

Chapter Title: BETTER LIVING THROUGH PSYCHOBUREACRACY? COMMUNITY MENTAL HEALTH CENTERS

Book Title: The Architecture of Good Behavior

Book Subtitle: Psychology and Modern Institutional Design in Postwar America

Book Author(s): JOY KNOBLAUCH

Published by: University of Pittsburgh Press

Stable URL: <https://www.jstor.org/stable/j.ctvzgb8dq.6>

JSTOR is a not-for-profit service that helps scholars, researchers, and students discover, use, and build upon a wide range of content in a trusted digital archive. We use information technology and tools to increase productivity and facilitate new forms of scholarship. For more information about JSTOR, please contact support@jstor.org.

Your use of the JSTOR archive indicates your acceptance of the Terms & Conditions of Use, available at <https://about.jstor.org/terms>



University of Pittsburgh Press is collaborating with JSTOR to digitize, preserve and extend access to *The Architecture of Good Behavior*

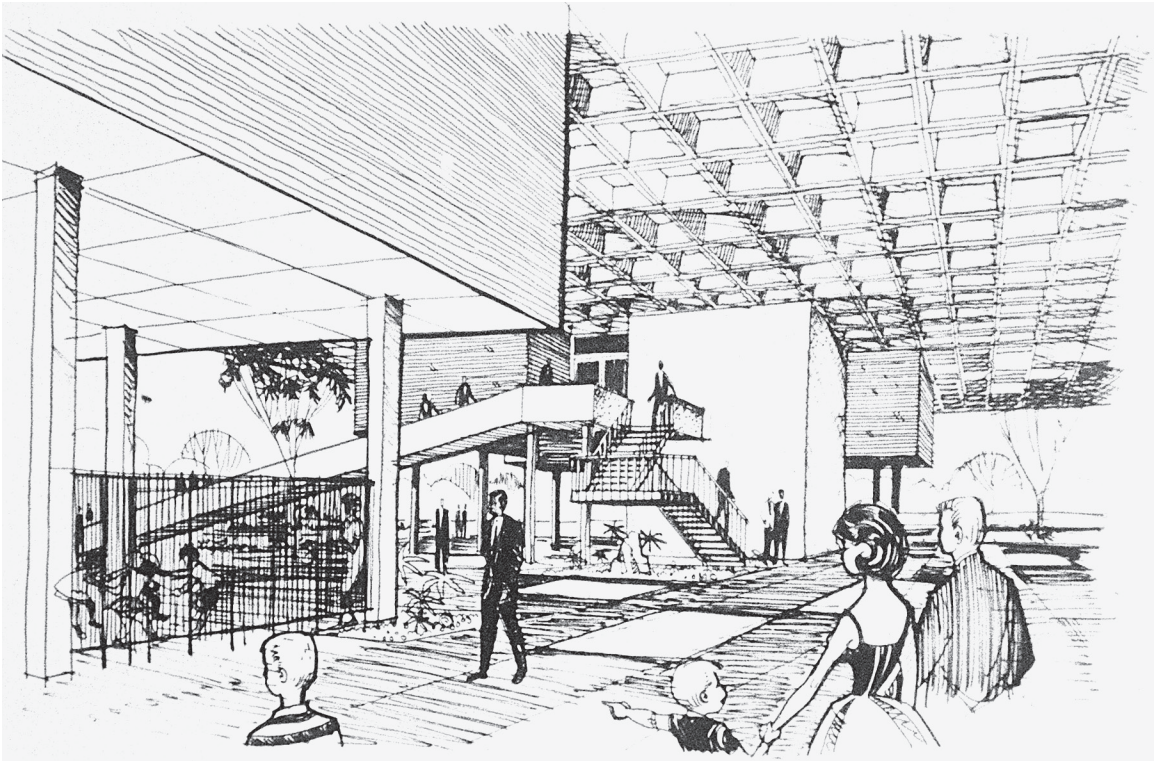
JSTOR

BETTER LIVING THROUGH PSYCHOBUREACRACY?

COMMUNITY MENTAL HEALTH CENTERS

IN 1963 ROBERT FELIX, as the director of the National Institute of Mental Health, offered American architects the opportunity to design a new type of institution. That same year, President John F. Kennedy had signed the Community Mental Health Act, calling for a national system of two thousand facilities to meet the mental health needs of all Americans—regardless of their ability to pay. The community mental health centers (CMHCs) were to be more permeable than previous institutions; these facilities would provide psychiatric care on a mostly outpatient basis in facilities located within patient communities instead of remote, residential institutions. The CMHC program's creators touted their model, trying to persuade their audience that patients and their families would come and go more easily and to assuage fears of involuntary commitment. Felix called on architects, in a manner similar to the USPHS's plea to participate in Hill-Burton, to create an architectural design for an institution that would become as much a part of American life as the elementary school and post office.¹

The vision of a new federal typology in each community bore traces of a postwar optimism about translating affluence to social good for all Americans, and architects found they could contribute. The larger and longer context of shifting political and presidential regimes seemed beyond their control and, based on their written records, largely beyond their ability to comment. Signed into law only weeks before Kennedy's assassination, the program was picked up by his successor, President Lyndon Johnson, under Johnson's Great Society banner.² Rather than battle poverty through redistribution, Johnson chose bold legislation and high-profile presidential commissions. CMHCs seemed



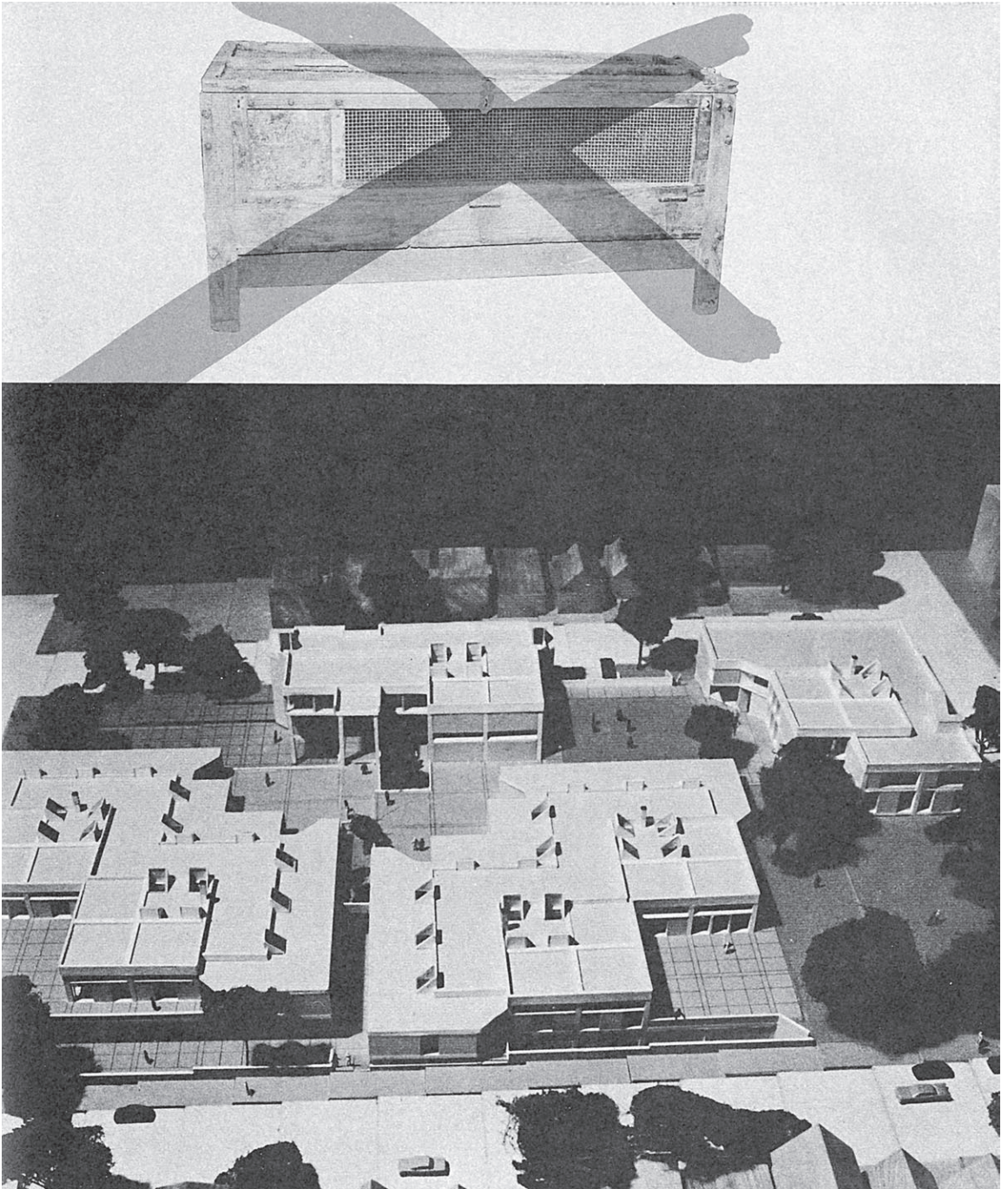
2.1. Proposal by architect Wilmont Vickrey and psychiatrist Joseph J. Downing for a new typology known as the community mental health center (CMHC). CMHCs were to be more open and include more community functions, as evidenced by the children seen playing here among the articulated components of the central building and beneath the massive, suspended volume of another component. Coryl La Rue Jones, ed., *The Community Mental Health Center*, Vol. 2, *Architecture for the Community Mental Health Center* (New York: Mental Health Materials Center, 1967), 83.

a perfect fit with his ambition to improve American cities and thereby demonstrate the greatness of the American way of life. Accompanied by a range of other legislation including the Civil Rights Act of 1964 and Medicaid and Medicare in 1965, the CMHC program aligned with Johnson's politically savvy if not always earnest attempt to improve the lives of African Americans. What began as an optimistic attempt to replace the abuses of a state-run mental hospital system quickly ran into tensions over funding during the costly war in Vietnam and accusations of unequal targeting of urban and minority populations amid an increasing amount of youth and racial unrest in U.S. cities in the late 1960s. The architects' ambition to use vivid designs to create a new image of mental health inhabited a social and political context with its own ambitions, only some of which were architectural.

The CMHC program provided funding and influence to architects who sought to use architecture for social good; it allowed them to undertake aesthetic research and bureaucratic innovation within a political climate that shifted over the long time period required of such a massive architectural campaign. The overall bureaucratic structure was similar to the earlier Hill-Burton construction program (in providing subsidies and the shared goal of equal facilities for all on a national scale), but the forms of the buildings were quite different. Specific forms or even a shared aesthetic was not the result of the national biopolitical aims between Hill-Burton and community mental health centers or within the CMHCs themselves. Forms were only somewhat determined by the increasing influence of psychologists in the designs. The search for psychologically functional environments to manage the psyches of the nation's population did not have a single aesthetic; rather, it yielded knowledge about (or at least theories of) design and behavior that could be in the background of many kinds of designs.

The program was expansive, including all Americans as possible patients in such centers, and enabled the centers to address the most troubled of patients using new forms of drugs and empowered them to engage in talk therapy with milder forms of maladjustment, including alcoholism and family dysfunction. Government-sponsored psychology expanded rapidly after World War II, and the community mental health movement combined psychology with the epidemiological and public health backgrounds of three of the early directors of the NIMH: Felix, Richard Yolles, and Bertram Brown.³ These men believed in a cycle wherein poverty produced mental illness, which in turn produced poverty, and fostered an interest in urban sociology, urban research, and urban policy. The language of the program emphasized its enlightened approach in contrast to the horrors of previous institutions to justify the large federal presence in the mental health of so many citizens.

Psychologists at a design workshop sponsored by NIMH explained the link between the new drugs and the new open environment of the health centers: "Community mental health centers are keyed to the reinforcement of human dignity. Locks, barred windows, strait jackets and other methods of physical coercion and restraint are virtually abolished. Tranquilizing and anti-depressant drugs are important tools, since they have made it possible for the patient to enter more swiftly and intensively into the open door treatment program and return more rapidly to the community."⁴ The idea of physical openness was an important shift; these centers were mostly outpatient facilities where patients would now come and go voluntarily. The idea was expressed visually as well, contrasting a nineteenth-century Utica crib used to restrain patients into a small space with a new kind of architecture composed of articulated concrete volumes typical of a kind of "humanized" modern architecture. The welcoming look of the building, the arrangement of spaces within, the textures and mood created



2.2 Graphic juxtaposition of the old and new models of the institution from the NIMH volume on the Rice Design Fete. At the top is a Utica crib, used to restrain patients in the nineteenth century. Coryl La Rue Jones, ed., *The Community Mental Health Center*, Vol. 2, *Architecture for the Community Mental Health Center* (New York: Mental Health Materials Center, 1967), 13.

were to be important tools of psychiatry, continuing a long-standing emphasis on the healing powers of the environment.⁵

Community mental health centers have been written about as an innovation in mental health policy as well as an extension of psychology into a greater realm of engagement beyond the couch or clinic.⁶ The idea that the physical environment matters to the psyche is as old as nineteenth-century “milieu therapy,” if not older, and would grow further under the name “community psychiatry.”⁷ For Matthew Dumont, the city as a whole was a patient with the overtly political goal of providing mental health to enable participation in a democratic society. Ellen Herman and others have situated these efforts in larger attempts to calm a population and manage a national mood, including the FBI’s ongoing research and training, in *Prevention and Control of Mobs and Crowds*.⁸ The tools of the psychiatrist expanded to include education, community organization, urban planning, government administration, and political activism and, in the case of CMHC design, was also a tool to achieve a well-adjusted patient population. But scholarship has done less to examine the role of design, morphologically and aesthetically, in this project of expanding psychology as a tool of urban governance.

The architecture was compared to the former restraining devices, but much of the restraint was now in the form of drugs and persuasion to conform with what has been called the “therapeutic state.”⁹ Whether liberating or repressive—and in reality they were both—the new practices of community psychiatry were part of larger changes in the way the federal government adopted psychological knowledge to carry out its work of managing, pacifying, and tending to an increasingly urban and in the late 1960s increasingly dissenting population. Philip Rieff, James L. Nolan Jr., Ellen Herman, and others have written of the way psychology gained authority as an intimate way of knowing members of the population, labeling individuals with various diagnoses and explanations, and proposing treatments that would return them to a pacified norm of behavior.¹⁰ As Rieff wrote, these diagnoses replace religious as well as political identities with a never-quite-sick, never-quite-well regime of treatment that built upon institutional logics from earlier hospitals, as depicted by Thomas Mann’s *The Magic Mountain*. The varied designs for early community mental health centers show an architectural expression of the therapeutic state, a gentle form of power that claimed to be doing good and that many of designers and staff truly did greet with optimism at first. The old model of institutional care clearly needed improvement and new spaces.

Felix’s call to architects was only one way the NIMH fostered collaboration between architecture and psychology in creating these new institutions. In 1964 the NIMH appointed architect Clyde Dorsett to oversee the grant application process, a process which included three stages of drawings. Dorsett and the

Architectural Consultation Section approved forty to eighty projects a year in the first seven years of the program.¹¹ Dorsett also fostered innovative designs through a workshop at Rice University, the results of which were published as a pair of award-winning volumes packed with quotes from well-known architects such as James Stirling and Louis Kahn, as well as those with innovative ideas about human environment interaction such as Kevin Lynch and William Caudill. The workshop paired architects and psychologists in pursuit of building typologies that would fit with particular demographic and cultural qualities of American towns based on what sounds rather like market research. As hospital designers had done under Hill-Burton, but with somewhat more self-awareness in classifying types and certainly with more imaginative forms, architects designed CMHCs to fit the local population.

Bureaucratically, the CMHC program built on the national view taken by the Hill-Burton Act in that both programs set quotas based on population size. However, the CMHC program had a key difference: where Hill-Burton aimed at the number of inpatient beds per capita, CMHCs moved beyond beds to the more abstract, performance-based provision of twelve essential services. Also, where Hill-Burton had produced tree-like hospital hierarchies, the CMHCs embraced less hierarchical relationships. The act called for one center for every two hundred thousand citizens, building on the territories established by the U.S. Census Bureau. Because the distribution of centers was based in population density rather than travel distance, some residents in rural areas had to travel quite far, whereas urban areas had many centers.

Each geographically contiguous area was referred to as a “catchment area,” borrowing a term from human geography that suggests the population acts like a natural resource flowing to the center, as rainwater flows to a watershed.¹² The centers were to be located where they would best complement other “mental health resources” within that watershed, and matching construction funds were only granted if the center fulfilled programmatic needs for a population not already served. Toward this end, the composition of each catchment area was carefully studied as part of the grant application; the NIMH required grant applicants to provide demographic data for the catchment area to be served. Maps of both demographics and existing resources were used in the San Francisco example published by NIMH in 1967; among the values mapped were juvenile court cases, major transportation routes, land use, and the location of urban renewal projects, as well as correlations between income and education and between income and unemployment.¹³ In this way, the CMHC program was similar to the Hill-Burton Act in relying on long-standing social science tools such as surveys to realize the vision of planning and constructing a national network of institutions to communicate with each citizen to further the nation’s health.



2.3. Detail of nationwide map of CMHCs. Dark pins mark constructed facilities, light pins mark facilities under construction, and shading indicates catchment areas. A label pasted to the map is dated January 1976. Roni McCarty's home, Queenstown, Maryland.

The map of the nation became a key representation of the program. Dorsett tracked the CMHC program through a map of the United States divided into catchment areas. Once a grant was approved and a facility was under construction, Dorsett colored the area on the map yellow and marked it with a pink pin. When the building was completed, he would change the pin to a blue one. The image of the map was used as the cover of a brochure about the program called "A Citizen's Guide to the Community Mental Health Centers Act," fitting with the importance of the geographical component of the federal program. The use of a national map was an appropriate "poster child" for the program, as it expressed the intent to replace the broken system of state mental hospitals with a consolidated federal system.

The demographic data used in the grant applications came mainly from census data, which was then analyzed and presented by a social scientist. Such use of demographics to locate buildings is shared with the large survey that was part of

Hill-Burton and continued in a case by case basis with the CMHCs. The location and to a lesser degree the programmatic elements of a center were determined by quasi-scientific knowledge, a biopolitical model where the creation of outposts wore the garb of scientific social welfare. The strategy had a seeming innocence or objectivity, relying on data and resulting in a large system that varied place to place. When one challenged the location of a facility, the answer could be justified in seemingly objective data rather than politics. In the case of the Caudill Rowlett Scott project for the Maimonides Hospital of Brooklyn Community Mental Health Center in 1966–1967, a graduate student of the New York School of Social Work at Columbia University prepared data from the 1960 census.¹⁴ For the Ryburn Community Hospital in Ottawa, Illinois, an unknown contributor to Skidmore, Owings, and Merrill's grant application created maps that tracked statewide income and population growth by county, projecting the growth to 2020, almost sixty years into the future.¹⁵ Before such government programs for collecting data and the availability of university-educated social scientists to analyze the data, the decision about where and why to locate a facility would have had more to do with available land, often in a remote or otherwise undesirable area. In several cases, it appears that data analysis made it easier for applicants to locate a facility in more desirable, more central places, where it could be integrated with a community and easily reached by troubled members of a population.

Architects were given an opportunity to share information, to develop ideas, and to focus on the problem of designing within a society whose everyday life was increasingly psychologized. The status of psychologists rose rapidly in the United States after World War II, as did the number of psychologists practicing.¹⁶ The rising influence of the NIMH reflects the growing status of psychology, but it also reflects the federal government's growing involvement in the mental health of its citizen population. Before World War II, the only federal agency devoted to mental health was the Division of Mental Hygiene, an organization responsible for screening new immigrants for mental soundness, treating drug addiction, and providing counseling to federal prisoners.¹⁷ In 1949 the NIMH was formed as a cabinet-level agency within the National Institutes of Health, which was itself part of the Department of Health, Education, and Welfare. NIMH's budget grew rapidly, from \$8.7 million in 1950 to \$315 million in 1967.¹⁸ As the institute grew, the NIMH's budget and influence led it to conduct extensive research outside of laboratory and the psychiatric institution in an attempt to justify its role and compete within the also-expanding National Institutes of Health. In 1964 a majority of the NIMH's research budget was spent on work that was not directly related to psychiatry or biological sciences. Sixty percent of the funding went to psychologists, sociologists, anthropologists, epidemiologists, and others who studied the broader implications of environment on mental health. Supported by the Great Society agenda to expand what

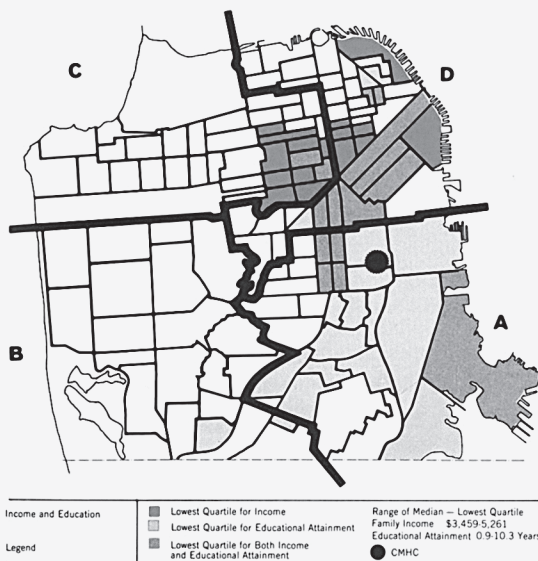


FIG. 2-5



FIG. 2-6



FIG. 2-7

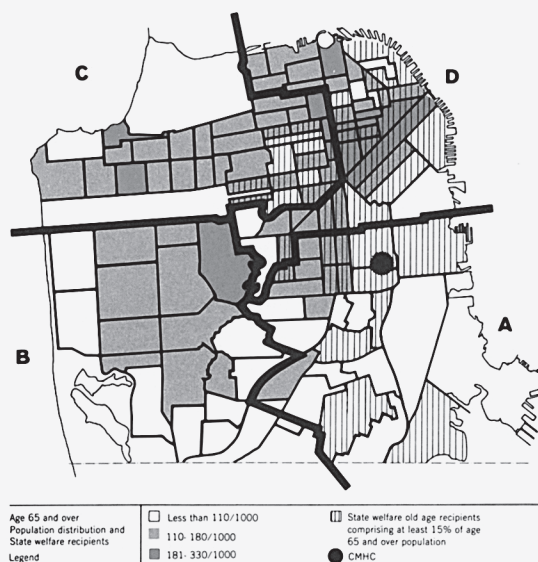


FIG. 2-8

2.4. The black dot in the southeast quadrant of these San Francisco maps shows the strategy of locating a facility with regard to income and education, income and unemployment, juvenile court cases, and population over sixty-five receiving welfare. NIMH presented these maps as a model for CMHC design. Coryl La Rue Jones, ed., *The Community Mental Health Center, Vol. 1, Planning, Programming and Design for the Community Mental Health Center* (New York: Mental Health Materials Center, 1966), 23.

historian Alice O'Connor calls "poverty knowledge," the NIMH studied the cycle of mental illness and poverty as well as urban and architectural factors related to mental health, spawning a Center for the Study of Metropolitan Problems.¹⁹ In addition to those research programs, the NIMH administered the construction of CMHCs, whose presence in the community would include preventing delinquency, alcoholism, and other socially disruptive conditions by engaging with nearby residents.

The new site of care was also the result of psychologists' efforts to extend their expertise to more patients. Following his work with the U.S. Army during World War II, psychiatrist and founder of a famed clinic William Menninger joined the efforts of the professional association of the Group for the Advancement of Psychiatry (GAP), which lobbied throughout the 1950s for recognition that every American citizen had a right to mental health. Moreover, they felt that psychiatrists had an obligation to use their expertise to advance the goal of a democratic right to mental health, thereby carrying "psychiatry out of the hospitals and into the community."²⁰ Group for the Advancement of Psychiatry members and other psychologists pushed the federal government to take over from what they felt were ineffectual and backward state governments in favor of a seemingly progressive, inclusive, and democratic program. The group's efforts led to *Action for Mental Health* in 1961; the report by the Joint Commission on Mental Illness and Health was influential in the passage of the 1963 CMHC Construction Act. Internationally, a report by the World Health Organization in 1955 recommended facilities include many of the same elements of the CMHC, such as outpatient services and community integration.²¹

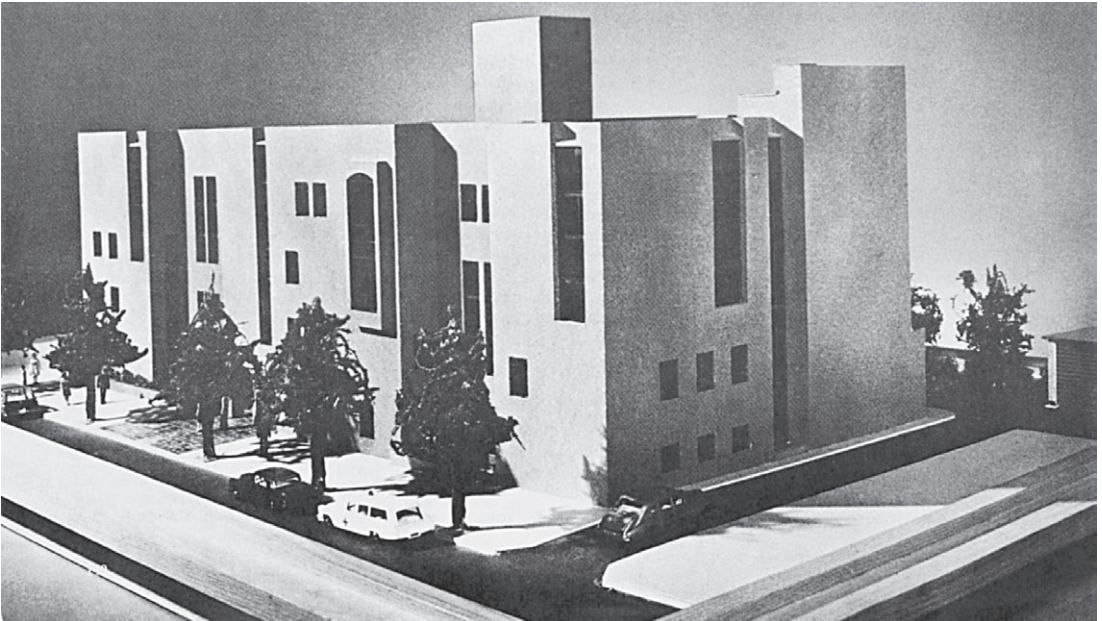
While professional and political motivations for deinstitutionalization were important, the movement of psychiatric care out of the hospital setting was made possible only by a new class of psychoactive drugs. These drugs had such an impact on treatment that the success of the new mental health centers would not have been possible without them. Introduced in 1955 the drug Thorazine is the most commonly known commercial variant of chlorpromazine, which was itself the product of research on the potential for histamines to be used as a sedative for surgery.²² The drug produced a state of calm and unconcern in patients, allowing many to wake up and begin to speak but also creating the zombielike patient familiar from films of mental hospitals. By the early 1960s, Thorazine and similar drugs had advanced to the point that they made it possible for many patients to function somewhat normally outside of institutions. The biological restraint provided by the so-called chemical straitjacket had a profound impact on the amount of physical restraint the architecture needed to provide, thus making the community mental health center possible. Even those who needed inpatient care could be allowed greater freedom within the walls of the new institution.

FORM FOLLOWS PATIENT PSYCHE

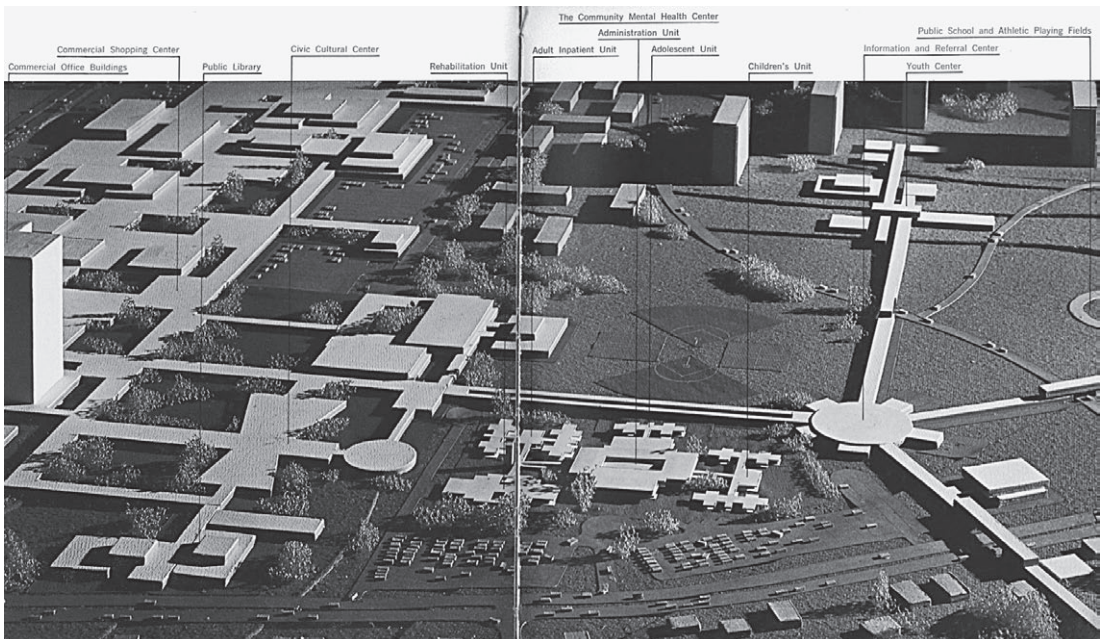
Moving beyond institutional models of care meant moving beyond the remote residential hospitals for the insane, as they were called, constructed in the nineteenth and early twentieth century, but it also meant a clear difference from the psychiatric wards in twentieth-century medical hospitals. The austere, affordable, legible, steel, glass, and brick buildings built under Hill-Burton legislation became an image to be avoided particularly as they had become understaffed and overcrowded; this antipathy soon accelerated as these environments were depicted in novels and films such as *The Snake Pit* (1948), *Titicut Follies* (1967), and *One Flew over the Cuckoo's Nest* (1962 in book form and 1975 in film). From the start, Dorsett and others focused on the need for spaces that did not feel institutional or hospital-like.

CMHC exteriors were designed to respond to the aesthetics of their context and to speak to the demographics of the catchment area. Attention was paid, as it was under Hill-Burton, to creating a welcoming entry that appeared distinct from that of a hospital. Caudill Rowlett Scott's design for the Maimonides Hospital of Brooklyn Community Mental Health Center tried to match the character and scale of the surrounding environment and thus follow the staff's desire that the building be "a departure from anything resembling a hospital."²³ Caudill Rowlett Scott designed a vertical mass in red brick, at the same five- or six-story height as its neighbors. As was often the case, the design attempted to look smaller than it was "by breaking up the massing" to match the residential scale of surrounding buildings. The strategy of camouflage is also seen in a design by architect David McKinley and psychiatrist A. R. Foley for a "continuous form," where a prototypical solution for a suburban environment used a low, sprawling form to match the surrounding environment (fig. 2.6). A few suburban mental health centers simply moved in to locations in strip malls. In the Woodlawn neighborhood in Chicago, a group of psychiatrists affiliated with the University of Chicago quickly realized the importance of placing the center within locally owned buildings and not the medical campus owned by an out-of-town landlord.²⁴ Such things sent the right or wrong message, as Dorsett and the Architectural Consultation Service of the NIMH came to realize. Dorsett observed that the book is very much judged by its cover, that the "client group" will judge the facility in accordance with its location and its appearance.

The idea of the permeable institution that is enmeshed in its surroundings and permeated by the human geography and aesthetics of its catchment area was not limited to CMHCs at this time. Daniel Abramson has argued that hospitals were themselves moving in this direction in search of a solution to their continual problems of expansion and technological obsolescence.²⁵ Elements of East Coast schools were also turning to more context-sensitive projects behind the



2.5. Caudill Rowlett Scott's design for the Maimonides Hospital of Brooklyn Community Mental Health Center. Box 11, Folder 5, Clyde H. Dorsett Papers, Avery Drawings and Archives Collections, Columbia University, New York.

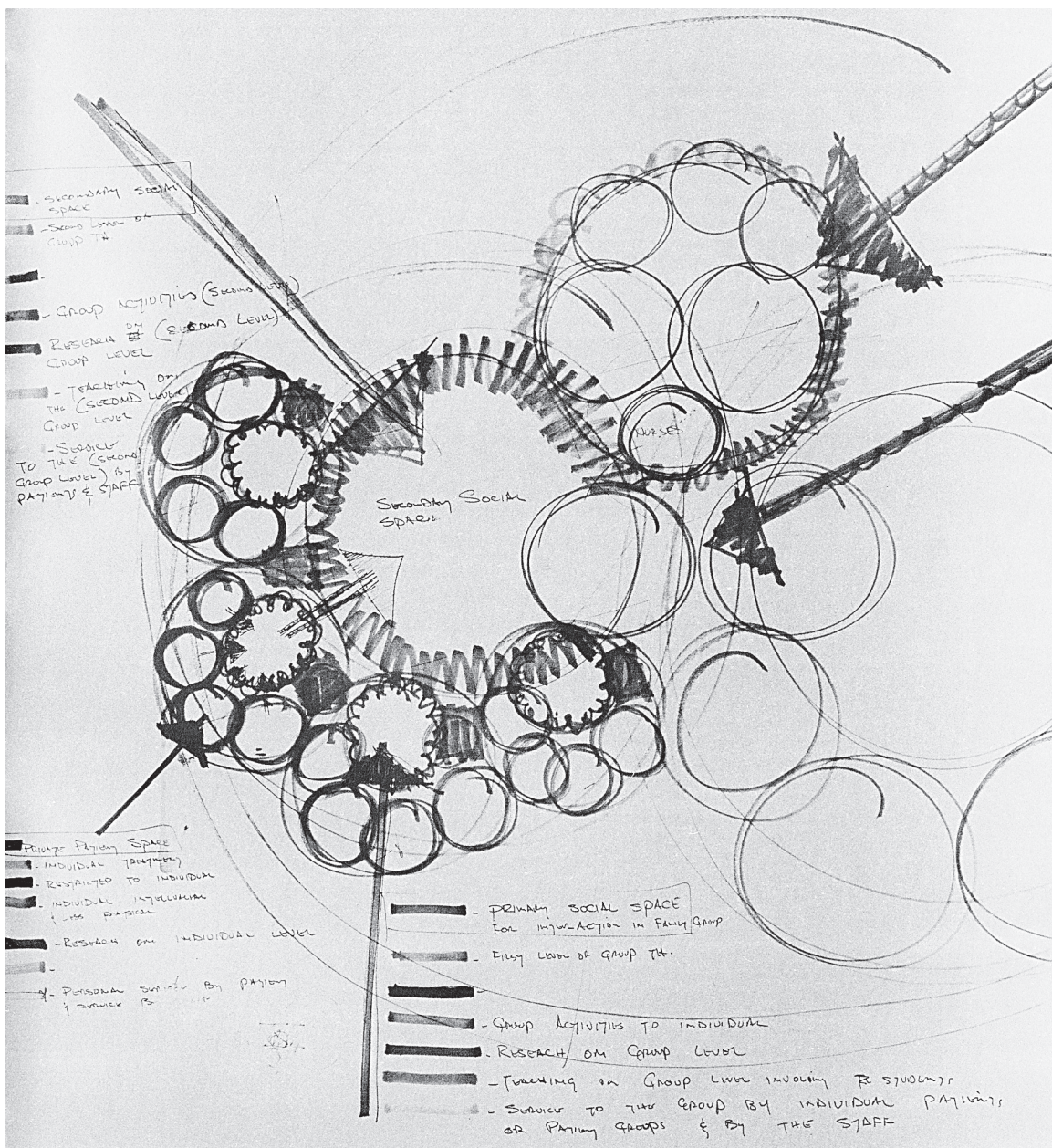


2.6. McKinley and Foley's continuous form, integrated with a suburban mall and hospital. Coryl La Rue Jones, ed., *The Community Mental Health Center*, Vol. 2, *Architecture for the Community Mental Health Center* (New York: Mental Health Materials Center, 1967), 32–33.

banner of Robert Venturi's 1961 *Complexity and Contradiction in Architecture*. However, the sources cited explicitly by Dorsett and his collaborators focus more on public relations and concealment. The NIMH guidelines illustrated the point with a quote from Museum of Modern Art curator Arthur Drexler's essay "The Disappearing Object." In the essay, Drexler described the nondescript space of airplane interiors and hotel chains as the way of the future, contrasted with the figurative design strategies of the Bauhaus. He argued that the object was no longer an isolated, discrete unit emphasized as the Bauhausers did with singular geometric shapes. Instead, he observed that "the object is no longer a finite thing; it is merely one element in a system, like a telephone, and what makes it work successfully is the coherence of a system whose invisible forces are removed from me in space and time."²⁶

Drexler recognized that to design in ignorance of the systems that surround an object was the strategy of a previous age, not one suited for the age of technology, mass consumption, and large social organizations that characterized the postwar United States. Instead of maintaining the illusion of singularity, designed objects should dissolve or disappear into their environment by understanding the environment and satisfying user needs. Drexler criticized designers who continued in the Bauhaus tradition, producing bad design by "naively" trying to make singular objects. Instead, designers should understand that they are asked only to design uninteresting containers and to remember that "what is inside the box is what is really interesting." The alignment with CMHC design philosophy is clear, not only for the desire to dissolve the individual center into the larger system of psychiatric care, the catchment area, and the social community, but also for the focus on the inside of the container: the human element within the facility.

The architecture needed to care for and support its human cargo, or its mission would fail. Architect Kiyoshi Izumi collaborated with the well-known psychiatrist Humphrey Osmond and compared psychiatric facilities to space capsules in which the patient's personal space was like the privileged tip of a rocket, where the precious "soft goods" of a mission are placed.²⁷ Izumi and others worked to visualize and then design spaces to fit the social interaction between patients, as in the case of Izumi's scheme for the Rice Design Fete. The scheme was for a prototypical community: a 150,000-person catchment area in the southwestern United States composed of ethnic and social groups ranging from suburban residents to "hillbillies." Working with Osmond, Izumi planned to create an environment in which such diverse residents could be encouraged, slowly, to interact with each other in increasingly larger groups.²⁸ Izumi's diagram makes these interpersonal forces visible, and the architecture of a similar facility he had designed the year before suggests that the final form would also make these forces legible. The circulation within Izumi's plan

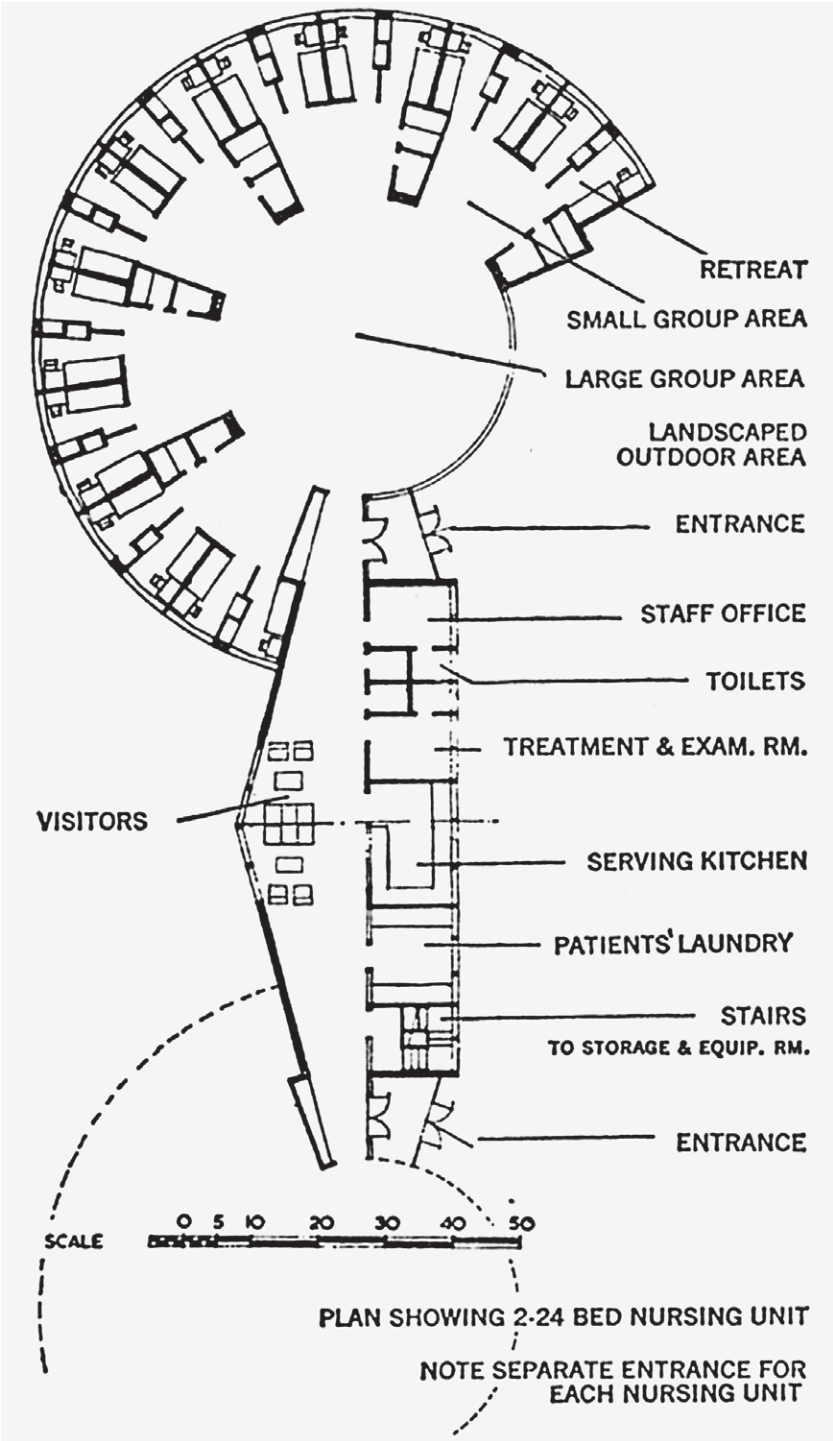


2.7. Architect Kiyoshi Izumi collaborated with the well-known psychiatrist Humphrey Osmond and compared psychiatric facilities to space capsules, in which the patient's personal space was like the privileged tip of a rocket, where the precious "soft goods" of a mission are placed. Kiyoshi Izumi's diagram for Rice Design Fete. Coryl La Rue Jones, ed., *The Community Mental Health Center*, Vol. 2, *Architecture for the Community Mental Health Center* (New York: Mental Health Materials Center, 1967), 34.

reflects his idea of the territoriality of the inhabitants, in stark contrast to the uniform, double-loaded corridor. In this Saskatchewan scheme, the primacy of the large circle remains as an echo of the diagram or merely as a symbol of the community in the mental health center. At least in theory, the concern for interaction between patients would be visible in the form of the building via a series of circles translated into radial walls.

For CMHC designers the attention to the patient's social behavior was translated into a close attention to program. The designers often used words such as "humanized" to reflect the departure from the rigidity of the machine aesthetic of the earlier hospitals in favor of what they claimed was a greater attention to human factors of design. Frequently, architects justified a design by claiming that the form reflected patients' behavior, movement patterns, habits, and anxieties. In short, they sold their designs as producing a close fit between form and function, as manifested in the legibility of the patient's attributes in the final design. The fit between form and function was mediated through an important document: the program. The NIMH volume on the San Francisco prototype called the program "the first basic document [used to] establish true needs" and then "shape and order them, as environment and space."²⁹ The components of the program, such as the number of offices, bathrooms, and so on, were located using the sequences of treatment, then assembled by the architect using other psychiatric considerations such as a prevailing theory that hierarchical, territorial clusters of spaces made patients comfortable and thus more likely to interact in group therapy. The result was a strategy of draping form around the programmatic components, calling out individual treatment rooms, gathering spaces, and clusters of offices to achieve a maximum of what might be called programmatic transparency—that is, the visibility of the shapes of the interior functions on the exterior.

Dorsett and his colleagues were aware that the patient's needs were a moving target, and he wrote that the spaces were "to be *individually tailored* to their needs as they progress from early diagnosis through a continuity of treatment and back to a productive life in the community."³⁰ Dorsett's choice of metaphor here was not accidental; in many important ways the design of the new institutions resembled the tailoring of a suit of clothes that fit the client's body closely.³¹ The architecture of the CMHC was *tailored* to the architect's and the psychologist's image of the patient, even at times differentiating between various stages of treatment. The tailoring of form to program was a psychologically based goal, but it also reflected Dorsett's and the group's admiration of the work of architects Louis Kahn and James Stirling. Using Kahn's words from an interview in *Perspecta*, the NIMH text reinforced the need for the program to reflect the realities of limited resources and the demands of the various constituencies in

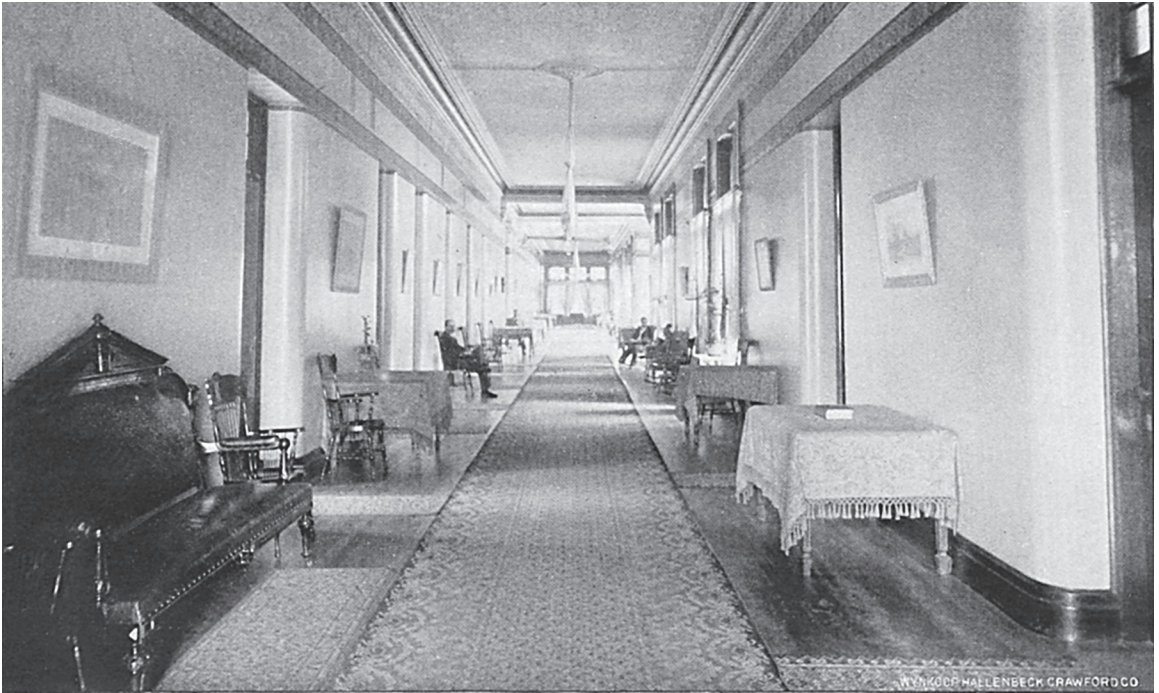


2.8. Plan by Kiyoshi Izumi for Saskatchewan. Laurence B. Holland, ed., *Who Designs America? The American Civilization Conference at Princeton* (Garden City, NY: Anchor Books, 1966), 306.

a clear “form drawing.” According to Kahn, the form drawing would produce an architecture with “a proper separation of parts and the differing visual expressions.”³² In the adjacent margin, a quote from Stirling advocated “the direct expression of the actual accommodation volumes in relation to each element determining the plastic composition of the building. . . . If space can be imagined as a solid mass determined in shape and size by the proportion of a room or the function of a corridor, then an architectural solution could be perceived by the consideration of alternative ways in which the various elements of the programme could be plastically assembled.”³³ Community mental health center designers looked to Stirling’s architectural legibility such as the references in the 1959 Leicester University Engineering School where the auditorium, the laboratories, and the offices were clearly visible as singular, plastic volumes on the exterior. This articulation of program took on a more specific function at the CMHCs—that of making the patient, the government client, and other architects believe that the form would allow the building to attend closely to its mission of psychiatric care.

Hallways were a space of particular concern in CMHCs. Designers worked to shape the circulation to suit patient needs, contorting interior hallways to replace the straight, wide corridors of the old institutions. The hallways were a key way to demonstrate the tailoring of form to program while leaving the basic unit of the patient room or treatment room intact. The long, unyielding hallway was flawed from the perspective that form should be tightly linked to program, allowing the expression of the programmatic volumes on the exterior and being responsive to patient and staff flow. Architects saw the long hallways as a problem, monolithic, inflexible shapes on the plan of a facility that they were arguing had a tight fit between form and program. The hallway that persists unaltered by programs, territories, and densities, as well as its external environment, for such a distance not only evoked the monolithic, un-homelike impression of a modern hospital but also implied a certain hardness, unresponsiveness, or deafness to the spaces around it. How could such a form be claimed to be responsive to its human inhabitants and to present a tight fit between form and function? Instead of trying to justify the long hallways, most of the architects of the new institutions chose to use more complex shapes for circulation, more clearly inflected by the program within.

Many new hallway schemes were targeted at improving the monotonous experience of the long, straight double-loaded corridor of the old hospital. From the nineteenth-century Kirkbride-type mental hospitals—which had been organized as a series of pavilions along a long spine—to the postwar block-style hospitals, the long, straight corridor had been a central feature, constituting the “ward” on which the life of an institution centered.³⁴ The long galleries were important for ventilation; as extensions of day rooms they allowed patients’ rooms



2.9. Soft materials in a ward hallway at the Buffalo State Hospital for the Insane. *Annual Report of the New York State Hospital Commission* (1898), n.p.

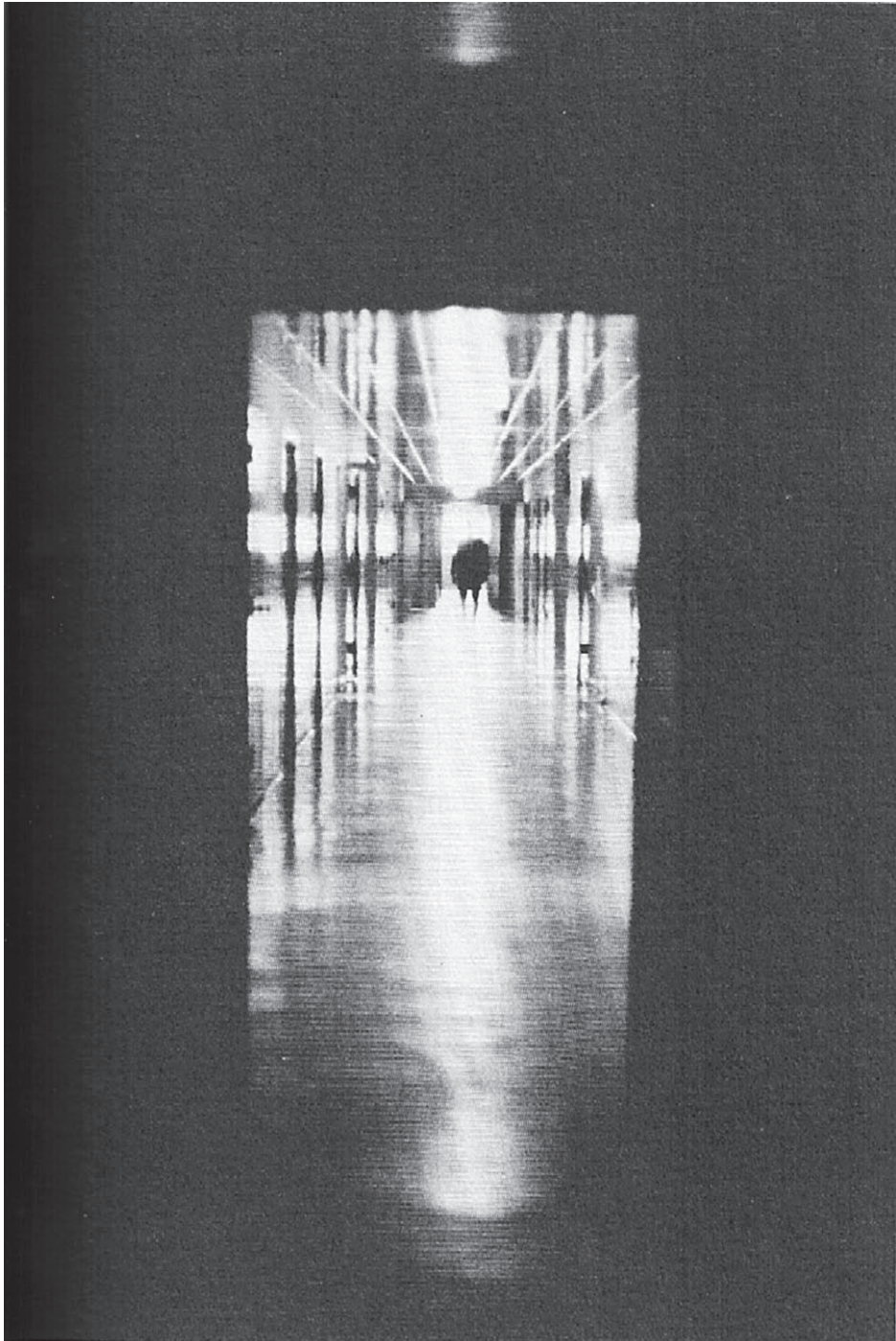
to be aired out during the day. Their length also provided an indoor alternative to outdoor walks on inclement or simply muddy days, a concept reminiscent of the amorous galleries at the phalansteries proposed by Charles Fourier and copied in the United States at communitarian utopias in the mid-nineteenth century. Isaac Ray, superintendent and principal designer of the Butler Hospital for the Insane in 1848, argued passionately instead for the single-loaded corridor with windows along one wall to allow a view to the outside.³⁵ But the hallways were not universally loved even then, and the sheer size of these buildings—some of the largest built in the United States at the time—led Ray and others to object to the huge expanse of dead wall found in such arrangements. Nevertheless, the problem was comparatively minor in the nineteenth century, given the width of the corridor as well as the texture and placement of carpets and furnishings in these institutions. The spaces were often more like rooms themselves, sufficiently responsive to human needs to avoid concerns beyond clearing out odors, noise, and so on. This feeling of softness changed in the postwar hospital environment, however, and it was these hospital wards that concerned patients, staff, and architects.

The long hallways of the postwar hospital were only used for circulation and egress, leaving the hall as a space cut off from natural light with wall surfaces dominated by the regular pattern of doors, opening onto standard-sized patient rooms. Indeed, meeting the requirements of the Hill-Burton legislation basically required a long, double-loaded corridor to promote quick egress of non-ambulant patients in case of fire as well as easy circulation for the gurneys and equipment that came to be a central part of the modern hospital. Unlike the nineteenth-century mental hospital, the mid-twentieth-century mental health center was slick with easy-to-clean plastic or vinyl materials and glossy with new metal and glass building materials. Combining the long, narrow hallway with such disorienting materials was seen as a danger by some psychologists early on, and by the 1980s institutional environment expert Mayer Spivack wrote compellingly of the dangers of combining these materials with long corridors. He described how they exacerbated the problems of “paradoxical images” or mismatch between perception and environmental reality in patients, particularly schizophrenics. Evoking a Tati-esque critique of modern design, Spivack wrote:

All surfaces—floors, walls and ceilings—have either been painted or constructed of materials with a highly reflective glossy surface. The walls are the usual hard plaster, slickly painted. Polished plastic flooring stretches unbroken by pattern, and meets the walls without even an edge, curving dizzily up into the walls. The ceiling is like a mirror; it is covered with perforated metal soundproofing squares, probably chosen because of their washability, and painted with a glasslike gloss white.

The total effect is that of looking down a gun barrel. Reflections, shadows, silhouettes all stream endlessly down the walls, floor, and ceiling directly at the observer. I found it nearly impossible to keep my eyes focused when looking down the corridor.³⁶

Spivack, putting himself in the patient’s shoes, described a streaming, swirling environment unwittingly caused by the cost- and maintenance-saving material choices in the modern institution. Adding the acoustical problem of such a hard environment, Spivack described the distorted sounds of footfalls and sneezes bouncing along through such a long space. Hoping to communicate the hallucinogenic quality of these spaces, he produced series of photographs documenting various illusions, such as the appearance of a man walking through the glass wall of a vestibule, an illusion produced by a double reflection and poor lighting. He was concerned about the disruptions caused by the light at the end of the hallway, a well-intentioned design choice advocated in Christopher Alexander’s patterns as aiding orientation but in Spivack’s view resulting in multiplied unexpected shadows and a lack of expected shadows. Still more disturbing, these distortions would shift as the observer or the observed walked

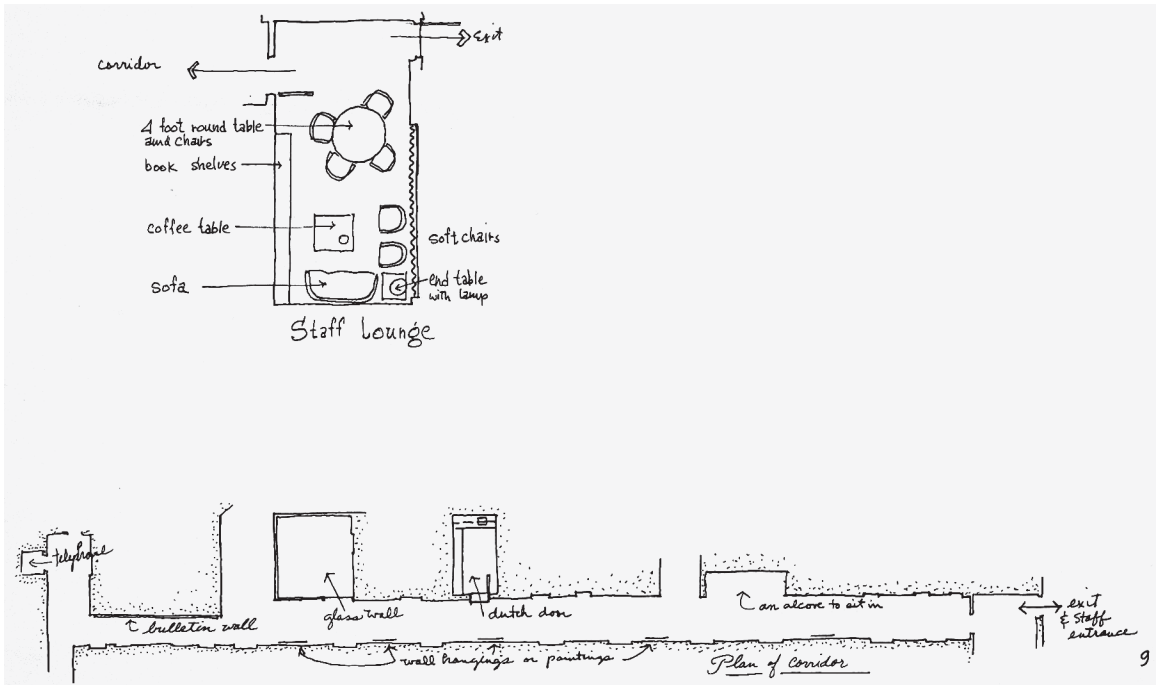


2.10. Spivack's illustration of the problem where "the sunlight so blindingly contrasted with the dim artificial illumination within that people appeared as blurred silhouettes." Mayer Spivack, *Institutional Settings: An Environmental Design Approach* (New York: Human Sciences Press, 1984), 99.

down the corridor, past an unbroken rhythm of doors. Spivack described what he saw and what he imagined a patient would see: "People had fuzzy outlines, were at indeterminate distances, had no feet, ankles, wrists or necks; they also appeared to float over the floor because of the contrast."³⁷ The effect of the materials was the result of good intentions, translated into the choice of affordable, easily maintained materials, which nevertheless resulted in one of the largest problems of institutional environments.

The long hallway became almost universally objectionable for CMHC architects. In redlining applicant drawings from his desk at the NIMH, Dorsett often traced in yellow the path of the patient from entry, to reception, and through facility spaces such as interview rooms, group therapy spaces, or inpatient rooms for emergency or temporary care. At times, these paths were long and convoluted because many schemes included the CMHC as part of a larger hospital complex. Dorsett often approved the projects anyway, but the tracings and his comments reveal his concern with the way that moving through the hallway would impact the patient's experience of the building. Later in his career, when Dorsett produced more developed reports as a private consultant, he would sketch something akin to a Noli plan with only the circulation spaces and a few accessible rooms drawn. The drawing from Dorsett's report on Augusta shows the hallway as a connecting space with attachment to gathering spaces, waiting rooms or lounges, and *poché* for the private spaces.

CMHC designers also worked toward a literal softening of the materials in the circulation spaces, as at Elmcrest Psychiatric Institute, published in *Architectural Record* in 1975, or at the Ridgeview Institute in Smyrna, Georgia, thirty minutes from Atlanta. But they also worked to devise new forms of circulation, to eradicate the central hallway wherever possible by contorting, looping, widening, zigzagging, and creating subzones of circulation. Numerous schemes were produced to widen the hallway into a space that could again be used as a room, as well as for circulation. A typical example was designed by noteworthy hospital designer and visionary E. Todd Wheeler of Perkins and Will, who also published two books on hospital design.³⁸ A sketch of the Charles F. Read Zone Mental Health Center, built in Chicago in 1968, showed the central circulation space populated with recreational activities, shuffleboard, seating areas, and a bookcase, all under the watchful eye of the nurses' station.³⁹ Rather than a sudden transition from main hall to patient room, the scheme marked off a separate zone of space at the corners where the doors to the patients' rooms were. The overall shape is like that of a pound sign or octothorpe, with subzones for movement along the edges of the main room leading to the corners where their intersection is marked with a column. Elsewhere, in a scheme by architect Sim Van der Ryn in Berkeley, this transitional column was dubbed an "onlooker column" for Van der Ryn's proposal that an onlooker could stand behind it or



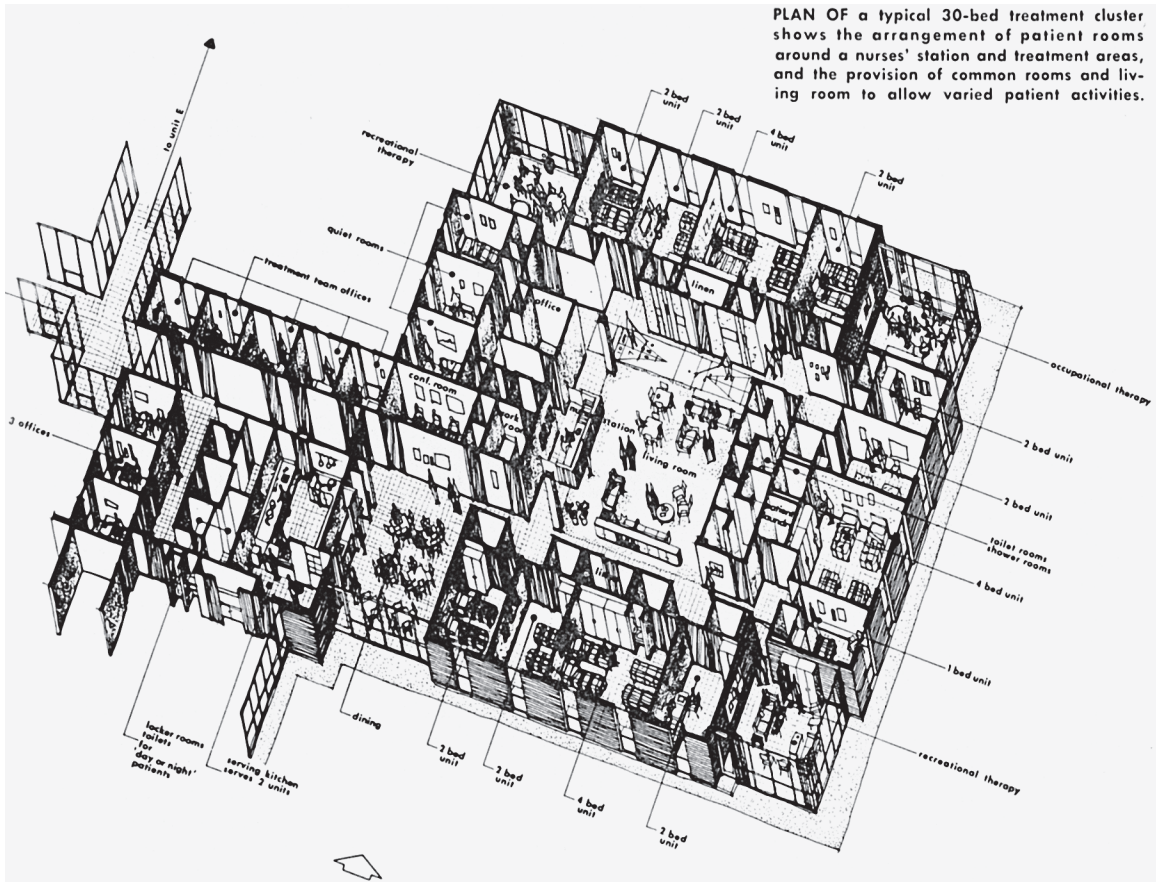
2.11. Noli-style hallway plan (cropped). Dorsett’s undated report on Augusta Area Mental Health Center, Box 5, Folder 1 Clyde H. Dorsett Papers, Avery Drawings and Archives Collections, Columbia University, New York.

lean on it, thus receiving psychological and architectural support which would make it easier for him or her to observe and then join social interaction in the main space. Whether or not such arrangements would work, the important point is that the comparatively subtle gradations of space in such designs provided a more nuanced alternative to the long hallway, arrived at by designers and psychologists who sought to create an environment to fit their idea of the sensitive and fearful mental patient.

When architects and psychiatrists were forced to work within that long hallway, they sought ways to sculpt and soften the space to make it suitable for the new institution. The proposal to redesign the Stone Treatment Building at Topeka, the site of the Menninger Clinic, was even tailored to the patient’s changing mental health. In 1961 a series of influential conferences were held, attended by Richard Neutra, Dion Neutra, and Alfred Paul Bay (who would later participate in the Rice Design Fete held by Dorsett), among others. The architect, Lawrence Good, proposed to repopulate the hallway with modular furniture, textiles, and plants. As expressed in a diagram, reading from

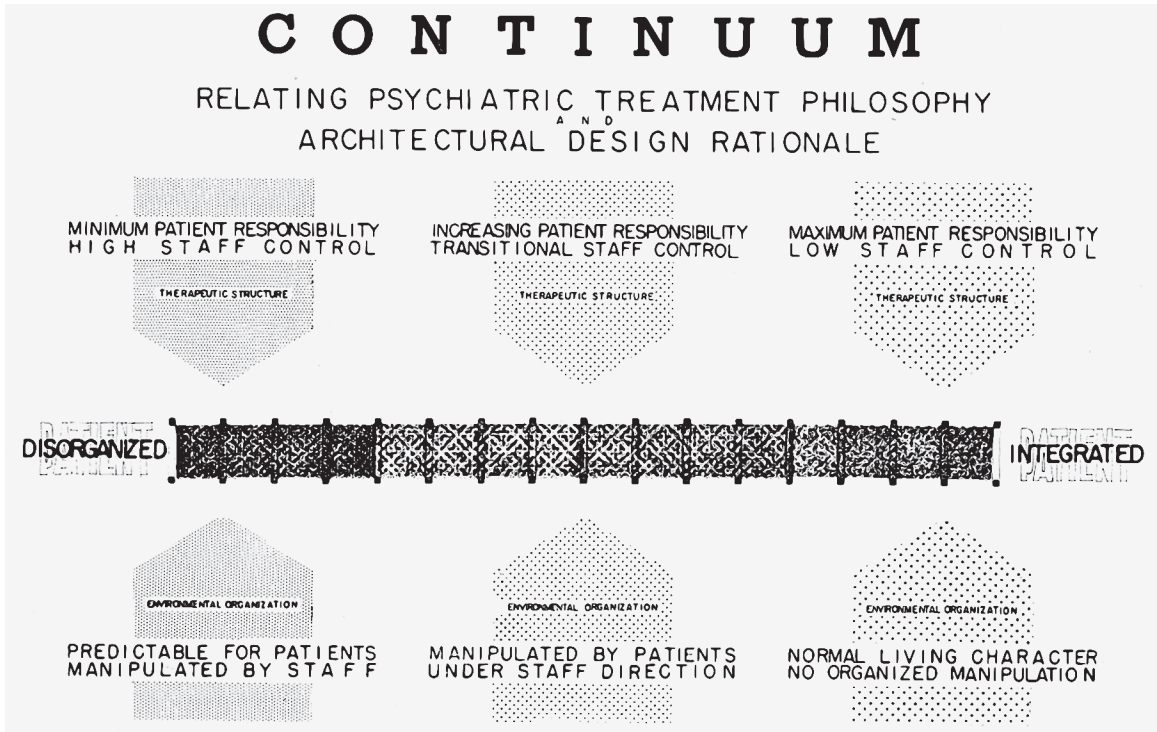


2.12. View of a central lounge space at the Ridgeview Institute, of the same configuration as Wheeler's Zone Mental Health Center. Private Psychiatric Hospital—Brochure, Ridgeview Institute, Box 18, Folder 25, Clyde H. Dorsett Papers, Avery Drawings and Archives Collections, Columbia University, New York.



2.13. Populated with figures playing shuffleboard and standing in pairs or alone, Wheeler’s design for the Charles F. Read Zone Mental Health Center shows the circulation space as its own complex zone for activity. Long ward hallways are replaced with shuffleboard and onlooker columns in the corners to divide the central lounge space from zone in front of the patient rooms. E. Todd Wheeler/Perkins and Will, Charles F. Read Zone Mental Health Center, *Hospitals* 42 (February 1, 1968): 111.

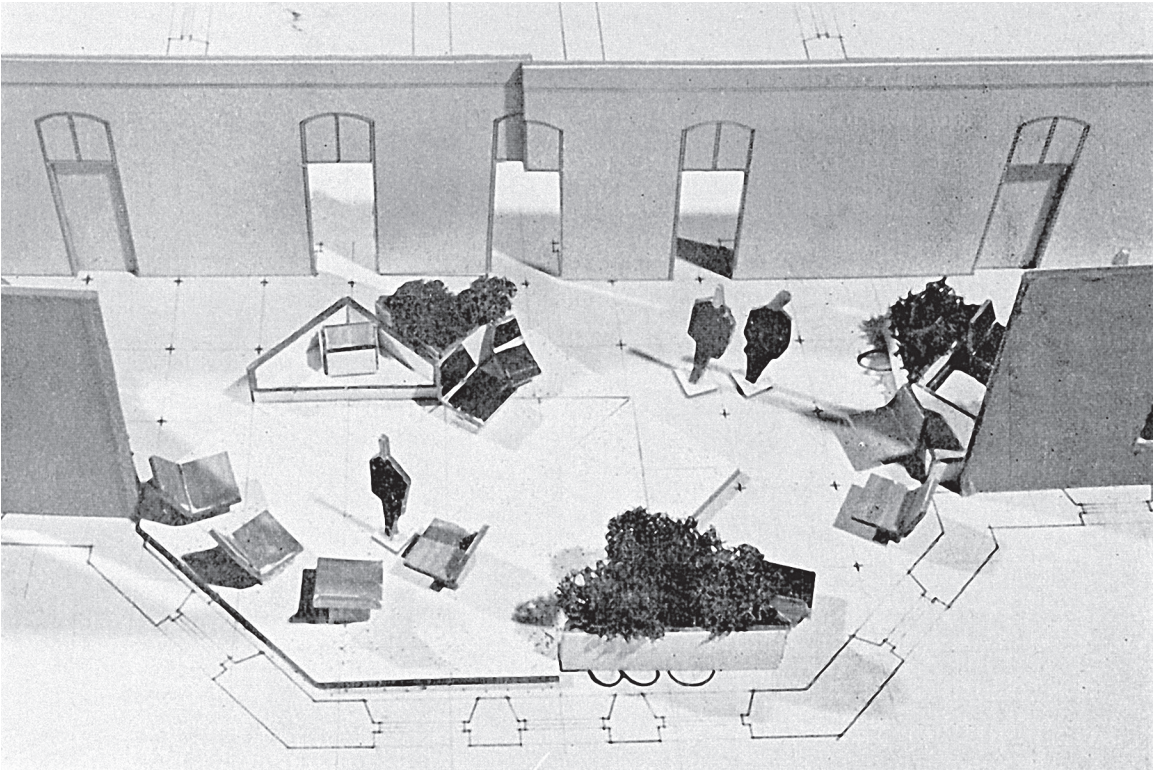
left to right, the patient would move from blue to red to green spaces. Upon arrival at the short-term care facility, the patient would be housed in a blue area in what the designer called “introstatic” spaces: small, personalized areas separated from the distractions of the larger facility.⁴⁰ The blue areas would also be highly controlled by the staff. Next, the patient would move to a red area, a space with more flexible furnishings and materials. The furniture was intended to “force” patients to interact with each other and with their environment, by moving the furniture. Lastly, the patient would occupy green areas, “normal in character,” meaning that there would be no proscribed furniture arrangement, and the patients would be responsible for their own living



2.14. Furniture follows recovery and in turn influences mental health in a diagram for modular furniture that would be chosen based on a patient's recovery stage at Topeka. Lawrence R. Good, Saul M. Siegel, and Alfred Paul Bay, *Therapy by Design: Implications of Architecture for Human Behavior* (Springfield, IL: C. C. Thomas, 1965), 20.

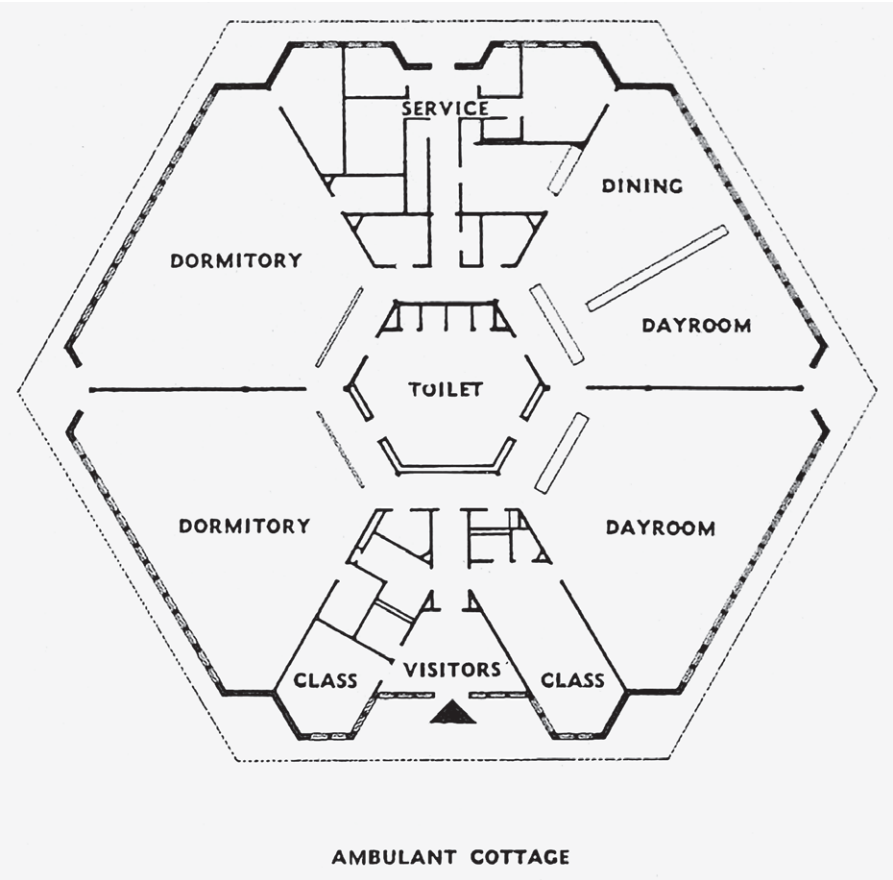
habits. The result was a progressive program of therapy, using psychologists and furniture to develop a self-controlled individual using individualized furniture units.

Richard Neutra's comments were influential for CMHC designers given the architect's emphasis on the connection between environment and human needs. He remarked on the explosion in statistical information available to guide design and approved of the study of mental illness as a means of creating mental health for the community. Good, the designer of the scheme, was president of the Environmental Research Foundation in Topeka and argued that technological solutions were not themselves sufficient. Instead, he referenced Bruno Zevi's belief that architecture is only created when it is experienced by a human subject moving through its spaces.⁴¹ Neutra concurred and applauded the redesign for its attention to human needs, reiterating his belief that "man is the measure of things" and that design must address man's psychosomatic nature and connection to the natural environment.⁴²



2.15. Furniture tailored to the middle stage of a patient's recovery, termed the red stage. Lawrence R. Good, Saul M. Siegel, and Alfred Paul Bay, *Therapy by Design: Implications of Architecture for Human Behavior* (Springfield, IL: C. C. Thomas, 1965), 31.

Triangular and even hexagonal forms were common in such experimental schemes for institutions. Good explained that the triangular forms were used because the asymmetry allowed a triangle to frame space without the rigidity and closure of a square. In this way, a simple form could produce more flexible environments and more complex flows of space.⁴³ No doubt the triangles appealed to Dorsett and the NIMH as a “fresh and creative” look that would distract from the impression of alienation or even manipulation that plagued long hospital wards.⁴⁴ The design for the New Jersey Woodbridge State School for “severely retarded” boys and girls used triangular rooms arranged in a hexagonal plan, as shown in a 1965 brochure. The triangle and hexagon produced an alternative to existing institutions, producing an image of warm and domestic “cottages” scattered on a wooded site, integrated with the landscape rather than standing apart from it.⁴⁵ While the resulting plan resembles a panopticon, the center was occupied by toilet rooms rather than a nurse’s station or other type of powerful central control point. Instead, the radial arrangement produced



2.16. Plan of one hexagonal cottage at the Woodbridge State School. The aim of the centrally located toilets is probably not surveillance but shortening the hallways, appearing naturalistic on the landscape and simply looking unlike previous institutions. Box A2, Roni McCarty’s home, Queenstown, Maryland.

by joining the narrow ends of the triangles made the hallways connecting the rooms far shorter. While surveillance from nurses’ stations was a common concern, it appears to have been less important than the geometry of the hallway and central location of the bathrooms in this case.

At the most personal scale, Dorsett proposed a new type of bathroom mirror that was intended to reinforce the patient’s sense of his or her ego.⁴⁶ The designers observed that while it is “culturally unacceptable” to linger in front of a mirror in the kind of communal, institutional washrooms provided in a hospital, the patient needs to do so to produce a coherent image of self. Because it would not be practical or safe to provide psychiatric patients with private bathing facilities, the alternative proposal was to redesign the mirror. The mirror was curved

to create a surface on which patients would see “a visual image of space—a volume enclosing the user,” allowing them to linger. From the welcoming image on the exterior to the intimate design of a bathroom sink, community mental health centers sought to tailor forms to a theory of patient psyche. Under the umbrella of a massive federal program, design research explored a new building type and devised new strategies for patient-oriented design.

THE SPECIALIST ARCHITECT

Rather than confirming a history of architecture in which one architect (or even a single firm) is clearly the author, CMHC architecture involved complicated authorship typical of large organizations. In almost all cases, a partnership between psychiatrists, social workers, and architects was central to the design process. On the architects' side, two or more architectural firms were often involved in the same project, as at Maimonides in Brooklyn where Caudill Rowlett Scott was the consulting architect, Kahn and Jacobs was the project architect, and Kaplan was the project manager.⁴⁷ In addition to partnerships between firms and between architects and social scientists, the community mental health centers were shaped by Dorsett from a distance through legislation, funding, and paperwork. He called himself a “specialist architect” and described his work as formalizing the ideas of others, putting the new knowledge from institutional design and management of community mental health centers into the right hands, where it could be used to build treatment centers.⁴⁸

Dorsett gained operational skills in the same way as many of the so-called organization men of his generation by watching the logistical expertise of the U.S. military under high-stakes wartime operations. He served in the military during World War II, participating in the Normandy invasion and other combat operations with the army in Europe. For his service, he received two Bronze Star Medals.⁴⁹ After the war, he completed a bachelor in architecture from North Carolina State University in 1953 and went on to design small, modern schools using innovative prefabrication methods in North Carolina. In 1963 he completed a master of science in hospital architecture at Columbia University, where hospital and public health planning and design was one of four options in the master of science in architecture, along with central business district design, general program, and urban planning.⁵⁰ At Columbia, Dorsett prepared a detailed study of an existing hospital in the Bronx, as well as a tower design for an urban hospital, which was later published in the journal *Hospitals*, along with a classmate's more sprawling design.⁵¹

One of the main ways Dorsett influenced the forms of mental health centers was through changes in building code. In line with a larger shift toward specifying performance rather than dimensions, he worked to change the way mental health centers were classified as less like hospitals and more like communal



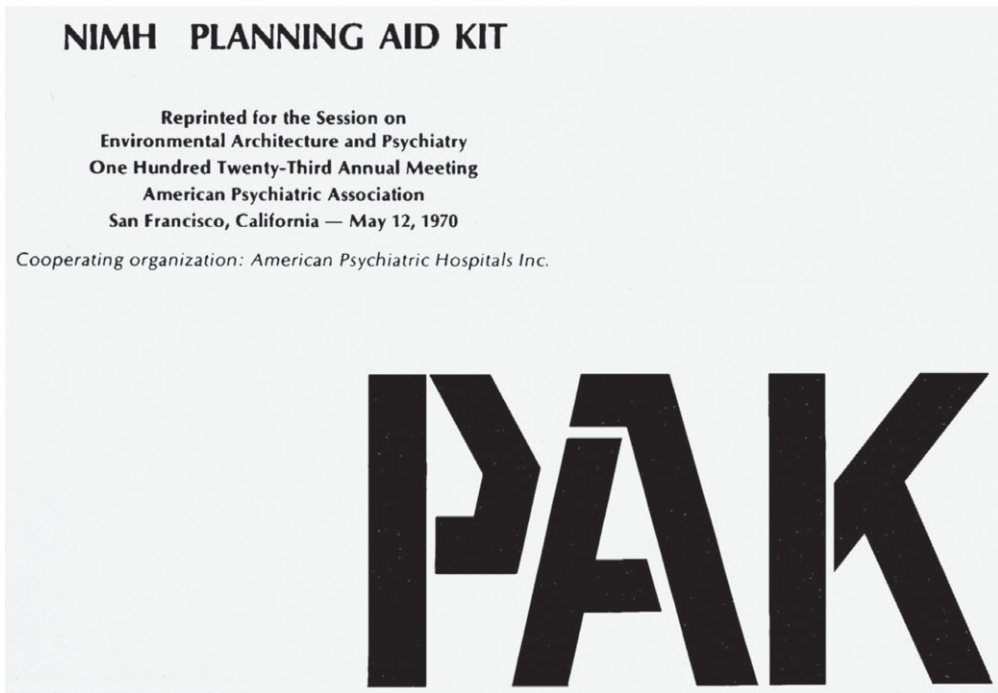
2.17. Clyde Dorsett described himself as a specialist architect. "Community Mental Health Centers Team, Everyone's in a Different Game," P.H.S. World (May 1966), 26, Box 4, Folder 01, Clyde H. Dorsett Papers, Avery Drawings and Archives Collections, Columbia University, New York.

living environments. Building codes are written assuming that occupants will react to scenarios such as fire in ways similar to past behavior, with past calamities written into the shape of future structures. They map the movement of fire through combustible material assemblies, but they also map the movement, or lack of movement, of human occupants toward exits under urgent conditions. Dorsett explained that it was no longer common for patients to be confined to their beds in community mental health centers as had been the case with patients who were restrained or otherwise unable walk. He argued that continuing

to follow the Hill-Burton regulations for hospital accreditation (primarily regarding the “life safety” of the occupants) would yield an overly clinical or institutional environment. In these hospital codes, the stairwells needed to be enclosed, and hallways needed to be wide, long, and unencumbered with the kind of furniture he admired in the Topeka case study. His efforts were successful, and by 1970 the surgeon general affirmed the ambulatory nature of community mental health center patients, shifting the code to accommodate the vision of community psychiatry in a lasting and widespread way.⁵²

Shifting the code was challenging and only one part of creating guidelines for a new type of institution; Dorsett and his team’s Planning Aid Kit (PAK) and collaboration with Christopher Alexander’s patterns also helped disseminate architectural ideas. Dorsett led an NIMH group known as the Architecture Consultation Section, which included a small staff of one architect and a few junior designers who struggled to approve the many drawings during the peak years. To extend their influence, they worked with the National Bureau of Standards to create something in line with the work on “performance specification techniques” already being done with exterior wall assemblies in units for the Federal Housing Administration and for offices in federal office buildings.⁵³ They theorized a gradient from concrete criteria, such as requiring particular hardware, to more abstract criteria, such as “requesting performance,” and noted that on the abstract end of the spectrum new challenges arose. The creation of meaning or a calm mood might be a performance request, phrased in terms of what the environment needed to do rather than what it should be made of. Questions of performance were inherently complex as well as subjective, and the authors sought a mechanism that would avoid the usual politics, where the outcome was defined by whoever was making the list. The task appears to have been significant and undertaken with the good intentions of avoiding institutionalized environments as well as translating the many intimate, emotional, political, and aesthetic needs of staff, patients, families, and the NIMH into a form that could be used in many institutions. The ambition was to create a code that would keep patients safe, provide healing, and eventually replace large parts of building code but that would be flexible enough to allow different communities to create buildings to suit them. The result was a tool that collected the personal hopes and fears of patients, their families, and the staff to be used as a demonstration of care while having little effect on mental health or politics.

It had already become evident in the work with housing that some performance requests were too open-ended, and while it seems that basic functions should have been clear enough, many of the government’s goals for such environments included the ambition that residents should “identify” with the “place.” The Planning Aid Kit, which resulted from the NIMH’s emphasis on community psychiatry, was an attempt to navigate this complexity. The kit was



2.18. Paperwork as a tool of the architect to demonstrate attention to user preferences. Planning Aid Kit, Box 19, Folder 1, Clyde H. Dorsett Papers, Avery Drawings and Archives Collections, Columbia University, New York.

described as a “formal explicit way” to help participants “to inform each other.” The kit led in stepwise manner from uniting the participants, articulating the problems, and selecting courses of action (such as rehabilitation or custodial care) to listing the necessary activities and performance characteristics, or PCs that the environment needs to provide. The nine main PCs were described as gradients of psychological functions, including commonality to privacy, familiarity to remoteness, or ambiguity to legibility.⁵⁴ An environment could be specified as providing a degree of the performance characteristic “sociopetal-ity” to “sociofugality” following a common theory that spaces can encourage gathering (sociopetal) or push people apart (sociofugal) borrowing terms from physical science. Through meetings and paperwork, architecture researchers devised new tools of psychological bureaucracy for design. Dorsett’s effort was informed by an ongoing conversation among architects seeking universal, social science–based solutions. Two such groups were the Environmental Design Research Association, which published the PAK in its initial volume, and the Design Methods Group, whose membership included Christopher Alexander, who also published Dorsett’s ideas in his book of “patterns.”

Dorsett and his staff distilled their ideas about architecture and behavior into “patterns” that allowed them to influence many projects at a distance as required by overseeing such a large construction program. Learning from the experience of evaluating forty to eighty projects a year, Dorsett and his team developed some frequently used design solutions for problems of entry, waiting, and creating the right mood through architecture. His notes and reports often reference letter-sized sheets with “patterns” that could be sent along with the reviewed drawings to communicate to the project architects. The ideas were eventually formalized and published by Alexander in 1973, spreading these ideas about institutional design from CMHCs to a wider audience.

Alexander’s 1977 book *A Pattern Language* presented his theory of architecture as a collection of moments and spaces that could be mixed and matched to produce meaningful environments. After starting his career with the Joint Center for Urban Studies at Harvard and MIT in the 1950s and 1960s, Alexander moved to the West Coast and in 1967 established a Center for Environmental Structure at the University of California–Berkeley with support from Edgar J. Kaufmann of the National Bureau of Standards.⁵⁵ Where other systems thinkers were mainly concerned with grammar and form, Alexander had a humanist interest in meaningful environments that fit well with the softer goals of the NIMH program. In 1971 and 1972, he was directly involved as a consultant in the design of a community mental health center at the Stanislaus County Hospital, located in California’s Central Valley, along with project architect Nacht and Lewis. Alexander and Dorsett may have met at that time but had likely known of each other longer, they also shared a contact through Friedner Wittman, who worked for both architects and who stated the importance of the patterns to the bureaucratic expertise of the CMHC designer or specialist architect.

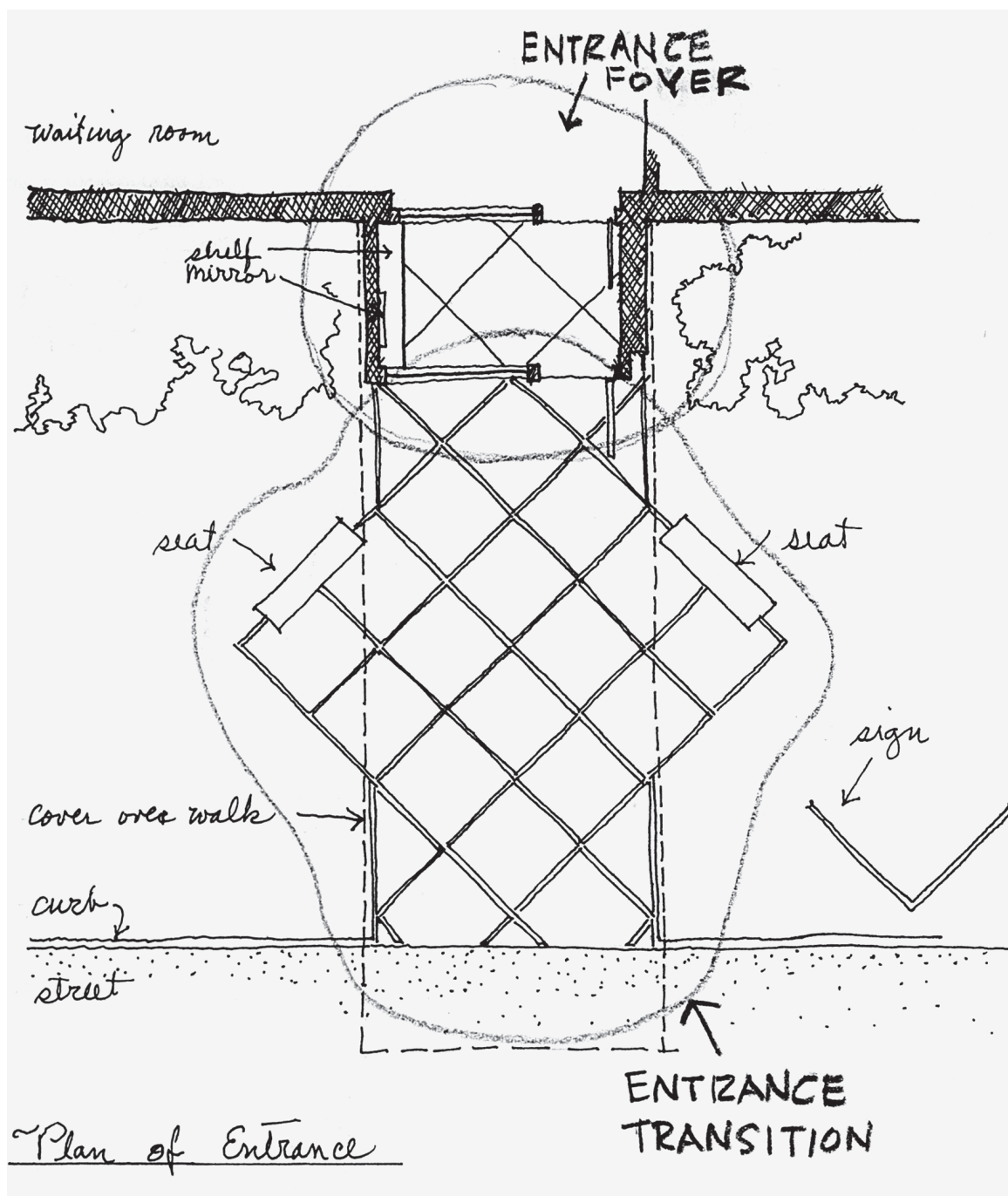
Wittman had worked with Alexander on *The Timeless Way of Building* as part of the Center for Environmental Structure, and later he assisted Alexander in getting a grant from the NIMH’s Center for the Study of Metropolitan Problems.⁵⁶ He had also been the West Coast representative of the ACS, but by the 1970s he had been sent to the NIMH’s Facilities Engineering and Construction Agency as the CMHC projects slowed. In a report addressed to Robert Wakefield, the head of the NIMH’s Center for the Study of Metropolitan problems, Wittman described the patterns and testified to their utility for the work that the Architectural Consultation Section had done. He wrote, “We feel dissemination of the Patterns to governmental agencies and applicants could greatly reduce the need for architectural consultation site visits, and would make available continuously the expertise we now provide in one- or two-day visits or by letter / telephone.”⁵⁷

Wittman’s remark was a junior architect and bureaucrat’s attempt to justify a research apparatus to a government agency; perhaps that context trumped any

loyalty to the ACS or architecture as a profession, as he indicates here a reduced need for architectural labor. After all, the publication of the system of knowledge would save the NIMH and other government agencies considerable expense for travel and salary. Wittman's remark is also evidence that Alexander's type of systemization was being framed as a competitor to design knowledge, making it more understandable that some architects felt Alexander's transferable knowledge and other variants of social science-informed design constituted a threat to their interests. Certainly, federal agencies' specialist expertise was not the same as each designer's creating solutions one at a time. Instead, Dorsett, Alexander, and Wittman focused on the particular points of pain in the experience of visiting community mental health centers, devoting attention to designs that would calm visitors and staff.

In *A Pattern Language*, Alexander thanked Dorsett for a pattern called "Reception Welcomes You," focusing on a part of the building that designers of community hospitals and community mental health centers found crucial to the overall vision of the new typology. The pattern pointed out and responded to the tendency for large public buildings to make humans feel like objects in that they are "processed by the receptionist as if you were a package."⁵⁸ In these patterns, the institutional experience was used as a model of what not to do, and the knowledge gained in designing community mental health centers was codified into Alexander's architectural manuals. Dorsett often attached copies of the relevant patterns to his reports, using the 1968–1970 versions that were being developed by Alexander and the Center for Environmental Structure.⁵⁹ Dorsett emphasized the importance of creating a homelike environment, which he believed could be communicated to the patient by stretching out the transition from exterior to interior at the main entry. He believed a gradual transition would produce a sense of arrival and a desire to linger. In an undated report on the Augusta Area Mental Health Center, Dorsett used language similar to that of the entrance transition pattern, but he supplied his own prototypical plan to direct the architects. He encouraged architects to change the patient's approach path and to produce changes between light and dark using a covering over the walkway. He also recommended a change of paving patterns, so that the patient would feel a sense of arrival. This language is similar to Alexander's but contains Dorsett's comments specifically referencing the applicability to the community mental health center environment (fig. 2.19).

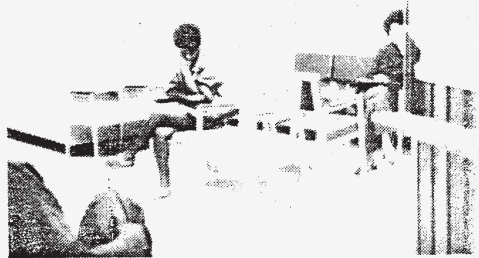
Other patterns attached to CMHC reports concerned the position of the coffeepot, the process of getting information from the receptionist, and the anxiety of sitting and waiting in a lobby, with references to the bureaucratic terror of this experience as conveyed by Franz Kafka in *The Castle* and *The Trial*. The pattern on waiting cited a 1966 study on welfare recipients' views of the bureaucratic system.⁶⁰ Alexander and his collaborators encouraged



2.19. "Augusta Area MHC, University Hospital, Augusta, Georgia," Dorsett Consultation Report, Box 5, Folder 1, Clyde H. Dorsett Papers, Avery Drawings and Archives Collections, Columbia University, New York.

Free Waiting

Large institutions with busy professionals subject their clients to endless waiting; this waiting has a deadening effect on people.



This problem arises in the following way:

Interviewers squeeze as many interviews as possible into a tight schedule. But the exact length of any one interview is unpredictable. This means clients will inevitably be kept waiting.

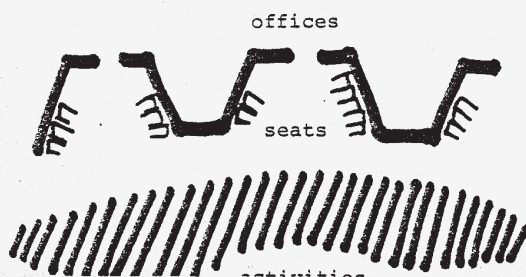
Further, since people never know exactly when their turn will come, they cannot even take a stroll or sit outside. They must stay in the narrow confine of the waiting room, waiting their turn. But this, of

course, is an extremely demoralizing situation: Nobody wants to wait at somebody else's beck and call. (Kafka's greatest works, *The Castle* and *The Trial*, both deal almost entirely with the way this kind of atmosphere destroys a man.)

Evidence for the deadening effect of waiting comes from Briar's study (Scott Briar, "Welfare From Below: Recipients' Views of the Public Welfare System", in Jacobus Tenbroek, Ed., *The Law and the Poor*, Chandler Publishing Company, San

Francisco, 1966, p. 52.) We all know that time seems to pass more slowly when we are bored or anxious or restless. Briar found that people waiting in welfare agencies always thought they had been waiting for longer than they really had. Some overestimated their waiting time as much as four times.

For most people the best antidote for the waiting feeling is to get involved with something interesting that has nothing whatever to do with waiting. (continued over)



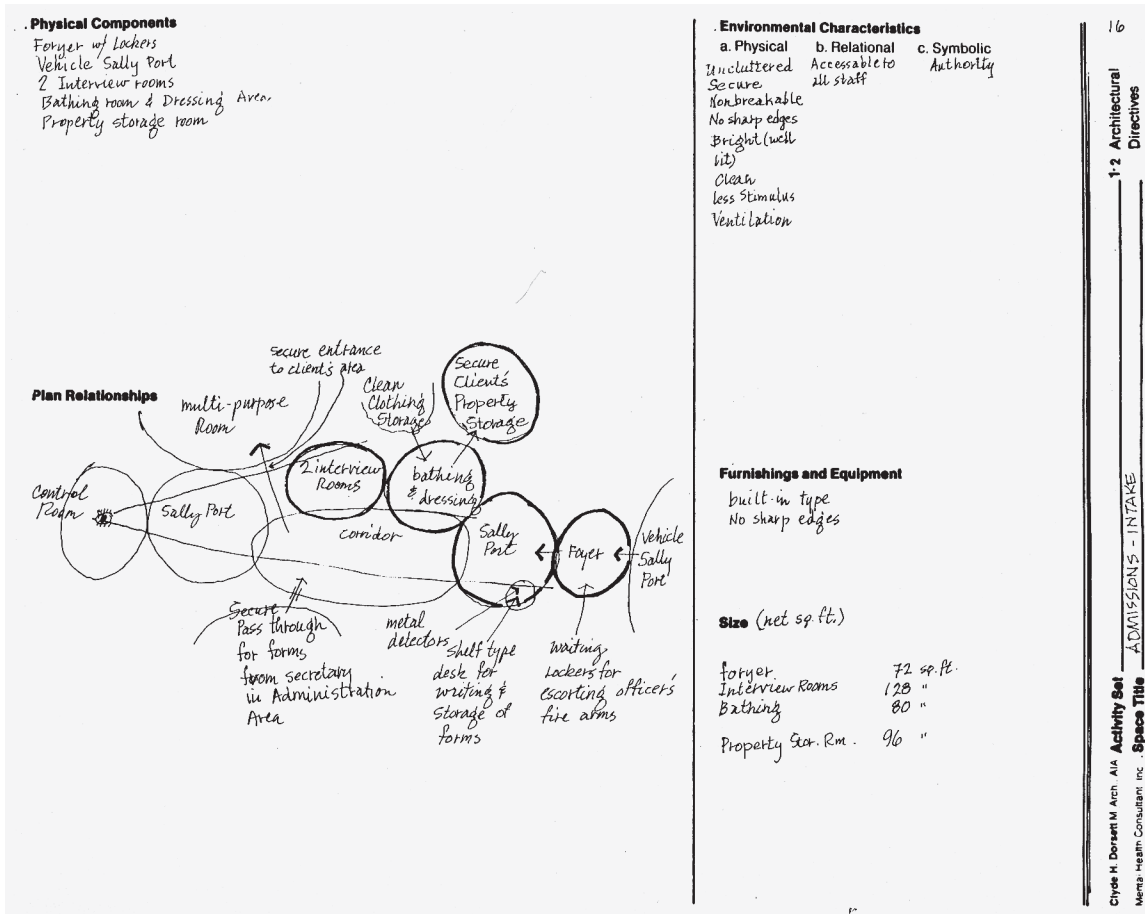
Therefore:

Place a number of seats within sight of the interview office (use the average number of people waiting at any one time plus a safety factor). Place exhibits and reading material near the seats. Connect the exhibit and seating area to a larger open area, with activities for waiters and non-waiters alike (e.g. public arena, pool tables, coffee counter). Equip this larger area with a public address system, for calling people to their appointment.

2.20. Diagram of "Free Waiting" that gives the impression of choice by locating activities near the people who are waiting. Pattern for Free Waiting, Environmental Patterns Kit, Series II: Professional Papers, Box 17, Folder 6, Clyde H. Dorsett Papers, Avery Drawings and Archives Collections, Columbia University, New York.

architects to remember that seemingly endless waiting has a “deadening effect on people.” A diagram showed how waiting areas should be placed within sight of the interview location, with reading material and other activities nearby (fig. 2.20). Ideally, the waiting space would provide a feeling of freedom, with an area for walking around that could also be used by those who are not waiting. The presence of such people would make the wait less oppressive and seemingly more voluntary.

Essentially, these bureaucratic architects and programming experts were in search of forms that would fit a psychologized understanding of institutional architecture with its need to handle patients as well as consider their experience. The result was a set of innovations that treated psyche as a management problem. Dorsett’s evaluations often included his own bubble diagrams, which were similar to those made by Izumi, Caudill, and others. Through these diagrams, PAKs, and patterns, they expressed the fit between the activities of the institution and the spatial envelope that housed it. An example of such diagrams as visual communication of psychology and architecture is seen in the admissions diagram produced for the Southern Nevada Psychiatric Facility (fig. 2.21). The diagram describes important adjacencies for processing a “client” or patient, including places to bathe incoming patients, lockers for storing their possessions, interview rooms, and a recommendation for a specific “shelf-type desk,” all under the watchful symbol of an eye at the control room. In an institution, the flow of documents through the space is almost as important as the flow of patients, and the diagram also identifies an important location for a secure pass-through for patients’ records. The admissions diagram is tailored to a specific flow; the architecture should accommodate the processing of one to four patients—at most two at a time—and the process should last from an hour to an hour and a half. The architect recommended that the configuration should “make the admissions experience for the arriving client comfortable, informative and safe.” The environment should be “bright (well lit), clean,” but also “secure, nonbreakable, [with] no sharp edges,” along with the ever-present request for good ventilation. From ventilation to soft materials, from a smooth admissions sequence to the careful coordination of patient interaction, the architecture of the permeable institution was at the forefront of new techniques for housing and healing a population that would rather be elsewhere. The forms and the diagrams present a pragmatic view of architecture: it is less about the appearance of the facility than the way the arrangement of partitions can facilitate the chronic use of the environment. The key feature of such diagrams is utility as an instrument rather than resemblance to a built reality as a plan or section might show. These diagrams, kits, and patterns are definitely instruments, recommending and communicating the arrangement of components that will work best for the smooth and gentle treatment of the patient.



2.21. Detail from a page of the Matrix for Admissions/Intake Activity for the Southern Nevada Psychiatric Facility Forensic Program, showing a diagram of “plan relationships,” inverted by author. Box 9, Folder 38, Clyde H. Dorsett Papers, Avery Drawings and Archives Collections, Columbia University, New York.

By the 1960s, with the growth of architectural programming at the hands of Caudill and the like, design was increasingly concerned with the elaboration and choreography of such abstracted spatial bubbles. Such architecture was tailored to the goals of the social institution it housed, which acted within a national bureaucracy and functioned as a large mechanism to house and manage yet smaller units. By visualizing the invisible—social forces, territorial hierarchies, and flows of people and objects—the diagrams eased communication in the large bureaucracy and incorporated abstractions into a discursive format. Dorsett was able to produce diagrams to direct applicants about best practices, and applicants were able to convince Dorsett and NIMH of their responsiveness to psychological factors.

CONCLUSION

Despite the significance of its goals and the new institutional typology proposed, the CMHC program had many critics and failed to create the kind of change its proponents hoped for. The avant-garde schemes for a new, enlightened mental health care typology were not realized, though not due to a lack of architectural inventiveness. The program lacked adequate staffing grants for years, and because a certain bureaucratic expertise was needed to apply for the funding, the lowest-income areas did not receive assistance. The system also faced accusations of attempted social control under the ostensibly innocent idea of mental health. Given the late 1960s context of racial tensions, urban riots, and the targeting of CMHCs at low-income, often urban and minority populations, the use of drugs made many people uneasy. Psychoactive drugs internalized the architecture of restraint, altering the internal environment of the patient's mind and allowing the external architecture to persuade rather than contain. In a sense, the drugs made it possible for the environmental controls to be dissolved into the individual patient's brain chemistry. Unsurprisingly, the internalization of control was frightening, particularly by the late 1960s and early 1970s as criticisms of psychiatry generally—and the CMHC programs specifically—grew.⁶¹ In 1968 Kenneth Keniston published an essay, "How Community Mental Health Stamped Out the Riots (1968–1978)," chronicling a fictitious "Operation Inner City" that followed a strategy of total saturation of psychological experts to stop the riots once and for all.⁶² In 1969 psychotherapist and New York University associate professor Chaim Shatan published a critique of community mental health, arguing that the growing emphasis on preventive psychiatry would lead psychiatrists to be more and more involved in social control. He accused the CMHC program of using management techniques instead of seeing many disorders as behavioral adaptations to larger social and class issues.⁶³

The federal program was also subject to national and international politics; Lyndon Johnson won his fight against Barry Goldwater in 1964, but the struggle left its mark as the president chose to devote more resources to the geopolitical struggle in Vietnam. Facing a lack of public faith, growing New Left movements among the youth, and organized movements for racial justice, he found it harder to hold onto the power to push through his domestic policies. When Johnson lost the election in 1968, efforts to extend CMHC funding had to go through two Republican presidents, Richard Nixon and Gerald Ford. President Jimmy Carter took on the issue of mental health and crafted a new bill, but his legislation was vulnerable, and in 1981 Ronald Reagan passed a version that dismantled the funding into state-by-state block grants, losing the force and vision of the program.⁶⁴ As with other social legislation, the aid was broken down into segments for various groups, and no leadership could assemble consensus to

keep the program going. Some CMHCs remain but without the architectural vision of the early program; instead they mainly inhabit buildings that look as any other office might.

After an optimistic beginning and two solid years of construction, construction tapered off after 1967. With the first phase of construction closing, the NIMH increasingly renovated existing facilities rather than building new ones. Moreover, the NIMH's mission shifted to include an even larger range of services, including corrections, child care, drug abuse, alcoholism, and elderly services.⁶⁵ The ACS was also transitioning, having gone through a program where they trained the newly created Facilities Engineering and Construction Agency, now tasked with administration of construction funding and supervising construction within the Department of Health, Education, and Welfare. Wittman, who had been in charge of the western arm of the ACS, moved over to the Facilities Engineering and Construction Agency. Dorsett and the ACS were now primarily concerned with "problem" CMHC projects and with the dissemination of mental health facility information that had come from their own work. Dorsett described the ACS's new role of serving as a kind of "clearinghouse" for architectural information rather than paying close attention to individual designs.⁶⁶ After 1970 the growth of CMHCs slowed drastically, and in 1972 Dorsett found enough time on his hands that he applied for a sabbatical to continue developing forms and other planning kits that the Facilities Engineering and Construction Agency and others could use for meetings with user groups.

In 1972 Dorsett described the funding for CMHCs as at a "low ebb."⁶⁷ By 1973 there were only 493 federally funded CMHCs, and not all of those were fully operational. By 1975 603 had received some funds, but only 507 were operational.⁶⁸ In 1973 the initial period of funding came to an end, and it was not renewed. After that time, most of the CMHC's proponents—and the specific organizations that had worked for the program—were reabsorbed into the larger NIMH or moved off into private consulting. As the funding for ACS and the CMHCs dried up, Dorsett, Wittman, and even Leonard Duhl, who organized and led a group of architects and psychologists, did not cease work. They merely turned to private consulting, consulting for international organizations, prison-related work, or academia. In 1980 Dorsett left the NIMH but maintained his role as architectural consultant, expanding into private consultation. He was hired by the World Health Organization and the U.S. Agency for International Development in Grenada, West Indies. The fact that Dorsett continued his career as a private consultant reinforces a classic American narrative of the privatization of formerly government affairs in the 1970s, as does his involvement in prison reform following his research on psychiatric care.

The architecture of CMHCs was simultaneously a fascinating example of the development of architectural knowledge under favorable political conditions

and a cautionary tale of architecture's presumption, its desire to do better. While a new typology was not created, several methods and design strategies were carried forward in other typologies, particularly the studies of open prisons by the Federal Bureau of Prisons. Community mental health centers persist in unremarkable buildings throughout the United States where it seems every few years someone suggests novel designs could smooth the process of adjusting mental health—somehow not realizing that this has already been tried. After the optimistic programs of Johnson's Great Society floundered with reduced funding and were eventually almost entirely dismantled by Presidents Nixon and Ford, social science and architecture research increasingly focused on crime and prison reform.