he had taken years before. Now the only doctor he trusted was himself.

Encounters with the system

A societal system of structural racism and devaluation on the basis of class looms over many of my patients. It affects their expectations coming to the ER, how they see me, the options I have to offer them, and how they receive those options. Housing, education, and employment segregation are all part of the world most of my ER patients live in, as is the structural racism of the health-care system.

Having learned through my own analysis that cultural and societal forms and historical events affect my internal world, I attended to how these realities, especially of race and class, affected my patients. Several years before George Floyd was murdered, the ER medical team asked Psychiatry to evaluate an African American man in his late 40s. The man had once sold drugs but had left the street world behind. Brothers from that time were out to get him, he said. He had caught them on his home security camera hiding drugs in his car. He was afraid to drive his car or to look for the drugs for fear it was a setup for an arrest for possession. He said he had driven to a police precinct to tell his story and have the police look for the drugs. But he feared that if they did find drugs, they would arrest him, so after sitting in the parking lot in the dark for an hour, he drove away. As I sifted out what was paranoia and what was reality in the man's story, I presented the case to a visiting psychiatrist from Asia. Curious, he interviewed the patient. But coming from a country where adherence to authority was embedded in community culture and less fraught with a history of slavery, current oppression, and ambivalence toward the police, the psychiatrist disbelieved any element of the patient's narrative that stitched together paranoia, anxiety, and realistic fear. He curtly dismissed that a traffic stop could put my patient at risk. Unaware of the complexities of street life, he denied possible police duplicity. He missed the legitimate anxiety threaded through my patient's story and found him more profoundly disturbed than I ultimately decided was truly the case.

The shadow of child protective services

Black boys and girls are all too often perceived as older, more responsible, more sexually mature, and more threatening than justified given their age. One door frequently leading to crisis treatment for African American children on the lower rungs of the socioeconomic ladder, especially boys, is disruptive behavior at home or at school. Once that door has opened, things can escalate quickly. In school, disruptive behavior can start with a taunt, throwing objects, overturning a desk, leaving the classroom, or leaving the building, all resulting in multiple, even daily, calls to a distressed parent or guardian, suspensions, an individualized education plan, and visits to an overtaxed school-based social worker. Educational policies, therapeutic approaches, a paucity of resources, and a lack of time will often lead well-meaning and caring therapists and administrators to respond with efforts to manage the external behavior rather than address the underlying, unconscious emotional conflict. The fact that unconscious racial bias results in administrative actions escapes attention. The data overwhelmingly show that even with minor infractions, Black children are dealt with more harshly, more often suspended, more often referred to the juvenile justice system, less often diagnosed with learning disabilities, and less often seen as smart. As a result, nothing fundamental changes, and the suffering continues; as the student seeks again to master the anxiety, the disruptive behavior returns. Then, often with ideas –

or plans – of suicide in play, there might be a call to the police, an emergency petition requiring a psychological evaluation, and an ambulance or squad car ride to the ER.

Having a disruptive child evaluated in an ER under an emergency petition (EP) can evoke anxiety, distrust, and resistance. Real-world distrust of the police, who can execute the EP, and of a health-care system that can commit a child to a hospital or recommend an investigation that might remove them from the home, can increase the anxiety of a patient and their parent. Child Protective Services (CPS) is a dark shadow, a force to be reckoned with in an impoverished community. African American children and adolescents are more likely to enter the system of investigations and interventions, including foster care and juvenile detention, than any other racial group – and to stay in the system longer. Once in the system, with attachments in disarray, distrust rampant, and behavioral problems inadequately addressed, the child or adolescent may be transferred from one foster home to another to yet another. One evening, a boy in his early teens was brought to the ER. His foster mother, feeling threatened and frightened by his outbursts, had called the police, who had brought him in under an EP. I determined that he was not a danger to himself and did not require hospitalization. But his foster mother refused to take him back. The foster care agency responsible for him took him to their office overnight while they searched for the next placement – as he absorbed yet another traumatic rejection.

Another patient brought to the ER by the police was an African American girl in her mid-teens, perhaps on her way to foster care and feisty, angry, and sullen. The girl would leave her house in the middle of the night and skip school the next day. Then, one day, she left the neighborhood and disappeared into the city. She was reported missing. A few days later, the police found her on a street corner with a teddy bear and ten dollars, speaking gibberish. Now, in the ER, she was speaking intelligibly, but she was desperate to go back to the city before her grandmother arrived. I feared for her safety. I wondered if she were being groomed for trafficking. I wondered if either her home or The System had the resources to help her.

I *am* The System in the ER. I can recommend that a patient be kept against their will or the will of their family for up to 72 hours for a psychiatric evaluation. That evaluation might result in a recommendation for a psychiatric hospitalization the patient and family don't want. Although it is rare with children, more common with suicidal adults, I can recommend that a physician commit the patient to the hospital against their will for up to a week until a review by an administrative law judge. I can make a report to Child Protective Services, most likely resulting in an investigation. It is not surprising, then, that I am sometimes challenged angrily by a distraught or righteous parent. To different degrees, patients and their families distrust The System. And so they distrust me.

The outcomes of my actions as a mandated reporter can be significant. The law requires that if a child or adolescent I treat has been abused, mistreated, or severely neglected, I must report it to CPS within hours. On occasion, the circumstances are clear-cut. One distraught aunt brought in her nephew, who was under her care. He was emotionally unstable, skipping school, getting into shouting matches, and breaking things at home. She was frightened of what might happen were he to act out defiantly in the community. She didn't recognize that his extreme behavior was an effort to master an internal turmoil, and so her attempts at discipline didn't work. The behaviors were worse after the child had been left alone with her boyfriend. With his "spare the rod and spoil the child" mentality, he had beaten the boy to end the acting out. In a combustible mix in which the medical system was

mistrusted and mental health treatment was considered a sign of weakness and unmanliness, he was again threatening the child.

Although he had no legal standing, he was pressuring the aunt by phone to return home with the boy. Despite her alarm at her boyfriend's disciplinary methods and her strong desire to seek help, she was torn. An abrupt departure against medical advice was possible. The boy was having thoughts of self-harm. I recommended to the attending physician that she quickly fill out and sign an emergency petition requiring that the boy have a psychiatric evaluation. She did so. With the decision taken from her, the aunt settled and the boyfriend retreated. As the situation stabilized, the aunt was able to accept what became a recommendation that her nephew be admitted to an inpatient psychiatric unit. I did not need to make the extreme request I was considering, that CPS take emergency guardianship to protect my patient's life. I did request that CPS investigate the boyfriend's role in my patient's life.

Other times, the circumstances are murkier. What might be perceived as neglect on the part of the parent or caretaker, such as not providing guardianship papers, not returning phone calls from doctors and other ER workers, or being unavailable to sign a child into an inpatient unit, may be due to external factors rather than intentional neglect: The parent may have a job with little leeway or might have to meet the demands of other children without an available relative or neighbor or friend to help. Sometimes, what looks like neglect is simply the disorganization caused by exhaustion or a wrong phone number. The child, it turns out, has not been abandoned. Yes, I have seen the rare parent, pushed to her limits by a destructive, unruly child in a system where she has inadequate resources, throw up her hands and say, "Let foster care take him" or simply not show up until contacted by CPS. I recall one angry mother shouting at her child, "I am finished with you." But she responded to my nonjudgmental attention to her emotion, her distress, and her almost unworkable circumstances and found a reservoir of love and commitment for her child that allowed her to once again engage The System for the child's benefit. I did not call CPS.

Sometimes, the ER reveals the consecrated dedication of members of the African American community to their children. One woman, whose family difficulties were telegraphed by the fact that she had kinship guardianship, alternated between being choked up and effusive that I had spent the extra hour needed to line up and explain to her the option of a day hospital admission for the child in her care. Another strong woman from the African American community was guardian for quite a few children not her own. She had resigned her job as a midlevel agency worker to care for otherwise unsupervised, ungoverned, and unloved foster children, while working The System for housing, food stamps, government stipends, Medicaid, Big Brothers Big Sisters mentors. And yet, she was about to lose two of her rambunctious and previously traumatized charges because she had violated government regulations, including one mandating public housing occupancy limits, that ignored the realities of her community. I took time to listen, to acknowledge, to not judge, while seeking to untangle The System's strictures. I knew the odds she was up against, and I thought: "I could not give up my career to do what she is doing." She decided, slowly, to open up the tightly held purse of her story to me, a white, male worker. Her investment allowed me to recognize her plight, and her to take a deep breath, exhale, pull herself together, and believe, at least for a minute, that by working what we both knew was a broken system, she might actually succeed in her mission to provide a future for the children in her care.

I stand quite in awe of some patients who, with grit and flexibility, have navigated through a childhood and adolescence of exploding munitions and broken lives. In a brief ER interview, I am sometimes unable to divine the unconscious springs of the strength and resilience I observe. An agitated white girl on the edge of adulthood, with suicidal impulses but no plan, walked into the ER alone one day. She was frightened and didn't feel safe – from an abusive and controlling older boyfriend, or from herself. She had grown up in the inner city in dilapidated housing, raised by a mother who had prostituted herself in the apartment to pay for her severe drug habit. As a preteen and teen, she had been raped by men connected to her mother. She was often hungry. She had missed weeks of school and been in foster care. Taking from The System what she could, managing despite a system that for years had failed her, she had found the inner strength to finish high school and was learning a skilled trade. She had a toddler of her own and was raising her half-brother, struggling to see that they got fed, got off to preschool or school, had toys and playmates, did homework. Now she had found a refuge from her abusive boyfriend with a relative who lived in a safe and distant suburb. As she and I talked, I leaned carefully in the direction of her brighter future; she oscillated anxiously between opportunity and perceived stability, risk and familiarity. Nurtured by my gently supportive interview, her agitation lessened, her thoughts became more organized. Then her phone rang. She didn't answer; then she did. It was her boyfriend. Her old patterns, which had made her resilient and had protected an inner core against her many traumas, seemed to kick in. Her shoulders slumped and tightened. Her damaging, familiar world called. Her inner struggle was visceral, visible. She determined to return, to make it work. As she walked out, I felt admiration for all she had accomplished, against the odds. And deep sorrow for all she was giving up.

Seeking recovery from substances

Many of my patients self-medicate, using alcohol and marijuana to excess. It's also common for patients to test positive for cocaine or heroin. More than a few men and women in their 40s and 50s come into the ER saying bleakly, "I'm tired of this life" – tired of the cycle of using, coming down, seeking, and using again. Yet given the opportunity of a substance rehabilitation program, many turn it down, leaving for the streets and another high. The physical and psychological dependence are too much to overcome with the 28-day programs they have tried in the past. Such programs begin the healing process, but due to the structures of insurance coverage, the substance abuse – the symptom – becomes the focus of attention, not the particular experiences and underlying suffering the substance use is covering up. Probing beneath the surface of addiction, one often discovers a pain driven by deep-seated trauma: rape, abuse, loss, neglect, crushed aspirations, a broken heart, racism. As clear as the link may be between addiction and trauma, I have too few effective resources to offer a patient wanting to get clean.

Conclusion

Psychoanalysis in the United States has traditionally been a practice of long-term, individual therapy conducted within the safe and comfortable surroundings of a consulting room. Increasingly, attention is being directed to applications in the community at large. In either setting, the work demands much of us. Applying the analytic framework challenges us to

continually sample and make sense of our inner world – our biases, memories, fantasies, and personal traumas – and then employ what we can learn from them for the benefit of someone in pain. The circumstance of being a white clinician in an urban ER is at once one of the most challenging applications of psychoanalytic ideas and techniques and an exemplar of the fundamental relationship.

My patients, Black and white, compel me to ask, "Who am I to them? Who are they to me?" I have come to realize that racial myths and realities affect both me and them and are central to our relationship and our work. Recognizing that I have benefitted from opportunities provided by structural racism, and that this has psychological implications for my patients as it does for me, has enabled me to better understand, negotiate, and build upon the intricate dynamics of interactions in the ER. Reflecting on my defensive reaction to the pain of being called a "fucking white overseer" uncovered my anguish stemming from a distant family legacy of which I was only dimly conscious. I believe that this insight has been essential to my ability to effectively hear and help my patients.

Crossing the racial divide demanded that I look at how both history and systemic but generally unspoken racism have shaped us and continue to shape us through thousands of daily interactions. In the ER, even as I do my best to understand, empathize with, and act for the good of my patients, I'm forced to maintain the unpleasant awareness that, for many of them, I am The System, which holds power and controls access to resources. Haunted as we are by the traumas of our history and our society, an authentic human connection across the racial divide is a hard-won victory. My psychoanalytic sensibility and curiosity have allowed a fuller use of myself; in the difficult work of developing them, I have learned that the more I face painful realities with my patients, the greater my empathy and effectiveness in meeting their needs.

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Notes on contributor

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