"Where the Need is Greatest": Social Psychiatry and Race-Blind Universalism in Harlem's Lafargue Clinic, 1946–1958

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SUMMARY: Between 1946 and 1958, Harlem was home to a small psychiatric facility, the Lafargue Clinic. An interracial institution run entirely by volunteers, the clinic helped expand mental health care into underserved African American communities. Relying upon extant case files, this article examines how the Lafargue staff handled clinical situations with African Americans. In its attempt to forge a new antiracist approach, the staff struck a balance between viewing Harlem patients as psychological products of their unique social context (social psychiatry) and applying modern psychiatric principles to African Americans without adjusting for racial or sociological difference (race-blind universalism).

KEYWORDS: Lafargue Clinic, Harlem, social psychiatry, African Americans, universalism, Wertham

Between 1946 and 1948, over a dozen media outlets both in Manhattan and nationwide paid an unusual amount of attention to the grand opening of a single psychiatric facility, the Lafargue Mental Hygiene Clinic. Granted, outpatient clinics offering psychotherapy for people coping with everyday stresses may not have been as commonplace as they are today. Yet, the creation of one in New York City was generally not thought to be newsworthy enough for a local daily, let alone *Time* or *Life*. So what was

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special about this place? Most journalists seemed to agree that the clinic was extraordinary in three ways. First, it was located in Central Harlem, the world's most famous black-identified urban area and a place with few mental health providers. Second, volunteers ran the clinic, offering free care without permanent funding or public subsidies. Third, and most startling for many writers, the clinic founders intended for African Americans and the poor to use this institution.[1]

There were several reasons why writers were so shocked by this last aspect of the clinic. Several reporters indicated that the Lafargue founders' contention that poor African Americans in Harlem needed psychotherapy was strange and new to them. Some even noted that the Lafargue backers had challenged several commonplace assumptions in claiming that African Americans could benefit from psychotherapy. Apparently, Lafargue's founders did not believe that blacks were a happy-go-lucky race with natural immunity to stress and neuroses. As well, they were not convinced that psychotherapy was only for highly educated and wealthy whites. Instead, they assumed that African Americans were emotionally complex enough to be susceptible to emotional disease and smart enough to benefit from psychotherapy. What is more, they thought that Americans who lived under the most disadvantaged and uncomfortable circumstances might need a psychotherapist most.[2]

1. Black community newspapers, mainstream New York dailies, and at least twelve national magazines covered the event. The following is but a sampling: Richard R. Dier, "Harlem Mental Hygiene Clinic Drawing Support," *New Jersey Afro-American*, 30 March 1946, p. 11; [Earl Brown?], "Clinic for Sick Minds: Basement of a Harlem Church is Haven for Mentally Ill," *Life*, 24 February 1948, pp. 99–100, 102; "Psychiatry in Harlem," *Time*, 1 December 1947, pp. 50, 52; Constance Curtis, "Harlem's Mental Health Clinic Doing OK," *New York Amsterdam News*, 13 April 1946, pp. 1, 23; S. I. Hayakawa, "Second Thoughts," *Chicago Defender*, 4 January 1947, 11 January 1947; James L. Tuck, "Here's Hope for Harlem," *New York Herald-Tribune*, 26 January 1947, pp. 1–2, reprint, Lafargue Clinic Records, Manuscripts, Archives and Rare Books Division, Schomburg Center for Research in Black Culture, New York Public Library, Astor, Lenox and Tilden Foundation, New York [hereafter LFC-SCRBC], box 2, folder "Clippings Re. Lafargue"; Dorothy Newman, "Help for the Troubled in Harlem," *New York Post*, 16 March 1946, p. 30; "Why Segregate Negro Psychiatry," *New York Post*, 6 September 1946, p. 34; Lawrence Galton, "Communities on the March," *Woman's Home Companion*, January 1947, clipping, LFC-SCRBC, box 3, folder "Clippings Re. Lafargue"; Lloyd and Mat Morain, "Do You Know?," *The Humanist*, Spring 1948, p. 186; Earl Brown, "Timely Topics," *New York Amsterdam News*, 15 February 1947, p. 13; Lilian Scott, "Patients Wait in Line for Treatment at Famed Inter-Racial Chicago Clinic in Harlem," *Chicago Defender*, 3 January 1948, clipping, LFC-SCRBC, box 3, folder "Clippings Re. Lafargue."

2. "Psychiatry in Harlem" (n. 1), pp. 50, 52; Tuck, "Here's Hope for Harlem" (n. 1), pp. 1–2; Robert Bendiner, "Psychiatry for the Needy," *Tomorrow*, April 1948, pp. 22–26; "Harlem Pioneers with Mental Clinic," *Headlines and Pictures*, July 1946, reprint, pp. 1–2, LFC-

As pedestrian as the founders' convictions might sound to us today, reporters in 1946 presented these claims as though the Lafargue Clinic had first discovered them. Nevertheless, these egalitarian ideas were not new, especially not in New York City. Ellen Dwyer and Daryl Michael Scott have demonstrated that, during the World War II era, a growing number of psychiatrists and mental health professionals nationwide had begun to eschew the older racialist assumption that the African American psyche was innately different and inferior. David Rosner and Gerry Markowitz have already shown how a cadre of such psychiatrists and their liberal allies in New York had been struggling to increase mental health services for black children in Central Harlem for almost a decade before the Lafargue Clinic began.[3] In fact, this liberal "psychiatric network" even created its own child guidance clinic in Harlem, the Northside Center, at about the same time. Significantly, these Northside Center founders even held many of the same antielitist and antiracist assumptions as did the Lafargue founders.[4]

However, historians know very little about how these antiracist and antielitist intentions translated into actual clinical practice with African Americans. Had antiracist clinicians at institutions such as Lafargue or the psychiatric network's Northside Center successfully provided a more progressive form of therapy for their black patients? Scholarship on the connections between race and psychiatry in the United States has grown, but the historiography on clinical encounters with African Americans has focused chiefly on racialist psychiatrists in late-nineteenth and early-twentieth-century mental hospitals.[5] Mid- and late-twentieth-century psy-

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SCRBC, box 3, folder "Clippings Re. Lafargue"; Sidney M. Katz, "Jim Crow is Barred from Wertham's Clinic," *Magazine Digest*, September 1946, reprint, pp. 1–5, LFC-SCRBC, box 3, folder "Reprints"; Kenneth Spencer, "Sans Funds, Lafargue Clinic Lives," *The People's Voice*, 13 July 1946, clipping, LFC-SCRBC, box 3, folder "Clippings Re. Lafargue"; Ralph G. Martin, "Doctor's Dream Comes to Harlem," *New Republic*, 3 June 1946, pp. 798–800.

3. Ellen Dwyer, "Psychiatry and Race During World War II," *J. Hist. Med. Allied Sci.*, 2006, *61*: 117–42; Daryl Michael Scott, *Contempt and Pity: Social Policy and the Image of the Damaged Black Psyche, 1880–1996* (Chapel Hill: University of North Carolina Press, 1997); Gerald Markowitz and David Rosner, *Children, Race, and Power: Kenneth and Mamie Clark's Northside Center* (Charlottesville: University of Virginia Press, 1996).

4. Dennis A. Doyle, "The Universal Mind Assumption: Harlem and the Development of a New Racial Formation in American Psychiatry, 1938–1968" (Ph.D. diss., Stony Brook University, 2006).

5. John S. Hughes, "Labeling and Treating Black Mental Illness in Alabama, 1861–1910," *J. South. Hist.*, 1993, *58*: 435–60; Peter McCandless, *Moonlight, Magnolias, and Madness: Insanity in South Carolina from the Colonial Period to the Progressive Era* (Chapel Hill: University of North Carolina Press, 1996); Kirby Ann Randolph, "Psychiatry Versus the Negro" (paper

chiatric records, of course, are difficult to locate and access even for the immediate postwar period. Although patient records for the Northside Center are not available to scholars, some Lafargue case files still exist.[6] In this paper, I make use of nine case files that I determined to be adequately representative of the Lafargue Clinic's remaining box of twenty-nine case records.[7] Owing to this very limited sample size and the lack of details regarding the larger body of cases Lafargue saw, I realize that my conclusions can be little more than suggestive. Yet, combined with the printed record, these surviving case files do afford us a rare first glimpse of how postwar psychiatrists applied emerging antiracist principles to clinical situations with African American patients.

Through a close analysis of these selected Lafargue case files, I suggest in this paper that the Lafargue Clinic's staff struck a balance between two guiding clinical principles: race-blind universalism and social psychiatry. Universalism referred to the application of modern psychiatric principles to African Americans without making adjustments on the basis of race. Such a practice was predicated on a belief that blacks and whites shared

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presented at the New York Academy of Medicine, New York, 27 February 2001); Kirby Ann Randolph, "Central Lunatic Asylum for the Colored Insane: A History of African Americans with Mental Disabilities, 1844–1885" (Ph.D. diss., University of Pennsylvania, 2003); Matthew Gambino, "'These Strangers Within Our Gates': Race, Psychiatry, and Mental Illness Among Black Americans at St. Elizabeths Hospital in Washington, DC, 1900–1940," *Hist. Psychiatry*, 2008, *19*: 387–408. See also Elizabeth Lunbeck, *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America* (Princeton, N.J.: Princeton University Press, 1994), pp. 121–26, 149, 150, 205.

6. The Schomburg Center possesses the largest extant cache of Lafargue patient records made available to the public. Dr. Hilde Mosse had saved these records and her brother gave them to the Schomburg after she died (Diana Lachatanere to Dennis Doyle, personal e-mail communication, 15 June 2009). The Frederic Wertham Papers, housed at the Library of Congress, contains a mere handful of Lafargue case files (two as far as I have been made aware) that Wertham had saved. The Wertham collection was closed when I conducted my research, so I was not able to gain access to this collection. The Lafargue had more than thirty patients over the course of twelve years, so more files must have been produced, of course.

7. Demographically, the files cited in this paper are fairly representative of the patients whose cases are documented in the remaining Lafargue patient records. As did the cases used here, the collection's files skewed young, with patients ranging in age from eight years old to their late twenties. Most of the patients were either working class or working poor, living in apartments or tenements. A slight majority of the patients whose files remain were male, and the same goes for my sample. Although the race of every patient was not clearly identifiable, the majority of the case files, eighteen, referred to Americans of African descent. The eleven remaining files, two of which [patient pseudonym ERU] and [No. 2067] I used in this paper, were those of white patients or patients whose racial identity I was unable to precisely determine.

the same complex "emotional landscape"[8] described by psychodynamic and psychosexual theory. Social psychiatry was the practice of assessing a patient's emotional problems and needs within the context of his or her everyday life. Lafargue's social psychiatrists wanted to know the patients' social context and the patients' own perceptions of their needs.

From day to day in the Lafargue Clinic, universalism and social psychiatry proved to be mutually reinforcing, rather than antagonistic, principles of social justice. On the whole, Lafargue clinicians seemed to have little trouble interpreting their African American patients' own perceptions and social contexts in light of modern psychodynamic concepts. However, there is some suggestion in the limited extant case records that there may have been a possible limit to these social psychiatrists' progressive relationship with universalism, one moment when a patient's own needs and socioeconomic profile did not matter to the postwar clinician. In the three extant cases that involved suspected homosexuality, Lafargue clinicians dropped almost all attempts to situate the patient and his or her own views. In defense of postwar American society's heterosexual norms, universalism may have sometimes trumped social psychiatry. While this should not disprove my overall contention that social psychiatry and universalism were compatible, it does indicate that those two principles may not have always operated in tandem during these early attempts at antiracist treatment of black patients.

A Free Clinic in a Harlem Church Basement

The Lafargue Clinic had opened after World War II, at a moment when mental health services for New York City's African Americans were still limited and inadequate. Blatantly disregarding recent state and municipal regulations banning racial discrimination in publicly supported child care, many caregivers excluded Harlem's emotionally troubled black children. To remedy this lack, Domestic Relations Court Justice Justine Wise Polier and a liberal cadre of philanthropists and professionals opened some mental health services to black children within the public schools, family court, and correctional system. Polier's psychiatric network even helped create private mental health options for some of Harlem's black children, including those at Harlem's Northside Center and the Wiltwyck School in Esopus, New York. Nevertheless, mentally ill adults and their

8. I thank Christopher C. Sellers for introducing me to this very useful phrase. Emily Martin utilizes a similar phrase, "interior landscape," in *Bipolar Expeditions: Mania and Depression in American Culture* (Princeton, N.J.: Princeton University Press, 2007), p. 51.

families were still largely limited to public institutions that either excluded blacks, were unable to handle all their needs, or were known to treat them unfairly. Many psychoanalysts and private practitioners refused to see black patients even if they could afford it. Both the state's Psychiatric Institute on 168th Street and Broadway and most other psychiatric wards in the city excluded black patients. Harlem Hospital was the only local municipal hospital serving Harlem's communities, but it did not even have its own psychiatric wing.[9] Harlem residents did have access to three other uptown Manhattan hospitals, but none of these offered substantial inpatient or even outpatient services.[10]

For most black Harlem adults with emotional ills, Bellevue was the primary psychiatric option. However, most Harlemites wanted little to do with "overcrowded, understaffed" Bellevue's various psychiatric wards, regarding admission there as a last resort at best.[11] Many in Harlem, including staff reporter Constance Curtis of the *New Amsterdam News*, believed that Bellevue's white staff (especially in the outpatient Mental Hygiene Clinic) were too racially prejudiced to adequately understand their problems, diagnose their ills, and treat them as full human beings. This belief was not unfounded. At that time, Bellevue's staff did contain racialist clinicians who still believed that African Americans possessed a racially unique and inferior psyche. Other Harlemites understood a Bellevue visit to be the first step toward involuntary commitment to state mental hospitals, where black New Yorkers were overrepresented.[12] For these reasons, many black Harlemites avoided even the scant public care that was available to them, making it all the more likely that undiagnosed problems could worsen and become too difficult for families to handle themselves.

On 8 March 1946, the Lafargue Mental Hygiene Clinic opened in Central Harlem, providing the underserved African American population with an alternative to Bellevue and Harlem Hospital. This new outpatient facility was not a publicly funded institution. Instead it was a privately run

9. A. Peter Bailey, *The Harlem Hospital Story: 100 Years of Struggle Against Illness, Racism, and Genocide* (Richmond, Va.: Native Sun, 1991), p. 41. At the time, Harlem Hospital's only psychiatric service was a small outpatient mental hygiene clinic run by black neuropsychiatrist Dr. Harold Ellis.

10. Cheryl Greenberg, *"Or Does it Explode?" Black Harlem in the Great Depression* (New York: Oxford University Press, 1991), p. 15. These included Morningside Heights Community Hospital, St. Luke's on Columbia University's campus, and the charitable Sydenham Hospital.

11. Martin, "Doctor's Dream" (n. 2), p. 798.

12. Constance Curtis, "Mental Hospitals Bar Negroes," *New York Amsterdam News*, 27 April 1946, pp. 1, 25; Curtis, "Charge 'Favoritism' at Bellevue," *New York Amsterdam News*, 4 May 1946, pp. 1, 23. See also Curtis, "Jim Crow School Kids as Mentally Unfit," *New York Amsterdam News*, 25 May 1946, pp. 1, 19.

free clinic that operated rent-free out of the Parish House basement of St. Philip's Protestant Episcopal Church, a predominantly black institution located on 215 West 133rd Street, between Convent and Seventh Avenues.[13] Staffed by volunteers from across the color line, Dr. Hilde Mosse and Dr. Frederic Wertham headed the clinic's staff of accredited professionals and local laypeople.[14]

Open on Tuesday and Thursday nights from six to eight o'clock (although the staff usually kept the doors open until nine), this interracial clinic diagnosed and treated as many patients as it could handle. Because demand was so high, the clinic encouraged appointments, and the waiting list was still full in the clinic's final years.[15] For example, in 1947, the staff saw an average of twenty-two cases in its two hours of nightly operation. Accommodating this backlog of patient demand was an unpaid staff of mental health professionals who volunteered their free time. In 1956, the staff of forty-seven included three medically accredited psychiatrists, two psychiatric nurses, and three psychiatric social workers, as well as a team of psychologists, general social workers, psychology students, lay case workers, and educators. Unlike at the Northside Center, most of the patients this staff served were adults. According to one internal document, the clinic saw an average of 69.4 percent adults and 30.6 percent children between 1947 and 1956.[16]

13. Hilde Mosse, M.D., "Child Psychiatry and Social Action: An Integral Part of the History of American Child Psychiatry" (unpublished manuscript), 1981, p. 5, LFC-SCRBC, box 4, folder "Manuscript by Hilde Mosse, 1981"; Dier, "Harlem Mental Hygiene Clinic" (n. 1), p. 11; "Harlem Pioneers" (n. 2), p. 1. Marion Hernandez was also a parishioner and vestrywoman in St. Philip's Protestant Episcopal Church, Rev. Bishop's parish. See Board of Managers, St. Philip's Parish House, invitation, 1 May 1948, St. Philip's Church Records, Manuscripts, Archives and Rare Books Division, Schomburg Center for Research in Black Culture, New York Public Library, Astor, Lenox and Tilden Foundation, New York, box 40, folder "Correspondences, 1933–1968."

14. Mosse, "Child Psychiatry and Social Action" (n. 13), pp. 3–5, 7; "Lafargue Clinic Gives Harlem Free Expert Psychiatric Aid," *New York State J. Med.*, 15 October 1946, reprint, LFC-SCRBC, box 3, folder "Reprints."

15. Lafargue Clinic, letter to patient [ERU]'s mother, 20 February 1958, LFC-SCRBC, box 3, folder Patient Record [pseudonym ERU]. Not all case files in the collection had corresponding case numbers. I have identified each unnumbered case file by a letter code that bears no relation to the patient's name, thus preserving his or her privacy.

16. John Hohenberg, "Harlem Clinic Now Official VA Agency," *New York Post*, 23 February 1947, p. 10; Lafargue Clinic, "Lafargue Clinic 1946/1956" (internal memorandum on "Staff Current"), [n.d.], p. 1, LFC-SCRBC, box 1, folder "Memoranda, 1953–4"; Donald Blomquist, Betty Moore, and Hilde Mosse, "Statistics Lafargue Clinic: 1947/1956," 6 March 1956 [unpublished internal office document compiled on 2 February 1956], p. 2, LFC-SCRBC, box 1, folder "Memoranda, 1953–4."

The Lafargue Clinic offered short-term psychotherapy to its patient mix of adults and children. A 1952 memo to new staff members indicated that the "clinic was entirely oriented to psychotherapy" and directed them to devote most of their time to "only those who could be treated" in the clinic with talk therapy.[17] This meant that the clinic focused on adults and children with neuroses (emotional disorders that did not prevent patients from functioning normally in everyday life), mild psychoses (personality disturbances), "[s]ocial and family problems," and children with behavior problems.[18] Psychotherapy with such a wide range of patients varied, including counseling, group therapies, play therapy for children, and short-term analysis.[19]

This new psychotherapeutic alternative in Harlem was the brainchild of an interracial trio of intellectuals. Frederic Wertham, who was neither black nor from Harlem, was the chief psychiatrist at Queens General Hospital and a renowned expert in child psychopathology and forensic psychiatry. Richard Wright and Earl Brown were two young members of Harlem's secular black intelligentsia. Richard Wright was a celebrated novelist and leftist thinker, and Earl Brown was an aspiring journalist and local politician. For almost ten years, Wertham had unsuccessfully requested that Mayor Fiorello LaGuardia's administration create adequate mental hygiene (preventive psychiatry) facilities in Central Harlem. Frustrated by the lack of governmental response to Harlem's apparent mental health crisis, the three decided in either late 1945 or early 1946 that they had to create their own psychiatric clinic.

17. [Frederic Wertham?], "Lafargue Clinic Organization" (internal memorandum), 1 September 1952, p. 1, LFC-SCRBC, box 1, folder "Lafargue Clinic Routine 1949, 1952–3." See Lafargue Clinic (untitled internal memorandum regarding staff assignments), February 1952, LFC-SCRBC, box 1, folder "Lafargue Clinic Routine 1949, 1952–3." Patients diagnosed with severe psychoses (debilitating personality impairment) and other more serious conditions were referred to area hospitals.

18. Blomquist, Moore, and Mosse, "Statistics Lafargue Clinic: 1947/1956" (n. 16), p. 2; Hohenberg, "Harlem Clinic Now Official VA Agency" (n. 16), p. 10; Lafargue Clinic (untitled internal memorandum regarding staff assignments), February 1952, LFC-SCRBC, box 1, folder "Lafargue Clinic Routine 1949, 1952–3."

19. In making diagnoses, Wertham's staff performed a number of projective tests. Wertham and Mosse used only a select number of them, some of which Wertham had either designed or modified himself. See Louise Zucker, "The Clinical Significance of the Mosaic and Rorschach Methods," *Am. J. Psychother.*, 1950, *4:* 473–87, p. 479; Hilde L. Mosse, "The Duess Test," *Am. J. Psychother.*, 1954, *8:* 251–64, p. 262; Louise Zucker, "The Use of the Rorschach Test in an Outpatient Clinic," *Am. J. Psychother.*, 1949, *3*: 34–45; Hilde Mosse, "Ideas for a Paper for International Congress of Psychiatry in Vienna, 1961," 22 July 1960, LFC-SCRBC, box 4, folder 13, "Ms. By Hilde Mosse, 1961"; Clesbie R. Daniels, "Play Group Therapy with Children," *Acta Psychother.*, 1964, *12*: 45–53; Werner Wolf, *Contemporary Psychotherapists Examine Themselves* (Springfield, Ill.: Charles C. Thomas, 1956), pp. 33–40.

The urgency with which Lafargue's founders threw themselves into this new project was a product of three shared assumptions about the black psyche and its relationship to Harlem. First, all three men adhered to what I refer to as the "universalist assumption," the antiracialist proposition that blacks and whites did not possess racially unique psyches. Instead, whites and blacks were both endowed with the same capacity and potential to emotionally mature; react to stimuli; develop healthy personalities, unhealthy emotional disorders, or severe mental illnesses; and benefit therapeutically from modern psychiatry. To continue to deny black Harlemites adequate psychiatric services was equivalent to denying them full recognition of their humanity. Second, the three founders interpreted the apparent wartime upsurge in Harlem's rates of juvenile delinquency to mean that the maturational needs of many of Harlem's black youngsters were not being adequately met. Third, they strongly believed that the stresses and strains of being African American in Harlem (e.g., racism, slum living) had predisposed both children and adults to more emotional illness and behavioral problems than could be expected in white communities. For all of these reasons, Wertham strongly insisted that Harlem needed a psychiatric clinic immediately, because "this is where the need is the greatest."[20]

According to Wertham and his comrades, a clinical approach combining "race-blind" universalism with "social psychiatry" was the best way to meet Harlem's urgent mental health needs. In the clinical setting, universalist psychiatrists attempted to apply psychodynamic theories to the cases of black patients without making any adjustment for the then biological fact of race. This "race-blind" approach may have been somewhat reductionist and naive, but it was a necessary historical break from psychiatric racialism, the old assumption that black skin was an automatic indicator that the patient's mind would be fundamentally different from the (white) textbook norm. As Wertham said, "we're not here to make a study of the Negro . . . We're simply here to treat them like other human beings."[21] However, this did not mean that the Lafargue founders intended that their clinic would treat the patients as though they were simply middle-class whites with more melanin. On the contrary, one of the founders' key assumptions was that race did matter in the clinic but that it mattered only as a social fact and not as a biological one. According to them, black skin could potentially serve as a clinical indicator that the patient may have been addled by the additional social pressures placed on those who American society had labeled as "Negro" or "colored." Nevertheless, the

20. Martin, "Doctor's Dream" (n. 2), p. 798.
21. Ibid.

Lafargue clinicians did not assume that the social fact of being "Negro" in Harlem left the same psychological imprint on each patient. Instead, Wertham and Wright fully expected that slum living and racial discrimination would affect their patients in different ways. To uncover these individualized effects, the Lafargue clinicians balanced their race-blind universalism with careful attention to the immediate social contours of the patient's lives, an approach then known as "social psychiatry."

Social Psychiatry in Action

Social psychiatry was a relatively new clinical approach in the 1940s. It was influenced by the older mental hygiene movement, in which psychodynamically oriented clinicians and mental health educators in outpatient settings tried to prevent severe mental illness by helping ordinary people learn to handle the strain of everyday life. Social psychiatrists generally did the same things, albeit in a more clinical setting. Rather than simply ascribing emotional ills to internal conflicts in the distant psychosexual past, social psychiatrists also paid attention to the social environment's effect on a patient's emotional health. As an approach, social psychiatry gained acceptance during World War II, when military clinicians used on-the-spot psychotherapy to help soldiers deal with the strains of their environment, the battlefield.[22]

Likewise, the Lafargue staff tried to consider the patients' personal mental health needs in light of their lives within the often difficult environs of Central Harlem's slums. Central to Wertham's social psychiatry was the theory that emotional disease was a combination of two kinds of factors: "micro-dynamic," or psychodynamic, factors and "macro-dynamic," or sociological, factors. He argued that his staffers had to "understand a patient's personal and biological history to get at the micro-dynamic factors in his case, and his economic position and group culture to grasp the macro-dynamic factors."[23] Appreciating the "economic position" of the patient meant realizing how the typical Harlem adult faced a life structured by inequality and adversity: he or she was often poor, good work was hard to find in a city where many skilled unions still banned blacks, single and married mothers worked to support children, racial covenants

22. Brown, "Timely Topics" (n. 1), p. 13; Richard Wright, "Psychiatry Comes to Harlem," *Free World*, September 1946, p. 58. Earl Brown became a city council member as a Democrat in 1949. See also "Harlem Pioneers" (n. 2), p. 3; Hilde Mosse, "Aggression and Violence in Fantasy and Fact," *Am. J. Psychother.*, 1948, *2*: 477–83, p. 478; Mosse, "Ideas for a Paper" (n. 19), pp. 1–2; Bendiner, "Psychiatry for the Needy," (n. 2), pp. 23–24; Martin, "Doctor's Dream" (n. 2), p. 798.

23. Bendiner, "Psychiatry for the Needy" (n. 2), p. 23.

and housing discrimination still restricted many blacks to high-rent slum kitchenettes, and crime and gangs were seemingly endemic problems.

Consequently, the clinic was more than willing to consider the working poor of Harlem from a wider variety of vantage points than a purely psychoanalytic approach might dictate. In fact, Lafargue's staffers spent quite a bit of time identifying general medical and social problems for their patients, problems that were not purely psychodynamic and that were more along the lines of general medical and social problems. While the Lafargue's orientation was psychotherapeutic, the staff never lost sight of the fact that its patients were disadvantaged and lacked easy access to decent medical care, educational resources, and employment and housing opportunities.

In fact, Wertham and Mosse's staff recognized that many of these patients had suffered from the institutional neglect of Harlem's black population. Other social and medical institutions in the city and state had ignored such patients, allowing their bodies and lives to become marred by previously unrecognized physical maladies, reading disabilities, congenital disorders, and social problems. After these years of neglect, Lafargue's staff tried to read their patients' bodies and reconstruct their life stories in new ways. When they could, they attempted to get these stories heard outside of Harlem in the form of medical cases deserving immediate specialized attention.

For instance, Lafargue took care not only to diagnose patients with severe mental and physical illness but also to refer them to appropriate medical facilities. Since Lafargue was psychotherapeutic, it could not treat psychoses or organic brain disease, only neuroses and minor emotional disturbances. But patients did come in with what Lafargue determined to be major personality disturbances, some of which had an organic component. Twenty-one percent of adult patients between 1947 and 1956 were diagnosed as psychotic. As well, 1.1 percent of adults and 7 percent of children had been diagnosed with neurological disorders. Of the black patients who arrived at the clinic with severe mental illnesses, mental retardation, or neurological disorders, many had previously gone undiagnosed. This diagnostic neglect was largely a product of the African American community's lack of access to proper medical care, not only in New York City but nationwide. Yet, Lafargue's medically trained staff was able to pick up cases of encephalitis, mental defectives, and paranoid psychoses. Once detected, hospitalization was recommended, with 11.7 percent of Lafargue patients receiving inpatient hospital care of some kind.[24]

24. Blomquist, Moore, and Mosse, "Statistics Lafargue Clinic: 1947/1956" (n. 16), pp. 2, 3.

Some other Lafarge patients arrived at the clinic with untreated biomedical problems. Between 1947 and 1956, 3.3 percent of adults and 3.5 percent of children demonstrated significant physical ailments.[25] Most of these patients had come to the clinic for help with emotional problems. However, Lafargue's staffers actively looked for any signs of physical ill health in all of their patients, referring those with previously undiagnosed conditions to specialists. The clinic's volunteers worked under the assumption that Harlem residents' access to quality medical care was so inadequate that an individual's physical ailment might never be detected unless Lafargue reported it.[26] In this way, the clinic helped some of its patients to improve their access to quality medical care outside of Harlem.[27] In 1946, the clinic referred its first patient, Rachel, for suspected menorraghia or metrorrhagia (excessive menstrual bleeding). Apparently, after three months of psychotherapeutic sessions, the patient actually felt comfortable enough with her white female psychiatrist to tell her about problems with vaginal bleeding and her menstrual cycle.[28] Concerned, the psychiatrist referred Rachel to a highly regarded university gynecology clinic outside of Harlem. Rachel actually had the gynecology exam done and reported back to her psychiatrist about her visit.[29]

In some cases, patients chose not to comply with Wertham's or Mosse's referrals for general medical attention. In the case of Chris, the teenage son of African American migrants from the rural South, his noncompliance was more than understandable. In an interview with Chris's mother, the clinic's physician in charge discovered that both of the parents had "had treatments for bad blood almost four years ago" and that Chris had "had my last test last summer, was negative." What is more, Chris "had

25. Ibid., p. 2.

26. W. Michael Byrd and Linda A. Clayton, *An American Health Dilemma: Race, Medicine, and Health Care in the United States, 1900–2000* (New York: Routledge, 2002), pp. 210–14; Keith Wailoo, *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health* (Chapel Hill: University of North Carolina, 2001), p. 100. In the 1950s, most African Americans were not insured, owing to continued discrimination by unions, employers, and private health insurance companies.

27. Blomquist, Moore, and Mosse, "Statistics Lafargue Clinic" (n. 16), p. 3; Bendiner, "Psychiatry for the Needy" (n. 2), p. 25.

28. Lafargue Clinic, physician in charge's notes of psychotherapy session, 21 May 1946, p. 4, and 18 June 1946, p. 5, LFC-SCRBC, boxes 3 and 4, folder Patient Record No. 450.

29. H. L. Mosse to Hans Lehfedlt, 21 June 1946; Lehfeldt to Mosse, 2 July 1946; Lafargue Clinic, physician in charge's notes of psychotherapy session, 2 July 1946, LFC-SCRBC, boxes 3 and 4, folder Patient Record No. 450. Other general medical issues included intersexuality and congenital syphilis. See Lafargue Clinic, report of psychotherapist's case conference with Wertham, 3 February 1953, p. 22, LFC-SCRBC, box 3, folder Patient Record No. 1877.

positive test almost five years ago, when he was six. He got treatments in his arms and buttocks until age eight."[30] Owing to their growing familiarity with the rural black southern culture that some of their patients carried northward with them, Mosse and Wertham translated the mother's southern colloquialism of "bad blood" into the medical diagnosis of syphilis. Suspecting that the child still suffered from congenital syphilis, Mosse and Wertham referred both Chris and his mother to a local health clinic for a Wasserman and a spinal tap.[31] Chris assented to the Wasserman, but not surprisingly, he "didn't let them do the spinal tap."[32] According to the local clinician, Chris "would not stay quiet for any interval," making it impossible to administer the delicate and extremely painful procedure.[33] Three months later, the clinic referred him again for a spinal tap. This time, not only did Chris skip the appointment with the medical clinic, but he and his mother also ended his sessions, possibly to avoid the pain of the spinal taps.[34]

In other cases, Lafargue provided patients with assistance of a less painful nature, social work. In Wertham's version of social psychiatry, social work played a central role. Psychiatric social workers, general social workers, and case workers were valued members of the staff, and Wertham encouraged them to learn a variety of psychotherapeutic techniques. Social and case workers regularly sat in on and participated in Lafargue's case conferences. As a social psychiatrist, Wertham did not draw a discrete dividing line between the social welfare needs and emotional needs of patients. In 1947, Wertham told the participants of a Juvenile Aid Bureau seminar, "I feel very much like a social worker and do such work and the sharp distinction made between psychiatrist and social worker isn't right."[35] Wertham felt that such a distinction was especially wrong for Har-

30. Lafargue Clinic, report of physician in charge's initial interview with mother, 20 February 1948, p. 2, LFC-SCRBC, box 3, folder Patient Record No. 1020.

31. Ibid., p. 3; Wertham and Mosse to Dr. Bullin, 20 February 1948, LFC-SCRBC, box 3, folder Patient Record No. 1020.

32. Lafargue Clinic, physician in charge's notes on session with patient and mother, 12 March 1948, LFC-SCRBC, box 3, folder Patient Record No. 1020.

33. Vernon A. Ayer and David R. Bullin, Social Hygiene Diagnostic and Consultation service examination report, 15 March 1948, LFC-SCRBC, box 3, folder Patient Record No. 1020.

34. Lafargue Clinic, physician in charge's notes on appointment with patient and mother, 6 April 1948; and physician in charge's notes on missed appointment, 18 May 1948, LFC-SCRBC, box 3, folder Patient Record No. 1020.

35. Minutes, Meeting, Teen-Age Seminar Presentation, Service Unit, Juvenile Aid Bureau, 25 February 1947, p. 11, LFC-SCRBC, box 4, folder "Articles by Frederic Wertham, Hilde L. Mosse, and others."

lem. According to Wertham, Harlem's restrictive social conditions predisposed black residents to anxieties and neuroses. Moreover, Wertham and Mosse imagined that any improvement in Central Harlem's conditions might actually relieve the main source of anxiety for an estimated third of their patients. They hoped that meeting most of the other patients' social welfare needs could relieve some of the psychic pressure that slum living had exerted on them.

Rather than constituting a mere supplement to psychotherapy, social welfare assistance was an integral component of therapy. For these cases, the Lafargue staff members hoped to relieve some of their patients' emotional problems by addressing the immediate social causes of such anxieties. Martha's social worker described the black Harlemite as a "very tense person." She had complained of back pains, muscle tightness, and an inability to "relax."[36] Martha was a separated mother of three boys, two of whom had been diagnosed by the clinic with behavior problems.[37] Over the course of the three years in which she visited the clinic, Martha lived at three different addresses and experienced difficulty securing financial aid and permanent housing for her family. Eventually, the staff handling Martha's case determined that her lack of both "suitable" housing and welfare assistance had caused both her anxiety and her somatic complaints.[38] Lafargue's welfare specialist even suggested that "the behavior problems her boys are developing may be traced to housing problems."[39] Subsequently, the Lafargue staff intervened on her behalf with these agencies. The physician in charge and two social workers helped Martha to file with the New York Housing Authority and assisted her in acquiring beds and furniture. Lafargue staff also worked with the Department of Welfare to help locate Martha's estranged husband and, in the process, helped her to navigate New York City's labyrinthine public assistance bureaucracy.[40]

36. Lafargue Clinic, case worker's session, 2 March 1953, pp. 1–2, LFC-SCRBC, box 3, folder Patient Record [pseudonym AB].

37. Blomquist, Moore, and Mosse, "Statistics Lafargue Clinic" (n. 16), p. 2; Lafargue Clinic, social worker's record of session, [13] October 1953, pp. 1–2, LFC-SCRBC, box 3, folder Patient Record [pseudonym AB].

38. Lafargue Clinic, social worker's session, 3 March 1953, p. 1, LFC-SCRBC, box 3, folder Patient Record [pseudonym AB].

39. Lafargue Clinic, social worker's record of session, 19 May 1953, p. 17, LFC-SCRBC, box 3, folder Patient Record [pseudonym AB]; Lafargue Clinic, playroom therapist's notes on playgroup session with patient's son, 7 January 1954, LFC-SCRBC, box 3, folder Patient Record [pseudonym AB].

40. Lafargue Clinic, social worker's record of session, 18 March 1952, p. 2; 3 March 1953, p. 2; 19 May 1953, pp. 16–17; 9 June 1953, p. 3; 20 October 1953; 13 January 1955, p. 2; City of New York Department of Welfare, consent form, 29 February 1952; Percy L. Frank to Mosse, 8 June 1953, LFC-SCRBC, box 3, folder Patient Record [pseudonym AB].

As Martha's case demonstrates, Lafargue helped link patients to much-needed social resources both within and outside of Harlem. Besides providing links to public housing and public welfare offices, they established working relationships with social agencies such as the Juvenile Aid Bureau.[41] With St. Philip's permission, Wertham even convinced Alcoholics Anonymous to set up a desegregated chapter in the church parish house.[42] In Rachel's case, Mosse requested that her social worker find employment for her in the city. Rachel had been shuffled between an aunt and her father, lived temporarily at her parsimonious father's apartment in Harlem, and complained about her lack of both money and work. Toward this end, the social worker arranged interviews for her with private companies and referred her to an employment agency.[43]

In other cases, the staff found that some patients did not suffer from any medical illness but instead were victimized by institutional neglect of their basic social needs. Rather than simply turning away from these individuals, the staff members actually took it upon themselves to bring deficits in "the elementary social care of patients" to the attention of the appropriate agencies.[44] This practice was very much in line with the mental hygiene concept of preventive psychiatry. If left unattended, Mosse and Wertham warned, social deficits could eventually cause emotional deficits. Thus it made sense for them to improve the material conditions of patients at risk for emotional illness.

In one instance of institutional neglect of basic social needs, an eight-year-old African American male was brought to the Lafargue Clinic because he had been falling asleep in class. Tests done through school and other social agencies revealed that nothing was medically or emotionally wrong with him. The New York City Bureau of Child Guidance, the public school system's mental health arm, referred the puzzling case to the Harlem clinic as a last-ditch effort to determine the elusive cause of the boy's somnolence. In his very first visit, Lafargue's staff located the cause of his mysterious daytime slumbering. Apparently, his sleepiness was not caused by trauma, disease, or some obscure neurological disorder. According to Mosse, the reason was simpler and more mundane: cramped housing conditions prevented him from falling asleep at night. This little

41. [Hilde Mosse], typed entry, Lafargue Clinic Diary, 27 January 1955, LFC-SCRBC, box 1, folder "Lafargue Diary, 1955–1956."

42. Bendiner, "Psychiatry for the Needy" (n. 2), pp. 24–25.

43. Lafargue Clinic, physician in charge's transcript of psychotherapy session, 9 April 1946, p. 4; 2 July 1946; 16 July 1946; social worker's report on patient, 2 July 1946, pp. 1–2; social worker's interview with patient's aunt, 12 March 1946, pp. 1–2, LFC-SCRBC, box 4, folder Patient Record No. 450.

44. Mosse, "Child Psychiatry and Social Action" (n. 13), p. 8.

boy had to sleep at the foot of a cramped bed with five of his brothers! With "ten feet constantly in his face . . . he could not sleep." Mosse blamed the "callousness of agencies" for neglecting the basic welfare of a child. In allowing him to unnecessarily lose sleep, they might have jeopardized his intellectual and physical development. As treatment, Mosse prescribed a new bed. After two months of the Lafargue Clinic's harassing the agencies charged with the child's welfare, the boy did finally get his own bed.[45]

The clinic staff's willingness to help change their patients' living situations may have won the confidence of some of the more recalcitrant patients. For example, Mosse was able to win over a black Harlem gang leader who had come to the clinic on its first day of operation. Even long after her sessions with George had ended, Mosse continued to follow his case, visiting him in the state hospital where he had twice been committed for criminal acts.[46] Before George had become her patient, he had arrived at the clinic hoping to enlist the staff's help in ending his gang's war. As Mosse recalled: "One of the gang leaders became my patient at the clinic. He came to the clinic accompanied by two bodyguards who stood in front of the door of the parish house. He was afraid that a member of a rival gang might grab him. He asked me, 'Please help us make peace.' I helped establish peace through group sessions."[47] Owing perhaps to Mosse's willingness to intervene in this gang war—to intervene in Harlem's street life—George eventually came in and received help for previously undiagnosed internal problems.[48]

Wertham also intended for his social psychiatry to inspire Harlem patients to oppose the racism and economic exploitation that structured their lives. The Lafargue founders imagined that their psychiatric sessions and social work interventions would free patients from their mental fogs, allowing them to more clearly detect socioeconomic inequity. Armed with the greater sense of self-mastery that psychotherapy was supposed to instill,

45. Ibid.

46. Hilde L. Mosse, "The Misuse of the Diagnosis Childhood Schizophrenia," *Am. J. Psychiatry*, 1958, *114*: 791–94, esp. pp. 791–92. The article identifies the young man as George. After he was arrested for his alleged involvement in his gang's murder of a police officer, the court had George committed as a schizophrenic. George spent his teen years in two different mental institutions, where the young man attempted suicide four times. He was eventually released but was recommitted to a state mental hospital following his arrest for a drunken altercation. Mosse visited him at the state mental hospital when George was twenty-two years old.

47. Mosse, "Child Psychiatry and Social Action" (n. 13), pp. 4–5.

48. Ibid., p. 5. According to Mosse, "this boy had a severe reading disorder and almost never attended school." See also Mosse, "The Misuse of the Diagnosis Childhood Schizophrenia" (n. 46), p. 714; Tuck, "Here's Hope for Harlem" (n. 1), p. 2.

maybe some of them would be both emotionally stable and politically outraged enough to organize for "progressive" social change in Harlem. Wertham told the radical *People's Voice* newspaper in 1946: "The Lafargue Clinic is not trying to help adjust people to a vicious environment. We give them the best in psychiatric care to help build strong citizens, fighters against this debilitating ghetto! We want our patients to function in a changing world, and work with others to do it." In 1947, Wertham told an interviewer that if his patients could learn to see the extent to which their problems were caused by unfair socioeconomic conditions, they would be "better equipped to use their energies constructively—for instance, to change intolerable conditions."[49] According to Wertham: "Psychiatry holds the answer to the problems of confused minority people everywhere. In Harlem, New Orleans or El Paso the will to survive must be instilled in the people. Psychiatry can do this if it gets the people before it's too late."[50]

Despite such a radical vision of psychiatry's usefulness to Harlem, the early Cold War was not an easy time for Wertham to be completely forthcoming about his leftist political views. Yes, the Lafargue Clinic had actually been named after the French Marxist, Paul Lafargue, and cofounded by Richard Wright, onetime Communist Party member. Mosse even claimed that Wertham's sociological perspective had been informed by Marxism to some degree.[51] Yet, to the general public, Wertham became much more famous in the 1950s for his active participation in what has largely been remembered as a conservative movement: the nationwide campaign to censor violent and sexually explicit comic books. As Wertham's biographers have argued, few at the time suspected that his true motivation for fighting the comics industry had little to do with a reactionary postwar nostalgia for a simpler past and was perhaps more in line with the Frankfurt School's Marxist critique of capitalist mass culture.[52]

However, Wertham was not hit with accusations of communism, because he was careful to either code or veil his criticisms of capitalism.[53]

49. Therese Pol, "Psychiatry in Harlem," *The Protestant*, June–July 1947, p. 30.

50. Tuck, "Here's Hope for Harlem" (n. 1), p. 2.

51. Hilde Mosse, "Ideas for a Paper" (n. 19), p. 2. Mosse claimed that Wertham's social psychiatric approach was inspired by his "discovery" that the Marxian "law of dialect [*sic*] materialism works in [the psychiatric field] as it does in others."

52. James Gilbert, *Cycle of Outrage: America's Reaction to the Juvenile Delinquent in the 1950s* (New York: Oxford University Press, 1986); Bart Beaty, *Frederic Wertham and the Critique of Mass Culture* (Jackson: University of Mississippi Press, 2005).

53. See Pol, "Psychiatry in Harlem" (n. 49), p. 30. In print, Wertham would decry "poor economic conditions," but he would not always refer explicitly to what caused them. If he did, he often used the term "hostile world" as his code word for capitalism, especially capitalism

In his 1948 interview for the magazine *Tomorrow,* Wertham denied that his clinic was politically motivated. Such a denial did afford both him and the article's sympathetic author Robert Bendiner a way to avoid the communist label. Yet in that same interview, Wertham also stated that it was "not constructive in Harlem to be conservative" and that it was "far better to be subversive than to be subservient."[54] In another interview, he proclaimed that "Lafargue Clinic is only the beginning of a great progressive experiment" in a profession otherwise protective of the status quo.[55] While his vision of a progressive future may have been vague and unclear to some readers, his theories of what psychiatry could offer Harlem's African Americans were not.

Race in Lafargue Practice

Much of Wertham's political commitment to the clinic was driven by a strong humanist conviction that racism and racial inequality had made life unnecessarily difficult and stressful for many of Harlem's African Americans.[56] According to Wertham: "Anything that happens is worse for Negroes than for whites . . . A Negro child has at birth only half the chance to live that a white child has—and those are the best odds he has from then on."[57] Wertham felt that the racial restrictions and added pressures facing Harlem's blacks caused them more stress and frustration than the average white New Yorker experienced. According to writer Robert Bendiner, Wertham guessed that "perhaps a third of Lafargue's patients would not need treatment at all if they were white, [and] ordinarily mild neuroses arising from other causes are stimulated beyond the bounds of safety by the pressures of the community."[58] Consequently, Wertham sus-

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intertwined with racial discrimination: "Psychiatry in Harlem" (n. 1), p. 52. In an unpublished manuscript, Mosse implied as much, claiming that Wertham believed that although a psychiatrist might not be able to "change social conditions . . . one had to understand them and make patients understand their exact conscious and unconscious position in society, that is the forces and their impact on him so that he can get enough strength to survive in what is essentially a hostile world." Mosse, "Ideas for a Paper" (n. 19), p. 2.

54. Bendiner, "Psychiatry for the Needy" (n. 2), p. 24.

55. Pol, "Psychiatry in Harlem" (n. 49), p. 30.

56. Bendiner, "Psychiatry for the Needy" (n. 2), p. 23. According to Wertham's interviewer, journalist Robert Bendiner: "When he talks of Negroes and their genuinely oppressive problems, he is at his most emotional." My decision to label Wertham as humanist here is the result of a conversation I had with Wertham's most authoritative biographer, James Gilbert, on 21 April 2006 at the Annual Meeting of the Organization of American Historians.

57. Ibid., p. 23.

58. Ibid., p. 24.

pected that blacks, more than whites, needed psychiatry just to help them make it through daily life in such a racially unequal society.[59]

Wertham expected his clinicians to share his beliefs about the color line's toll on the human psyche. Not surprisingly, Wertham was intolerant of those who disagreed with his racial politics.[60] An internal memo of the clinic explicitly stated that if "staff members think that all colored people are given the breaks they are disqualified from working in this clinic."[61] On such grounds, Wertham did actually dismiss one psychiatrist from the clinic, offering her the chance to "return when she has a better understanding of what the role of the Negro is in our society."[62]

Wertham wanted his staff to be advocates for their African American patients, so he distrusted those "who say that everyone is alike before science." For Wertham, this stance of "objective neutrality" and his own race-blind universalism were not synonymous. Wertham found "pretense of objective neutrality . . . all wrong 'because a psychoanalyst is just not neutral—neutrality is impossible, merely a subtle rationalization for leaving everything the way it is.'" This neutrality implied a willful neglect of the black patient's whole social context, not just of his or her biological race. For the most part, the neglect of the sociological was something Wertham generally could not abide. For Wertham, as we have seen, psychotherapists were to be in the business of facilitating life change. Accordingly, Lafargue clinicians had to be aware of the total contour of the lives they were intent on changing in Harlem.[63] If a clinician truly wanted to make a difference in Harlem, he or she needed to be aware that racial inequality could be a factor in his or her patients' cases.

Still, even though Wertham was sure that racism could be emotionally harmful to African Americans, he and the Lafargue staff did not look for

59. Ibid., pp. 23–25. Testimony of Witnesses. In the Court of Chancery of the State of Delaware in and for New Castle County, *Belton v. Gebhart,* Civil Action 258 and *Beulah v. Gebhart,* Civil Action 265, 22 October 1951, bound transcript of testimony, pp. 121–22, 126, 179–80, NAACP Papers Part II, Manuscript Division, Library of the United States Congress, Washington, D.C., box 319; "Harlem Pioneers with Mental Health Clinic" (n. 2), pp. 1–2.

60. Jack Greenberg, *Crusaders in the Courts: How a Dedicated Band of Lawyers Fought for the Civil Rights Revolution* (New York: Basic, 1994), p. 137. According to Greenberg, former attorney on the NAACP legal team during its school desegregation battles, "Wertham was of an imperious nature and quite temperamental, and everything had to be precisely as he wanted it."

61. [Frederic Wertham], memo, "Lafargue Clinic Organization," 1 September 1952, p. 2, LFC-SCRBC, box 1, folder "Lafargue Clinic Routine, 1949, 1952–1953."

62. Lafargue Clinic, "Lafargue Clinic 1946/1956: Staff Past," p. 1, LFC-SCRBC, box 1, folder "Memoranda, 1953–1954." The psychiatrist's name was Walkenstein.

63. Bendiner, "Psychiatry for the Needy" (n. 2), p. 23.

racism's effects on every single black patient. Instead, Wertham consistently claimed that he never searched for evidence of the psychological impact of the "race question" in a patient. In a 1951 racial segregation case in Delaware, Wertham testified, "I have never made any specific studies with regard to any question of race prejudice. That only comes out in a general study of all kinds of other things." The "race question" was only one of a number of environmental factors of which Wertham believed a clinician should be aware when dealing with a patient. It was a significant factor, but Wertham was also convinced that it would not be "scientific" for a clinician to actively search for evidence of the psychological scars of racism on a patient, adult or child. Such a search would only dehumanize patients, he feared, reducing them to an issue.[64]

In practice, Wertham left it up to the clinicians and case workers to assess whether race directly mattered in a particular patient's case. Extant memoranda regarding the Lafargue method of taking case histories did not instruct staff to look for evidence of racism's emotional impact. These instructions contain no mention of racial issues. In practice, staff only examined the "race question" if a patient brought it up. In the nine case records examined in this paper, the case workers and clinicians were careful not to steer the patients into questions of racism or prejudice. Still, four of the nine patients did make mention of racism or racial prejudice in relation to their cases. But of these four cases, only once did the therapist ask a patient to probe the racial issue further.[65]

Perhaps ironically, the one case in which the clinician further explored a patient's racial issues involved a black clinician and a white patient, rather than a white clinician and black patient. A black male psychotherapist had asked a white female patient named Cheryl to explore any feelings of guilt about her successful sexual relationships with black men. Depressed and suicidal after the failure of her marriage to a black man, she had mentioned to her therapist that she felt uncomfortable and somewhat guilty about the interracial nature of her relationships. She revealed that her "[f]amily is hostile because she married a Negro. Was told by family not to visit them. Feels that she is somewhat responsible for the fact that her brother also married a Negro." After her marriage failed, she entered into another interracial relationship, this time with

64. *Belton v. Gebhart* (n. 59), p. 181.

65. Lafargue Clinic, written notes of psychotherapy session with patient, 6 June 1946, p. 6, LFC-SCRBC, box 3, folder Patient Record No. 506; Lafargue Clinic, written notes on session with patient, 7 June 1955, pp. 10–11, LFC-SCRBC, box 4, folder Patient Record No. 605; Lafargue Clinic, written notes of initial interview with patient, 2 January 1950, pp. 1–2, LFC-SCRBC, box 3, folder Patient Record No. 1455.

an older black man, a married man with a teenage son. She was unable to commit to him, partly because he was so "content with the fiction of marriage" to his schoolteacher wife. After three months of sessions, the black therapist perhaps sensed a pattern and asked Cheryl whether she had difficulty sustaining a relationship with this man because of a racialized guilt over her first marriage. He asked: "Guilt involved—because he's a Negro?" to which she responded "Don't think so . . . but I'll think about it." Although Cheryl herself did not think that this was the case, the psychotherapist made this suggestion on the basis of what the patient had said in previous sessions about the guilt of race-crossing.[66]

Although the clinic staff members were obviously aware of race as a clinically relevant factor, they were assigned patients without reference to race.[67] A prime example of universalism in practice, Wertham did not want his therapists to take race into account until they saw the patient; only then could they determine whether and how race factored into the patient's specific case. Although his staff was to be generally aware of the indirect, social impact of racism on black patients, Wertham still wanted the clinicians to deal with patients as individual cases. Consequently, the Lafargue staff rarely kept written track of the patients' races during the intake sessions. This appeared to be general policy at the clinic, especially after the first two years. One internal memorandum dated March 1956 and compiled by Hilde Mosse and two other staff members revealed that there was "no record kept of color except 1946/1948 by Miss [Betty] Moore for Dr. Wertham's use only."[68] In an extensive list of instructions given by Lafargue psychologist Louise Zucker in 1952 on how to take a case history in the intake session, she did not advise staffers to indicate the patient's race.[69] Consequently, many of the intake forms or "face sheets" for the extant case files left the space for racial identity blank. And during the late 1950s generic intake sheets were replaced by forms that Lafargue staff had created, forms that did not even include a space for race.[70]

Yet, even when a patient apparently made race an issue, this did not mean that Lafargue's clinicians automatically pursued this line of think-

66. Lafargue Clinic, written transcript of intake for initial interview of patient, 11 October 1955, pp. 3, 4; psychotherapist's notes on session, 3 January 1956, LFC-SCRBC, box 3, folder Patient Record No. 2067.

67. Bendiner, "Psychiatry for the Needy" (n. 2), p. 24.

68. Blomquist, Moore, and Mosse, "Statistics Lafargue Clinic" (n. 16), p. 3.

69. [Louise Zucker], "Mrs. Zucker's Suggestions for First Examination" [1952?], LFC-SCRBC, box 1, folder "Lafargue Clinic Routine, 1949, 1952–3."

70. Lafargue Clinic, intake or face sheet, 27 May 1954, LFC-SCRBC, box 4, folder Patient Record No. 2006.

ing. The clinician, not the patient, remained the chief architect in the construction of the patient's case. In one case, a clinic psychiatrist passively rejected a patient's attempt to racialize her alleged lesbianism. In one session with a clinic psychiatrist, Joyce, a black female patient, defended her homosexuality with a severe rebuke of young black men in Harlem:

> There are a lot of nice girls who'd like to go steady with one fellow—but they don't find them. There is something wrong with the men of our race. All they want is [to] drink, go to the corner and go to bed. Their thoughts all tend to standing on corners—making as much money as possible—flashing out the other men—worrying about who is looking best on the Avenue—who can buy the most drinks—that seems to be the code they are living by. It's the thought of working, working, and where they can get in our race.[71]

With this statement, Joyce attempted to justify her relationships with women as a reasonable response to the alleged dearth of marriageable black men in Harlem. Whether or not this was simply a rationalization, this sweeping generalization of black male Harlemites as vain hustlers was her stated impression. Her psychiatrist recorded this impression as the only time Joyce brought up race as an issue. In the sessions that followed, neither patient nor psychiatrist made any mention of race. The psychiatrist gave no indication that either she or Joyce had continued to pursue the idea that her homosexuality was a social response to a lackluster heterosexual dating scene in Harlem. Instead, during the next week's session, the psychiatrist continued questioning Joyce on her earliest sexual experiences, hoping to uncover psychosexual reasons for her homosexuality.[72]

The clinical decision to ignore the potential significance of race and environment in explaining Joyce's sexual identity does indicate that the Lafargue brand of social psychiatry had limits, but it should also be interpreted as an indication of universalism at work. According to Elizabeth Lunbeck, racialists had long parsed the gender of black patients through a racially specific set of norms. Likewise, white psychiatrists prior to the 1930s also tended to judge the sexual behavior and orientation of white patients according to one set of norms and that of black patients according to another. According to racialists, blacks were omnisexual in the sense that homosexuality was just one of a wider range of sexual behaviors that was thought to be normal for this more animalistic race but abnormal and perverse for the more evolved white race.[73] By contrast, Lafargue clini-

71. Lafargue Clinic, written transcript of physician in charge's psychotherapy session with patient, 21 June 1946, p. 6, LFC-SCRBC, box 3, folder Patient Record No. 506.

72. Lafargue Clinic, physician in charge's last therapeutic session with patient, 28 June 1946, p. 6, LFC-SCRBC, box 3, folder Patient Record No. 506.

73. Lunbeck, *The Psychiatric Persuasion* (n. 5), pp. 126, 149, 150. See also Ann Laura Stoler, *Race and the Education of Desire: Foucault's History of Sexuality and the Colonial Order of*

cians, operating on the premise of racial equality in the workings of the human psyche, judged black sexuality against one set of universal norms regarding "natural" human sexuality. According to the general standards of Cold War–era American public culture, homosexuality was a dangerous social aberration. In mainstream psychiatry, by the 1950s homosexuality was generally considered to be a personality disorder, a problem of arrested psychosexual development.[74] So when Joyce, a black woman, arrived at the clinic in late spring 1946 with her "chief complaint" being that "I got involved with women," the Lafargue psychiatrist did not evaluate her according to a racially separate set of norms.[75] Instead, she judged her black patient according to a universalized set of Cold War–specific norms for human sexual behavior and psychosexual personality formation. In defense of these universalized heterosexual norms, the clinician pushed race-blind universalism to its most extreme, to a point at which the social facts of the patient's blackness and residence in Harlem disappeared. Stripped of the social context of race and place, what mattered in this case was that the patient was human and had not developed into a normal heterosexual human being. As such, homosexuality, regardless of the race of the individual, became a fundamental psychosexual problem requiring immediate attention.

Consequently, in most of her session with Joyce the Lafargue psychiatrist aimed to uncover the psychological nature and the causes of the patient's homosexuality. In her five recorded sessions of 1946, Joyce talked about topics that the clinician believed would reveal the psychosexual development of her condition. In some of these sessions, Joyce talked about her relationships with her mother and father, her parents' relationship, her earliest heterosexual experiences, when and why she began having sex with women, her husband's sexual inadequacies, venereal disease, and her physical difficulties with both male penetration and her own menstruation.[76]

Things (Durham: Duke University Press, 1995); and Stephen Robertson, *Crimes Against Children: Sexual Violence and Legal Culture in New York City, 1880–1960* (Chapel Hill: University of North Carolina Press, 2005), pp. 150–51, 212–14.

74. Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis* (Princeton, N.J.: Princeton University Press, 1987), pp. 20, 30, 35, 38–42; Robertson, *Crimes Against Children* (n. 73), p. 153–54, 184, 199–202; David Serlin, *Replaceable You: Engineering the Body in Postwar America* (Chicago: University of Chicago Press, 2004), p. 10.

75. Lafargue Clinic, report of intake and initial interview with patient and husband, 24 May 1946, p. 1, LFC–SCRBC, box 3, folder Patient Record No. 506.

76. Ibid., pp. 1–2; physician in charge's written transcript of psychotherapeutic session with patient, 28 May 1946, pp. 2–3; 31 May 1946, pp. 3–4; 7 June 1946, pp. 4–5; 21 June 1946, p. 6; 28 June 1946, p. 6, LFC-SCRBC, box 3, folder Patient Record No. 506.

Initially, Joyce herself wanted to put aside her homosexual feelings, to cure herself of them. Yet, by the third session, Joyce had begun to reconsider this goal. During that session, she explained that she had left her husband after "He hit me. Knocked me down. I told him then that it was over. He is jealous of me with men and women." Even though he was willing to reconcile, Joyce "didn't want him anymore." After separating that month, they eventually divorced two years later. Over the course of the third and fourth sessions it became evident that the initial goal of curing her homosexuality had not been Joyce's alone. According to the young woman, "the reason I made all the effort like going to doctors was for [my husband]."[77] By the last two sessions she realized that, without him, there was no immediate personal incentive for her to end her homosexual behavior. Realizing this, Joyce began to think of a new reason for her homosexuality, including her hypothesis that lesbianism was an alternative to dating Harlem hepcats. In Joyce's own estimation, her changing life situation had given her homosexuality a new meaning; it was no longer a problem requiring discussion or a fix.

Nevertheless, the Lafargue clinician ensured that homosexuality remained a focal point in Joyce's case. In Joyce's penultimate and final sessions, her psychiatrist was still making homosexuality and sex the chief topics of discussion, despite Joyce's attempts to talk about her more general feelings of depression. After the fifth session, Joyce stopped attending the clinic without any explanation.[78] Yet given the changing place of Joyce's husband in her personal life, it is reasonable to assume that the psychiatric construction of her homosexual feelings as a "problem" had become irrelevant to her. Referring to her homosexuality in her third session, she claimed: "To me there is no more problem. I was trying to straighten myself out for his sake."[79] This last statement, coupled with her abrupt abandonment of therapy, suggests that Joyce could no longer relate to the psychiatrist's focus on her homosexuality.

When Joyce resurfaced at the clinic eight years later, she did not arrive for help with homosexuality. Instead, Joyce was now in a long-term heterosexual relationship with another man and had come to the clinic only for help with a self-described "nervous" condition.[80] This time, Joyce did not

77. Lafargue Clinic, physician in charge's written transcript of psychotherapeutic session with patient, 7 June 1946, p. 5, LFC-SCRBC, box 3, folder Patient Record No. 506.

78. Lafargue Clinic, physician in charge's written transcript of psychotherapeutic session with patient, 21 June 1946, p. 6; 28 June 1946, p. 6, LFC-SCRBC, box 3, folder Patient Record No. 506.

79. Lafargue Clinic, physician in charge's written transcript (n. 77), p. 5.

80. Lafargue Clinic, single sheet with intake information, 8 June 1954, LFC-SCRBC, box 3, folder Patient Record No. 506.

bring up homosexuality or even sexuality in general. However, after perusing Joyce's case file, this second clinician introduced the homosexuality issue himself. This new psychiatrist, a septuagenarian white male who had worked at state training schools with African Americans, was pleased to learn that Joyce was now finally in a long-term, heterosexual relationship and wrote that the "Pt. straightened out her sex difficulty really good." With Joyce's sex problem apparently "straightened out," this clinician felt freer than had the previous psychiatrist to then address some of this patient's other "personality problems."[81]

Lafargue's clinicians had universalized homosexuality into a psychological condition that was as abnormal for blacks as it was for whites. Clearly, they did not interpret homosexual sex and desire to be behaviors and feelings that fell within the limits of the normal for blacks. Instead, homosexuality was a medical condition, one that only psychiatrists could identify, regardless of whether the patient considered him- or herself to be homosexual. With their black patients, Lafargue also universalized this belief that homosexuality was something that clinicians, not patients, had the sole expertise to define. Take the cases of two black male Lafargue patients, Robert and Roy. Both apparently had been raped by older men when they were mere children, and each vehemently denied being a homosexual or a "sissy." However, Lafargue psychiatrists interpreted their victimization as evidence of a "history" of "homosexual experience" and an "indication of homosexual tendencies."[82] This idea that the boys were homosexual "participants" rather than victims of assault was not uncommon within either psychiatry or courtrooms. With homosexuality defined in this era as the product of either a weak personality or immature psychosexual development, rape by an older male was understood as a symptom of a boy's pathological tendency to be passive and invite such attacks.[83] Judging by the case record, neither Robert nor Roy considered themselves homosexuals or blamed themselves for being raped. The record does not indicate how the patients reacted to their clinicians' diagnoses, probably

81. Lafargue Clinic, psychiatrist's written record of examination, 8 June 1946, LFC-SCRBC, box 3, folder Patient Record No. 506.

82. Lafargue Clinic, intake and initial interview with patient, 2 January 1950, pp. 1–2; Ernest H. Taves to Mosse [1951]; social worker's report on patient, 13 March 1951, pp. 6–8; "Report Presented at Staff Conference, March 20, 1951," pp. 1–2, LFC-SCRBC, boxes 3 and 4, folder Patient Record No. 1455; Greta Freyd to Mosse, 16 December 1952, p. 5; Lafargue Clinic, intake or face sheet, 6 January 1953; Walter M. Sonnebaum to Robert E. Johnson, 3 January 1953; Lafargue Clinic, physician in charge/psychiatrist's examination of patient, 8 January 1953, p. 6; Lafargue Clinic, report of case conference with Wertham, 3 February 1953, pp. 22–23, LFC-SCRBC, box 3, folder Patient Record No. 1877.

83. Robertson, *Crimes Against Children* (n. 73), pp. 153–54, 172–73, 199–200.

because this was one instance when even social psychiatrists did not think that their patients' opinions mattered.

Although the above evidence may be limited, the clinic's handling of homosexuality in these three cases might suggest that race-blind universalism and social psychiatry were not always compatible intellectual partners. At Harlem's Northside Center, tensions did exist between strict race-blind universalism and social psychiatry, with its recognition of both African American patients' social context and their ability to assess their own needs. However, this tension took the form of professional struggle among members of the Northside staff rather than internal slippage within one clinician's own approach.[84] These Lafargue cases of alleged homosexuality may be examples of that singular moment when universalism trumped social psychiatry within a racially progressive clinical situation, when the social psychiatrist's most deeply held assumption about human nature—the heterosexual norm—distracted him or her from the patients' own perceptions and lived contexts.

But overall, universalism facilitated rather than impeded social psychiatric thinking. The race-blind universalism was an integral component of the matrix of ideas and assumptions informing the social psychiatrist. A patient's blackness was clinically acknowledged only as a physical indicator of the extra emotional stress that might be socially imposed on him or her. Thus an awareness of the social fact of blackness, in combination with the clinic's devotion to universalism, generally shaped how Lafargue's staff understood, diagnosed, and treated patients.

In fact, this dual devotion made Lafargue's psychiatrists confident that they diagnosed and treated black Harlem patients with more accuracy than anyone else could provide. In particular, Hilde Mosse contended that many of her young black male patients at Lafargue had been misdiagnosed elsewhere as schizophrenic.[85] In the March 1958 issue of the *Ameri-*

84. Markowitz and Rosner, *Children, Race, and Power* (n. 3), pp. 76–78. At Northside Center in 1960, the staff actually forced out the center's clinical director, Albert Bryt, a strict psychoanalyst who did not mesh with a staff deeply committed to social psychiatry.

85. Mosse found Bellevue and the Creedmoor State Mental Hospital to be the chief offenders. This was not only because African American Harlemites were often sent to those places; it was also because Dr. Lauretta Bender, one of the leading American proponents of the childhood schizophrenia diagnosis, served at both institutions in the 1950s. Bender served as the senior psychiatrist in charge of the Children's Service of Bellevue Hospital's psychiatric division between 1935 and 1956. She was appointed director of Psychiatric Research at Creedmoor State Hospital's Children's Unit in 1956. Lauretta Bender, "Schizophrenia in Childhood—Its Recognition, Description, and Treatment," *Am. J. Orthopsychiatry,* 1956, *26*: 499–506; Bender, *Aggression, Hostility, and Anxiety in Children* (Springfield, Ill.: Charles C. Thomas, 1953), pp. 162–70.

can Journal of Psychiatry, Dr. Mosse made the powerful charge that Bellevue and New York's state mental hospitals had overdiagnosed schizophrenia among "[c]hildren in trouble for many reasons."[86] Analyzing sixty cases of Lafargue children an outside clinic had diagnosed as schizophrenic, she concluded that for "practically all of them the diagnosis was wrong." She argued that most of these children simply had behavior problems and were not schizophrenic. Most were juvenile delinquents from poor slum areas of New York City, such as Harlem. They had committed crimes and had been sent to state mental hospitals or Bellevue, institutions where the diagnosis of childhood schizophrenia was liberally meted out. There, psychiatrists did not use a social psychiatric methodology and generally diagnosed delinquents with schizophrenia. Mosse argued that such diagnoses removed the child's behavior from its social context, ignoring the difficult life situations of these children and the "social pathology to which the child is reacting."[87] From the perspective of a social psychiatrist sure of her familiarity with Harlem, the behavior of these sixty children did not appear to be bizarre or random enough to be genuinely schizophrenic. Instead, Mosse the universalist interpreted such behavior as normal human reactions to social trauma that happened to occur with more frequency in some of Harlem's rougher neighborhoods.[88]

However, in her article, Mosse carefully resisted making the outright claim that racial discrimination had caused this mislabeling of urban black children. Still, she implied as much, concluding her article with the warning that the overdiagnosis of childhood schizophrenia was "a threat to children living in a socially difficult milieu."[89] As far as her experience indicated, a poor black child ensnared within the court system was likely to be sent to a public institution and misdiagnosed as some sort of psychotic. Psychosis was, as it is now, a diagnosis that had been disproportionately applied to African Americans. According to Mosse, young black Harlemites—including her former patient, George—"got into trouble because of gang membership and are not psychotic."[90] Of course, Mosse believed that Lafargue's antiracist clinicans would have been far more likely to seek and provide socially contextualized diagnoses. Mosse suggested that as long as Bellevue's staff remained blind to the social realities

86. Mosse, "The Misuse of the Diagnosis Childhood Schizophrenia" (n. 46), p. 791. According to Mosse: "Schizophrenia is not a disease of childhood. Its onset is in adolescence and preadolescence."

87. Ibid.

88. Ibid., p. 794.

89. Ibid.

90. Ibid., p. 792. See also pp. 791, 792.

that these children had to face, they would never be able to accurately assign meaning to their behavior.

The nonmedical staff members of Lafargue were equally confident in their clinic's unique ability to properly diagnose Harlem's African Americans. In a 1946 *New Republic* article, an anonymous black social worker at Lafargue (possibly Robert Johnson) alleged that most white psychiatrists did not know how to evaluate African American behavior. He claimed that a Bellevue clinician had misdiagnosed a boy suffering from "sexual fantasies" because he had sung a lascivious rhythm and blues song. Dismayed that a lack of cultural familiarity with black folks could so dramatically distort diagnosis, the Lafargue staffer opined: "God Almighty, everybody in Harlem knows that song. It's a popular recording. That psychiatrist just didn't know Harlem, that's all. Before he can diagnose that kid, he should know the cultural pattern of the community, what the kid lived through and how it affected him. That again is social psychiatry . . ." Of course, the social worker implied that the Lafargue staff was culturally sensitive, that it was attuned to the "cultural pattern" of Harlem's neighborhoods. Allegedly, this cultural familiarity gave the clinic staff an edge in understanding, diagnosing, and treating Harlem patients.[91]

Given this general awareness of black Harlem's "cultural pattern," Mosse felt that the Lafargue staff was much less likely than the average clinic to overdiagnose psychosis in African Americans. An internal memorandum cowritten by Mosse asserted as late as 1956 that "when we diagnose psychosis we mean it."[92] Mosse was overly cautious with this label because she believed that such a misdiagnosis could actually be "dangerous" for black patients.[93] Typically, long-term institutionalization and electroconvulsive therapy (ECT) followed whenever a black Harlemite was diagnosed as schizophrenic. Mosse's first Lafargue patient had been given ten ECT treatments at another clinic. Having diagnosed the patient as depressed, Mosse felt that "[s]hock treatment was certainly contraindicated and harmful."[94] Mosse was personally disheartened that "symptoms are frequently misinterpreted. This has serious consequences . . ."[95]

91. Martin, "Doctor's Dream" (n. 2), p. 800. "Cultural pattern" was a popular term that Ruth Benedict had coined. The idea was that society is like an organism. Just as an organism has a behavioral pattern, a population has a behavioral pattern as well. The only difference is that a human population's distinctive behavioral pattern is a learned one, a cultural pattern. See Ruth Benedict, *Patterns of Culture* (New York: Houghton Mifflin, 1934).

92. Blomquist, Moore, and Mosse, "Statistics Lafargue Clinic" (n. 16), p. 3.

93. Mosse, "The Misuse of the Diagnosis Childhood Schizophrenia" (n. 46), p. 794.

94. Mosse, "Child Psychiatry and Social Action" (n. 13), p. 8.

95. Mosse, "The Misuse of the Diagnosis Childhood Schizophrenia" (n. 46), p. 792.

In several Lafargue cases, the allegedly misdiagnosed patients had been given ECT. Mosse suspected that each patient's personality and affect had been damaged by the unnecessary shock treatments. Mosse's 1956 article in the *American Journal of Psychiatry* really can best be understood, then, as an attempt to spare some African American patients such a fate by at least changing some clinicians' minds.

Conclusion

The Lafargue Clinic was the product of a complex interaction among psychiatrists, patients, families, outside agencies, and Harlem's local leaders and young radicals. Underlying this interaction was an abiding faith in universalism, social justice, and Wertham's brand of social psychiatry. Integrating all these forces together in practice was not easy. Both staff members and patients experienced difficulty in determining how much of a patient's problem was a matter of either psychosexual conflicts or a more complex emotional battle with external forces such as racial discrimination. The clinic's strict psychoanalytic response to homosexuality illustrates how universalism could potentially blind a clinician to the patient's own perceptions and social context. Nevertheless, universalism generally existed in balance with social psychiatry and the social justice commitments of the Lafargue staff, founders, and church community. In balance, the Lafargue Clinic was a special social institution, one that prided itself on its ability to bear witness to the social needs of patients from some of postwar Harlem's most difficult neighborhoods.

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