

Urban History, Page 1 of 22 © Cambridge University Press 2017. This is an Open Access article, distributed under the terms of the Creative Commons Attribution licence (<http://creativecommons.org/licenses/by/4.0/>), which permits unrestricted re-use, distribution, and reproduction in any medium, provided the original work is properly cited.
doi:10.1017/S0963926817000025

Remembering the West End: social science, mental health and the American urban environment, 1939–1968

EDMUND RAMSDEN and MATTHEW SMITH*

School of History, Queen Mary, University of London, Mile End Road, London
E1 4NS, UK

Centre for the Social History of Health and Healthcare, University of Strathclyde,
Level 4, Lord Hope, 141 St James Road, Glasgow G4 0LT, UK

ABSTRACT: Analysing the urban renewal of Boston's West End during the 1950s, we examine how psychiatrists, social scientists and urban planners understood the relationship between the urban environment and mental health. For psychiatrist Erich Lindemann, the West End offered a unique opportunity to study how acute stress and loss affected populations, thus contributing to social psychiatry, which sought to prevent mental illness by addressing factors in the social and physical environment. While Lindemann's project provided a sophisticated response to the often simplistic arguments about the cities and mental health, it also highlighted the challenges of applying social psychiatric theory in practice.

Introduction

In 1958, the Boston Redevelopment Authority began its demolition of a 48-acre portion of Boston's West End, displacing 2,700 lower-working-class families. For Erich Lindemann, chief of psychiatry at the nearby Massachusetts General Hospital (MGH), this urban renewal programme offered a unique opportunity. By studying the effect of acute stress and loss on the population, they could contribute to the emerging field of social psychiatry which sought to prevent mental illness through identifying and ameliorating the effects of destructive factors in the social and physical environment. The results of Lindemann's project, 'Relocation and mental health: adaptation under stress', would not only contribute to an emerging community mental health programme, but would also become critical to debates surrounding urban renewal and the relationship between the

* Edmund Ramsden would like to acknowledge the generous support of the Wellcome Trust in making this research possible. Matthew Smith would like to acknowledge the generous support of AHRC award AH/L009641/1.

built environment and mental health more generally. Such was the case in Boston, where 'Remember the West End!' became a rallying call for those who lamented the destruction of a once vibrant neighbourhood, and throughout the US, where urban renewal was increasingly seen to inflict unreasonable upheaval upon socially and economically disadvantaged populations for questionable purposes.

In focusing on the case of the West End, this article seeks to address the important, but too rarely explored, influence of concepts and studies of mental health on the fields of urban planning and design. That slum environments were a cause of immense social, physical and psychological damage was a well-established trope in the literature of housing reformers, while pioneers in the public housing movement continually pressed medical and social science experts for evidence of the links between housing and mental and physical health. However, there has been little exploration of the studies that were carried out to address directly these critical relations, and which would have a profound influence on debates surrounding slum clearance, public housing and urban redevelopment. As we shall explore in this article, the interests of social psychiatrists did not neatly elide with those supportive of improving the houses and neighbourhoods of the city. As social psychiatrists sought to transform theory into practice through the study of the urban environment, more established associations between the built environment and mental health became fractured and older assumptions called into question.

The study of the West End challenged the ways in which the city, especially deprived neighbourhoods, had been portrayed as potentially pathological environments for mental health. Such neighbourhoods did not consist merely of dilapidated buildings and rundown infrastructure; they were also vibrant communities to which their residents were emotionally attached. The psychiatric consequences of the West End's destruction would therefore challenge ideas that mental health could be best enhanced by improving the built environment and undermined hopes that a universally applicable theory of social psychiatry could be developed for urban environments. Rather than developing the means to generalize, the more researchers such as Lindemann explored cases like the West End, the more questions emerged, fragmenting and undermining overarching arguments and causal explanations about the relationship between mental health and social class, race, deprivation, the built environment and cities. The prevention of mental illness required an understanding and reconfiguration of the complex network of psychosocial factors which were intertwined with physical spaces and places – a community psychiatry that simultaneously studied and embedded itself within a local area. This emphasis on inter-disciplinarity, inter-agency collaboration, and, above all, local community engagement in planning processes, would offer an important impetus and inspiration for those seeking to reform programmes of urban redevelopment in ways

that empowered, rather than marginalized, low-income populations. In this way, the study of urban psychiatric health not only served to draw connections between urban environments and mental illness, but also to unpick and complicate these relationships, offering new insights into the relations between the physical and the social.

Mental health and the city

For American psychiatry, the quarter century following World War II represented the most tumultuous, divisive and daunting period in its history. The military importance of psychiatry had increased during the war, initially with respect to the psychiatric screening of recruits, and later regarding the treatment of combat-related disorders.¹ Both tasks also changed the way in which American psychiatrists understood psychiatric epidemiology.² The task of elucidating the causes of mental illness during the post-war period, however, was 'stymied by practical obstacles and conceptual controversies over the very nature of mental health and illness'.³ These challenges, however, did not prevent American psychiatrists from convincing both the psychiatric establishment and the federal government that mental disorder was on the increase and needed to be prevented. The psychiatric discipline which was more influential than any other during the post-war period in formulating preventive approaches to the perceived mental health crisis was social psychiatry.⁴

Social psychiatry was essentially a preventive approach to psychiatry which harnessed the insights of the social sciences in order to identify

¹ G.N. Grob, 'World War Two and American psychiatry', *Psychohistory Review*, 19 (1990), 41–69; H. Pols and S. Oak, 'War and military mental health: the US psychiatric response in the twentieth century', *American Journal of Public Health*, 79 (2007), 2132–42; N. Wake, *Private Practices: Harry Stack Sullivan, the Science of Homosexuality, and American Liberalism* (New Brunswick, NJ, 2011), 157–86.

² H.Y. Wu, 'World citizenship and the emergence of the social psychiatry project of the World Health Organization, 1948–c. 1965', *History of Psychiatry*, 26 (2015), 166–81. For more on American psychiatric epidemiology, see J.A. Moran, 'The signal and the noise: the historical epidemiology of insanity in ante-bellum New Jersey', *History of Psychiatry*, 14 (2003), 281–301; N.D. Campbell, 'The spirit of St Louis: the contributions of Lee N. Robins to North American psychiatric epidemiology', *International Journal of Epidemiology*, 43 (2014), i19–i28.

³ A.M. Lovell, 'What might be a history of psychiatric epidemiology? Towards a social history and conceptual account', *International Journal of Epidemiology*, 43 (2014), i1. These challenges, as the late historian Gerald Grob and the sociologist Allan Horwitz argued recently, have not since been resolved. A.V. Horwitz and G.N. Grob, 'The checkered history of American psychiatric epidemiology', *Milbank Quarterly*, 89 (2011), 628–57.

⁴ Although few historians have directly examined the history of social psychiatry *per se* in recent years, a number of scholars have begun to explore post-war interest in the social environment. D.G. Blazer, *The Age of Melancholy: Major Depression and its Social Origins* (New York, 2005); R. Hayward, 'Enduring emotions: James Halliday and the invention of the psychosocial', *Isis*, 100 (2009), 828–38; M.E. Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948–1980* (Chicago, 2011); M. Raz, *What's Wrong with the Poor: Psychiatry, Race, and the War on Poverty* (Chapel Hill, 2013).

and target the environmental causes of mental illness.⁵ One indication of both the newfound influence of psychiatry, particularly at the federal level of government, and its emphasis on prevention, was the passing of the National Mental Health Act of 1946, which led to the foundation of the National Institute of Mental Health (NIMH) in 1949. NIMH's mandate, articulated assertively by its first director Robert Felix, was to fund an ambitious programme of research dedicated towards understanding and ameliorating the causes of mental illness, with a particular focus on the relationship between the social environment and mental disorder featured strongly.⁶ Federal government interest in preventing mental illness went further with the Mental Health Study Act of 1955, which provided \$1.25 million for a Joint Commission on Mental Illness and Health (JCMIH) to conduct a thorough analysis of mental health care and research.⁷ Six years later, JCMIH published its final report, *Action for Mental Health*, which recommended that the focus of American psychiatry should not be the maintaining of the overcrowded and inadequate state hospital system, but rather the prevention of mental illness through community initiatives.⁸ In 1963, President John F. Kennedy consolidated such ambitions further in a speech to Congress about the need 'to seek out the causes of mental illness and mental retardation and eradicate them'.⁹ 'Prevention', Kennedy continued, 'should be given the highest priority in this effort', with 'overcoming adverse social and economic conditions' the crucial objective.¹⁰ Later that year, this shift in emphasis from treatment to prevention was ratified in the passage of the Community Mental Health Act, which paid for the construction of 1,500 community mental health centres (CMHCs) across the country; an amendment passed in 1965 paid for the staffing of such centres.

Central to all such initiatives was the city. American psychiatrists and sociologists have often depicted cities as 'sites of social disintegration

⁵ For more on the relationship between the social sciences and psychiatry during this period, see A. Scull, 'The mental health sector and the social sciences in post-World War USA. Part 1: Total war and its aftermath', *History of Psychiatry*, 22 (2011), 3–19; A. Scull, 'The mental health sector and the social sciences in post-World War USA. Part 2: The impact of federal research funding and the drugs revolution', *History of Psychiatry*, 22 (2011), 268–84.

⁶ E.F. Torrey, *American Psychosis: How the Government Destroyed the Mental Health Treatment System* (Oxford, 2014), 17–36.

⁷ A.R. Roberts and L.F. Kurtz, 'Historical perspectives on the care and treatment of the mentally ill', *Journal of Sociology and Social Welfare*, 14 (2015), 83–4.

⁸ Joint Commission on Mental Illness and Health, *Action for Mental Health* (New York, 1961). The follow-up to JCMIH was a Joint Commission on the Mental Health of Children. It also emphasized prevention. Joint Commission on the Mental Health of Children, *Crisis in Child Mental Health: Challenge for the 1970s* (New York, 1970). For a British study on the urban environment and children, see M. Thomson, *Lost Freedom: The Landscape of the Child in the British Post-War Settlement* (Oxford, 2013).

⁹ J.F. Kennedy, 'Message from the president of the United States relative to mental illness and mental retardation', 5 Feb. 1963, John F. Kennedy Presidential Library and Museum, <https://www.jfklibrary.org/Asset-Viewer/Archives/JFKPOF-052-012.aspx>.

¹⁰ *Ibid.*

conducive to insanity'.¹¹ Thought to lack the homogeneity, cohesion and neighbourliness of smaller towns and villages, cities have instead been characterized as places where social problems flourish and mental health suffers. The city had long been identified by both social scientists and physicians as being a site of mental pathology. As early as the mid-nineteenth century, according to geographer Felix Driver, English social scientists became convinced that certain undesirable behaviours could simply be mapped onto particular urban environments.¹² Although such thinking focused squarely on the 'swarms' of working-class people living in crowded slums, the educated middle class were also susceptible to the deleterious effects of urban life.¹³ Following the American Civil War, neurasthenia became a popular disorder for overworked professionals, office workers and socialites, especially those living in cities. As David Schuster has described, the pursuit of outdoor activities in the countryside was thought to be one way of both preventing and treating such disorders.¹⁴ During the 1920s, sociological interest in the city intensified, as researchers at the Chicago School launched ecological investigations into the impact of urban life upon a range of social phenomena, including crime, delinquency and social disintegration.¹⁵ Influenced by German sociologist Georg Simmel and his 1903 essay 'The metropolis and mental life', the Chicago School also began considering the city's role in mental disorder.¹⁶

The most influential work on mental illness to emerge from the Chicago School was Robert Faris and H. Warren Dunham's *Mental Disorder in Urban Areas*. Based on the concentric zone theory of Ernest Burgess, they used admissions data to map the geographical origins of patients admitted to Cook County Psychopathic Hospital.¹⁷ The innermost zone consisted of the central business district, home to 'transients inhabiting the large hotels, and the homeless men of "hobohemia"'.¹⁸ Zone II was the 'zone of transition', characterized by deteriorated residential buildings occupied by unskilled labourers and their families, including

¹¹ H. Pols, 'Anomie in the metropolis: the city in American sociology and psychiatry', *Osiris*, 18 (2003), 194.

¹² F. Driver, 'Moral geographies: social science and the urban environment in mid-nineteenth-century England', *Transactions of the Institute of British Geographers*, 13 (1986), 275–87.

¹³ *Ibid.*, 281.

¹⁴ D. Schuster, *Neurasthenic Nation: America's Search for Health, Happiness, and Comfort, 1869–1920* (New Brunswick, NJ, 2011).

¹⁵ R.M. Carpiano, 'The neighborhood and mental life: past, present, and future sociological directions in studying community context and mental health', in R.J. Johnson, R.J. Turner and B.G. Link (eds.), *Sociology of Mental Health: Selected Topics from Forty Years 1970s–2010s* (London, 2014), 101–24.

¹⁶ G. Simmel, 'The metropolis and mental life', in K. Wolff (ed.), *The Sociology of Georg Simmel* (Glencoe, IL, 1950), 409–26.

¹⁷ R.E.L. Faris and H.W. Dunham, *Mental Disorder in Urban Areas: An Ecological Study of Schizophrenia and Other Psychoses* (Chicago, 1939).

¹⁸ *Ibid.*, 2.

many recent immigrants. Zone III constituted the 'zone of workingmen's homes' and was populated by second generation immigrant communities. Zones IV and V were home to upper-middle-class families, where 'stability is the rule and social disorganization exceptional or absent'.¹⁹ Using detailed maps, Faris and Dunham demonstrated that many mental disorders, though not all, were to be disproportionately found 'in the deteriorated regions in and surrounding the center of the city, no matter what race or nationality inhabited that region'.²⁰ Such slums, 'populated by heterogeneous foreign-born elements' formed 'a chaotic background of conflicting and shifting cultural standards, against which it is quite difficult for a person to develop a stable mental organization'.²¹

Faris and Dunham's research attracted both praise and criticism.²² As historical geographer Chris Philo has described, Faris and Dunham's influence extended to researchers in the UK.²³ Detractors, however, suspected that the higher rates of schizophrenia in poorer areas were the result of 'downward drift', rather than something inherently pathological about slums.²⁴ Those with schizophrenia 'drifted' to poorer areas as they cut ties with family and friends, and their prospects deteriorated. Faris and Dunham anticipated and dismissed this possibility, and the pattern which they identified between mental disorder with urban slum would be corroborated by other researchers.

If Chicago was a large, relatively new and heterogeneous metropolis, then New Haven, Connecticut, was something quite different.²⁵ Settled by Puritans in 1638, New Haven was older, more stable, smaller and more homogeneous in terms of ethnicity and race. It nevertheless attracted the interest of social psychiatrists, most notably Yale-based sociologist August Hollingshead and psychiatrist Frederick Redlich, whose study, funded by NIMH in 1950, was published as *Social Class and Mental Illness: A Community Study* (1958).²⁶ Hollingshead and Redlich began by claiming

¹⁹ *Ibid.*

²⁰ *Ibid.*, 35. Manic depression was associated with affluent communities.

²¹ *Ibid.*, 158–9.

²² G. Devereux, 'Review of *Mental Disorder in Urban Areas*', *Psychoanalytic Review*, 27 (1940), 251–2.

²³ C.P. Philo, "'The same and the other': on geographies, madness and outsiders', Occasional Paper 11, Loughborough Institute of Technology, Department of Geography (1986), 35–46, <http://eprints.gla.ac.uk/116553/1/116553.pdf>.

²⁴ A. Meyerson, 'Review of *Mental Disorder in Urban Areas*', *American Journal of Psychiatry*, 96 (1940), 995–7.

²⁵ Another major NIMH-funded study on the urban environment and mental health was the Midtown Manhattan project. We do not discuss it here, however, because its findings emerged after the regeneration of the West End. L. Srole *et al.*, *Mental Health in the Metropolis: The Midtown Manhattan Study* (New York, 1962). See also D. March and G. M. Oppenheimer, 'Social disorder and diagnostic order: the US mental hygiene movement, the Midtown Manhattan Study and the development of psychiatric epidemiology in the twentieth century', *International Journal of Epidemiology*, 43 (2014), i29–i42.

²⁶ A.B. Hollingshead and F.C. Redlich, in *Social Class and Mental Illness: A Community Study* (New York, 1958).

that: 'Americans prefer to avoid the two facts of life studied in this book: social class and mental illness.'²⁷ In New Haven, not only were a rigid class structure and mental disorder very real 'facts of life', but they were also inextricably linked. People of lower classes were both more likely to succumb to mental illness and struggled to access treatment.²⁸

Central to the project was a firm understanding of New Haven's social history and its particular five-tier class system, which profoundly shaped residents' experiences, perceptions and understanding of themselves. At the top of the 'Index of social position' was class I, consisting of 'proper New Haveners' from 'old families' who could trace their ancestors back to the seventeenth century.²⁹ Members of class II tended to be upwardly mobile, working in professional or managerial vocations, but lacked the ancestral roots and ethnic homogeneity of class I.³⁰ Class III consisted primarily of high-school-educated administrators, small business owners and technicians who lived in "good" residential areas in the suburban towns'.³¹ Members of class IV were ethnically and religiously diverse, with men working in skilled manual labour and women working in manufacturing.³² Finally, class V consisted of people in low-paid and low-skilled work that was often temporary or seasonal, many of whom were recent immigrants from Italy and Poland.³³

In terms of psychiatric epidemiology, members of class V were three times more likely to be treated for a mental illness than members of classes I and II combined (1,668/100,000 vs. 553/100,000), and especially psychosis.³⁴ Lack of personal, economic and emotional security and stability was thought to be a key factor. Symbolic of such privation were the dilapidated tenement buildings in which most class V members lived. As a field worker described:

The typical building is...built...leaving no space for building a front yard. The house is built so close to the house next door that the residents...can almost reach across to touch its begrimed clapboards. If there is a backyard, grass will have been succeeded by gravel, mud, broken bottles, and rusty bits of old metal. An old car with the tires cracked away from the rims may be gradually disintegrating as is the whole neighbourhood...The door which is gouged and defaced with the names and initials of occupants and which has lost great slivers of its wood is swinging on its hinges so that it cannot be fully closed...There has been glass in the door, but it has been replaced by plywood roughly tacked on.³⁵

²⁷ *Ibid.*, 3.

²⁸ *Ibid.*, 11.

²⁹ *Ibid.*, 53, 69–73.

³⁰ *Ibid.*, 85–94.

³¹ *Ibid.*, 99–100.

³² *Ibid.*, 104–6.

³³ *Ibid.*, 122. 'Negroes', who consisted of 4% of New Haven's population in 1950, were thought to occupy a distinct social structure, and were overlooked in the study.

³⁴ *Ibid.*, 210.

³⁵ *Ibid.*, 119.

Lack of adequate sanitation, according to one respondent, meant that residents would “‘piss out the windows”. Near the end of the interview, the man slapped the interviewer on the knee and said, “Look, there’s one of the bastards doing it now.”³⁶ Thin walls and overcrowding left residents feeling that they were practically living with one another, which could ‘lead to trouble’.³⁷

Such depictions contributed to the idea that deteriorated physical environments were unhealthy spaces. In so doing, they added further weight to the long-standing argument that slum clearance and housing provision was, above all, a critical public health measure. In his recommendations to the New Haven Redevelopment Agency, city planner, Maurice Rotival, described the city as a ‘diseased organism’, the ‘mind’ and ‘soul’ of its citizens likewise deteriorated:

isn’t it more logical and of greater impact of the life on the citizens, to attack the disease in the very corp, i.e., the very center of the city where the danger, where the disease lies, that it is also where the surgeon should put the knife and maybe some times, by a daring operation, restores the life to certain parts of the organism in the process of destruction.³⁸

Such use of medical and organismic metaphor was not uncommon among those promoting the benefits of urban renewal. Indeed, housing reformers had, from the late nineteenth century, built much of their case for slum clearance on the costs of poor housing and ‘blight’ to mental and physical health.³⁹ One of the pioneering figures in the early public housing movement, Edith Elmer Wood, assiduously collected statistical survey data in the 1920s and 1930s of crime, delinquency, infant mortality and disease, documenting correlations between physical, mental and moral health with housing.⁴⁰ Particularly useful were the statistics collected by the Chicago sociologist Clifford Shaw on delinquency areas, published in 1929, which, by having plotted the addresses of delinquents, allowed Wood to build correlations between criminal activity and deteriorated dwellings and highlight the ‘relationship between congestion and bad conduct’.⁴¹ It also allowed her to move beyond the problem of the individual dwelling, or rather, connect it to the unwholesome ‘social atmosphere’ of the ‘bad neighborhood’. The lack of yard and indoor space

³⁶ *Ibid.*, 120.

³⁷ *Ibid.*

³⁸ ‘Minutes, New Haven Redevelopment Agency, May 17, 1951’, Rotival papers, Yale University, box 37.

³⁹ R. Lubove, *The Progressives and the Slums: Tenement House Reform in New York City 1890–1917* (Pittsburgh, 1962); D.M. Abramson, *Obsolescence: An Architectural History* (Chicago, 2016).

⁴⁰ E.E. Wood, ‘The costs of bad housing’, *Annals of the American Academy of Political and Social Science*, 190 (1937), 145–50; E.E. Wood, ‘What do delinquency areas prove?’, Edith Elmer Wood papers, Avery Library, Columbia University, box 69, folder 1.

⁴¹ Wood, ‘What do delinquency areas prove?’; C.R. Shaw, *Delinquency Areas: A Study of the Geographic Distribution of School Truants Juvenile Delinquents and Adult Offenders in Chicago* (Chicago, 1929).

would lead the child to the unsupervised companionship of the street 'where one rotten apple is liable to spoil a barrelful of sound ones'.⁴² Her description intertwined the medical with the social by drawing upon the metaphor of contagion: while not every child would succumb through contact with sickness, it would nevertheless 'be rather far-fetched to deny a causal relationship between a case of smallpox and the case from which it was apparently derived'.⁴³

In promoting more comprehensive programmes of urban redevelopment, Wood was committed to the 'neighborhood concept' or 'unit' promoted by those such as the sociologist Clarence Perry and architect, Clarence Stein, who had, in turn, drawn upon Ebenezer Howard's vision of the Garden City in England. At the President's Conference on Home Building and Home Ownership of 1931, which, for the first time, brought together a wide range of disciplines and professions to focus on the problem of housing, the neighbourhood unit offered a solution to the complex combination of factors that caused illness and delinquency:

There is no sufficient reason for believing that an appreciable reduction in delinquency rates will result from improvement of individual houses if other things remain unchanged. The conclusion, on the contrary, is that a reduction in delinquency rates is most likely to result from a program which combines improvements in housing with modifications in other elements of the complex. This combination means, at the least, the development of improved housing in neighborhood units.⁴⁴

By constructing a neighbourhood – deflecting traffic, using arterial highways as boundaries and establishing within them essential institutions such as the school, church, playground, community centre and shopping facilities – a community would be created and local social control encouraged: 'At the least a program of this nature will provide a physical setting in which community organization can more easily be developed than in the usual arrangement of houses.'⁴⁵

The aim of large-scale urban redevelopment was further aided by technical and methodological advances, most notably the new techniques for building and neighbourhood appraisal provided by the American Public Health Association (APHA). The APHA's Committee on the Hygiene of Housing, founded in 1937 under the direction of a leading figure in public health, Charles-Edward Amory Winslow of Yale, had established a series of 'basic principles' for healthful housing as

⁴² *Ibid.*

⁴³ *Ibid.* For an excellent account of the power of the metaphor of contagion in this period in the US, see P. Wald, *Contagious: Cultures, Carriers, and the Outbreak Narrative* (Durham, NC, 2008).

⁴⁴ 'President's conference, tentative report of the Committee on Housing and the Community, submitted for discussion at the conference on December 3, 1931', Wood papers, Columbia, box 4, folder 6.

⁴⁵ *Ibid.*

determined by physiological and psychological needs – that housing be adequately ventilated, heated, pest-free and sanitary, and not be overcrowded.⁴⁶ The committee then developed an appraisal method based on these standards for housing and urban environments that allowed surveyors to establish which dwellings were substandard and to what degree, requiring either demolition or rehabilitation. By mapping areas of the city according through the appraisal technique, patterns of blight and obsolescence could be established, and larger areas identified for treatment, a process Winslow believed critical to public health.

Nevertheless, the precise relationship between sickness and housing remained a thorny issue, central as it was to the justification of housing standards and slum clearance. While the evidence of the relationship between housing characteristics and the transmission of physical diseases, such as tuberculosis, proved uncontroversial, as the sociologist Stuart Chapin explained to Winslow in 1953, ‘the mental hygiene aspects seem to be a much less tangible and more difficult problem’.⁴⁷ From the 1950s, social and behavioural scientists such as Chapin began to address these complex relations.⁴⁸ Many were supported by NIMH, its first director Robert Felix being a public health-trained psychiatrist and supportive of new and preventative approaches to mental health problems.⁴⁹ A particularly important ally for social and psychological students of urban problems would be Leonard Duhl, a member of the Professional Services Branch which focused on community-based research and psychosocial well-being. The branch has been described as ‘catalytic’ in stimulating interest in social and environment factors in mental health and illness, and its support of social psychiatric studies of urban life would provoke radical revaluations regarding the relationship between housing and health well beyond the confines of psychiatry.⁵⁰

Social psychiatry at Massachusetts General Hospital

On 1 July 1954, psychiatrist Erich Lindemann was appointed Professor of Psychiatry at Harvard Medical School and Chief of the Psychiatry Service

⁴⁶ American Public Health Association, *An Appraisal Method for Measuring the Quality of Housing* (New York, 1945).

⁴⁷ ‘Letter, Chapin to Winslow, June 23, 1953’, C.-E.A. Winslow papers, Yale University, box 6, folder 150.

⁴⁸ F.S. Chapin, ‘Some housing factors related to mental hygiene’, *American Journal of Public Health*, 41 (1951), 839–45.

⁴⁹ J.G. Kelly, ‘The National Institute of Mental Health and the founding of the field of community psychology’, in W.E. Pickren and S.F. Schneider (eds.), *Psychology and the National Institute of Mental Health: A Historical Analysis of Science, Practice, and Policy* (Washington, DC, 2005).

⁵⁰ *Ibid.*, p. 243.

at MGH.⁵¹ His predecessor, Stanley Cobb, had done much to develop and extend the boundaries of psychiatric research beyond clinical knowledge, using experimental methods to understand the interrelations between mind and body critical to psychosomatic medicine. Lindemann sought to take Cobb's approach further, to encompass the social, environmental and ecological. Lindemann likened his approach to psychiatry to that of public health: just as the focus in medicine was turning from the curative to the preventative, in the field of mental health 'dealing with the "causalities" as done now, is not enough'.⁵² A new role for psychiatry beckoned, that of 'the guardian of the health of a population'.⁵³

For Lindemann, as for other social psychiatrists, preventative psychiatry required collaboration with the social sciences. He had become convinced of this when investigating the relationship between grief and psychosomatic reactions. Treating the survivors of Boston's infamous nightclub fire at Coconut Grove in 1942, surgeons had requested psychiatric help in studying and alleviating the grief reactions that were complicating recovery from burns.⁵⁴ Lindemann found that physical recovery was closely related to effective grief responses, which were, in turn, dependent upon the support of an effective 'network of human relationships'.⁵⁵ The nightclub fire had caused 'changes in a person's human environment, the loss of significant persons, the acceptance of change in one's own appearance due to injury and the transition of a person into a new context of human relations'.⁵⁶ It offered an opportunity for understanding what factors facilitated healthy and adaptive responses and indicating measures to prevent maladaptive reactions. Lindemann embarked upon a longer and much expanded investigation of grief, first focusing on amputees, and then reactions to lifecycle transitions from one human environment to another, such as a child entering school: 'So a quest which arose in relation to situations of extreme stress was easily transferred

⁵¹ Lindemann earned his doctorate in psychology from the Universities of Marburg and Giessen (1922), and his medical degree from Cologne and Giessen (1926). He had held previous posts at the Department of Psychiatry, MGH, and the Harvard School of Public Health and the Department of Social Relations. He had considerable and broad research experience, laboratory and field, and was acclaimed for being the first to recognize psychotropic quality of sodium amylal.

⁵² 'Summary of second meeting with individuals from community agencies and institutions in Boston, Mass., March 27, 1957', Erich Lindemann papers, 1885–1991 (inclusive), 1950–74 (bulk). HMS c219. Harvard Medical Library, Francis A. Countway Library of Medicine, Boston, MA, box 38.

⁵³ E. Lindemann, 'The training program of the Massachusetts General Hospital', Lindemann papers, box 2, folder 6.

⁵⁴ E. Lindemann, 'Social science in relation to medicine and some of its recent contributions', *Cincinnati Journal of Medicine*, 30 (1949), 475–81.

⁵⁵ 'Summary of the discussion between Dr. John Knowles and Dr. Erich Lindemann on September 29, 1961', Lindemann papers, box 2, folder 31.

⁵⁶ E. Lindemann, 'Some implications of bereavement studies for a theory of behavior in extreme situations (disaster)', Lindemann papers, box 29, folder 36.

to the inevitable situations of minor stress which form part of normal living.⁵⁷

In 1948, and in collaboration with a citizen's group, the School of Public Health and the Department of Social Relations at Harvard, Lindemann established the HRS in the Boston suburb of Wellesley. The service embodied Lindemann's vision of an interdisciplinary and preventative mental health programme, uniting social scientists, psychologists, psychiatrists and social workers with an array of local 'caretaking' community leaders, agencies and professions, such as the police, schools, physicians and clergy. This approach served both scientific research and its application. Experts gained access to family units, neighbourhood life, organizations and institutions, acquiring knowledge of the complex forces and values operating in the community that influenced mental health. In return, they assisted those agencies, receiving referrals, providing consultation, advising on preventative intervention, curriculum planning and social activities that anticipated and ameliorated situations involving emotional stress, above all, ensuring that knowledge of mental health and illness, including preventative psychiatry, became well established throughout a community.

Methodologically, the ecological approach pioneered by those such as Faris and Dunham was important; Wellesley's residential areas could be divided into relatively homogeneous zones wherein variables such as income, age, family composition or race could be measured in relation to mental illness to create an 'epidemiology of mental disease'.⁵⁸ However, they also recognized this approach as problematic for the psychiatrist: while the identification of frequencies of illness in relation to populations was useful, it did not explain the meaning of these phenomena 'for the individual'; it established how many became ill, but did not explain 'which person'.⁵⁹ Similarly, Hollingshead and Redlich had identified relationships, but they fell short of providing explanations; it was only 'a study of the sick. It does not propose to say anything about the well.'⁶⁰ While calculating the use of psychiatric agencies was important, other formal and informal agencies and groups were also employed as a means of coping with stress. Preventative psychiatry required them to move beyond the measurement of hospital admissions to include modes of adaptation to stress – both successful and unsuccessful – throughout the

⁵⁷ *Ibid.*

⁵⁸ E. Lindemann and D.P. Aberle, 'The integration of psychiatry and social science in the perspective of family research', paper read before American Sociological Society, Dec. 1949, Lindemann papers, box 29, folder 22. See also 'Chapter for monograph by George K. Lewis, "Social Area Analysis", 1963', Lindemann papers, box 29, folder 2.

⁵⁹ Lindemann and Aberle, 'The integration of psychiatry'.

⁶⁰ 'Clara Mayo, #1 epidemiology', Lindemann papers, box 28, folder 8.

general population, a shift in focus from mental *illness* to a more inclusive mental *health*.⁶¹

Lindemann wanted to unite the broad units of the social scientist with the case-based knowledge and therapeutic concerns of the psychiatrist, placing the 'case' in the context of population and 'the "community" within which the malfunctioning is primarily manifest'.⁶² He found such a framework with 'crisis theory': that new life situations demanded new solutions both in the emotional and intellectual sphere, and resulted in a spectrum of mal-adaptive and well-adaptive responses.⁶³ Such an approach united broad environmental factors, so-called 'hazardous situations' that could affect an entire community, with the individual, for those whose 'internal psychic patterns make this situation especially meaningful emotionally, a crisis may develop'.⁶⁴ Most individuals returned to a state of emotional equilibrium, often through the aid of interpersonal relationships and a realignment of social interactions, but if complex bio-psychological control mechanisms or social support networks were compromised, the results of even seemingly innocuous events could be devastating. Mental health services could assist communities by specifying dangerous situations, identifying vulnerable individuals and families, connecting them to service agencies and advising those agencies to prevent emotional disorders. Through community involvement, psychiatrists, social scientists and social workers would gradually learn how specific crises led to specific adaptive responses, what Lindemann described as the 'long range goal'.⁶⁵ Wellesley's relatively homogeneous and comfortable middle-class population meant that 'the crises observed were largely idiosyncratic, with considerable variability along all dimensions simultaneously'.⁶⁶ Lindemann sought to study how a major crisis shared by an entire community affected individuals in accordance with their respective emotional, intellectual, economic and social resources: 'crises, are, par excellence, examples of such situations which have important effects on individuals, groups, and whole communities and have a potential for disturbing normal behavior patterns and interactional systems'.⁶⁷ The redevelopment of the West End provided

⁶¹ For an analysis of the role of 'stress' as concept and measure, in a more inclusive mental health, see E. Ramsden, 'Stress in the city: social science, mental health, and urban planning in post-war America', in D. Cantor and E. Ramsden (eds.), *Stress, Shock and Adaptation in the Twentieth Century* (Rochester, 2014); M. Jackson, *The Age of Stress: Science and the Search for Stability* (Oxford, 2013).

⁶² 'Revision of application for mental health training grant, July 1, 1961 – June 30, 1962', 24 Aug. 1960, Lindemann papers, box 8, folder 60.

⁶³ 'Community mental health program', Harvard University–Massachusetts General Hospital, 7 Jan. 1959, Lindemann papers, box 2, folder 6.

⁶⁴ E. Lindemann, 'The nature of mental health work as a professional pursuit, 1956', Lindemann papers, box 29, folder 28.

⁶⁵ 'Summary of second meeting'.

⁶⁶ E. Lindemann, M. Fried, E.J. Ryan and R. Rapoport, 'Human adaptation in complex situations', 1961, Lindemann papers, box 8, folder 26.

⁶⁷ 'Revision of application for mental health training grant'.

'an opportunity...to investigate some of the same basic problems more systematically'.⁶⁸

The West End

Boston's West End was directly adjacent to the MGH. It was home to a large, lower-working class, predominantly Italian American, but also Polish, Jewish and Irish, population. It had been designated as a slum in 1953, in accordance with the physical standards of housing quality, sanitation and occupation established by the APHA.⁶⁹ The Boston Redevelopment Authority decision to raze a 48-acre portion of the West End, displacing some 7,500 people to make way for the Charles River Park high-rent apartment complex, gave Lindemann the opportunity to observe 'psychosocial processes in a massive change event'.⁷⁰ He formed the Center for Community Studies in 1956, employing the social psychologist Marc Fried, who had been trained at Harvard's Department of Social Relations, as its research director. The Center's study, supported by NIMH through Leonard Duhl, was titled 'Relocation and Mental Health: Adaptation under Stress'. It was linked to a Mental Health Service, established in 1955 and, like the Wellesley programme, integrated the Hospital's psychiatric services into the local community by serving as 'a family counselling center and as a center for psychiatric consultation to the social agencies in the area'.⁷¹ Urban renewal in the West End offered the Service an immense opportunity for training, learning and further integration: 'What kind of families, from what kind of origin will be damaged most by this process? What kind will be benefited? Who will have adaptive, and who will have maladaptive, responses to this kind of crisis? This is the problem.'⁷² A new Psychology Unit was added to the Psychiatry Department, helping to train psychologists, psychiatrists and social workers through the West End study, described in terms of 'field station experience':⁷³ 'The psychologist must take the leadership for improving the scientific bases for mental health programs, and in

⁶⁸ *Ibid.*

⁶⁹ 'West End project report: a preliminary redevelopment study of the West End of Boston', Mar. 1953, Herbert J. Gans papers; Rare Book and Manuscript Library, Columbia University Library, box 2, folder 3, 'Urban redevelopment division, Boston Housing Authority'.

⁷⁰ 'Community mental health consultation with the social worker in the West End redevelopment program, Boston, Massachusetts, 1959-1960, John C. Baird, Social Work Fellow, CMH, May 1960', Lindemann papers, box 38. See also T.H. O'Connor, *Building a New Boston: Politics and Urban Renewal, 1950-1970* (Boston, MA, 1993); L.J. Vale, *From the Puritans to the Projects: Public Housing and Public Neighbors* (Cambridge, MA, 2000).

⁷¹ 'Annual report, Dept of Psychiatry, 1955-56', Lindemann papers, box 1, folder 17.

⁷² Lindemann, 'The training program of the Massachusetts General Hospital'.

⁷³ 'Community mental health: Harvard University - MGH, 7/1/59', Lindemann papers, box 2, folder 6.

developing methods for the evaluation of the results of the wide range of mental health services and activities.⁷⁴

In order to grasp the consequences of forced relocation, Fried considered it essential to understand the culture of those in the West End. Qualitative methods were employed to determine information about psychological characteristics, lifestyles, values and attitudes. Sociologist Herbert Gans, employed on the project from 1957, lived among the West Enders for eight months prior to their removal and recorded his observations in diary form, while a further series of extensive and more systematic ethnographic studies were undertaken by Edward Ryan. In addition to incorporating questions about ethnographic experience into its surveys, the Center also conducted group, joint husband–wife and clinical interviews in the home, all of which ‘provides a vividness and clarity about social relationships and an understanding of underlying factors in social and value configurations which survey interviews alone could not attain’.⁷⁵ The understanding of social roles, personality and lifestyle, coupled to measures of agency use and reported illness, would allow them to properly assess and compare pre- and post-location patterns of social adjustment and adaptation.

The Center’s studies challenged the assumption that the West End was a wholly pathological space conducive to mental illness: ‘In essence, the slum as represented by the West End is not an area of disorganization but a highly organized sub-social system with its own specific normative structure and sub-structures.’⁷⁶ The more individualistic and dyadic relationships that characterized the middle classes were substituted and extended through a broader group pattern of social ties, what Gans described as a ‘peer group society’: ‘the basic commitment is to the group rather than to an individual. It does not generally involve the kind of interpersonal intimacy between two people that we are so familiar with in the middle class although it is certainly as close, as warm, and probably includes a wider set of reciprocal obligations.’⁷⁷ This ‘familistic quality’ compensated for differences in ethnicity and the lack of kin among many in the West End, and Fried often commented on the relative lack of ethnic tension and group hostility.⁷⁸ This group orientation was reflected in, and reinforced by, the physical environment. Fried believed the working classes experienced the urban environment differently to the middle classes. For the latter, the apartment or house was a private space, clearly delineated from the street outside. For the working classes, the boundary between home and street was permeable; or rather, the concept of ‘home’ extended out into the street, an area of social interaction among the closely

⁷⁴ ‘Revision of application for mental health training grant’. The Community Health Program began in 1956, supported by the NIMH.

⁷⁵ Lindemann, Fried, Ryan and Rapoport, ‘Human adaptation in complex situations’.

⁷⁶ *Ibid.*

⁷⁷ M. Fried, ‘Developments in the West End research’, research memo, 15 Oct. 1960, Lindemann papers, box 28, folder 22.

⁷⁸ *Ibid.*

knit networks of family and friends. The community was not just a social but a spatial unit, relationships embedded in physical space.⁷⁹

Emphasizing the importance of spatial identity, relocation was described as a 'severely unhappy event' experienced as a 'tragic loss, in many ways quite comparable to the grief reaction upon losing a loved person'.⁸⁰ Simplistic survey methods could not capture responses that 'are often deeply affecting and most frequently express the fact of complete embeddedness, that the West End is home'.⁸¹ The crisis was further compounded by a failure to relocate families into housing suited to their needs. 'These observations lead us to question', they concluded, 'the extent to which, through urban renewal, we relieve a situation of stress or create further damage.'⁸² Gans agreed with Fried's assessment, not only questioning the benefits of renewal, but also criticizing the very description of the West End as a slum – the consequence of the simplistic application of APHA standards.⁸³ It was not the existing housing, but the destruction of 'socially and emotionally important social systems' that put the population 'under stress'.⁸⁴ While the area was crowded and some buildings dilapidated, it was a healthy, stable and fulfilling community; it was not a 'slum'. The avowedly objective methods of the APHA could be used to pursue policy objectives that did not necessarily serve the interests of the populations in the areas targeted; coupled with programmes of large-scale renewal that sought lower areal densities, improved facilities and a strengthened tax base, the application of physical standards could work against low-income groups with limited housing options.

The Center's publications and, in particular, Gans' sympathetic portrayal of the plight of the West Enders in *The Urban Villagers*, generated disquiet among planners and architects; Gans described having been 'considered a heretic by many of my colleagues in the planning profession'.⁸⁵ Nevertheless, the Center's work chimed with the growing chorus of disapproval surrounding aggressive urban renewal programmes that targeted poor and minority populations and unravelled the fabric of

⁷⁹ M. Fried with E. Fitzgerald, P. Gleicher and C. Hartman, *The World of the Urban Working Class* (Cambridge, 1973).

⁸⁰ Lindemann, Fried, Ryan and Rapoport, 'Human adaptation in complex situations'.

⁸¹ Fried, 'Developments in the West End research'.

⁸² M. Fried and P. Gleicher, 'Some sources of residential satisfaction in an urban slum', *Journal of the American Institute of Planners*, 27 (1961), 315.

⁸³ H. Gans, 'The human implications of current redevelopment and relocation planning', *Journal of the American Institute of Planners*, 25 (1959), 15–26; H. Gans, *The Urban Villagers: Group and Class in the Life of Urban Americans* (New York, 1962).

⁸⁴ H. Gans, 'An analysis of redevelopment and relocation planning for the West End of Boston', May 1958, Gans papers, box 1, folder 8.

⁸⁵ His 'arguments against renewal were not accepted by them', he continued, 'until the ghettos began to protest effectively against "Negro removal"'. Herbert Gans to Mark Granovetter, 7 Feb. 1974, Gans papers, box 1, folder 3. Gans' position on planning is complex, and he continuously argued that he was not against urban planning for genuine slums and the provision of public housing. For a further analysis of Gans' position, see Ramsden, 'Stress in the city'.

dense and richly diverse urban spaces. The noted critic of urban renewal, Jane Jacobs, was inspired by Gans to visit the West End and the adjacent North End for herself, writing to him about the latter: 'here is an area with the highest densities in Boston – above 200 dwelling units per acre – and you get an effect of terrific health and cheer in the place'.⁸⁶ Gans had even pushed Lindemann to allow project members to become involved directly in the issue of relocation, suggesting that he circulate early drafts of a paper critical of the redevelopment plans to West Enders and members of the Urban Renewal Administration in Washington.⁸⁷ Gans expressed his concerns: 'If the team is in the long run concerned with mental health service to the community, it should know the relocation plan problems...It could then decide whether it would be feasible and desirable to take some steps to affect the redevelopment and relocation plans for the area in the interest of contributing to the mental health of the present residents.'⁸⁸

Such direct political engagement was resisted by Lindemann. He knew of the suspicion with which many at MGH viewed the growing influence of the social and behavioural sciences, and their support for the West End redevelopment.⁸⁹ They needed to 'be neutral and "out" of the question whether the "crisis" was good or bad for the people or community'. While the project would duly identify the crisis as hugely damaging for the population, it steered clear of direct political and policy engagement, preferring to 'report and observe what was happening'.⁹⁰ For Lindemann, the study of urban renewal in the West End was a means to an end. That end was not a critique of urban renewal, but the development of a mental health service that was fully embedded within a community. This service would provide a continuous source of information, a theatre for training and an effective programme of consultation that dealt with the entire population, rather than a limited number of psychiatric cases. It was a further expansion of the Wellesley programme, now applied to a large

⁸⁶ 'Jane Jacobs to "Herb" Gans, November 24, 1958', Gans papers, box 1, folder 4. See J. Jacobs, *The Death and Life of Great American Cities* (New York, 1961).

⁸⁷ 'Herbert Gans to Erich Lindemann, June 30, 1958', Gans papers, box 1, folder 8. The paper was published as: 'The human implications of current redevelopment and relocation planning'. The Center's staff noted how West Enders had been all too apathetic in the early stages of the renewal plans.

⁸⁸ Gans felt they should be more active in community organization or, at least, surreptitiously assist certain individuals. 'Problems of relocation and redevelopment planning in the West End, as these affect the service function of the West End research project, January 23, 1958', Gans papers, box 1, folder 8.

⁸⁹ Lindemann continuously struggled to secure the support and space necessary, describing the situation as 'nothing short of tragic': 'It is perhaps not surprising that a new and different department with a novel orientation towards social phenomena and community mental health would find it slow going to convince the staff of the hospital that our approach though different is basically sound and worth the respect and support of our colleagues.' 'Letter to David Crockett, February 11, 1958'. For these reasons, Lindemann rebuffed Gans' suggestions – 'Lindemann to Gans, July 7, 1958', Gans papers, box 1, folder 2.

⁹⁰ 'Laura Morris to Lindemann, memorandum of meeting on Oct. 2, 1956, with Caplan and Duhl', Lindemann papers, box 38.

urban population, and would 'dovetail' with that of the Human Relations Service (HRS),⁹¹ where he described having been 'very selfish' in their aim of developing knowledge necessary for a public health approach in psychiatry.⁹² Accordingly, he sought to work with, not against, the Boston Redevelopment Authority. The Authority's actions were representative of a growing commitment to urban redevelopment throughout the US, and, hence, offered an opportunity of showing the value of expert personnel that could liaise between agencies and the population: 'Because of the fact that we exist as a research center for community problems the state and city are interested.'⁹³ From 1959, members of the community mental health programme began collaborating with relocation personnel, helping them resolve conflicts with 'uncooperative' residents and providing support for those suffering 'crisis reactions'.⁹⁴ Lindemann's group organized a series of meetings with the planners, architects, MGH administration, various community agencies and leaders, such as the new Charles River Park Association. These meetings were described as 'an opportunity for a "new approach", i.e., to attempt to look at the broad needs and concerns of a community in the remaking and to move from that point to involve the present and incoming population to a realistic concern and action on their own behalf'.⁹⁵ The renewal programme offered 'clear sailing towards developing a mental health program with a broader community focus and responsibility',⁹⁶ and Lindemann duly fostered ties to the 'new community'.⁹⁷ He also built ties to the State Department of Public Health and the commissioner of health, resulting in his appointment as the chairman of the Metropolitan Committee for Mental Health Planning, and, following his departure to Stanford in 1965, the establishment of a new centre and hospital: the Erich Lindemann Mental Health Center.⁹⁸

While one leading figure in urban planning, Melvin Webber, reflected that the simple clarity and naive optimism with regards fixing the city had been 'dimmed by the clouds of complexity, diversity, and...uncertainty',

⁹¹ 'Summary of meeting with faculty connected with the training program in community mental health, July 12, 1956', Lindemann papers, box 38.

⁹² 'HRS meeting, Lindemann, "preventative psychiatry", November 4, 1954', Lindemann papers, box 29, folder 19.

⁹³ 'Meeting of GEC, Dec 6, 1961', Lindemann papers, box 2, folder 31.

⁹⁴ 'Community mental health consultation with the social worker'.

⁹⁵ 'Minutes of meeting of exploratory group's first meeting re: future services and plans for a new West End, Laura Morris', Lindemann papers, box 2, folder 22.

⁹⁶ 'Summary of West End mental health service, L. B. Morris, n.d.', MGH Archives.

⁹⁷ 'Revision of application for mental health training grant'.

⁹⁸ 'Meeting of GEC'. It was based at the Government Center in downtown Boston, where the Community Crisis Stabilization unit had also advised on redevelopment. Paradoxically, the Government Center was itself subject to criticism, due to the urban renewal of Scollay Square featuring brutalist architectural design. The Metropolitan Committee was jointly sponsored by the State Department of Mental Health, Massachusetts Mental Health Association and United Community Services. Lindemann left for a visiting professorship at Stanford.

Lindemann's approach offered an immense opportunity.⁹⁹ Leonard Duhl, who had been a key supporter of Lindemann's programme, left the NIMH in 1966 to serve as a special adviser to Robert C. Weaver, secretary of housing and urban development (HUD). Weaver was overseeing HUD's new Model Cities programme which was concerned to correct the previous errors in urban renewal and bring local communities and diverse agencies into the planning process. Duhl, whose memorandum on 'demonstration cities' had influenced President Johnson's Task Force on Urban Problems, described his role as 'look[ing] at how the parts all tie together' to develop a 'total program'.¹⁰⁰ This was an approach which he, in turn, credited to Lindemann for having advanced the 'epoch-making work' of Hollingshead and Redlich, to address the 'total community'.¹⁰¹ For the 'first time coherent plans for physical planning' would, with the help of scientific expertise, be integrated with those of health, education and welfare. Even in the mental-health world, he declared, 'things have been happening...and all the things we have been fighting for...what Erich Lindemann has screamed and fought and knocked his head against the wall for years is suddenly coming easy'.¹⁰² This was a new ecology of mental health. With the further development of a community psychiatry, they had 'been presented with a unique opportunity. Our functions are being expanded for us. We are being challenged. Society...is now increasingly concerned with those things we are concerned with in mental health.' While European nations had long developed welfare policies and programmes focused on the most vulnerable, 'Perhaps this is our American and unique way of dealing with these problems'; mental health, Duhl declared, had become 'an umbrella for life'.

Conclusion

The influence of West End study extended far beyond the boundaries of psychiatry. This was, of course, what the study was designed to

⁹⁹ M.M. Webber, 'Comprehensive planning and social responsibility: toward an AIP consensus on the profession's roles and purposes', *Journal of American Institute of Planners*, 29 (1963), 233.

¹⁰⁰ 'Duhl, in conference transcript, social and physical environment variables as determinants of mental health, Washington DC, March 17, 1966', John B. Calhoun papers, 1909–96, located in Archives and Modern Manuscripts Collection, History of Medicine Division, National Library of Medicine, Bethesda, MD, MS C 586, box 67. Duhl and a colleague had submitted a two-page memorandum that privileged the 'social and psychological' over mere 'bricks and mortar', and suggested three cities be chosen for comprehensive rebuilding, combined with programmes of social and economic improvement. Robert C. Wood, chairman of the task force, and soon to be HUD undersecretary, attached it as an appendix to the task force's report, but it later became, he recollected, the basis of the Model City legislation. R.C. Wood, *Whatever Possessed the President? Academic Experts and Presidential Policy, 1960–1988* (Amherst, 1993), 79.

¹⁰¹ L. Duhl, 'The ecological view of psychiatry', presented at the 25th anniversary of Department of Psychiatry at MGH, Oct. 1960, Lindemann papers, box 1, folder 1; Duhl, conference transcript.

¹⁰² Duhl, conference transcript.

do; as both science and practice, it incorporated different methods and layers of analysis and united varied disciplines, professions and agencies to construct an inclusive community mental health programme that addressed the broad category of psychosocial well-being. It sought to engage and ally with agencies in housing and urban planning, as well as the communities affected by such programmes. This approach to community psychiatry, organized around crisis theory, proved very influential. It contributed to a community mental health movement that arose in the 1960s, its centres serving all those within geographically defined catchment areas in accordance with the needs and views of its citizens.¹⁰³ It provided a model, not just for community mental health, but for a new approach to urban degeneration – Model Cities – that would bring together a whole range of agencies, including those of health and social welfare, and increase citizen participation in urban planning. Having long served as a justification for slum clearance and public housing, the issue of mental health now moved beyond the provision of correlations between poor housing and social and mental disorder, and helped contribute to a framework for a more comprehensive programme that would, with the aid of the social and behavioural sciences, ameliorate complex social problems and help realize the ambitions of President Johnson’s Great Society.

However, such broad, comprehensive and ambitious programmes generated similar problems. Particularly prominent was the issue of resources. Both Model Cities and the community mental health programme were costly, demanding fiscal resources that were diverted elsewhere at the height of the Vietnam war. They also required immense inter-agency collaboration and co-ordination that proved difficult to realize, as such attempts at large-scale and top-down rational planning generated disquiet and resistance from various interested parties. Model Cities came up against a maze of federal and local agencies and bureaucratic resistance to change,¹⁰⁴ while community mental health, having extended psychiatry’s focus to consider the broad subject of psychosocial well-being, was perceived as a drain on the already stretched resources needed to treat critical and chronic mental illness.¹⁰⁵ Both programmes had used ambiguous concepts and terminology to smooth over differences and divisions, such a mental health, quality of life, crisis and stress, yet it was their very scale and breadth which contributed to

¹⁰³ J.F. Borus, ‘Community psychiatry at the MGH’, in T.P. Hackett, A.D. Weisman and A. Kucharski (eds.), *Psychiatry in a General Hospital: The First Fifty Years* (Boston: MGH Psychiatry Service, 1987), 53.

¹⁰⁴ B.J. Frieden, and M. Kaplan, *The Politics of Neglect: Urban Aid from Model Cities to Revenue Sharing* (Boston, MA, 1975).

¹⁰⁵ G.N. Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton, 1991). Emphasizing behavioural sciences and social work, CMHCs were also perceived as a threat to the professional authority of the bio-medically and clinically oriented psychiatrist.

confusion and fragmentation. This was reflected in Marc Fried's decision to leave MGH, feeling that social psychiatric problems were 'necessarily dealt with piecemeal and with only informal cooperation between the sub-units and individuals involved'.¹⁰⁶ Psychology merely served pre-existing specialist units in psychiatry, it did not help reconstitute them into a more effective whole, and, thus, it was becoming subordinate, fragmented and uncoordinated as a research field. Lindemann's vision that a truly preventative community psychiatry be realized that addressed the social and environmental causes of mental illness without the determinism and pessimism of earlier ecological approaches and united an array of agencies around the theme of mental health and infused them with a 'more optimistic bias', was, therefore, only partially successful.¹⁰⁷

While the purpose of the West End study was one of overcoming division and building unity, and gave impetus to ambitious large-scale planning and organization, the longer-term consequences of its studies of urban life would be to aid the growing criticism of such comprehensive programmes. The slogan '*Remember the West End!*' would become a rallying call against further redevelopment of other neighbourhoods of Boston, and throughout the US.¹⁰⁸ Social and psychological scientists increasingly undertook studies of the relations between the physical environment and behaviour in ways that privileged the diverse needs of occupants and appreciated varied situational contexts. The West End studies were identified as critically important to an emerging field of environmental psychology in their recognition of the need for new techniques that could capture the ways in which environments were experienced by those who inhabited them.¹⁰⁹ Mental health would remain a central feature of this work, as they sought to reduce the stress associated with various aspects of urban living; but potential stressors in the physical environment were now understood to be mediated through a complex of individual, social and cultural factors that they had only just begun to understand. The West

¹⁰⁶ 'Memorandum, M. Fried and Judy Rosenblith, proposals concerning a psychosocial research laboratory, January 9, 1963', Lindemann papers, box 1, folder 41. Fried pushed for an autonomous psychosocial laboratory or department of behavioural science, but would realize this aim outside of the MGH, as he and other members of the Center for Community Studies departed to establish the Institute of Human Relations at Boston College. Lindemann supported Fried's vision, but noted: 'Neither is it compatible with the present attitudes of the members of the faculty.' 'Lindemann to Duhl, 28 Sept. 1961', Lindemann papers, box 8, folder 26. In 1970, funding for training in psychology as part of the community mental health programme was terminated, the NIMH describing it as 'no longer an innovative enterprise', crippled as it was by 'lack of institutional support for key staff and the consequent attrition of the staff'. 'Stanley F. Schneider to Clara Mayo, April 10, 1970', Lindemann papers, box 8, folder 19.

¹⁰⁷ Lindemann and Aberle, 'The integration of psychiatry'.

¹⁰⁸ C.W. Hartman, *Between Eminence and Notoriety: Four Decades of Radical Urban Planning* (New Brunswick, NJ, 2002), 9.

¹⁰⁹ W.H. Ittelson, K.A. Franck and T. O'Hanlon, 'The nature of environmental experiences', in S. Wapner, S.B. Cohen and B. Kaplan (eds.), *Experiencing the Environment* (New York, 1976); H.M. Proshansky, W.M. Ittelson and L.G. Rivlin (eds.), *Environmental Psychology: Man and his Physical Setting* (New York, 1970).

End studies would, therefore, encourage closer relations between social and behavioural sciences and the planning and design professions, but in a very different way than had been intended by previous generations of housing reformers, now criticized for having helped impose pre-determined standards on diverse populations. While the 'optimism' that Lindemann sought to instil proved to be short-lived, both in the case of community mental health and urban redevelopment, the legacy of the West End study was the significant appreciation that there was no straightforward casual correlation between the physical environment and mental health, and that the amelioration of urban problems required not just the collaboration of diverse disciplines, agencies and methods, but techniques that captured, engaged and integrated the complex ways in which the urban environment was experienced by those who inhabited it.