REFUGE IN THE STORM:
PROGRAM AND DESIGN OF A THERAPEUTIC HOUSEHOLD FOR THE MENTALLY DISTURBED

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ABSTRACT

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Submitted to the Department of Architecture June 1978 in partial fulfillment of the requirements for the Degree of Master of Architecture.

This thesis makes the proposal that so long as they are not dangerously violent to others, people entering a state of schizophrenia should be given the opportunity to retreat to specially designed therapeutic households rather than to psychiatric hospitals and clinics which rely on a medical image and routine, a role hierarchy from doctor down to mental patient, and an over-dependence upon and often coercive use of drug therapy.

A short description of the experience of schizophrenia is given along with excerpts from personal accounts of "going crazy", with special attention to the human relationship to the nonhuman environment. From this study, a recurring set of psychological needs have been translated into environmental terms and organized under seven categories of design considerations: Image, Choice, Privacy, Interaction, Enhancement, Movement, and Transition. Under each of these categories are sub-categories which are discussed with some reference to their psychological or existential significance, some suggestions as to physical design responses, and a summarizing statement or norm for the design process.

From the major tenets of the thesis and the seven design considerations, and from my own working experience in several mental health care settings, I have created a design program and design for a site in North Cambridge, Massachusetts. The last chapter of the thesis includes a description of this site, the programmatic notes, the drawings themselves, and a description of the design and the thinking behind it.

Finally, I have included an appendix which presents a brief discussion of the "Age of the Asylum", the community mental health center movement, and mental health care planning in Massachusetts today.

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a proposal for the establishment of

"therapeutic households"

Who are the mentally disturbed? Who declares them so? At what point must society decide a deviant member should lose his rights to self-determination and be made to enter an institution designed for his care and, perhaps, recovery? Or are there non-coercive alternatives to institutionalization? What kind of place is considered "therapeutic" for what kind of people? Any discussion of considerations in the design of "mental health" facilities must grow out of this line of questioning because it is one's politics or philosophy which determines the treatment mode and an appropriate physical design response.

One of the strongest indicators of the character of a culture or society is its system of defining mental and behavioral deviance and its subsequent manner of dealing with the problem socially, legally, architecturally, and so on. However, the mental health field of today presents a confusing picture, sprawling across many disciplines and philosophies, riven by debate and conflict. Social workers, medical and para-medical personnel, clinical psychologists, and personal growth gurus all tend to advocate a different ideology which is related to their own educational backgrounds and professional emphases. Anthony Clare in his Psychiatry in Dissent has described the situation as a "fractious and acrimonious" debate:

> "It is my experience that, for example, the idea of the family as a begetter of psychopathology, the stereotype of the 'schizophenogenic' parent, and the conviction that all mental illness is environmentally determined, are all theories of causality of special appeal to social workers confronted in their day-to-day work by an awesome catalogue of economic hardship, fragmented personal relationships, and social stress. In contrast, such evidence as there is to support genetic and constitutional factors tends to command much less support from this quarter than from among medical and para-medical personnel, who are more accustomed to securing the foundations of the subject in a biological matrix, and less respectful of the causal claims of social factors. Clinical psychologists, understandably heartened by the modest success achieved by certain behavioral techniques in the management of a number of psychiatric conditions, and often out of sympathy with the theoretical approaches of their medical and social-work colleagues, are tempted to embrace an explanatory model rooted in behaviorist principles. In the midst of this ideological din, caught in a no man's land between psychiatrists, psychologists, and social workers, are the psychiatric nurses, whose main hope of professional survival is somehow to harness into a benevolent therapeutic force the contrary winds that blow around them."[1]

1. A. Clare, Psychiatry in Dissent, p. xiv.

Given this discordance amongst mental health professionals, it is no wonder that there have even been attempts to abolish the concept of mental illness and the medical

model of treatment altogether. If, like this writer, one has worked in several different kinds of mental health care facilities and met with many of the existing system's "mental patients", the motivation may be to re-examine the way society has dealt with these people, be they truly mentally disturbed or, as often seems to be the case, wrongfully labelled and stigmatized individuals who might have been dealt with in a less drastic manner - or not dealt with at all, as many would no doubt prefer. Critics of the psychiatric profession like Erving Goffman (Asylums), Thomas Szasz ("The Myth of Mental Illness"), and R.D. Laing (The Politics of Experience) have viewed the concept of mental illness as a means of obscuring and invalidating legitimate human needs, aspirations, and values which conflict with prevailing socio-cultural understandings. The more politicized adherents of the anti-psychiatry movement have even declared mental illness to be a means of political oppression of the downtrodden and exploited members of society. Psychiatrists are sometimes depicted as society's "reality police" (see Anthony Brandt's Reality Police: The Experience of Insanity in America), agents of the dominant political power. Even ex-mental patients are beginning to mobilize themselves by forming such groups as the Mental Patients' Liberation Front in order to overcome what they would testify to as

"They have a list of long Greek and Latin words and when they observe such and such symptoms in one of us, they pass the label for our phobia on us -- and that is the end of the matter. I cannot see that they have accomplished so much in merely being able to remember all those long-handled names for our madness. We, who have learned what madness is by going through it, -- (and you cannot have closer knowing than that) -- are separated from all others by a gulf so wide that it cannot be bridged. And there the matter lays -- divided, split, and sundered.

Ancient races said madness was 'Devil possession' -- and dealt with the victim after the manner that suited their time. Their sophisticated descendants, because they live in the present, and call themselves 'modern,' have dispensed with the devil idea -- and developed an intricate system of symbols. Words, technical phrases -- whose syllables clatter together and make a noise like scientific analysis. They do not have the insight to know that the whole thing is summed up with as much logic in some old voodoo witch doctor's symbol."

Lara Jefferson, The Inner World of Mental Illness, p. 6.

the suspension of constitutionally guaranteed civil rights and as institutionalized psychiatric abuse. Critics who would do away with the concept of mental "illness" would replace it with some alternative, non-medical construct such as deviance, maladaption, social disturbance, problems of living, or community disorder, and the person in need of help might be variously labelled as client, deviant, dissident, analysand, student, or consumer.

The major tenets of this thesis are the following:

1) that so long as they are not physically violent towards others, people entering a psychotic or schizophrenic state should be given the opportunity to retreat to specially designed therapeutic households rather than to locked, dehumanizing, anti-therapeutic psychiatric wards, hospitals, and clinics - also that the medical model of psychiatric treatment ought to be avoided as far as possible, referring specifically to the hospital-ward-clinic image and routine, the "illness" and diagnosis model, the doctor-psychologist-nurse-aide-patient role hierarchy, and an over-dependence and often coercive use of drug therapy

2) that the design of therapeutic households should be approached with the idea that architectural space is the "concretization" of existential space, that human transactions with the nonhuman environment form an integral part of psychological existence, and that the experience of the schizophrenic is a case in which these transactions become critically important through their loss or malfunction

3) that ideas of reference for such therapeutic households should come from such places as half-way houses, student fraternities and cooperatives, communes, communitarian utopian settlements, wholistic health retreats, and, especially, R.D. Laing's Kingsley Hall which will be discussed later in this thesis as a model anti-institution

4) that based on all the above, the architectural design considerations for a therapeutic household fall under the categories of Image, Choice, Privacy, Interaction, Enhancement, Movement, and Transition.

This thesis makes the proposal that specially designed, small-scale, residential facilities might well meet the needs of chronically institutionalized persons or of persons who have been only marginally coping in their lives up until the time of a serious mental break. Such a facility would operate under the belief that mentally disturbed people often need the opportunity to live out their delusions, obsessions, or other distresses with a minimum of restraint and stimgatization in order to recognize the potentially restitutive facets of their psychological regression. Included in this group would be many of those persons whom the Massachusetts Task Force on Community Mental Health describes as "adults whose mental illness and emotional problems are manifested by psychosis, suicide attempts, severe depression, episodes of confusion, etc." - in other words, those persons supposedly requiring hospitalization. [2]

"But whether the problem of variety versus security is shared by other schizophrenic people or not, it remains that I have been coping with it, thanks to Canadian freedom of action, by striving to learn where curiosity leads, and frequently by relying upon intuition. I am almost convinced that natural instinct could lead a schizophrenic to a cure, when tempered with common sense and a learned ability to test reality. It is another interesting paradox. Living with this illness is a matter of balancing opposites."

Norma MacDonald, The Inner World of Mental Illness, p. 179.

2. Task Force on Community Mental Health, "Developing Community Mental Health Programs: A Resource Manual", p. 55.

For the schizophrenic, themes of disturbance run throughout the cyclical efforts of the day. It is throughout the mundane daily activities of waking, bathing, brushing teeth, dressing, and so on that a person experiences his disturbance. This is the reason that some people in the mental health care field have begun to devalue somewhat the short sessions patients spend with their psychiatrists. What about the other twenty-three hours? In a hospital setting, a patient usually spends those other hours with his fellow patients and with low-status aides or "psychiatric technicians" who are often uneducated as to psychiatric theory but who are often the most significant individuals in the lives of the patients through sheer amount of time spent together, if nothing else. Hospitals, like most institutions, usually present conditions of what Mayer Spivack has called "setting deprivation" in which basic human needs are made near impossible to satisfy.[3] Why are people made to live in hospitals as patients then? A therapeutic environment for the mentally disturbed must be designed with the idea that all parts of a person's day are important in his developing mental state, in his learning about himself, and in others' interacting with and learning about him. For this reason, it would seem all the more evident that it should be special

3. M. Spivack, "Archetypal Place", Environmental Design Research.

home-like environments that the mentally disturbed might retreat to rather than the alien, depersonalizing, and antiseptic environments of hospitals and clinics.

Transactions with the nonhuman environment form an integral part of the human sense of self. In his Existence, Space, and Architecture, Christian Norberg-Schulz writes that architectural space may be defined as a "concretization" of existential space. Existential space is the schemata by which a person assigns order and meaning to his transactions with his environment.[4] Similarly, the thesis of Harold Searles' book, The Nonhuman Environment in Normal Development and in Schizophrenia, is that the nonhuman environment constitutes one of the most basically important ingredients of human psychological existence and that there is within the human individual a sense, whether conscious or unconscious, of relatedness to his nonhuman environment. Schizophrenics or psychotics and people who have undergone long-term institutionalization usually suffer a significant disturbance in body image and in relations to the physical as well as the social environment. Searles writes that "in the life of a psychiatrically ill individual, his ability or inability to relate himself constructively to the nonhuman environment may be of more than a little importance, both in

4. C. Norberg-Schulz, Existence, Space, and Architecture, p. 12.

causing his life to be significantly less, or more, grievous, and in constituting a real factor in the prognosis of his illness". In the course of development of psychosis, a person can in many instances maintain meaningful relationships with nonhuman elements of his environment for some time after his relationships with other human beings have become swallowed up in the mental disturbance. As Searles has suggested, when the psychotic person begins to emerge from his regressed state - whether through treatment or through some sort of natural cycle - relationships with nonhuman rather than human elements of his environment may form the initial development in a slow struggle back to "reality".[5]

5. H. Searles, The Nonhuman Environment in Normal Development and in Schizophrenia, p. 19, 43.

It is naive to assume that building design alone can bring about the psychotic person's recovery of his normal state of mind, but physical design is a prime opportunity for the creation of an important therapeutic tool. The experience of what I, with some discomfort, call "schizophrenia" is discussed in more depth in the next chapter of this thesis. It is this experience, especially as it involves transactions with the physical environment, which should be studied more carefully through reading the personal accounts of people who have undergone the trauma of a psychological breakdown, through interviews with these people,and through interactions

with and observation of those currently undergoing such an experience. Each person's experience may be quite different from that of the next, but a recurring set of psychological needs may be gathered, some of which may be translated into environmental terms and so used to create truly "therapeutic" environments for the mentally disturbed. Such therapeutic environments would be designed with the idea that the spatial experience of the human personality can be used in a treatment plan in which the physical environment is such that it stimulates and/or re-educates the perceptions of the severely regressed person with the goal of re-establishing his relationships to the nonhuman and, eventually, the human environment.

Having dispensed with the medical model image, what kind of place might a therapeutic household be? Because of its size and the specialized requirements of its inhabitants, it would necessarily be different from the normal family home in physical design as well as social structure. Society today is experiencing a breakdown in the dominance of the familial social structure and people are struggling to define new ways of living. Christian Norberg-Schulz talks about how the words "dwell", "protection", "peace", and "freedom" belong together. Freedom presupposes security which is only possible

through the preservation of human identity of which existential space is one aspect. This, he says, is the essence of "dwelling". But we must learn to dwell because experience today shows us that people do not spontaneously find their footholds.[6] Those who suffer the confusion, alienation, and terror of a mental breakdown have lost all footholds or "mind-holds". They, in particular, must be provided with some form of sanctuary or refuge in which to "weather the storm" and, eventually, to learn a new way to dwell in peace.

The half-way house movement offers a radical communal alternative for all kinds of groups of people who have been considered marginal or second-class citizens, from the elderly and the retarded to ex-convicts and ex-mental patients. In the case of the mental patients, as discussed above, there seems to be no reason why most of them ever should have been made to assume the role of patients in a medical establishment instead of retreating to a home-like place to regain their bearings in the world. Fraternities and sororities are another form of communal living which has often been scorned for its "establishment" associations and often rowdy misconduct, but the idea of an association of mutually reliant group members is the same ideal that binds

6. C. Norberg-Schulz, p. 36.

"...you are like a vessel in a storm. It puts out a sheet which helps the boat to weather the storm because it keeps its head to the wind, but it also gives it a feeling of comfort to those aboard the boat, to think they've got a sheet anchor that's not attached to the bottom but it's a part of the sea, that enables them to survive, and then as long as they think they're going to survive as a boat then they can go through experiencing the storm. Gradually they begin to feel quite happy with it even though the sheet anchor might have broken adrift and so on. I feel that if ever a person were to experience that sort of thing, he's got to have - well, one hand for himself, as it were, and one hand for the experience...Some people are equipped more for it and some are less - but he's got to have some way, some sort of sheet anchor which is holding on the present - and to himself as he is - to be able to experience even a little bit of what he's got to experience."

Jesse Watkins, The Politics of Experience, p. 164.

the more politically radical experiments such as communes and wholistic health retreats. In the latter two cases, the group members are usually bound by certain lifestyle principles which distinguish them from and often set them in opposition to the mainstream. The wholistic health retreats, with their emphasis on expanding physical, sensual experience, are interesting in reference to the design of therapeutic households in that the severely mentally disturbed often suffer disruptions in normal phyical and sensual experiences. All these examples of communal living tend to have a glimmer of utopianism in that they are founded with some notion of what the good life is or might be. People cannot plan their world without also designing themselves and their lifestyles.

I have made mention of R.D. Laing's communal living experiment, Kingsley Hall, which was located in London's East End, a working-class community. There might be the tendency to ask: how can you have really crazy people living in a non-institution with unlocked doors opening onto a normal residential neighborhood? Won't the residents wander out into the street doing bizarre things, antagonizing or frightening the neighbors? Kingsley Hall is the proof that a therapeutic household can work. It was a community in which individual members could work out their "madness" amidst other "mad"

people and those there more specifically to help. The community included three psychiatrists, a psychiatric nurse, and a psychiatric social worker. However, these professionals were against the formalization of roles such as medical director and they attempted to avoid theoretical models of "therapeutics" which might become coercive and obscure the genuine needs of the residents. Joseph Berke, who lived in the community for several years writes,

> "We were against formalizing roles like Medical Director because a) this would inhibit the freedom of the residents to develop spontaneous and mutually helpful relationships with each other, and b) the attendant social operations might be defined by the local medical authorities as constituting a nursing home or half-way house. The community could then find itself bound by a set of extremely restricting and (from the standpoint of the organic development of the community) alien rules and regulations as to how people should behave and by what means they should live. It was the whole point of Kingsley Hall that this was something we had to discover for ourselves. It could not be imposed from without."[7]

Joseph Berke's quotation appears in a book called Mary Barnes which he wrote in collaboration with Mary Barnes. It is an account of her journey through a state of extremely regressive "schizophrenia" in which she often refused to eat until she had become "like one of those half-alive cadavers

7. M. Barnes and J. Berke, Mary Barnes, p. 214.

the army had liberated from Auschwitz after the war". Many times her friend Joseph found her covered in her own feces which she had smeared over herself and, often, over the walls of her room. For several months at a time she was quite unable to bear the presence of any other people besides Joseph or "Ronnie" (Laing) and would remain holed up in her room, having food brought to her and her chamber pot emptied by others. From such a state she was able to recover her bearings through the devotion of Joseph and other members of the community and, importantly, through the discovery of her passion for painting (with paint!). Withstanding the behavioral extremes of people like Mary Barnes, Kingsley Hall was a place of colorful characters and extraordinary activities. The majority of the community and its visitors were not medical or para-medical men and women but were artists, dancers, writers, actors, and others who came because friends lived there, or because they liked communal life, or because they had heard that Kingsley Hall was a "groovy scene". Sometimes they came to demonstrate their wares at the poetry readings, film shows, music and dance recitals, and art exhibitions which took place in the big hall downstairs. Berke writes,

> "Their presence added an extra dimension to life at Kingsley Hall. They emphasized touch and smell as well as sight and sound. They showed how easy (or hard) it

> is to pass beyond the limits of verbal expression in order to reveal experiences which are remarkably like those which occur in dreams or psychotic reverie."[8]

8. M. Barnes, p. 260.

Mary Barnes describes Kingsley Hall with some allusions to the way the place was used, but R.D. Laing and the community had had little to do with the kind of place they were getting since they were offered rent-free use of the building for several years. Kingsley Hall was a three-story brown brick building which was elderly and quite spacious with such notable features as the great hall which was mentioned above, a roof garden and bird bath, and a special box someone had built in the basement which was painted black inside and installed with colored lights. (Mary would often go down to "The Box" to get away by herself and to find solace in a small place.) Judging by the number of bedrooms, the Hall would have housed a total of about fifteen people, but visitors were frequent and residents tended to move about from room to room. During the five years that Mary lived there, she managed to occupy six different bedrooms at different times, as well as the meditation room, the chapel, and the basement.

Unfortunately, the community lost the use of Kingsley Hall after about five years of operation, although a special housing association was set up with the goal of founding other similar communities. Mary Barnes moved out to her own

apartment and continued painting, having had several exhibitions of her work while still a resident of Kingsley Hall. In the future, Mary would like to help set up another place like Kingsley Hall to serve as a refuge for people who have entered the state of psychosis. She would like to live in it and to help others through the experience she so painfully managed to recover from. She has written,

> "When I think now of a place, I think of people, us people who are already involved, and I think of our spiritual needs. Our desires to worship God - the great need of the soul.
>
> Because we do this in different ways I want in such a community as ours to see real freedom and respect towards these different ways of life.
>
> ...a place grows into the sort of place people want it to be. It then serves the needs of these people.
>
> Similar people come along, mad people, therapy people, they 'fall' for the place, perhaps come in and 'wreck' it - because it's the only place they've ever found that would stand their feelings."[9]

9. M. Barnes, p. 350.

* * * * * * * * *

Thus far the discussion has concentrated on the kind of social structure and lifestyle a therapeutic household ought to offer. Having set the tone, the "politics" of the place,

the task now is to arrive at some kind of formulation of the architectural design considerations for a therapeutic environment. A more in-depth description of the experience of "schizophrenia" follows in the next section of this thesis. It is from this study that I have assembled a set of what I would consider to be reasonable goals for residents of a therapeutic household. The goals are:

1) to alleviate feelings of anxiety and fear and to establish instead a sense of trust in fellow residents and a hope for recovery

2) to expand the sensual life and enhance the experience of the outer world in the hopes of lessening the tendency to withdraw to an inner world of idiosyncratic order and meaning

3) to re-establish a stable body image, the boundary between self and non-self

4) to re-establish the spatio-temporal references, the sense of orientation in time and space

5) to widen the experience of success and satisfaction in social interaction and communication

6) to instill faith in the self as an active, responsible agent in order to re-assert the normal competencies of day-to-day life.

This set of goals, all interrelated and non-sequential,led me to formulate seven considerations for the design of a therapeutic household, which should be regarded as loose cate-

gories by which to discuss material which is largely speculative and demanding of further study. The design considerations discussed in the thesis are:

1) Image
2) Choice
3) Privacy
4) Interaction
5) Enhancement
6) Movement
7) Transition

Under each of these categories are sub-categories which will be discussed with some reference to psychological or existential significance, some suggestions as to physical design response, and a summarizing statement or norm for the design process.

From the major tenets of the thesis and from the seven design considerations, I have created a design program and design for a therapeutic household hypothetically located on a site in North Cambridge, Massachusetts. The program, drawings, and description of the thinking that guided the design form the last chapter of the thesis. Finally, I have included an appendix which presents a brief discussion of the "Age of the Asylum", the Community Mental Health Center movement, and mental health care planning in Massachusetts today.

the experience of "schizophrenia".

There can be arguments over the possible causes of "schizophrenia" and over whether one should use the term at all since it is a medical diagnosis with certain corresponding implications as to hypothesized cause and appropriate treatment methods. However, whatever the cause and whatever the treatment methodology, the fact remains that some people do come to exhibit strange behaviors and to give indications that they are perceiving, thinking, and feeling in certain patterns which are deemed abnormal, crazy, psychotic, schizophrenic, or indicative of their having taken the "X-route", as R.D. Laing has called it in order to avoid traditional psychiatric categorization.[1]

1. R. Laing, The Politics of the Family, p. 51.

Anthony Clare in his Psychiatry in Dissent has classified the signs and symptoms of schizophrenia in three categories as follows:

I. Disorders of perception
   A. Sensory distortions
   B. Sensory deceptions
      1. Illusions
      2. Misinterpretations
      3. Hallucinations
II. Disorders of thought and speech
   A. Disorders of the stream of thought
      1. Flight of ideas
      2. Retardation
      3. Perseveration
      4. Thought blocking
   B. Disorders of the possession of thought

1. Obsession and compulsion
2. Phobias
3. Thought alienation

III. Disorders of the content of thinking
   A. Delusions
   B. Disorders of the form of thinking
      1. Lack of causal links
      2. Inability to maintain the boundaries of a concept
      3. Interpenetration of unrelated themes[2]

Understandably, the behavior which accompanies these disorders can be bizarre and incomprehensible to those around the affected person. Normal communication, of course, is usually disrupted and the person becomes unable or "unwilling" to carry on with his usual responsibilities and activities. He may exhibit a marked lack of affect and response to other people's overtures or he may overreact with violent scenes apparently unrelated to what other people perceive to be the situation. He may maintain a seemingly uncomfortable physical posture for long periods of time or he may constantly pace up and down, gesturing and shouting at imagined others. Whatever the behavior, the schizophrenic person appears to have withdrawn into an inner world only tenuously attached to the spatial and temporal world most people agree to call reality. Once precipitated into psychosis, it is as if the person has a course to run. He is embarked on a stormy voyage of self-discovery, often frought

2. A. Clare, Psychiatry in Dissent, intro.

"My wife became very worried. She came in and told me to sit down and lie down in bed and because she was alarmed she got hold of the man next door to come in. He was a civil servant and he was also a bit alarmed and he calmed me down, and I was rambling on to him, and the doctor came up and I was talking of a lot of these feelings I had in my mind about time going back. Of course, to me they sounded perfectly rational, I was going back into sort of previous existences, but only vaguely. And they obviously looked at me as I were mad, I could feel - I could see the look in their faces and I felt it was not much good talking to them because they obviously thought I was quite round the bend, as I might have been. And then the next thing was that an ambulance came and I was taken off..."

Jesse Watkins, The Politics of Experience, p. 150.

with terror and disorientation, from which he may never return. Successful navigation through this inner world may return him to the "normal" world, but he will have different insights about the world and about himself.

Much of the fear in the schizophrenic experience appears to be the result of a breakdown or idiosyncratic permutation of the usual processes by which a person differentiates his inner self from the external world. The schizophrenic may become disoriented in his inner and his outer worlds as he experiences a crippling disruption in the processes of the human/environment transaction. He loses his usual sense of a boundary between himself and his environment or, in other words, his body image becomes blurred. He loses many of the temporal and spatial references which tend to mark out the normal person's cognition of his surroundings. His power of adjustment to perceptual contradictions is diminished and often his perceptions are distorted or seriously impoverished.

It may be useful to digress for a moment to discuss the human/environment relationship in general. William Ittelson, in his Environment and Cognition, has used the term "transaction" to describe the human relationship to the environment because it denotes movement or behavior across or beyond boundaries (trans: across, over, beyond, through,

"I cannot escape from the Madness by the door I came in, that is certain - nor do I want to. They are dead - past - the struggles of yesterday. Let them lay in the past where they have fallen - forgotten. I cannot go back - I shall have to go onward - even though the path leads to 'Three Building' - where the hopeless incurables walk and wail and wait for the death of their bodies.

I cannot escape it - I cannot face it - how can I endure it."

Lara Jefferson, The Inner World of Mental Illness, p. 7.

through and through).[3] "Transaction" carries a double implication: one, that all parts of a situation enter into it as active participants; and two, that these parts owe their very existence as encountered in a situation to such active participation. The parts co-exist and their interaction with each other affects their own identities. Humans and their actions, then, are of and and in the world to which all humans and all actions belong as integral constituents. Environments surround. A person cannot be a subject of an environment because he is of the environment. In this environment which has no real fixed boundaries in space or time, the limits of human exploration are not predetermined. It remains to be seen how the individual explorer will go about setting his own boundaries to the environment with which he transacts.

Just as the bounds of the external environment cannot be absolutely delimited, so, too, an individual's sense of self cannot be simply defined by the outer limits of his skin. At any one moment, an individual carries a body-image which may be regarded as an extension of the body in the form of an imaginary envelope which modifies the perception of the forces affecting the self by magnifying or suppressing the psychological

3. W. Ittelson, Environment and Cognition, p. 18, 19.

"I felt all my nerves tingling; an odd light feeling in my head. The force of the impulses charging out of my brain were actually swaying my body. For one split second I had the feeling I had stepped out of my body and was standing there watching. In that short space of time I felt myself praying a desperate prayer as a helpless third person. I looked on the person I knew was myself - and knew I had never seen her. She seemed bigger than any human I ever saw. So deadly and menacing that I felt a nausea of fear and prayed to God to make the nurse hurry!"

Lara Jefferson, The Inner World of Mental Illness, p. 34.

effect of those forces. The body image is the complete feeling or three-dimensional Gestalt that an individual has of his spatial intentions, values, and knowledge. It is a psychical, unstable boundary which is subject to events both inside and outside the boundary. Edward Hall in his study of "proxemics" discusses the idea of the body image as does Robert Sommer in his book Personal Space.

As described above, then, the environment has no fixed limits and no thing and no one can be truly isolated and identified as standing outside and apart from his environment. At the same time, the human sense of self in the body image is a projection into the environment of the individual's spatial intentions and social predilections. Consequently, as Harold Searles has written, it seems that human beings in general "have anxiety - usually at an unconscious level, and under extraordinary circumstances at a conscious level - not merely lest we regress ontogenetically (to an infantile or an intrauterine state for example) but also lest we regress further, phylogenetically as it were, to an animal, vegetable, or even inorganic state".[4] The schizophrenic suffers this kind of anxiety to an extreme as he finds himself pulled into uncontrollable identifications with elements of his environment -

"Things which were fragments of primeval evolving life possessed me for a timeless instant on waking from sleep: as they fluttered forth they were yet more real and necessary than the dim whitewashed room and the painted iron bedstead on which the bodily sight opened, which scarcely shut the mental eye. The margins of time and space being loosened, I was conscious of an intense but ecstatic agony: I was in the sea, and under an icy rock of unimagined hardness. My life was a single maddened spark, hammering the rock, in a body whose other feeling was as nothing, though birds and fish plucked and gnawed it to the bones. Huge gulls came down close, and as they swooped they cried 'Ja-ack, Ja-ack!' Archer seemed to be somewhere at hand: he too was part of the ancient elemental life: we were to each other as two oscillating atoms which, when they meet, will have the unique, wonderful experience of exploding, not into void, but to a living molecule!"

Thomas Hennell, The Witnesses, p. 36.

4. H. Searles, p. 179.

both human and nonhuman elements of it - in the attempt to find relief from an almost unendurable instability of his own ego boundaries. What had been internalized is now externalized and vice versa. Searles describes how one of his patients underwent the experience of feeling his mind had expanded to the limits of the room in which he sat. Robert Sommer has written about how schizophrenic persons will exhibit behavioral evidence of the idiosyncracies of their personal space or body image by sitting too close to other people or, more commonly, not being able to bear the proximity of another person.[5] This behavior may simply indicate an unwillingness to engage in human interactions, but it may also be related to the permeability of the perceived barrier between the schizophrenic individual and his environment.

Some psychologists draw a comparison between the schizophrenic's experience and that of the infant. Harold Searles has written:

> "I have expressed my conviction that the normal individual and the schizophrenic individual are alike in having a developmental phase in which the ego is subjectively indistinguishable from the surrounding environment, including the nonhuman elements in that environment; and further, alike in that the unconscious (now, in the schizophrenic, to a considerable extent in consciousness) possesses much content which is of nonhuman origin (that is to say, which

> "Of nights, the cell grew smaller, and I dwindled with it as we descended in a spiral curve: then my body was no bigger than a glow-worm. And then we were on the point of entering nether worlds, hollow globes filled with electric light, guarded by small uniformed men, who were half-mechanical. Here sat figures, each in the sphere of his own worship, whose limits imprisoned him: and I feared to recognize them."
>
> Thomas Hennell, The Witnesses, p. 87.

5. R. Sommer, Personal Space, p. 31.

originated from past perceptions of elements in the nonhuman environment." [6]

Some psychologists, too, hypothesize that the abundant evidence of a schizophrenic's inability to distinguish between the self and the non-self is testimony to a degree of failure to achieve at the normal time in infancy as clear-cut and profound a differentiation of the self as is normally achieved.

Studies of early human development show that human beings learn the means of organizing perceptual responses over time. The infant does not have a clearly differentiated body boundary but evidently experiences a world in which the body and environment tend to fuse. The inside and outside worlds are discovered gradually through a process of successful and unsuccessful transactions between the body and the environment in which the child detects and responds to sensations emanating from inside (coenesthesia) as well as from outside the body. Accumulation of these sensations of collision develops consciousness of an individuated self in the world - or an awareness of the difference between self and non-self. This early experience marks the establishment of the primordial model of three-dimensionality of the human mind.

Paul Sivadon has described the dynamics of the human

6. H. Searles, p. 170.

". . . then I started going into this . . . real feeling of regression in time. I had quite extraordinary feelings of -- living, not only living, but feeling and experiencing everything relating to something I felt that was -- well, something like animal life and so on. At one time I actually seemed to be wandering in a kind of landscape with -- um -- desert landscape as if I were an animal, rather a large animal. It sounds absurd to say so, but I felt as if I were a kind of rhinoceros or something like that and emitting sounds like a rhinoceros and being at the same time afraid and at the same time being aggressive and on guard. And then going back to further periods of regression and even sort of when I was just struggling like something that had no brain at all and as if I were just struggling for my own existence against other things which were opposing me. And then at times I felt as if I were like a baby -- I could even hear myself cry like a child. . ."

Jesse Watkins, The Politics of Experience, p. 151.

personality in an admittedly simplified way as the totality of processes through which the individual experiences the meaning of his relationship to the world and organizes the situation so as to preserve best his own constancy, while adjusting to the demands of the environment. By constantly renewing the internalization of spatial situations, Sivadon says, the personality is constructed and enriched over time. The human infant gains a sense of passing time because his expectation of already known situations, and therefore, of recurring anterior space relations, enables him to identify time. A child's concepts of time, then, evolve almost parallel to those of space. In order to describe the sense the human consciousness has of succession and, so, of time, one must borrow from the concepts of space. Modern physics synthesizes the two into a single concept of space-time with movement as the bond between them.

The enriched human personality becomes increasingly capable of integrating a wider and wider space to the extent that it can display a harmoniously organized history consisting of a well-assimilated past and a plan firmly anchored in the future. The person who suffers a schizophrenic break, though, experiences a disruption in the normal process of personality growth over time and,

"Lying there I came as close, I think, as I ever have to a state of emotion unaccompanied by thought. I simply felt. Again, I have never learned words to describe sensations so far removed from what is called normal. General misery, physical discomfort, degradation not born of intellectual concept, but a deep, bodily and inner mental state; a feeling of being lost, lost utterly with no sense of place or time, no idea as to whom voices belonged, no clear realization of my own identity, lost in mind and body and soul, lost to light and form and color; a distinct, acid nausea of self-revulsion -- all these were in the feeling that swept over me. But they do not describe it any more than a list of ingredients describes any assembled whole. It was all the more complete in that I was not conscious of intellectual activity of any kind. My whole being was given over to feeling. I had not the slightest defence, either within myself or without. The sensation grew, rolled upon me like a gigantic wave. I gasped, struggled; there was a sickening, acute moment, then a welding. The emotion became me. I went down with it whence it had come, to some far depth beyond the bounds of any remembering."

Jane Hillyer, The Inner World of Mental Illness, p. 160.

in fact, often loses his usual temporal references of experience:

> "While personality develops in the form of a temporal continuum resulting from the internalization of previously experienced situations, disintegrations result, first of all, in a loss of temporal references before the spatial references are affected. Experiences of prolonged isolation always confirm this initial disintegration of the concept of time. One step further and the spatial references disappear..."[7]

Lost and terrified in unfamiliar territory, the schizophrenic person has no sense of orientation in the geography of inner space and time, nor in outer space and time, and the perceived boundary between the two may become so porous that one becomes confused with the other.

The stronger (strength does not mean inflexibility) this primary boundary in a person, the more individuated and more capable of vividly experiencing the environment he is. The schizophrenic, in his withdrawal to an inner world, usually restricts his behavioral space as if by avoiding active exploration of space, he allows himself to mold the surroundings as he find necessary (by his own peculiar meaning system). The miscellaneous distortions in the schizophrenic's experience can be described in toto as resulting from his relating to the nonhuman environment not as being what it really is or as what others

7. P. Sivadon, "Space as Experienced: Therapeutic Implications", Environmental Psychology, p. 411.

"I even felt it so strongly I looked at the clock and in some way I felt that the clock was reinforcing my own opinion of time going back although I couldn't see the hands moving...I felt alarmed because I suddenly felt as if I was moving somewhere on a kind of conveyor belt - and unable to do anything about it, as if I was slipping along and sliding down a chute as it were...And this gave me a rather panicky feeling...I remember going into the other room to see where I was, to look at my own face, and there were no mirrors in that room. I went into the other room, and I looked into the mirror at myself, and I looked in a way strange, I seemed as though I were looking at someone who was familiar but very strange and different from myself...and then I had extraordinary feelings that I was quite capable of doing anything with myself, that I had a feeling of being in control of all my faculties, body and everything else...and I started rambling on."

Jesse Watkins, The Politics of Experience, p. 148.

perceive it to be, but rather as if it were a limitlessly plastic modelling clay which he unconsciously molds and remolds to serve the momentary needs of his existence.

The psychology of perception explains how the normal person manages to steer his way through the physical world despite the often disturbing contradictions between what is perceived and what is known to exist. (the visual constancies, for instance) It is possible that mental or emotional disturbances may deprive a person of the ability to adjust to this dichotomy and to accept it as the total experience. He may become painfully aware of the inconstancies of perception and cognition and be acutely worried by them. Instead of experiencing one perception as supporting of another, the schizophrenic seems to experience time and space as frozen abstractions. The mechanics of orientation, haptic sensing, and perceptual analysis break down. Ittelson has observed that mental patients often have poor visual acuity, distorted size constancy, variation in orientation to the vertical and the horizontal, reduced peripheral acuity, and poor vision in the dark.[8]

The schizophrenic sometimes experiences sensory impressions more intensely than normal. The senses of smell, hearing, and touch may be over-sensitive, exaggera-

"Night terrors returned more sharply: sometimes they were shared with others, sometimes solitary. None could say whether this was a live shell or an express train by which all things were whirled out of time and shape, nor what were these mazy plans of passages and narrow cells whose details were now printed on the brain with such exactitude. Once the basis of life had appeared godly and simple, but now it gathered speed, range and destructive violence, as a snowball rolled from a summit grows to an avalanche, sweeping half a mountain.

'Earth's rolled out.'
'Time's broken in half.'
'Creation's doubled.'
'Where are we?'
'In God's wheelbarrow,' then spoke a voice like the doctor's."

Thomas Hennell, The Witnesses, p. 99.

8. H. Proshansky, W. Ittelson, and L. Rivlin, Environmental Psychology, p. 9.

ted, and sometimes painfully acute, or else confused with one another. Psychiatrist Humphrey Osmond and architect Kyoshi Izumi took LSD with the idea that they might experience a state akin to that of the schizophrenic. Izumi reports that in his experience of perceptual distortion, he sometimes felt textures to be related to temperature and to color.[9]

On the other hand, a person in a schizophrenic state may experience a severe impoverishment instead of an exaggeration of his perceptual responses. Harold Searles has drawn the comparison between this state and that of the subject in isolation experiments described by Heron et al and Lilly. In these well-known studies, hallucinations occurred to the subjects as if to fill the void caused by experimentally induced sensory deprivation. In Searles' clinical experiences with hallucinating individuals, he was sometimes amazed to learn how unpeopled and otherwise bleak was the basic perceived world upon which hallucinatory phenomena were projected.[10]

"These two carried electric torches which seemed to project tormenting heat into the brains of those at whom they were directed. In fact electric light now became an intense discomfort to me, because it was needlessly strong, and there was no escape from it, or possible means of turning it off. The guards were quite insensible to complaints on this matter."

Thomas Hennell, The Witnesses, p. 87.

9. K. Bayes, The Therapeutic Effect of Environment on Emotionally Disturbed and Mentally Subnormal Children, p. 40.

10. H. Searles, p. 166.

image

A SECURE REFUGE

The person who suffers a psychotic break has probably become overwhelmed within the mainstream of society or by the particular home and work environment in which he has been living. In reaction to whatever pressures he has experienced, his madness contains elements of reason and meaningfulness. Madness may be construed as action which the person exerts in order to remove himself from a disagreeable situation and to change himself. This change can be accompanied by a storm of disorientation and anxiety so that the person may feel unable to undergo the experience without trusted people around in an environment which communicates reassurance, stability, and continuity. The person experiencing a state of schizophrenia may come to distrust himself, to be unable to predict the strength of his own feelings and the range of his behavior. He may be afraid that he will hurt himself, someone else, or the things around him.

The protective function of the therapeutic household, then, is twofold: 1) it offers an alternative to and refuge from the home, social, or work environment which precipitated a person's psychotic break, and 2) it gives the disturbed person the impression that it will withstand and

"And that then, occasionally, I had this sort of vista ahead of me as though I was looking down - looking to an enormous - or rather all the - not looking so much as just feeling - ahead of me was lying the most horrific journey - a journey to the final sort of business of being aware of all - everything, and that I felt this so strongly, it was such a horrifying experience to suddenly feel that, that I immediately shut myself off from it because I couldn't contemplate it, because it sort of shivered me up. I - it drove me into a state of fear, so much - I was unable to take it."

Jesse Watkins, The Politics of Experience, p. 155.

protect him from his own emotional violence. The household should imply through its image a feeling of reassurance, stability, and continuity. This is one of the main reasons that the recommended therapeutic environment be patterned after the home rather than a hospital or clinic. For a person who has suffered a disturbing change in his sense of orientation to the geography of both his inner and outer worlds, hospitalization and the loss of home may well aggravate his condition and be experienced as a further loss of the sense of self. To move to a therapeutic household with its more familiar associations and set of expectations could not be construed to be as drastic a change of lifestyle as a move to the hospital or clinic with its staff in uniform, the surroundings alien and sterile, and the expectations for behavior unknown.

THE THERAPEUTIC HOUSEHOLD SHOULD OFFER A STABLE, SECURE REFUGE FROM THE MAINSTREAM OF SOCIETY, FROM THE PARTICULAR ENVIRONMENT WHICH PRECIPITATED A RESIDENT'S PSYCHOTIC BREAK, AND FROM THE RESIDENTS' FEARS OF THEIR OWN EMOTIONAL VIOLENCE.

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SENSITIVE SITING

The original nineteenth century notion of siting insane asylums on beautiful, "salubrious" landscaped grounds in the country was a good idea in that institutions were then located away from the polluted industrial towns and surrounded instead by the natural landscape. However, this isolation served to draw attention to the institution as a special place for crazy people, a stigmatized place where normal people dare not go. True, the residents could find refuge from the mainstream of society and from whatever environment had precipitated their mental disturbances, but surely they also sensed in their isolation a sign that society would not tolerate their presence. Isolation bred a condition of institutionalization in the patients - over-dependence on the asylum as social system which in turn created the foundation for abuse of the system and the patients. For these reasons, it would seem that a modern-day country retreat would be inappropriate for most disoriented, psychotic people who could never be quite sure that they were not being placed there indefinitely or who might suffer further withdrawal into their own idiosyncratic inner worlds due to the loss of a neighborhood connection. This connection symbolizes, though it does not guarantee

the residents' feeling of relatedness to the society at large.

The site for a therapeutic household should be part of an existing, stable neighborhood pattern. A densely packed, urban site would probably be inappropriate because it would not offer secure, private outdoor space as a buffer zone, a tolerance zone between the neighborhood and the new household. Behavior in the new house might get chaotic at times, some residents might have to scream and battle with hallucinations, some might wander out into the front yard behaving bizarrely. All residents could not be looked after at all times by staff and other concerned residents. A comfortable distance from the adjacent houses might buffer these uncontrollable occurrences and allow a relaxation of security concerns.

Just as the house should not be stigmatized by excessive isolation, it should not stand out due to its appearance. In the design of defensible space for modern-day housing developments, it is important that the new housing not stand apart from the existing neighborhood by the use of unfamiliar forms and materials or by an unharmonious siting. Otherwise, it stands isolated and provocative, a target for vandalism. Similarly, a therapeutic setting designed to stand out in an existing neighborhood will be

stigmatized and vandalized in a spiritual if not a physical sense.

THE THERAPEUTIC HOUSEHOLD SHOULD BE PLANNED FOR A SITE LARGE ENOUGH TO ALLOW A TOLERANCE ZONE BETWEEN IT AND THE NEXT HOUSE, BUT IT SHOULD NOT BE STIGMATIZED BY EXCESSIVE ISOLATION OR BY A DESIGN INSENSITIVE TO THE EXISTING NEIGHBORHOOD FABRIC.

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THE IMAGE OF HOME

A feeling of security springs from familiarity. The message of home is familiar: it is shelter and protection and it is intimately bound up with an inhabitant's sense of self.

Home as mother and home as self are familiar archetypal symbols. The home is like the mother who offers shelter for the young and undifferentiated ego of her child. It is the first safe territory from which to venture out into the world and to return to for protection and the gathering of strength to venture out again. The house boundary and the bodily boundary become intimately associated through this process of individuation so that the house becomes the sym-

Fig. 3
The archetypal symbol of home as mother is represented in this 15th century painting by Piero della Francesca. The young, undifferentiated ego-personality is protected by the mother - in this case, by the Madonna, whose outstretched arms and cloak form a kind of house for the human figures below.

bol of self as well as mother. In children's drawings, houses often appear as faces with windows for eyes and nose, a door for a mouth, and a roof for a forehead or hat. The house has a hearth like a heart, a lawn like the boundaries of personal space, and a rear side with the anal implications of service and trash removal. The symmetry of the facade corresponds to the frontal "symmetry of mobilization" characteristic of an animal's posture of self-defense. The facade is like the ego, the presentation of self to the public world. The attic above is the superego; the basement the dark id. [1] Houses often appear in dreams as physical representation of the mind with its well-used rooms and those yet to be explored.

THE THERAPEUTIC HOUSEHOLD SHOULD PRESENT THE IMAGE OF HOME WITH ITS UNIVERSAL CONNOTATIONS OF PROTECTED SHELTER FOR A CHILD' EARLY STRIVINGS FOR INDIVIDUATION AND AUTONOMY.

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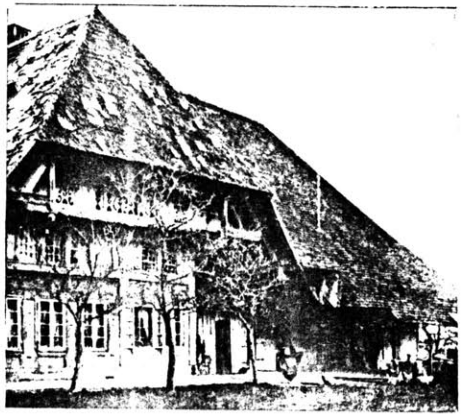

Fig. 4
The roof plays a primal role in our lives. The most primitive buildings are nothing but a roof. Alexander argues that a greater sense of shelter is felt when the roof is prominent and when it is used. Despite 50 years of the "modern movement", he says that people still find the simple pitched roof to be the most powerful symbol of shelter.

1. K. Bloomer and C. Moore, Body, Memory and Architecture, p. 46.

choice

AVOIDANCE OF AMBIGUITY

Kenneth Bayes has written that "there is almost universal agreement on the necessity to avoid ambiguity in buildings for emotionally disturbed and mentally subnormal children"[2], and there is frequent reference in the literature to the need for avoiding ambiguity and complexity in the design of therapeutic environments for mentally disturbed adults. However, Kyoshi Izumi, an architect who has designed several psychiatric facilities, writes that "there is a place for the exciting and the ambiguous architectural concepts but the challenge is to know when and where these are appropriate".[3] Herbert McLaughlin, a California architect who has become rather well-known for his designs for community mental health centers and group homes, calls for more excitement and "non-determinacy" in psychiatric facility design, and he says that architects involved in these kinds of projects would do well to attend more to what is being done today in the field of design as a whole, referring to the flamboyant work of John Portman.[4] Similarly, if we look to Robert Venturi's Complexity and Contradiction in Architecture, we find the author asserting that there is good and bad ambiguity and that ambiguity collects precisely at those points of greatest poetic or artistic effectiveness.[5]

2. K. Bayes, p. 15.

3. K. Bayes, p. 18

4. H. McLaughlin, Architectural Record, July 1975, p. 106.

5. R. Venturi, Complexity and Contradiction in Architecture, p. 29.

The danger in endeavoring to avoid complexity and ambiguity in designing a therapeutic environment is that the designer might create impoverished places of limited sensual attraction, causing already withdrawn and disturbed individuals to have all the more reason to give up on the outside world. Bayes mentions how autistic children sometimes insist on being in "cells" for sleeping and the adult mentally disturbed often require some sort of neutral place in which to calm themselves by avoiding the complexity and confusion of the rest of the environment. Neutrality in the environment, though, may impart an impression of sensory deprivation. It has been pointed out that severe hallucinations in mental patients almost always occur under conditions of sensory deprivation, i.e., in seclusion rooms which are often small cells with high ceilings, a small, inaccessible window, no furniture except a bare mattress and a chamber pot, and a glaring light on overhead. Hospital environments in general present an image of sterility and crystalline unyieldingness, an impression of sensory deprivation.

Ambiguity, then, should not be confused with richness and excitement in the environment. What is ambiguity or what is the kind of ambiguity that should be avoided if possible - at least in the areas of the building which are

Fig. 5
Architect Herbert McLaughlin calls for more excitement and "non-determinacy" in psychiatric facility design. At Kaplan & McLaughlin's Elmcrest Psychiatric Institute, spatial transition and variety of light and color are enhanced by varied ceiling treatment. Here residents return from outside activities through an entrance near the snack-bar where they can help themselves within usual family limits.

intended to be more calming and meditative?

In perception there are two distinct and sometimes conflicting experiences of what is seen and what is known to exist. The normal person manages to steer his way through the physical world in spite of these disturbing contradictions. As discussed in Chapter Two, it is possible that the schizophrenic loses this ability to adjust, and that he may become painfully aware of the conflicting inconsistencies of perception and cognition. In a study of mental or emotional disturbance it is therefore important to know the contradictions of which normally we are largely unconscious. These include the size, shape, and color constancies (if two objects of the same size are at different distances from the viewer, the one at a greater distance actually appears to be smaller; an object such as a circle tilted away from the viewer appears to have changed shape, in this case, to an ellipse; a surface of some perceived color appears to change color under a different lighting condition). The example typically given in reference to this problem of perception is in how the mentally disturbed may be particularly upset by long corridors because they appear to be receding off to an unknown end of an unknown size.

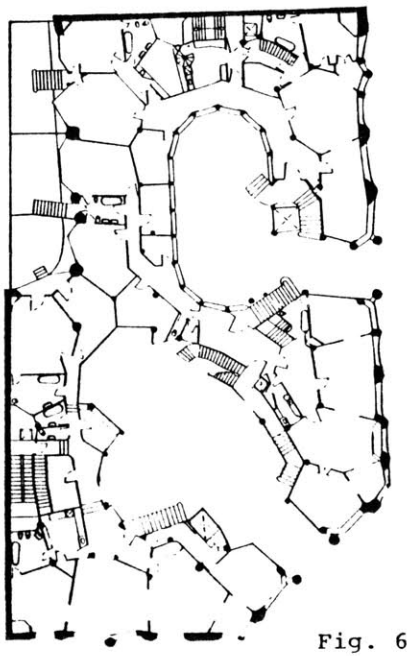

Fig. 6a

One important aspect in the avoidance of ambiguity in theraeputic facility design is that spaces or rooms should

be clearly defined architecturally. For instance, there should be clear differentiation between the inside and the outside of the building, or in other words, the transition area between the different zones of the building must be clearly expressed and articulated. Kenneth Bayes quotes Aldo van Eyck as saying that architects should break away from the contemporary concept (van Eyck calls it "sickness") of spatial continuity and the tendency to erase away articulation between spaces. It is a requirement which results in the need for extreme caution or careful purposefulness in the use of open planning, where spaces may merge into another without definition.[6]

Ambiguity must be avoided in the detailing of the building. For instance, all doors should perhaps open in the same way with the same kind of door handle and fastening. The quality of the fittings is important, too, in that high quality imparts a notion of permanence and security while minimizing breakage and facilitating maintenance. Sensitivity must be applied in the design of lighting schemes. Concealed lighting can be confusing to disoriented and hallucinating persons as can artificial mixed with natural lighting. Bayes points out how van Eyck used fittings with exposed bulbs as a direct and clear expression of the light source.[7] Among the things which Osmond and Izumi found to be confusing or

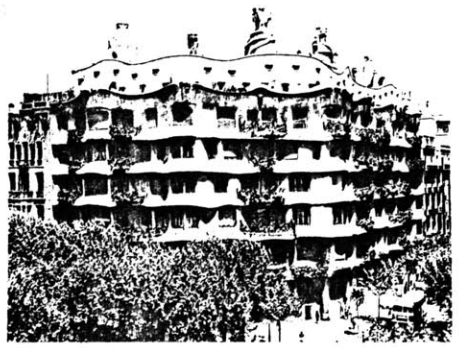

Fig. 6 b

Fig. 6 a and b
Antonio Gaudi's Casa Mila is exciting to most people. However, such a plastic modelling of form and floor plan echoes the lack of structure in the perceptions and thinking of the schizophrenic. Absence of the right angles people are accustomed to living and moving within might further disorient the schizophrenic, while the undulating facade and garish roof sculptures might appear to be frighteningly unstable and sinister in meaning.

6. K. Bayes, p. 15.

7. K. Bayes, p. 15.

frightening during their experimental LSD "trips" were glazed doors and sidelights juxtaposed, highly reflective surfaces and mirrors opposite one another, fissured or perforated ceilings and strongly grained timber, and tile floors of highly contrasting colors such as black and white which appeared to become a landscape of advancing and receding squares.[8]

Bayes calls for honesty of expression in design but says that when applied to the structure and services of the building, "there should be nothing which unduly confuses, denies, or distorts the structural organization, but as long as there is no uncertainty as to the stability of a building, there is a degree of comfort, a feeling of freedom from responsibility, if the structure is closed".[9] Residents of a therapeutic household may well have a sense of insecurity if it looks as though the building could be dismantled by a handyman with a tool kit. As with structure, it is questionable whether there is intrinsic value, apart from interest, in making visible the services of a building. However, Bayes points out how van Eyck interrupts a glass brick wall with a strip of clear glass so that the course of rainwater between the roof and ground can be seen from inside the building.[10] This kind of detailing serves to dispel ambiguity and confusion by creating the opportunity for residents

8. K. Bayes, p. 15, 25.

9. K. Bayes, p. 16.

10. K. Bayes, p. 16.

to be aware of happenings outside while remaining securely inside.

THERE IS A PLACE FOR THE EXCITING AND THE AMBIGUOUS ARCHITECTURAL CONCEPTS, BUT THE CHALLENGE IS TO KNOW WHEN AND WHERE THESE ARE APPROPRIATE.

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FREEDOM OF CHOICE

One measure of institutionality is the degree to which the individual's freedom of choice is preserved. A total institution dictates that its inmates follow a predetermined routine and surrender previous identity for a prescribed role in the workings of that routine. Supposedly, that prescribed role in a mental hospital - the role of mental patient - is therapeutic. I argue that the role of mental patient is not a therapeutic one in that it removes the individual's sense of autonomy and freedom of choice, and it marks the individual for life with the stigma of institutionalization and psychiatric diagnosis.

One runs into difficulties if trying to specify exactly what kind of environment will be therapeutic. It is a questionable practice to force a person to remain in one

setting according to how his state of mind is perceived by staff members. What will be "therapeutic" (calming? exciting? private? social?) for one person will not necessarily be so for the next. What will be therapeutic for one person at one particular time may not be so an hour later. In addition, a designer cannot guarantee that what he or she designs to carry certain intentions for use or appraisal by the users will necessarily be used and appraised in the intended manner.

The important thing, then, is to design a therapeutic household to include a variety of setting types that the residents and staff might use as they see fit. This act of choosing is especially critical in the life of schizophrenics in that they are often compelled by their disorientation and idiosyncratic meaning systems to constrict their powers of choice and to withdraw from the outside world. After working with emotionally disturbed children, Mayer Spivack has described the children's behavior as "opaque" in that it allows no clear message for others about who the children really are. As he says, "all have extraordinary ways of removing themselves from inspection". However, Spivack goes on to say that choice to participate in "relational settings" (those places designed to facilitate interactions of minimum commitment between residents and staff, and between residents

and residents) provides a means of gaining knowledge of the residents through the smokescreen of their confusing or bizarre behaviors.[11]

Freedom of choice in the environment may allow the residents to avail themselves of the options necessary to support their idiosyncratic meaning systems, but at the same time it may offer incitements to varied, non-rigid behaviors leading towards autonomy and personality integration. Depending on the type and degree of his disorientation and mental disturbance, a person may find himself to be incapable of choice or unaware of the availability of choice. Staff or other residents might then offer suggestions to the resident as to choices of behaviors or appropriate settings. If his behavior became intolerable to the group, they might compel him to remove himself from the group by retreating to his own private area. The number and kinds of choices available to staff and residents in the household are of critical concern in the individual's recovery of his bearings and in the workings of the group as a whole. Group living becomes acceptable and can contribute to the development of the individual personality only if individuality and the exercise of personal choice can be balanced with the interests of the group.

11. M. Spivack, "Response to Needs", p. II-2-1.

SINCE IT IS IMPOSSIBLE TO CREATE ONE TYPE OF PLACE THAT WILL BE "THERAPEUTIC" FOR ALL PEOPLE AT ALL TIMES, IT IS NECESSARY TO OFFER A RANGE OF PLACE TYPES AMONG WHICH RESIDENTS CAN LEARN TO EXERCISE FREE CHOICE OF SETTINGS TO MEET THEIR NEEDS CONSTRUCTIVELY.

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DIFFERENTIAL SETTINGS

The mentally disturbed person who is suffering from inner disorientation and lack of a sense of relatedness to the outer world, both human and non-human, may regain his capacities for constructive inter-relationships by living in an environment which allows him to exercise free choice amongst a range of types of places. Much of the work of regaining a sense of orientation involves resolution of the ways in which an individual can effectively exercise his environmental options to meet his particular needs. The individual resident should learn the constructive use of his environment by his own explorations, by contact with other residents who might have similar concerns, and by the sensitive intervention of staff members.

Spivack has cited the need for providing at least two kinds of places in the life space of emotionally disturbed

children, one offering low level sensory stimulation and the other a higher level sensory stimulation, each within vision distance of the other and separated by a group place of intermediate stimulus level.

> "Low level sensory stimulus refers to those kinds or quantities of information present in the child's perceptual field which do not intrude on his awareness, but present a source of reassurance as to the reliability and continuation of life processes. This term should not be confused with 'sensory deprivation'.
>
> "High level sensory stimulus refers to those kinds and quantities of events present that (also) do not intrude on awareness, but may stimulate the child's awareness or offer involvement with elements of the surround, or with other people. The number and frequency of kinds of options are increased in the case of high level sensory stimulus. Elements of both levels of sensory stimulus are all the sound, sight, smell, and touch issues of the surround as one moves through it in response to the locations and situation of other people."[12]

Later Spivack seems to say that all settings in the life space would be "rich" but the richness of the low level stimulus settings would consist of or at least offer a view of natural elements (sand, moving water, light, stones, trees, grass, wind, etc.) while high level stimulus settings would offer more options for people to interact with one another. Spivack becomes rather confusing when he writes that the choices available to residents should "offer either a rich, low level stimulus group place, or a rich, low level indi-

Fig. 7
In MLTW's Koizim House, the living area includes several kinds of spaces. The largest space has a two story high ceiling and various options for inhabiting or for leaving the room. Next to this dramatic space (to the right in the photograph) is a smaller, softer, more contained area. The therapeutic household must include this kind of range of stimulus levels to make meaningful freedom of choice in the environment.

12. M. Spivack, p. II-13-1.

vidual place - or a rich, high level individual place - i.e., some place to be alone where there are specific issues of involvement".[13] One might conclude here that he means to say that the level of stimulation that a place presents does not correspond simply to the number of people that it accommodates but to the number of options for interaction the environment suggests.

In Therapy by Design the authors, Good, Siegel, and Bay, have called for a similar range of options in the life space and have defined these as "differential settings". For the most regressed residents they specify that there should be places which are shielded from the distractions and complex stimuli of the other areas of the ward (they are speaking of a hospital re-modelling) with a high degree of staff control. The design character here would be "introstatic", or in other words, involving the residents in controlled and predictable activities. Spaces would generally be small and intimate with the opportunity for concentrated one-to-one therapeutic relationships with the residents and staff. For the more integrated residents, the authors call for more resident involvement in the organization of therapeutic programs and manipulation of the environment. The design character would be "extrodynamic", suggesting activity and movement that involve the

13. M. Spivack, p. II-13-3.

residents in less predictable and more creative activities. Equipment and furnishings would be portable and suitable for spontaneous or programmed manipulation by residents and staff. Materials, lighting, and colors, as well as the arrangement of furnishings would be easily changeable, thus encouraging involvement and personal contacts. The authors also suggest that there be a third setting for the most integrated residents which would be "normal" in its design.[14]

In his design for the Marcel Riviere Institute, architect Paul Sivadon operated under a notion similar to that of Good, Siegel, and Bay. He organized the building complex so that it requires the resident to travel through an insecurity-inducing space in order to move between two poles of attraction: "a village where he feels secure and fulfills his need for dependency" and a "social center where he finds satisfaction for his stomach and his mind, but in an environment where he is exposed to the danger of encounters". Sivadon says that this design is a bipolar structure which aims "to orient the patient's behavior toward a succession of regressive and progressive attitudes, of situations of dependence and autonomy, to plunge it into the proximity-distance dialectic which represents the spatial aspect of personality's progress". In the design of the village area, Sivadon was concerned that he should avoid creating situ-

14. L. Good, S. Segal, and A. Bay, Therapy by Design, p. 18.

ations where residents would have any feelings of captivity or of being caught in an impasse. Therefore, he created easy paths of retreat with territorial lookouts and provided double exits from hallways of relatively wide and deep dimensions. The Social Center is a place where one meets the crowd in a more complex architectural structure. The spatial obstacles to be surmounted to reach the Social Center include a vast empty space with paths arranged in semi-diamond shapes, which supposedly do not aid orientation and are anxiety generating and "sociofugal". Coming from the third village, one must walk under an arch and through a pass which also creates insecurity.[15]

15. P. Sivadon, p. 417.

THE THERAPEUTIC HOUSEHOLD SHOULD PRESENT A RANGE OF PLACE TYPES ORGANIZED FROM 1) THOSE OFFERING THE HIGHEST DEGREE OF SENSORY STIMULATION, OPTIONS FOR HUMAN INTERACTION, AND OPPORTUNITIES FOR CREATIVE MANIPULATION TO 2) THOSE OFFERING MORE SIMPLICITY AND PREDICTABILITY AND MORE OF A SENSE OF QUIET RETREAT.

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THE INTIMACY GRADIENT

It is almost an archetypal ordering principle for all buildings that they be laid out in a sequence from the

entrance and the most public parts of the building leading into the slightly more private areas, and finally into the most private domains. In his book Pattern Language, Christopher Alexander calls this ordering principle the "intimacy gradient".[16] Ignoring the need for the existence of this kind of gradient may seriously disrupt social interaction in a building because when there is homogeneity of social space, it is impossible to give encounters the dimension of added meaning by choice of space. All the rites of protocol and most of the rules of politeness (giving one's place, keeping one's distance, etc.) correspond to the art of situating oneself and situating others in relation to oneself.

The experience of schizophrenia often grossly distorts a person's sense of social distance, either because the person's body image has blurred or because he so fears the consequences of social interaction. Robert Sommer in Personal Space discusses this phenomenon:

> "The most extreme form of withdrawal from other people is manifested by schizophrenic individuals who are fearful of being hurt in social intercourse. Our studies have shown that they not only remain too far from others but on occasions come too close. This was particularly evident in decoy studies in which male and female schizophrenics sat immediately alongside a male decoy whom they knew slightly or not at all, which happened rarely if ever among the normal group.

16. C. Alexander, A Pattern Language, p. 612.

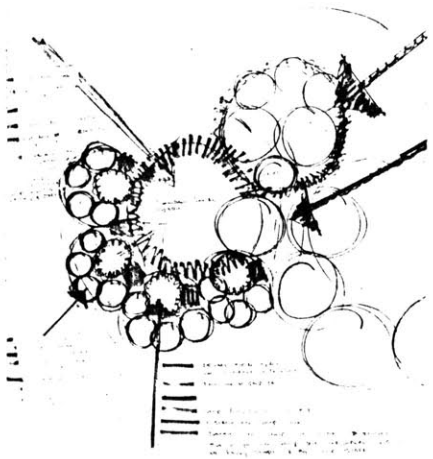

Fig. 8
Architect Kyoshi Izumi writes that the success of an architectural solution is dependent upon an understanding of basic social interaction. His diagram for a community mental health center shows a hierarchy of social spaces - first a space where the patient finds complete privacy; then a space where he can relate to a limited number of people; and finally, the large group space shared by all.

> This behavior on the part of the schizophrenic violates the personal space of others who become offended by this excessive closeness. One can speculate on whether this relates to the schizophrenic's lack of a stable self-image and clear self-boundaries. A person unsure of who he is may not be clear as to where he ends and the next person begins."[17]

People are usually the single most problematic issue for the mentally disturbed person. He desperately needs to reach them for their care and support, but often he cannot accept this without breaking down the barriers of his psychosis. Since his condition developed as a defense against issues he could not manage, it is the only trusted mechanism he knows for survival, and he is repeatedly forced to "keep people out" in order to defend his survival system.[18] As mentioned in a previous section, Paul Sivadon terms this ambivalence the "proximity-distance dialectic" and asserts that it may be formulated spatially, as in his Marcel Riviere Institute for the mentally disturbed. An emotionally or mentally disturbed person may experience this ambivalence in one of two ways: either he has an intense fear of autonomy and of leaving the person or place that gives him a sense of security or he has an intense repulsion at the idea of relating closely to other people.

17. R. Sommer, Personal Space, p. 70.

18. M. Spivack, p. II-1-1.

Sivadon's proximity-distance dialectic refers more to

the person who is fearful of leaving a place or person of security. He says that a dual tendency orients the behavior of every human being: to evolve towards a greater degree of autonomy, thus a greater distance from the mother and her substitutes, and to maintain the conditions of security, which implies proximity and dependence. Proximity yields a sense of security, making possible the internalization of a situation and leading to a desire for autonomy. In turn, autonomy and maintenance of a greater distance creates a fear of isolation, leading to a return to the source of security.

In both the case of excessive dependence on security through proximity with others and of repulsion from contact with others, the existence of an intimacy gradient in the therapeutic household creates the opportunity for learning more reasonable or comfortable habits of social interaction. A resident may place himself in the situations which suit him best - from the totally private bedroom to the intermediate social areas to the communal living areas. With the proper design, he may observe situations before making the commitment of entering into them or he may quickly retreat should he feel the need.

THE THERAPEUTIC HOUSEHOLD SHOULD RESPOND TO THE PECULIAR

PROXIMITY-DISTANCE DIALECTIC OF "SCHIZOPHRENIA" BY OFFERING
AN INTIMACY GRADIENT WITH EASILY ACCESSIBLE PATHS OF RETREAT.

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privacy

THE NEED FOR RETREAT AND PRIVACY

In the discussion of the "intimacy gradient" it was stated that residents of a household must have places where they can be alone. This is a fundamental and essential need which, if ignored, results in social disruption or even mental damage. Christopher Alexander discusses this need in his pattern "A Room of One's Own":

> "A person in a household without a room of his own will always be confronted with a problem: he wants to participate in family life and to be recognized as an important member of that group; but he cannot individualize himself because no part of the house is totally in his control. It is rather like expecting one drowning man to save another. Only a person who has a well-developed strong personal self, can venture out to participate in communal life."[19]

There is a critical point up to which intimate contact with others increases one's empathy for them, but to prolong that contact causes a build-up of a protective resistance to them.

Privacy has been defined in Environmental Psychology as "the claim of individuals, groups or institutions to determine for themselves when, how, and to what extent information about them is communicated to others".[20] Psychological privacy maximizes an individual's freedom of choice by permitting him to feel free to behave in a

19. C. Alexander, p. 669.

20. H. Proshansky, W. Ittelson, and L. Rivlin, p. 177.

particular manner or to increase his range of options by removing certain classes of social constraints. In private a person can behave in whatever crazy way he may wish without fear of social disapproval or censure. Some of the important functions of privacy are:

- Privacy protects and maintain the individual's need for personal autonomy, which is a sense of individuality and conscious choice in which the individual controls his environment, including his ability to have privacy when he desires it.
- Both social and biological factors create tension in everyday life so that people need periods of privacy in which they may experience periods of emotional release.
- Privacy provides the opportunity for self-evaluation, to take stock of self in the light of the continuing stream of information received in day-to-day experience. A person must remove himself from these events so that he can integrate and assimilate the information they present. At this time the individual not only processes information but also makes plans by interpreting it, recasting it, and anticipating his subsequent behaviors.
- The availability of privacy serves the function of limited and protected communication which meets the need to share confidences and intimacies with trusted individuals. At the same time, it establishes a psychological distance in all types of interpersonal situations when the individual desires it or when it is required by normative role relationships.21

In the case of persons experiencing a state of schizo-

21. H. Proshansky, W. Ittelson, and L. Rivlin, p. 177, 178.

phrenia, the need for a private retreat often becomes more acute since they may become terrified at the prospect of meeting others or their tolerance for interactions may require that they retreat often. The mentally disturbed person may find that group relationships become overwhelmingly complicated and may wish to keep the number of other people within visual reach to some limit. Or he may wish to see no one.

To satisfy this fundamental need for privacy, to help residents cope with their lowest levels of regression, and to permit the beginning and subsequent development of their identities, there must be places solely and completely identified with each resident. Even in a shared bedroom (which some people prefer, especially some ex-mental patients who may have become accustomed to having one or more roommates), each bed should be located in a partial recess, a corner, or some other configuration of the room in order to denote territorial rights. The individual private areas should be places where self-identification can be reasserted, where there is a personal cupboard with a mirror, a small pin-up board, a place to display possessions, and a small work surface. As Alexander writes,

> "The bedroom is often the repository of most of these items of personal property around which the individual

"Although I painted in bed and only dressed to go out for paint, I was, by now, in the house, going myself to the kitchen for food. This could be quite a dangerous venture. It was 'safe' to go out at night, like a mouse, but at night there were 'only the crumbs'. Somehow, I had to make the trip when there was food, during the day.

If I moved quickly, when Noel or Paul told me, then there was some protection. Otherwise, I had to face the kitchen alone, in the light of day. To get 'caught' in the kitchen seemed so perilous that I would peep out of my rooms, and bob back many times, perhaps waiting several hours, to catch a 'safe' moment. Even so, sometimes when just about to flee back to my room, with food, I would get 'caught'. Someone would come in the door and I would have to pass them, to get out. Terrified, in a panic inside, I would try to look as if I wasn't there, and somehow slide out, back to the safety of my room.

It was so difficult to get my body near another person. There was no question of talking, except to Noel and Paul. Other people seemed so big and powerful."

Mary Barnes, Mary Barnes, p. 198.

builds his own satisfactions and which help to differentiate him from the other members of the inner circle of his life."[22]

These private areas or bedrooms, functioning as places of retreat and assisting in the development of a more stable identity should be of unambiguous and simple design, imparting, if possible, a feeling of calm and security. There must be a predictability about the private environment to compensate for the lack of predictability that the individual may experience in himself.

FOR THE NEEDS OF PRIVACY, RETREAT, AND THE STRENGTHENING OF INDIVIDUAL IDENTITY, IT IS ESSENTIAL THAT THERE BE AN AREA SOLELY AND COMPLETELY IDENTIFIED WITH EACH RESIDENT OF THE THERAPEUTIC HOUSEHOLD.

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SEMI-PRIVATE PLACES

The intimacy gradient should not be so strict that it ignores the need for places to be alone alongside and in view of the common areas. Small, well-articulated places or alcoves adjacent to common areas become semi-private because of the opportunity they give for establishing territorial rights over them. These places allow for a sense of

22. C. Alexander, p. 671.

Fig. 9
Because of its small scale and high degree of containment, a bed alcove can be a particularly comforting place in which to retreat. In a double bedroom, the alcove forms a completely private, individual territory.

togetherness even when there is no planned group activity and when people wish to engage themselves in their own ways. This way there is flexibility in the use of a common room in that people feel more free to come and go without the fear that they will disrupt the focus of a group activity (there should be other places, though, which allow for group activity focus, in which members of the group are disinclined to get up and so disrupt the proceedings). Residents may also wish to observe a group activity from within the safer boundaries of a smaller, adjacent place before deciding whether to join in or not.

Alcoves off the common rooms give people the chance to make a quick retreat, more immediate though not as complete as a retreat to one's private room. Should a person become overwhelmed with the confusion of the more complex and shifting common rooms and activities, he might find solace within the more contained boundaries of a smaller place. Should he need to step aside from the common group to speak to someone intimately, this kind of place offers the opportunity in a casual manner. Bayes has discussed these special places in reference to disturbed children's needs, saying that the designer should

> "...insure that the planning of the building is not so rational as to avoid any corners or cubby holes (what Simmonds calls sulk bins) that occur naturally

"I know that the linen room was very often my sanctuary. I looked through its little dusty window upon the lower park and the lawns and trees and the distant blue strip of sea like sticky paper pasted edge to edge with the sky. I wept and wondered and dreamed the abiding dream of most mental patients - the World, Outside, Freedom; and foretasted too vividly the occasions I most feared - electric shock treatment, being shut in a single room at night, being sent to Ward Two, the disturbed ward...The prospect of the world terrified me: a morass of despair violence death with a thin layer of glass spread upon the surface where Love, a tiny crab with pincers and rainbow shell walked delicately sideways but getting nowhere, while the sun - like one of the wooly balls we made at occupational therapy by winding orange wool on a circle of cardboard - rose higher in the sky its tassels dropping with flame threatening every moment to melt the precarious highway of glass. And the people: giant patchworks of color with limbs missing and parts of their mind snipped off to fit them into the outline of the free pattern."

Janet Frame, Faces in the Water, Environmental Psychology, p. 400.

> in old buildings and satisfy a child's mood for isolation. Disturbe children are often not able to cope with their changes of mood, for instance elation or despair. These moods should be respected and the environment provided to meet them."[23]

23. K. Bayes, p. 20.

Bayes goes on to describe how an environment might be designed to provide comfort for a resident's moods of despair, suggesting that there be curves and warmth, relative quiet and darkness, and enfolding chairs. Body-sized articulations seem to welcome a person's presence and the tactile qualities of the surfaces and edges he encounters affect him significantly through his haptic sense. Special, semi-private places should be made separate from the common room by some articulation of the boundary such as by change of color, lowering of the ceiling height, use of edge trim, and so on.

THE PLANNING OF THE LARGE LIVING AREAS SHOULD INCLUDE CORNERS, CUBBY HOLES, ALCOVES, OR SPECIAL BODY-SIZED ARTICULATIONS TO SATISFY IMMEDIATE NEEDS FOR RETREAT FROM THE GROUP, FOR SPECIAL NON-GROUP ACTIVITIES, OR FOR OBSERVATION OF THE GROUP WITHOUT COMMITMENT TO ITS ACTIVITIES.

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interaction

RELATIONAL SETTINGS

As discussed earlier, one of the central issues in the experience of schizophrenia is an ambivalence about other people - wanting and needing their care and support and yet often being unable to accept it. The psychotic person's zone of personal space may be distorted and he may suffer from bizarre feelings that he can no longer tell where his own self ends and the next person begins. The critical flight distance of schizophrenics (that distance at which the presence of other people will cause them to vacate their places) tends to be abnormally large. Eye and body contact is especially threatening so that gaze-avoidance and the establishment of a large zone of inviolable personal space become necessary behaviors to ward off unbearable intrusions. In working with emotionally or mentally disturbed children, Spivack reports that he has repeatedly seen children "using space or spatial elements of a surround to put protective distance between themselves and others" and that "it is often important not to approach a child when he has set up such a signal system or signal distance". If the space is not available for a disturbed person to retreat to or if the population density of an area becomes too high, then the whole group may experience

a marked increase in its tension level so that idiosyncratic behaviors increase in ratio and spatial scope "like heating molecules". Ordinarily quiet people become anxious and may cry out or fly into tantrums.[24]

When people are as difficult to know as schizophrenics often are, then a case can be made for designing specific contexts that attempt to help them feel secure enough, or curious enough, to permit a temporary excursion into the world of other people. Spivack has proposed the term "relational settings" for such contexts.

> "Essentially, a relational setting is a context or situation provided by the surround, that invites two people to relate or participate in an event which is accessory to and outside of the personal relationship. It becomes a vehicle or means of interaction: the setting itself becomes a behavioral object around which relational behavior can occur."[25]

Sometimes the only kind of communication that can be achieved with severely disturbed persons is a nonverbal, physical, being with them. Sometimes trust is built up between two people by starting out with this kind of non-demanding physical proximity. The spatial configuration of a room should allow for two people to be near to but not immediately next to each other. Each person should be able to maintain his own comfortable dimensions with respect to the other people present. Such an arrangement was dis-

24. M. Spivack, p. II-17-2.

25. M. Spivack, p. II-11-1.

cussed above in "The Need for Privacy" where it was suggested that alcoves off of a common area can permit options for being present but separate. Another idea might be to have furniture which so encompasses the occupant that he can see out but others can see little of him.

Spivack writes that in an effort to try to learn about children who appear to be and often are wholly unapproachable, he has sought ways of engaging them, using elements of the environment as a vehicle, or the environment itself as a subject of autonomous investigation. Interpersonal proximity exercises such as those used in some forms of child psychiatry have been used with schizophrenic adults at Sivadon's Marcel Riviere Institute and "normal" adults at places like the Esalen Institute in California where sensory, movement, and interpersonal awareness training is emphasized. In both of these examples, various exercises are conducted by which the subject learns to maintain contact with others through some mediating object.

At the most regressed or isolated levels, a person may sometimes be approached through the medium of water, the archetypal symbol of sensuosity and relaxation. At more integrated and trusting levels, a disturbed person may participate in exercises which facilitate the learning

"What helped me to get a feel of my own body was dancing. Sometimes when Ronnie played the piano, at other times alone in the hall downstairs, I would fling myself about, dancing with my arms, kicking with my legs, whirling and twirling my body in the air. Often I danced with a ball, throwing and bouncing it. Sometimes Leon danced with me. Other times, I sang as I danced. Rock-a-bye, folk songs, hymns, bits of anything and everything. Dancing and singing alone in the Hall, or playing with a bat and ball, I felt movement, was aware of myself. People sometimes played ball with me. 'Give me a catch.' This was all right. But, "Mary why don't you speak to us? Come and sit in the kitchen with Helen and me.' This was all wrong. Speechless, my body motionless, I would wait until such a person had gone."

Mary Barnes, Mary Barnes, p. 122.

of distance through gesture, movement, and bodily proximity with others. General massage may be an effective tool for building trust. In group exercises, an individual who sees other people going through the same motions as himself learns to see himself as others do.

The physical environment can offer a rich variety of contexts that invite relational behavior by inducing eye contact, by permitting personal proximity without being too close, by offering choice of exit and entry, or appearrance and disappearance, by allowing one person to offer something to another, by making available invitations to "come and try this", or by explaining the nature of natural events with distinct characteristics.

Because of the strong relationship between hunger for food and hunger for affection, the design of places for the preparation and eating of food becomes an especially important opporutnity for creating a relational setting. Shared food has more capacity than almost anything to be the basis for communal feelings. The kitchen, therefore, should be a place that is large enough to accommodate several people, or as in the farmhouse kitchen, food preparation and other group activity may be completely integrated in one large room. A large table in the middle might be for dining, talking, playing cards, or food preparation.

The kitchen work might be done communally at the table and on the counters around the walls. There might be a comfortable old chair in the corner where someone might sleep through all the activities.

THE THERAPEUTIC HOUSEHOLD SHOULD INCLUDE WHAT SPIVACK HAS CALLED "RELATIONAL SETTINGS" WHICH INVITE TWO PEOPLE TO RELATE OR PARTICIPATE IN AN EVENT WHICH IS ACCESSORY TO AND OUTSIDE OF THE PERSONAL RELATIONSHIP.

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INTERMEDIATE SOCIAL SETTINGS

The private rooms or areas for each residents should relate to a primary social grouping of four or so people an intermediate-sized place between the extremes of privacy in the bedrooms and of communality in the living areas. The provision of a primary social setting for a small number of residents, which is adjacent to their private bedrooms, helps them to identify their privacy with the simplest of their social relationships. The relationship of these intermediate areas with the largest common areas extends this link further to include more complex social interactions.

With the schizophrenic's frequent changes in self and environmental perceptions, it is important that he be provided with small, reassuring, and easily encompassed areas where relatively small groups may know each other well and support each other. The capability of one disturbed person to help another must be acknowledged by the design of living areas which instill a sense of community and interdependence. Small, closely knit groups of people tend to stabilize moods and increase feelings of security and belongness.

THE PRIVATE PLACE FOR EACH RESIDENT SHOULD RELATE TO AN INTERMEDIATE SOCIAL SETTING SHARED BY A SMALL GROUP OF RESIDENTS IN ORDER TO ENCOURAGE THE FORMATION OF CLOSELY KNIT SOICAL SUPPORT GROUPS.

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ACTIVE COMMON AREAS

The individual must have a personal sense of identification before he can adequately deal with, and interact with others. It has been suggested that the private rooms of a small number of residents be grouped together around an intermediate social area between the private and the

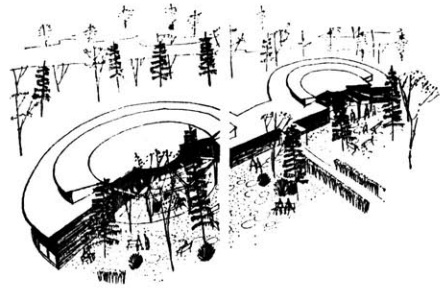

Fig. 11a

Fig. 11 a and b
In his Saskatchewan Hospital, architect Kyoshi Izumi created a strictly "sociopetal" ward. Corridors have been eliminated in the radial plan which includes three zones of sociability - the central large group area, the five small group areas, and the 20 individual bedroom retreats. This design would seem to be too literal an interpretation of the principles of sociopetal design. The lack of differentiation of the small group areas and bedrooms and the circular large group area might interfere with the establishment of a sense of orientation in the building.

communal zones of the intimacy gradient. A therapeutic household, including disturbed residents and live-in staff, should probably not include more than about twelve to sixteen individuals in all. Bayes reports that Humphrey Osmond says "group disintegration occurs at more than ten or twelve because there are not enough 'roles' to go around for each person to fulfill, which seems to support from current experience the old zodiacal principle and some of the great archetypal groups of history such as the apostolic and the Arthurian. Larger numbers cease to be groups and become 'aggregates' breaking up into groups in corners".[26] Ideally, the therapeutic household should remain a group united rather than two or more aggregated sub-groups.

To enhance social interaction when a resident is at a point where he feels he may benefit from it, it is necessary to have a physical milieu which has a positive valence for social interaction. When chairs and couches are placed in easy, informal groupings that are not overwhelming in numbers and that allow a certain amount of intimacy, the possibility for social interaction increases. Izumi and Osmond divide building plans and furniture arrangements into two types - the "sociofugal" which discourages the formation of human relationships by propelling occupants towards the perimeter or through the place with as little

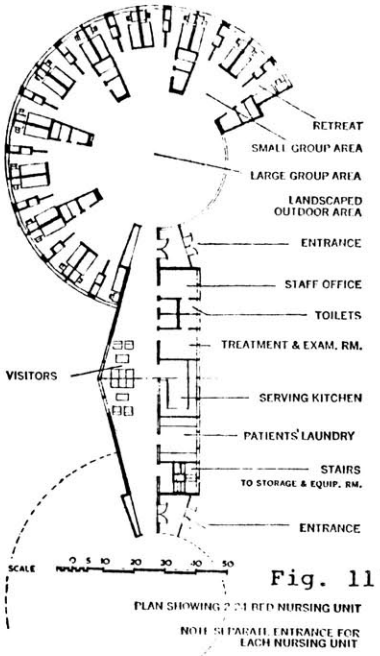

Fig. 11b-

26. K. Bayes, p. 18.

intermingling as possible, and the "sociopetal" which encourages the development of stable human relationships. The sociopetal layout depends on the occupants' being able to slip easily from one to another of the three zones of sociability or intimacy. A group room, unless it is designed for intensively focused interactional meetings, should be easy to enter without a feeling of intrusion and comfortable to walk through without a sense of having to confront others. Within a less rigid framework than the rectangle, it is possible to create an atmosphere that can meet the requirements of the moment. A room with three or four focal points allows several activities to take place at the same time and decreases the chances that one person will be a nuisance to the next.

Christopher Alexander has discussed principles for creating successful common areas. They should not be located at the extremes of a circulation spine because if people have to make a special effort to go there, they are not likely to use it informally and spontaneously. However, if the circulation path cuts too deeply through the common area, the space will be too exposed so that it will be uncomfortable to linger there and to settle down. The only balanced situation, Alexander says, is the one where "a common path, which people use every day, runs tangent to the common areas and is open to them in passing".[27] That

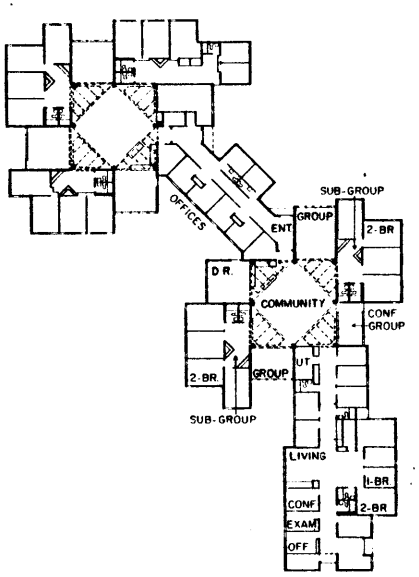

Fig. 10
In the new facilities at Elmcrest Psychiatric Institute by architects Kaplan & McLaughlin, four two-bed rooms form sub-groups which share a small social area. Three such eight-person sub-groups share the central community forum area.

27. C. Alexander, p. 620.

way people will be constantly passing by the area but because their path is to one side, they will not be forced to stop. If they so desire, they can continue on. Otherwise, they can stop for a moment, appraise the situation, and decide whether or not to enter.

THE DESIGN OF SUCCESSFUL ACTIVE COMMON AREAS REQUIRES A LAYOUT THAT HAS A POSITIVE VALENCE FOR SOCIAL INTERACTION BY ALLOWING EASE OF ENTRY AND EXIT AND PROVIDING SEVERAL FOCAL POINTS OF POTENTIAL ACTIVITY.

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PASSIVE COMMON AREAS

Thus far the discussion of common areas has dealt with those places where group activities would be of an energetic and varied nature, places where people might follow exercise or dance classes, have parties, or be engaged in several activities at once such as conversations, games, solitary reading or observation of the rest of the group. This kind of common area would of necessity be a high stimulus context, as Spivack has called it, offering many opportunities for activity, change, and creativity.

In addition to these kinds of places, there would have

to be common areas which provided a central focus for more purely communal activities. These areas would accommodate just as many residents but would be of lower level sensory stimulus to allow for more intensive focus amongst the group members when, perhaps, they wished to have a house meeting, an important therapy session, or just a low-keyed gathering together. The passive center-places of a house tend to be regions where the memories of self can be ritualized and new memories belonging to the family or household group can be accummulated and re-experienced away from the distractions which occur along the outer boundaries of the house. Center-places in houses embody a reference to the communal identity transformed architecturally to magnify and add meaning to the rituals and improvisations of the household. Consequently, they often recall and celebrate basic life-supporting elements such as earth, air, fire, and water.

Passive common areas would be much more contained than the active common areas with restricted view to the outside or to other rooms of the house. Accordingly, the shape of the rooms would be more purely geometrical or have a greater sense of center to encourage a feeling of oneness or togetherness amongst the inhabitants. Colors, textures, and surfaces would be softer and more absorbent, the furni-

ture low and plushy.

PASSIVE COMMON AREAS SHOULD HAVE A DISTINCT SENSE OF CENTER AND CONTAINMENT, A RESTRICTED VIEW TO THE OUTSIDE, SOFT COLORS AND TEXTURES, AND SOME REFERENCE TO BASIC LIFE-SUPPORTING ELEMENTS SUCH AS EARTH, AIR, FIRE, OR WATER.

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enhancement

The schizophrenic is often unusually vulnerable to environmental stimuli, the escape from which may be one of the main features of his psychosis. A more sympathetic environment may help to entice a severely withdrawn person to become more aware of his surroundings. The therapeutic household should enhance the residents' capacity to experience life sensually. A sympathetic environment presents a variety and choice of activities and of sensory stimuli, a richness of experience. Different kinds of places, inside and outside, some private, contained, quiet, removed, and subdued - others open, wide, bright, and colorful, are the ingredients of an architecture that has vitality and spirit. Elements of nature - sunlight, fire, water, and plants - can have particularly moving and/or soothing effects on people.

TEXTURE

The sensual life could be far richer if man became only slightly more aware of the tactile sense and if architects more often used texture as a design element, as a tactile as well as visual experience. During the first six months of life, touch is of prime importance to the infant's development of cognition of his world. Some

psychiatrists have suggested that because of his regression and withdrawal to infantile states, the schizophrenic may respond more immediately to texture than to color. Active touch is essential for a person's initial perceptual development. Perhaps it is also essential for a psychotic person's re-orientation to his physical surroundings. Patterns and decorative motifs repeated through a building may help in re-establishing the rhythm, harmony, and orientation that are lacking in such a person's experience.

Certain patterns, however, which consist of repeated lines in close juxtaposition are disturbing to look at because of their unpleasant flickering effect. While under the influence of LSD, architect Kyoshi Izumi experienced this discomfort markedly. Cracks between the boards of an old floor sometimes looked like canyons, patterns on the upholstery of a chair moved in and out, and the checkerboard black and white floor tiles appeared to be an unpassable landscape of ascending and descending rectangles.[28] The fact that some residents of a therapeutic household might experience such perceptual distortions does not dictate that designers should eliminate textural variations. They should, however, be aware of the possibility of causing discomfort for some people. Areas of low stimulation might have fewer, more subtle variations, while areas of high

28. K. Bayes, p. 25.

stimulation might have a more flamboyant decorative scheme.

TEXTURE MAY BE USED IN THE DESIGN OF THERAPEUTIC HOUSEHOLDS TO STIMULATE THE VISUAL AND TACTILE SENSES, PERHAPS FACILITATING IN THE RESIDENTS A RUDIMENTARY SENSE OF RE-ORIENTATION TO THEIR PHYSICAL SURROUNDINGS.

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COLOR

It has been suggested that in cases of mental unbalance, regression may be expressed by form becoming less important and the dynamic aspects of color gaining ascendancy in the visual field.[29] However, just as with other aspects of the design of therapeutic environments, one cannot guarantee that the use of particular colors will elicit particular responses, especially with a population of mentally disturbed individuals. For instance, red may sometimes lead to relaxation and blue to tension, which is the opposite of what one might expect. Kenneth Bayes has reported on much of the research in the use of color as a therapeutic tool in the treatment of the mentally disturbed, and the evidence seems to be highly contradictory in regards to the uncovering of a set pattern of therapeutic color response. The issue is

29. K. Bayes, p. 38.

further complicated by the difficulty in isolating other factors affecting color response such as lighting conditions and variations in hue, saturation, and brightness of colors. However, in discussing the emotional appeal of different colors, Bayes says that,

> "Colours are a direct experience, without intermediary and have an immediate effect on mood and feeling. There is considerable similarity in the response to each colour, in spite of the tendency noted by most observers for meaning to be influenced by intellectual or emotional associations and previous learning experiences. The following relationships are generally agreed and offer no surprises; they would be too obvious to record except that they are the result of experiments by many serious investigators."30

30. K. Bayes, p. 32.

He then goes on to outline the emotional loading of the colors:

> Red: exciting, stimulating, defiant, contrary, hostile, active, hot, passionate, fierce, intense.
>
> Orange: welcoming, jovial, lively, energetic, forceful, exuberant, hilarious.
>
> Yellow: cheerful, joyful, inspiring, vital.
>
> Green: calm, peaceful, serene, quiet, refreshing.
>
> Blue: calm, peaceful, soothing, tender, secure, contemplative, subduing.
>
> Purple: stately, dignified, mournful, mystical.
>
> Black: despondent, dejected, ominous, unhappy, but also strong, powerful, defiant, hostile.
>
> White: youthful, pure, clean, frank.

Bayes reports how Khlentzo, in his neuro-psychiatric clinic, uses strong colors in order to stimulate his patients, all of whom suffer in some way or another from apathy and an inability to respond either to people or surroundings. The use of strong color is intended to rouse them from indifference. Even if it is in the wrong direction, it at least enables action to be taken. The important thing, he feels, is to create movement in the environment to combat inner immobility. The warm colors are said to have the effect of making time appear to go more slowly and to encourage people to keep on the move. However, red may be better suited for producing random movement or heightened emotionality, while green has been suggested as a color that will inspire the development of ideas and the completion of organized actions.

Bayes also reports on the work of Stokes who combines music with flowing color effects in films to make depressed mental patients more accessible.[31] The use of colored lights probably elicits a stronger response since the subjective experience of being bathed in colored light is quite different from being surrounded by colored surfaces.

In the interest of honesty and predictability of the environment for residents who may be severely disoriented, color should be used as Rasmussen suggests in Experiencing

31. K. Bayes, p. 33.

Architecture. That is, color should reinforce the perceptions of other sensory stimuli.

> "Certain colors can make an object seem lighter, others heavier, than it is. It can be made to appear large of small, near or distant, cool or warm, all according to the color it is given. There are innumerable rules and directives for the employment of color to hide blemishes and defects...A small room can be made to appear larger by being given a pale color. Or if it is a cold room, with a northern or eastern exposure, it can be given artificial sunlight by being painted in warm tones, such as ivory, cream or peach. But there is something unsatisfactory about such camouflage. It is irritating to discover that the thing is not what we expected. In good architecture, consciously designed, the small room appears small, the large room large, and instead of disguising this it should be emphasized by the judicious use of color. The small room should be painted in deep, saturated tones so that you really feel the intimacy of four walls closing around you. And the color scheme of the large room should be light and airy to make you doubly aware of the broad expanse from wall to wall."[32]

32. S. Rasmussen, Experiencing Architecture, p. 220.

Since the research offers no conclusive evidence for a method of using color in therapy and since color response differs from individual to individual and even in the same individual according to his mood, color should be used in the therapeutic household in the same way that high and low level stimulus elements are - i.e., there should be a range of color options coordinated with other mood setters to guarantee that residents can find the place that will meet their needs.

Wherever possible - in the private bedrooms, for instance - residents should be able to exercise freedom of choice about the color of their surroundings. Colored lighting might be used in special rooms for certain activities, but in these instances it would be important to emphasize to residents just what special effects had been contrived so that they might be spared the potentially terrifying experience of thinking the environment had "gone haywire" or that their own minds had produced these vivid hallucinations. The best way to avoid such bad reactions might be to give residents the freedom to manipulate the lights and colors in order to create their own desired effects.

Color in rooms might be related to the activities that will be expected to take place there. For instance, orange has been suggested as a welcoming color, suitable, then, for entrance halls. Yellow, being a cheerful and inspiring color, might be used in exercise rooms. Green and blue, calm and peaceful, might serve best in bedroom areas. But as stated before, color responses are variable - not everyone will agree on their best employment. At the least, though, ignoring psychological meanings and emotional loadings, color can be used as an orienting device and for identification of individual ownership.

COLOR RESPONSES VARY FROM INDIVIDUAL TO INDIVIDUAL: HOWEVER, COLOR IN THE THERAPEUTIC HOUSEHOLD MAY BE USED 1) TO MAKE CERTAIN RESIDENTS MORE EMOTIONALLY ACCESSIBLE OR TO AROUSE THEM FROM INDIFFERENCE, 2) TO REINFORCE THE PERCEPTIONS OF OTHER SENSORY STIMULI, 3) TO FACILITATE ORIENTATION IN THE HOUSE, AND 4) AS ONE ELEMENT OF FREE CHOICE IN THE DECORATION OF THE INDIVIDUAL BEDROOMS.

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NATURAL LIGHT

Human beings are creatures of rhythms and cycles, and the human organism contains a number of very sensitive biological clocks. The mentally disturbed are usually physically disturbed as well and tend to be out of tune with their natural rhythms and cycles. Often people who are brought into hospitals in hallucinating, schizophrenic states have not slept well for days and are unable to say how many days have passed by without their taking notice.

Human regularity and mental stability have a great deal to do with sleep and the cycle of the sun. Some sort of natural regularity or natural "time" should be reintroduced into the lives of the mentally disturbed. This might be achieved in part by a sensitivity to a therapeutic environment's response to and use of natural light. It

"Joan returns. 'Oh, marvellous, Joan, please tuck me up.' Joan tucked me up with Teddy on the divan. It was just about tea-time. Soon everything was very quiet and lonely. Creeping up to my room, I lay very still, in the dark with Teddy. The next day, it got light. That seemed strange, that it was light and day. To me, inside it was dark and night. Time to keep still, to lie in bed. To get up, to move, was all wrong. Joan came. 'Mary are you getting up today?'"

Mary Barnes, Mary Barnes, p. 121.

might be best if all bedrooms could have eastern windows so that the inhabitants might be wakened naturally by the sun, but this is difficult to achieve, especially on an urban site. At least, the view from the bed to the light and some growing things might signal the time of day, and changes in the season and weather. Arrangement of the other rooms in the house to allow light in at particular times of the day is a natural way to inform inhabitants as to the time and to reinforce the use of certain rooms at certain times. Places which make effective behavior settings are usually those which are defined by light. People are by nature phototropic - that is, they tend to move toward the light and when stationary, they orient themselves to the light. "As a result", writes Alexander, "the much loved and much used places in buildings, where the most things happen, are places like window seats, verandas, fireside corners, trellised arbors; all of them defined by non-uniformities in light, and all of them allowing the people who are in them to orient themselves toward the light."[33]

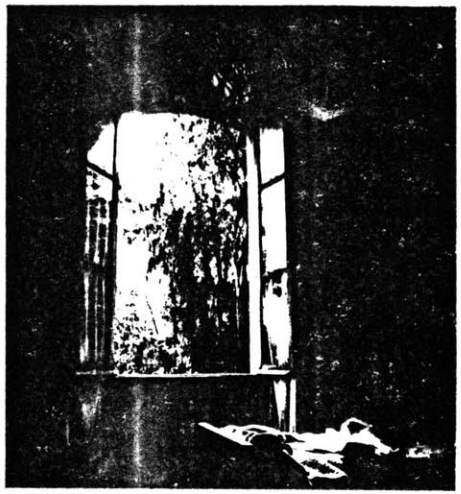

Fig. 12
Human regularity and mental stability have a great deal to do with sleep and the cycle of the sun. Bedrooms with windows to the east allow the inhabitant to be awakened naturally each day.

The phototropic nature of human behavior requires that light and dark patterns in an environment be coordinated with the environment's circulation system. It would seem that the mentally disturbed, in particular, would require

33. C. Alexander, p. 645.

attention to such fundamental orienting devices as natural light. Any entrance or key point in the circulation system ought to be systematically lighter than its surroundings so that residents will move towards it as a natural target.

THE THERAPEUTIC HOUSEHOLD SHOULD BE DESIGNED WITH A SENSITIVITY TO THE CYCLE OF THE SUN THROUGH THE DAY AND THE YEAR TO 1) INSTILL IN THE RESIDENTS A SENSE OF NATURAL TIME, 2) TO DEFINE BEHAVIORAL SETTINGS, AND 3) TO REINFORCE PATTERNS OF CIRCULATION.

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NATURAL SETTINGS

Landscaped natural settings can be microcosms of life itself, constantly in a state of flux, never static, changing with the seasons, the days, with the constant procession of wildlife. As with an awareness of the cycle of the sun, an awareness of the cycles of plant life can instill in people a sense of natural time and a faith in the regenerative powers of that time. Who knows how much crime and mental instability in our inner cities is due to the bleakness of the environment in terms of the absence of plant life? In

utopian visions of the ideal city, a marriage of city and country is projected as an alternative to the miles of concrete and asphalt. Nineteenth century insane asylum founders recognized the value of natural settings by specifying that institutions should be located outside city limits on spacious, "salubrious" grounds.

Natural settings provide a kind of sensory stimulation that is non-intrusive. The cyclical life of daily sunrise, yearly seasons, and special happenings such as thunderstorms and snowfalls all convey an honesty of event and a relatively constant set of expectations. Outdoor places give people a chance to "play", to loosen up in a less-structured, less demanding setting than the built environment. Plants, animals, sun, and weather may, at times, provide the only stimulation that will attract psychologically regressed persons to events outside themselves.

Each interior space in the therapeutic household should have its view of or access to a natural outdoor space or a groomed internal courtyard to lend that space natural light and something of the annual pageantry of nature. Whatever non-built space there is on the site should be carefully landscaped to create the same range of place types as inside the house. Greenhouse and outoodr planted areas become important relational settings and participation in

the cultivation of plants can be an especially pleasing and therapeutic activity for residents - an affirmation of the continuity of life.

AN EMPHASIS SHOULD BE PLACED ON THE DESIGN OF INTERIOR AND EXTERIOR NATURAL SETTINGS IN THE THERAPEUTIC HOUSEHOLD WHICH PROVIDE NON-DEMANDING SENSORY STIMULATION AND AN AWARENESS OF NATURAL TIME AND WHICH GIVE THE OPPORTUNITY FOR RESIDENTS TO PARTICIPATE IN HORTICULTURAL ACTIVITIES - AN AFFIRMATION OF THE LIFE PROCESS.

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FIRE

There is no substitute for the fireplace to create the spirit of the common area at the heart of the house. In her 1978 MIT thesis, Lisa Heschong writes that human fascination with fire perhaps stems from the power of its multi-sensory stimulation:

> "The fire gives a flickering and glowing light, ever-moving, ever-changing. It crackles and hisses and fills the room with the smells of smoke and wood, and perhaps even food. It penetrates us with its warmth. Every sense is stimulated, and all of their associated modes of perception, such as memory and a sense of time, are also brought into play, focused on the one experience of the fire. Together they create such an

> intense sense of reality, of the here-and-nowness of the moment, that it becomes completely captivating. We are likely to feel that we could spend hours mesmerized by the fire."[34]

With such powers of attraction, the fireplace area becomes a prime relational setting, drawing people together, providing a counterpoint to conversation, and bonding the group together in their simultaneous experience of the fire. The lighting of the fire is a quasi-ceremonial event, associated with holidays or special evenings with friends of loved ones. Sitting by the fire tends to elicit a rich flow of feelings, memories, and thoughts. Gaston Bachelard in his book The Psychoanalysis of Fire writes of the fireplace as the "object of reverie" and the "symbol of repose", a vehicle for philosophizing about life, time, and fate. Fire, Bachelard says, "magnifies human destiny; it links the small to the great".[35]

The physical structure of the fireplace itself can be a powerful vertical element within the house, signifying a centerplace or the hearth as heart. Such a strong vertical element in the horizontal plane is what Norberg-Schulz has called the simplest model of man's existential space.[36] He also discusses the vertical as the "expression of the very process of building, that is, man's ability to 'conquer nature' or as man's power of creation.[37]

34. L. Heschong, Thermal Delight, p. 42.

35. G. Bachelard, The Psychoanalysis of Fire, p. 14-16.

36. C. Norberg-Schulz, p. 21.

37. C. Norberg-Schulz, p. 21.

It could be argued that in the case of the schizophrenic residents of a therapeutic household, the fire might be a source of fear and might provoke more hallucinations. There are accounts of life in psychiatric hospitals which mention fire such as Hannah Green's I Never Promised You a Rose Garden in which a young, female patient repeatedly burns herself with cigarettes to punish herself and to determine whether she has yet regained normal human sensations. Fireplaces in state mental hospitals usually stand in long disuse with locked gratings over the openings to insure that patients do not decide to climb up into the flue to hide. However, in Mary Barnes, the account of life in R.D. Laing's Kingsley Hall, there were several fireplaces and no reported incidents of residents burning themselves or the building.

IN SPITE OF THE POSSIBILITY THAT THE FIRE MIGHT MAKE SOME RESIDENTS FEARFUL OR THAT THEY MIGHT BE IMPELLED TO BURN THEMSELVES, THE FIRE AND THE FIREPLACE ARE SUCH STRONG PLACEMAKERS THAT DESIGNERS SHOULD CONSIDER GIVING THEM A CENTRAL POSITION IN THE THERAPEUTIC HOUSEHOLD.

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Water has long been recognized for its physically and psychologically therapeutic effects. Until recently, hydrotherapy was a major treatment method in the state hospitals. Special baths fed by natural springs are places that have often attracted people from distant places to enjoy their reputedly curative powers. Most major cities used to have their public bath-houses, while Japanese society still enjoys public baths as places to meet friends and to soak away the tensions of the day before going home for the evening.

Fig. 13
Water has long been recognized for its therapeutic properties. Japanese society today enjoys the bath as a place to meet friends and to soak away the tensions of the day.

Water offers one of the most direct and simple ways of unwinding and soothing oneself. The therapeutic power of water may derive from its archetypal symbolism of the human unconscious which symbolism in turn may have derived from the fact that all life emerged from the sea and all life (except for a few viruses) requires water for its survival. At any rate, there are strong and profound reasons for making somethings especially important and pleasant out of bathing and the bathroom.

Murray Levine is director of a kind of half-way house for mentally disturbed young people called Marin Lodge in Woodacre, California. In a discussion about what he would do to remodel the place if he had the money and the freedom to do so, Dr. Levine said that one of the most

important additions to the house would be a water room with sauna, group hot tub, and showers. Such an environment would serve to make some of the residents more responsive sensually and interpersonally. Dr. Levine describes with enthusiasm a scenario in which residents of the house might be wrapped up in a demanding, frustrating group session until a point where the emotional pitch had reached an unmanageable limit. Then everyone might take a run to an outdoor pool or the water room to make a big splash, cool off, and soak away conflicts.

AN ARCHETYPAL SYMBOL OF THE UNCONSCIOUS AND AN EFFECTIVE MEDIUM FOR RELEASE AND RELAXATION, WATER SHOULD HOLD A MAJOR PLACE IN THE THERAPEUTIC HOUSEHOLD.

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movement

THE NEED FOR MANIPULATING THE ENVIRONMENT

In J.J. Gibson's theory, the human senses are regarded as aggressive, seeking mechanisms and not merely as passive sensation receivers as others have defined them. Gibson focused on the types of environmental information that the body deals with rather than on the variety of sensory apparatuses and responses of the body. He lists the senses as systems: the visual system, the auditory system, the taste-smell system, the basic orienting system, and the haptic system. These latter two systems are especially important constructs for the consideration of architectural designers in that they contribute more significantly to the human understanding of three-dimensionality which is, of course, essential to the experience of architecture.

The basic orienting system is, briefly, a person's postural sense of what is up and what is down and the establishment of knowledge of the ground plane. The haptic sense if the sense of touch reconsidered to include the entire body. It incorporates all the sensations of pressure, warmth, cold, pain, and kinesthesia (the sensing of body motion by detection of movement of joints and muscles through the entire bodyscape), and all aspects of sensual detection which involve physical contact both inside and

Fig. 14
In haptic form perception we have an experience of the form of an object as well as its tactile qualities. This play sculpture by Moller-Nielson is intended to be perceived not only visually but also as a tactile surface, haptic form, and kinesthetic motion. Such sculptures which invite touch and exploration and facilitate acquisition of a sense of orientation might be included in the yard of a therapeutic household.

outside the body. Haptically perceived landmarks and voids within the body constitute a vast and intricate psychological realm of inner feeling that seems to be much more influential in our comprehension of the environment than we generally recognize in conscious thought.[38] No other sense deals as directly with the three-dimensional world or carries with it the possibility of altering the environment in the process of perceiving it as does the haptic sense. No other sense engages in feeling and doing so simultaneously.

Perhaps because of the great significance of the haptic sense in environmental experience, physical places seem to function best when they leave things to be done by the inhabitants. Learning about a place is like learning about one's own body; it calls on all senses but is most directly a consequence of feelings that are confirmed haptically (visual and auditory sensations are by their nature perceived as more distant and figurative). The quality of movement through a house becomes especially important in the experience, physical and psychological, of the place. (Movement will be discussed further in a later section of this thesis.) A feeling of house-possession is further reinforced by opportunities to color and decorate the walls, to adjust lighting, to move furniture, to touch

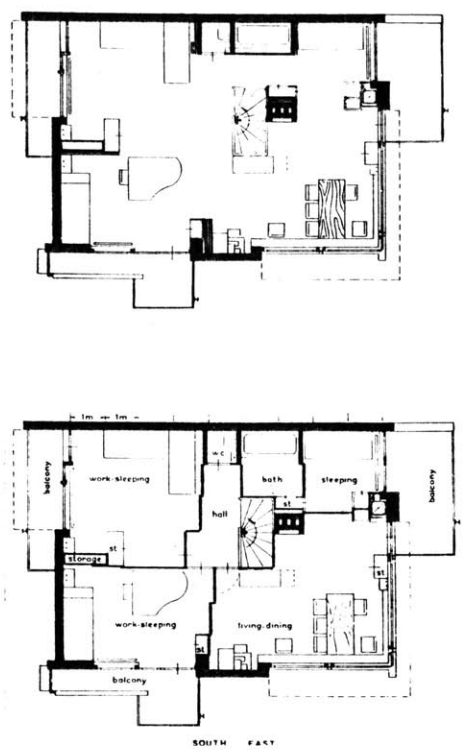

Fig. 15
The opportunity to manipulate the surroundings is critical for the schizophrenic who must re-acquire the ability to control himself and his fate. The upper floor of Rietveld's Schroder House, built in 1924, could be opened into one clear space (top) or closed into five individual rooms (bottom).

and alter the landscape that surrounds the house. Residents of a household must be surrounded at all times by visible, tangible evidence of their ability to influence the physical conditions of their lives.

This opportunity for manipulation of the surroundings is critical for the schizophrenic who has usually withdrawn from the outer world and has denied his ability to influence that world and, therefore, his fate. In the breakdown of boundaries between self and the environment, the control of the environment becomes the same as, or at least analogous to, the control of one's own self. Architecture or objects in the architectural environment may serve as symbolic mediators of a person's mental disturbances. This phenomenon is related to the way people tend to "forget themselves" by changing their spatial environments and to free themselves of anxieties and other weighty feelings by creative activity. A person may gain the insight to transform his relationships with objects and other people by manipulating or transforming objects in his environment in such a way as to express problems in analogical form. Spatial reduction of situations in analogical form in order to manipulate and assimilate those situations is a technique used by all people. In architectural design, the preparation of drawings allows the designer to reduce the problem to comprehensible, manipu-

38. K. Bloomer and C. Moore, p. 39.

"To the stupefaction of the nurse, for the first time I dared to handle the chairs and change the arrangement of the furniture. What unknown joy to have an influence on things; to do with them what I liked, especially to have the pleasure of wanting the change. Until now I had tolerated no change, even the slightest. Everything had to be in order, regular, symmetrical. That night I slept very well."

Marguerite Sechehaye, Autobiography of a Schizophrenic Girl, p. 80.

lable dimensions. For the creator of a work of art, however crude, the transformed object may come to represent anxiety itself from which he has been freed.

GIVEN THE FREQUENT WITHDRAWAL AND HELPLESSNESS OF SCHIZOPHRENIA, RESIDENTS OF THE THERAPEUTIC HOUSEHOLD MUST BE SURROUNDED AT ALL TIMES BY VISIBLE, TANGIBLE EVIDENCE OF THEIR ABILITY TO INFLUENCE THE PHYSICAL CONDITIONS OF THEIR LIVES.

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THE BODY-CENTERED EXPERIENCE OF ARCHITECTURE

The mentally disturbed lack inner rhythm, balance, and harmony, and this lack may be expressed in muscular uncoordination. A sense of rhythm can be enhanced through visual perception and, potentially, by every aspect of an environment, provided it is designed with a sensitivity to movement and the total body experience.

A historic overemphasis on seeing as the primary sensual activity in architecture has necessarily led people away from their bodies. The experience of space and enclosure, however, can and should be more than visual, going to a much deeper, sensual space. Bloomer and Moore have des-

"The next thing was the walls of my rooms. By this time I was living in a room on the roof. It felt like being on the edge of a mountain. There was paint and brushes about the place, left over from decorating. These I took to my room. All over the walls I painted moving figures, running, dancing, swimming. A mother kneeling with a baby at her breast, a baby as a bud, like a flower, and over my bed in red an outline of Christ crucified.

At night, by candle light, the figures moved me to sleep. In many colours on my door were twining stems with leaves. The table became bright orange with a bird. I now loved my room."

Mary Barnes, Mary Barnes, p. 133.

cribed this as a psychic relationship in which man internalizes and identifies with his environmental transactions:

> "One of the most hazardous consequences of suppressing bodily experiences and themes in adult life may be a diminished ability to remember who and what we are. The expansion of our actual identity requires greater recognition of our sense of internal space as well as the space around our bodies...Our feelings of rhythm, of hard and soft edges, of huge and tiny elements, of openings and closures, and a myriad of landmarks and directions...form the core of our human identity."[39]

39. K. Bloomer and C. Moore, p. 44.

The connection between memory and body experiences is strong. The experience of our bodies, of what we touch and smell, of how well we are 'centered' as dancers say is not locked into the immediate present but can be recollected through time.

Direction of movement has archetypal, symbolic meaning. Movement upward can be interpreted as a metaphore for growth, longing, and reaching. Putting oneself above may literally designate aloofness, detachment, privacy, and rumination. Movement downward can be thought of as absorption, submersion, and compression. The images of womb and tomb are associated with the earth, resurrection and the afterlife with the sky. The vertical axis of movement is also closely bound to the concept of transition through the cycles of life. The horizontal place is more earth-bound, the zone of communication and social interaction. "Verti-

cality" and "concentration", says Bachelard, comprise the basic properties of the house. He describes the cellar and the attic as particularly meaningful places. Quoting Joe Bosquet, he characterizes modern man as "having one storey only".[40]

Diagonal movement through space is less easily oriented and its termination less predictable than that of either the pure horizontal or pure vertical motion. Diagonal motion sometimes appears to be related to quick change or an upset of an existing order. In the Japanese garden, diagonals and asymmetry also suggest the indirectness of Japanese social etiquette:

> "The sukiya composition is invariably asymmetrical. If symmetry implies formality, completion, and a static state, asymmetry suggests informality, incompleteness, and movement...The approaches to residences and other buildings in the sukiya style are a good illustration of this point...The path leading from the gate to the main entrance usually bends and curves. If it is straight, it follows a diagonal line. In other words, it does not permit a direct view of the house from the gate, and in this aspect of sukiya design we see a reflection of certain traditional Japanese moral attitudes. For instance, the Japanese generally avoid looking a person directly in the face because he regards averted eyes as a symbold of respect and humiliation. In somewhat similar fashion, the path leading to the entrance of a sukiya-style house affords no head-on views but creates constantly varying and quite often beguiling vistas as

40. G. Bachelard, The Poetics of Space, Chapter 1.

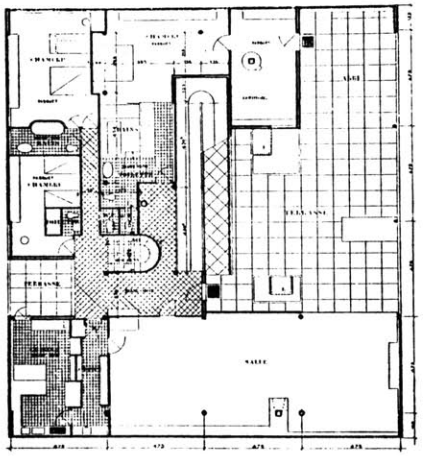

Fig. 16a

Fig. 16a and b
Le Corbusier was masterful in his elegant weaving of different kinds and patterns of movement in the Villa Savoye. The spiral stairway is clockwise, curvilinear, and incremental in its vertical progression while the ramp adjacent to it is counterclockwise, rectilinear, and continuous. By their relationship is generated a complex pattern of space-time relationships experienced primarily through body movement.

one moves along it.[41]

With no insult intended, one might see some similarity of needs between Japanese social etiquette and the schizophrenic's reluctance to meet others' gazes directly.

Bloomer and Moore have linked architectural design with dance choreography. All architecture functions as a potential stimulus for movement, real or imagined. A building is an incitement to action, a stage for movement and interaction. It is one partner in a dialogue with the body. Directional choice delivered by the location and articulation of stairways or even single steps embody human aspirations and hesitations silently. Exiting abruptly through a doorway in the horizontal dimension is more self-conscious and terminal than the more subtle shift of orientation via stairs and landings, assuming that they have not been designed exclusively for efficient and direct movement, such as stairways in halls isolated from communal activity.

A building may consist of an elegant weaving of different kinds and patterns of movement. LeCorbusier in the Villa Savoye placed a spiral stair near a ramp so that one person taking the stair might become acutely aware of his own motion by its periodic relation to that of another participant on the ramp. Stepping and spiralling is counterposed by continuous, two-directional motion.

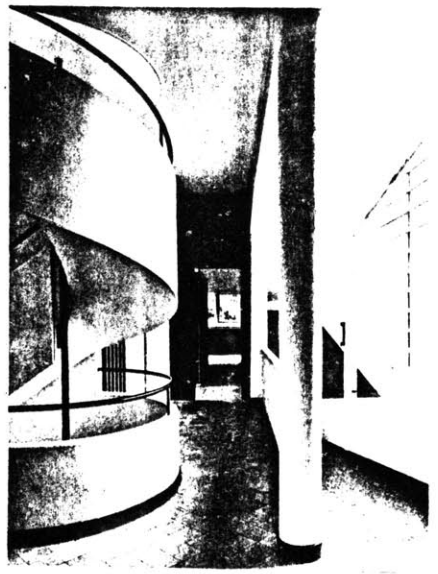

Fig. 16 b

41. Futagawa and Itoh, The Classic Tradition in Japanese Architecture, p. 96.

A DESIGN FOR A THERAPEUTIC HOUSEHOLD MUST ACKNOWLEDGE THE FORMATION OF HUMAN IDENTITY THROUGH THE INTERNALIZATION OF ENVIRONMENTAL EXPERIENCE BY FOCUSING ON THE HUMAN BODY AND THE CHOREOGRAPHY OF ITS MOVEMENT.

* * * * * * * * * *

SPACE, TIME, AND MOVEMENT

Architecture can be experienced truly only by moving within and around it. The emphasis on movement is significant, as it is the link between space and time. Hall suggests that there is a tendency to be too oriented towards either space or time at the expense of the other. A balance is needed, an understanding of the reality of time being one of the most fundamental needs for today. The element of time is introduced into architectural form through movement.

In order to describe the sense the reflexive consciousness has of time and of succession, one must borrow from the concepts of space. Modern physics has synthesized them into a single concept: space-time. What actually unifies the two is movement. Sivadon starts with this line of thinking in his analysis of the schizophrenic's personality regression and disintegration. If time seems to correspond to an internalization of space relations, that is, of movements,

Fig. 17
The schizophrenic often experiences the concepts of space and time as frozen abstractions. Marcel Duchamp and other Cubist painters sometimes attempted to introduce space and time into their paintings by representing figures in a frozen sequence of movements, like movie film.

the problems of the time organization of personality might be expressed in terms of space. Disintegrations of the human personality result first of all in a loss of the temporal references before the spatial references are affected. When a personality strives to restructure itself, says Sivadon, it uses spatial references primarily.[42]

42. P. Sivadon, p. 410.

The schizophrenic's restriction of the time perspective suggests that movement in space or through architectural form is closely related to an inner sense of time, probably more real than clock time. Large clocks, calendars, and the availability of daily newspapers might serve to remind disoriented persons of the time and the day of the year, but more value might be found in 1) rhythmic activities, repetitive rituals, or religious practices in relation to the rhythm of the day, the week, or the seasons of the year, and 2) the exercising of perceptual and muscular abilities through a program of organized physical training and through an architecture alive with potentials of movement and manipulation. Aldo van Eyck expresses the space-time relationship as follows:

> "Space has no room, time not a moment for man.
> He is excluded.
>
> "In order to include him - help his homecoming - he must be gathered into their meaning (man is the subject as well as the object of architecture).

"Whatever space and time mean, place and occasion mean more.

"For space in the image of man is place, and time in the image of man is occasion."[43]

43. A. Van Eyck, Progressive Architecture, Sept. 1962, p. 154.

A RECONSTRUCTION OF THE TIME ORGANIZATION OF PERSONALITY MIGHT BE BEST FACILITATED BY 1) PARTICIPATION IN MEANINGFUL RITUAL RELATING TO THE RHYTHM OF THE DAY, WEEK, OR SEASONS OF THE YEAR AND 2) THE EXERCISING OF PERCEPTUAL AND MOTOR ABILITIES THROUGH A PROGRAM OF PHYSICAL TRAINING AND AN ARCHITECTURE ALIVE WITH POTENTIALS FOR MOVEMENT AND MANIPULATION.

* * * * * * * * * *

"But my way proved very perplexing, though in this long evening it was by no means too late to distinguish a westerly direction for several miles. All the street-names were queer and goblinish; they seemed to have meanings which would start me off on false trails, in wrong directions. So I lost time, and when I asked the way it seemed that the streets and houses had been rearranged, or were shrunk to tiny imitation affairs. Their brickwork was excessively, dangerously red, and they vanished away to almost nothing, in exaggerated perspectives. Some gigantic cycnic had leered on the town; and its aspect was shockingly struck awry. Yet at last I was on the Great West Road, and leaving behind me the distant thumpings of Paddington Station; as though of the last red-hot rivets that were being beaten into London's iron coffin."

Thomas Hennell, The Witnesses, p. 45.

ORIENTATION

A resident of the therpeutic household must be aided in being able to tell just where he is in the building and to relate his present position to where he was before and where he wants to go next. The built environment may serve as an orienting system for the person whose condition is such that he has lost the temporal and spatial references with which to define himself, his relationship to the environment, and his relationships to other people. A sense of orientation may be offered in terms of an organization based on an intimacy gradient or a low level/high level

sensory stimulus gradient. Boundaries and transitions must be articulated and options for circulation through the building must be clarified and facilitated.

Spivack has stated a conviction that the size of a therapeutic facility must be limited in scale by the degre to which its dimensions stay within a "knowable whole" and that at least one path through should reveal, if possible, the entire limits of the facility.[44] There is an argument to be made, though, for having some places that are more difficult to get to which might offer some sense of solitude or even mystery. The idea of linking the whole together by a central spine is perhaps a good one, though, so long as this spine is not too long or does not present an image of endless repetition. In the schizophrenic experience of a breakdown between the concepts of space and time, being confronted with a long repetition of identical units of dimension or an endless corridor can exacerbate a state of disorientation.

> "...if through mental derangement the faculty of size constancy is upset, the horror of a corridor must be greatly intensified (cf. the dream image of the long corridor with death at the end). Izumi and Osmond, from their experiences under LSD, support this view. They refer to the need to retain a distinction between the sense of time and of space, explaining that a corridor tends to confuse the distinction owing to the exaggeration of its apparent length in perspective.

44. M. Spivack, p. II-20-2.

> ...corridors of a limited length may be necessary to avoid other planning defects. In this case the shape and treatment of the corridor can often alleviate its undesirable characteristics. Berenson, in widely splaying all corners of corridor intersections in his cerebral palsied children's unit, has achieved this and at the same time fulfilled the practical purpose of increasing the child's angle of vision when approaching a corner. Ounsted stresses the importance of the route that a child takes in going from one place to another, that this should be carefully visualized in the design so that there are changing vistas and a succession of experiences of visual significance."[45]

45. K. Bayes, p. 19.

A further discussion of the quality of circulation and sequence follows in the next section "Path and Sequence".

Some devices for facilitating orientation in a building are:

- Change of ceiling height or type in the circulation path
- Color and/or textural coding
- Graphic indications
- Directional illumination; special illumination of destination
- Repetition of architectural elements (rhythm)
- Framing element directionality

SPATIAL ORIENTATION SHOULD BE FACILITATED BY THE NATURE OF THE OVERALL ORGANIZATION OF THE BUILDING AND BY APPROPRIATE ARCHITECTURAL DETAILING OF CIRCULATION PATHS.

* * * * * * * * * *

PATH AND SEQUENCE

The design of circulation through the therapeutic household is indistinguishable from the building organization which should be based on the concept of the "intimacy gradient" and a low level to high level sensory stimulus gradient. If clear sequences are implied by the configuration of the building, then a resident may come to match his sequential behavior to that configuration by a process of sequential choice. Clarification in the building layout can contribute to the individual's clarification about what he is doing. Spivack discusses this idea for mentally disturbed children:

> "At 'path' intersections, clear expression should be given to the choices offered, allowing the child to predict and choose a comfortable next step. The number of choices at given intersections may vary, but should be limited according to the kind of intersection. For example, at the intersect between a path and a large or semi-large social space, options should be available to bypass the interaction space, or to choose semi-involvement or complete entry into the group...the 'path' boundaries should articulate the decision with emphasis." 46

Such recommendations, of course, apply to disturbed adults

46. M. Spivack, p. II-4-6.

as well.

The movement between rooms is as important as the rooms themselves, and the 'choreography' of movement has as much effect on social interaction in the rooms as the interiors of the rooms. As explained under "Intimacy gradient", it is essential that residents be able to exercise free choic of movement and social interaction in the house. Alexander reiterates this idea in his analysis of "The Flow through Rooms":

> "In a complex social fabric, human relations are invariably subtle. It is essential that each person feels free to make connections or not, to move or not, to talk or not, to change the situation or not, according to his judgement. If the physical environment inhibits him and reduces his freedom of action, it will prevent him from doing the best he can to keep healing and improving the social situations he is in as he sees fit...
>
> "The building with generous circulation allows each person's instincts and intuition full play. The building with ungenerous circulation inhibits them... The possibility of small momentary conversations, gestures, kindnesses, explanations which clear up misunderstandings which clear up misunderstandings, jokes and stories is the lifeblood of a human group. If it gets prevented, the group will fall apart as people's individual relationships go gradually downhill."[47]

47. C. Alexander, p. 628, 629.

The space allotted to circulation in the therapeutic household will most probably exceed that of a more common house.

Pathways through the building relate to sensory stimulus level by the number of sequential events they afford the residents a view of or adjacency to.

> "If sequences are planned to include sustained intervals of similar information, then low sensory stimulus occurs. If sequences are planned so that changes in information occur at frequent intervals, higher level sensory stimulus will occur."[48]

48. M. Spivack, p. II-5-3.

At the small scale of the therapeutic household, though, opportunities to design such radically different sequence will be limited. Differentiation will be more apt to be achieved through qualities of place rather than numbers of sequential events. The number of paths occurring in the household should probably be at least two, though, as Spivack has advised - one richer in sensory income and the other less stimulating for those whose disturbances require defense against too much outside intrusion.

Quality of the circulation areas should be related to the scale of activity areas served so that paths give intimations of the kinds of behaviors expected. A smaller, more intimate scale of access would be appropriate to sleeping and personal areas; some intermediary scale of path would relate to intermediate-sized social places; and a larger scale of path would indicate the likelihood of public exposure. Where paths share the characteristics of the

places they serve, behavior is likely to be less chaotic and more normal in appearance than where there is conflict between path and place.

CIRCULATION THROUGH THE THERAPEUTIC HOUSEHOLD SHOULD BE RELATED TO THE OVERALL ORGANIZATION OF THE BUILDING IN SEQUENCE, SCALE, AND QUALITY (PUBLIC/PRIVATE AND HIGH STIMULUS/LOW STIMULUS) OF PLACE.

* * * * * * * * * *

transition

BOUNDARIES AND EDGES

In the experience of schizophrenia, a person frequently loses a sense of self and non-self and of what is really out there and what is imagined or hallucinated. Consequently, in the design of therapeutic environments, the creation of distinct places to be and the formation of the boundaries and transitions between them become particularly important. Buildings are creations which serve to give meaning and order to an otherwise confusing, complicated existence. The design of a building to accommodate human activities is like the concretization of the potential of those activities. As Mayer Spivack has written,

> "If these boundaries and transitions are aesthetically and thoughtfully related according to human use and comfort, the building becomes a pleasant place to be, and the boundaries serve gracefully to separate events.[49]

Staying inside the boundaries of a building is like staying "inside" oneself emotionally. Going deep down inside a house is like going down inside oneself. Crossing architectural boundaries and transitions is akin to the existential boundary crossing experiences of going to sleep, waking up, being born, and dying. Especially with the maladjusted and disturbed, "where occasions should be emphasized, rhythms felt, festivals celebrated, actions clarified and articu-

49. M. Spivack, p. II-7-1.

> "Joe, lead me deep into myself.
>
> At one point I imagined going down from my middle floor room to the ground floor, to be put, to lie still in what was then the meditation room. When first going down in '65 I had wanted to be put in the Box in the basement. Being 'down' inside the house seemed the same as being down inside myself."
>
> Mary Barnes, Mary Barnes, p. 210.

lated"[50], the architecture should enhance the action of entering and leaving the bounds of the different parts of a building.

In addition to emphasizing the individual's existence, a building edge may serve to articulate the existence of a family or a family-like group. Human groups cannot function fully without the existence of articulated territorial edges. An architectural boundary exists to encourage and ritualize the activities which are sacred to the group, and the destruction or exaggeration of this boundary can sap the vitality of both the group and the community outside. A building edge, therefore, creates a reciprocal definition, a landmark which reinforces the feelings and identity of both the inside and the outside communities.

AS AN ASSEMBLAGE OF BOUNDARIES AND EDGES, THE THERAPEUTIC HOUSEHOLD CAN BECOME THE CONCRETIZATION OF EXISTENTIAL SPACE AND CAN SERVE TO GIVE ORDER AND MEANING TO AN INDIVIDUAL OR GROUP'S EXISTENCE.

* * * * * * * * * *

ENTERING AND LEAVING

Leaving and entering the house are especially signif-

50. K. Bayes, p. 14.

Fig. 18
Houses like this one with a graceful transition from the street to the inside seem to be more tranquil than those which open directly onto the street or sidewalk. The transition must relieve the momentum of the closedness and tension which are appropriate to street behavior so that people can relax completely.

icant events in that they necessitate a reorientation from a place of one or a few well-known people to a place of many little known people or complete strangers. Alexander explains the need for a graceful transition between inside and outside:

> "While people are on the street, they adopt a style of 'street behavior'. When they come into a house they naturally want to get rid of this street behavior and settle down completely into the more intimate spirit appropriate to a house. But it seems likely that they cannot do this unless there is a transition from one to the other which helps them to lose the street behavior. The transition must, in effect, destroy the momentum of the closedness, tension, and 'distance' which are appropriate to street behavior, before people can relax completely."[51]

51. C. Alexander, p. 549.

By the same token, when leaving the house, residents must feel that they are given the opportunity to prepare themselves for whatever sojourn into the outside world they must make.

For the mentally disturbed, the decision to go in or out, to enter, leave or stay are often painful or frightening alternatives. Perhaps a simple trip to the corner drugstore is the first trip outside the house and the yard the person has made in weeks, and he is afraid that he will do something "crazy" in front of the neighbors. Perhaps he is on the verge of deciding to give up on the place or

> "It was many months since I had been out of my room and longer still, nearly a year, since I had been out of the house. It was very strange and frightening, 'going out.' I was wholly concerned, in every way, on 'going in' and staying 'inside.' Going 'out' was a foreign, alien idea."
>
> Mary Barnes, Mary Barnes, p. 197.

to run away. On the other hand, maybe it is the first time he has visited the house and he has the misguided notion that it might be some kind of archaic madhouse. Whatever the case, the entrance to the therapeutic household is an extraordinarily sensitive region of the house boundary. A person must be able to linger over the decisions of whether to come or go, and he mut be reassured of the goodness and welcoming nature of the place. The entrance must be placed so that people who approach the building see it or some hint of it and can orient themselves readily as to direction or approach and as to what they might expect in regards to the character of the place. The transition space between the street and the front door may be articulated by a path with a change of light, sound, direction, surface texture or pattern, level, or elements which change the amount of enclosure. There should be places to stop and sit to contemplate one's intentions, to watch street activity, to look out for the postman, or to wait for visitors.

In his design for a children's home in Amsterdam, Aldo van Eyck was much concerned with the idea of transition and the distinction between inside and outside. He incorporated an interior "street" into his design as an area for common activity which forms the transition between

"I first went to Out-Patients at a mental hospital accompanied by a very voluble devil. How we ever reached there at all I don't know, because he would keep buzzing the wrong directions at me. But we found the place at last, and after walking three times round the building, an entrance grew up where there had not been one before."

Mary Cecil, The Inner World of Mental Illness, p. 213.

the outside world and the inside living units. Here he used external type materials and lighting. The walls are finished with the kind of rough-textured paviors that are often used for Dutch streets. Inside the living units the walls are white, smoothe, and softer to the touch. The white smoothness denotes intimacy and privacy while the rougher texture of the "street" suits the more active, impersonal events of the outside world.

Thus far, the discussion has centered around the outer edge and the entrance of the therapeutic household. The same principles of transition hold true for interior spaces. The character of the boundaries between the private and the communal realms and between the different activity areas affect the way the residents will be able to live their lives and make choices in the way they wish to relate to one another. Boundaries determine static or dynamic spatial qualities and either encourage or discourage movement between two places. Some boundaries are simply thick walls; others are only implied by change of level, light, texture, and so on, and are related to some focus of place such as a fireplace. The degree of enclosure the boundary makes must be related to both the intimacy and stimulus gradients of the house. More open space planning and implied boundaries would be used for

the communal, lively areas of the house, while the private realm or the quiet areas would be made up of more fully enclosed rooms.

AREAS OF TRANSITION BETWEEN INSIDE AND OUTSIDE AND BETWEEN THE ZONES OF THE HOUSEHOLD SHOULD BE HANDLED SENSITIVELY TO CLARIFY DISTINCTIONS, TO ALLOW FOR TARRYING OVER DECISIONS WHETHER TO LEAVE OR TO ENTER, AND TO CARRY INFORMATION AS TO THE KIND OF BEHAVIOR EXPECTED IN THE DIFFERENT SETTINGS.

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design for a therapeutic household in cambridge, massachusetts

SITE

The site is on Rindge Avenue in North Cambridge, a short walk from Massachusetts Avenue in one direction and a short drive to the Fresh Pond shopping area in the other direction. A few hundred feet away is a small commercial intersection which includes a drugstore, bakery, snack shop, and beauty salon. The proximity of these major streets and commercial areas is important for the success of the therapeutic household in that ease of transportation to and from means residents need never feel that they are isolated and inaccessible. The near-by commercial intersection provides a small-scale testing ground for making excursions into the "outside world" while Massachusetts Avenue and Fresh Pond are longer, potentially more anxiety-producing trips.

In addition to the small commercial intersection nearby, the neighborhood is made up of single-family and duplex houses, triple decker apartment buildings, two elementary schools, a branch of the city library, and a large Roman Catholic Church. The density of the houses and the variety of institutions nearby lend a looser quality to the neighborhood than one might find in a homogenous suburban area which depends more on car travel.

The other houses and buildings form a pattern that is continuous enough to guarantee neighborhood coherence and stability, but they are varied and loosely spaced enough so that a therapeutic household might find its niche with an adequate tolerance zone around it.

The nearby houses are constructed of various siding materials, from stucco to aluminum siding, wood siding, and brick. The flat-roofed triple deckers probably contain about three apartments while the gable-roofed, two-and-a-half story houses are duplexes or single-family homes. There is a variety of roof types and building widths, as well as materials, so that no strict adherence to the quality of the neighborhood fabric need be required in a new design.

The site itself is about 13,000 square feet, currently owned by the Catholic Church whose elementary school is situated directly to the rear. A driveway to the school runs along the left-hand side of the site, and many children crowd along it in going to and from school. The school is a rectilinear, three-story, brick structure. The houses to either side of the site are a triple decker and a two-and-a-half story, gable-roofed, stucco house.

The front of the site is to the North-North-East so that a building which loosely maintained the existing

street frontage line would leave an ample rear yard with exposure to the sun for almost the entire day.

PROGRAMMATIC NOTES

I designed this building with the idea that it would house 16 to 20 people, staff and residents mixed indiscriminately, with the majority of the rooms for single occupancy but with some doubles for 1) when people preferred the security or the entertainment of a roommate's presence, 2) when couples - staff or residents - wished to live together intimately, 3) when residents were suicidal or grossly disoriented, or 4) when residents were slightly brain-damaged in which case they often prefer roommates.

The programmatic notes I began with (and did not necessarily adhere to) are given in rough form below with the name of the room or area, the activities that might take place there, the intended character of the place, some architectural suggestions as to how to achieve the desired qualities, and the corresponding outdoor area, when appropriate. The rooms are divided into three zones of sociability: the Public, the Intermediate, and the Private.

PUBLIC

ENTRY

Activities:

Receiving and reading mail
Waiting for guests
Putting on and taking off outdoor gear
Storing outdoor gear

Intended character of place:

Most important transition zone
Welcoming, reassuring area
Often painful decision whether to come or to go; must give option to tarry over the decision
Warm area, accommodating

Architectural suggestions:

Some glimpse of living room
Entry large and well-defined from outside
Locus of choice about where to go in the house
Warm colors
Places to sit

Corresponding outdoor area:

Front porch or stoop and entry court

PARLOR

Activities:

Receiving guests, family, and community mental health workers
Receiving and reading mail

Intended character of place:

Structured for safe-feeling interaction
Traditional, semi-formal kind of place
Buffer zone between associations of world outside and therapeutic household retreat

Corresponding outdoor area:

Formal front yard or entry courtyard

CONFERENCE ROOM OR CONTAINED GROUP ROOM

Activities:

Group sessions calling for concentration and containment
House meetings
Family conference meetings

Intended character of place:

Sense of containment without imprisonment
Encouraging of relaxation and togetherness
Focus on center

Architectural suggestions:

Controlled view of outside (like closed courtyard)
Simple, geometrical form
Low ceiling
Soft colors, textures, and lighting
Soft, low, enveloping furniture (or pillows)

Corresponding outdoor area:

Closed landscaped area

LIVING ROOM

Activities:

Dance and movement classes

Art classes
Parties, light shows, music
Psychodrama (fantasy enactments)
Poetry readings, art exhibits

Intended character of place:

High sensory stimulus
Live, stimulating place, bouncing light and sound
Center of activity and socialization
Fireplace hearth as heart, symbolic center of house
Opportunities for movement and environmental manipulation at a maximum
Changeability

Architectural suggestions:

Several foci to room
Change of room with the seasons: use of fireplace, summer awnings outside, French doors to open wide to the outside when nice weather, "Skylids" to adjust to the intensity of the sun...
Changeability: "costume box" for the room and for psychodrama including wall hangings, floor mats, throw rugs, pillows, movable partitions, screens for light shows or slide shows, movable mirror, directional lighting fixtures, dimmers, and colored lighting option, sound system

Corresponding outdoor area:

Active outdoor area for games and movement classes and parties (cookouts)

DINING ROOM

Activities:

Evening meals, parties, snacks, afternoon tea
Announcements

Intended character of place:

Friendly place - acknowledge link between hunger for food and hunger for affections

Architectural suggestions:

Lighting important to give feeling of communion

Corresponding outdoor area:

Outdoor dining patio

"AEDICULAS", NOOKS, OR POCKETS

Activities:

Observation of general activity
Independent projects
One-to-one talks
Immediate retreat from larger group

Intended character of place:

Protective, comforting nooks related to areas indoors and outdoors

Architectural suggestions:

Lower ceiling than common areas
Body-sized articulation
View to outside
Deep, encompassing furniture

Corresponding outdoor areas:

Outdoor nooks, hideaways

KITCHEN

Activities:

Cooking by responsible residents

Food preparation classes
Between-meal snacks, coffee, tea
Observation
Socialization

Intended character of place:

Country-type kitchen, large and sunny

Architectural suggestions:

Ample sitting and working area
Light from two sides at least

Corresponding outdoor area:

Outdoor cooking, picnic area
Herb and vegetable garden

INTERMEDIATE

BREAKFAST OR SNACK PLACE

Activities:

Snacks
Dining alone or in small groups
Independent projects: artwork, writing letters, fixing things
One-to-one talks

Architectural suggestions:

Must have eastern (morning) exposure
Nice to look out on vegetable garden
Easy access to kitchen

GREENHOUSE

Activities:

Herb gardening for kitchen
Gardening classes

Intended character of place:

Year-round natural setting to give sense of continuity and renewability of life
A prime relational setting

Corresponding outdoor area:

Outdoor herb and vegetable garden

LAUNDRY

Activities:

Washing, drying, folding, ironing
Reading, socializing

Intended character of place:

A prime relational setting - if socialization space not included right in the laundry, should be directly adjacent and visible
Make laundry a pleasant task

INTERMEDIATE SOCIAL

Activities:

Small group socializing & meeting
Observation of larger common area

Intended character of place:

Unifies a small group, territoriality
Place where fearful residents can make tentative attempts at relating to others

Architectural suggestions:

Make area be central to small group of bedrooms (four or so) - have all bedroom doors open on to
Give view to large common area so that it is like a territorial lookout - provide immediate way down to larger social area (intermediate area will probably be above to guarantee privacy and territorial definition)

Corresponding outdoor area:

Gazebos, sundial court, specially defined areas

WATER ROOM

Activities:

Sensory awareness exercises
Group frustration and anxiety release

Intended character of place:

Relational setting
Something like Japanese bath and country club sauna and whirlpool room

Architectural suggestions:

Put down inside the house to give feeling of cave, being down inside house like being down inside self
Nice to relate closely to group room to allow for quick relief from group meeting pressures

MEDITATION LIBRARY

Activities:

Meditation, reading, writing, studying

Intended character of place:

Lofty feeling, elation
Contemplative, removed, quiet

Architectural suggestions:

Make roundabout way of getting there to give feeling of being special, hidden away
Open to the sky for lofty feeling - put at highest point in house

Corresponding outdoor area:

Roof terrace, sunbathing hideaway

PRIVATE

SHARED BEDROOMS

Activities:

Sleeping, dressing, grooming, reading, writing, one-to-one sessions with friends or counselors

Intended character of place:

Private, quiet, simple retreat

Architectural suggestions:

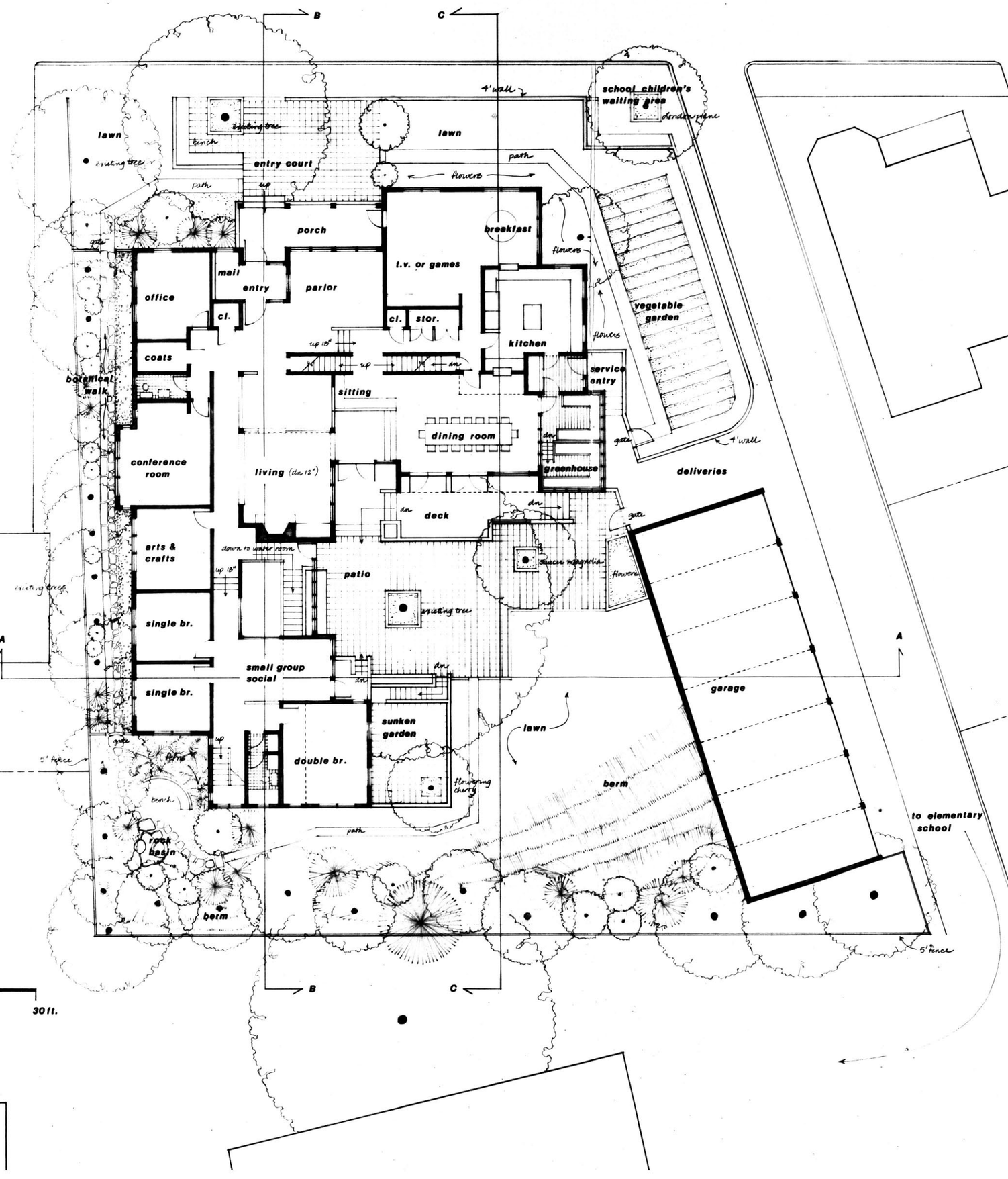
Make bed nooks, alcoves, or lofts to give each person a private area

SINGLE BEDROOMS

BATHS

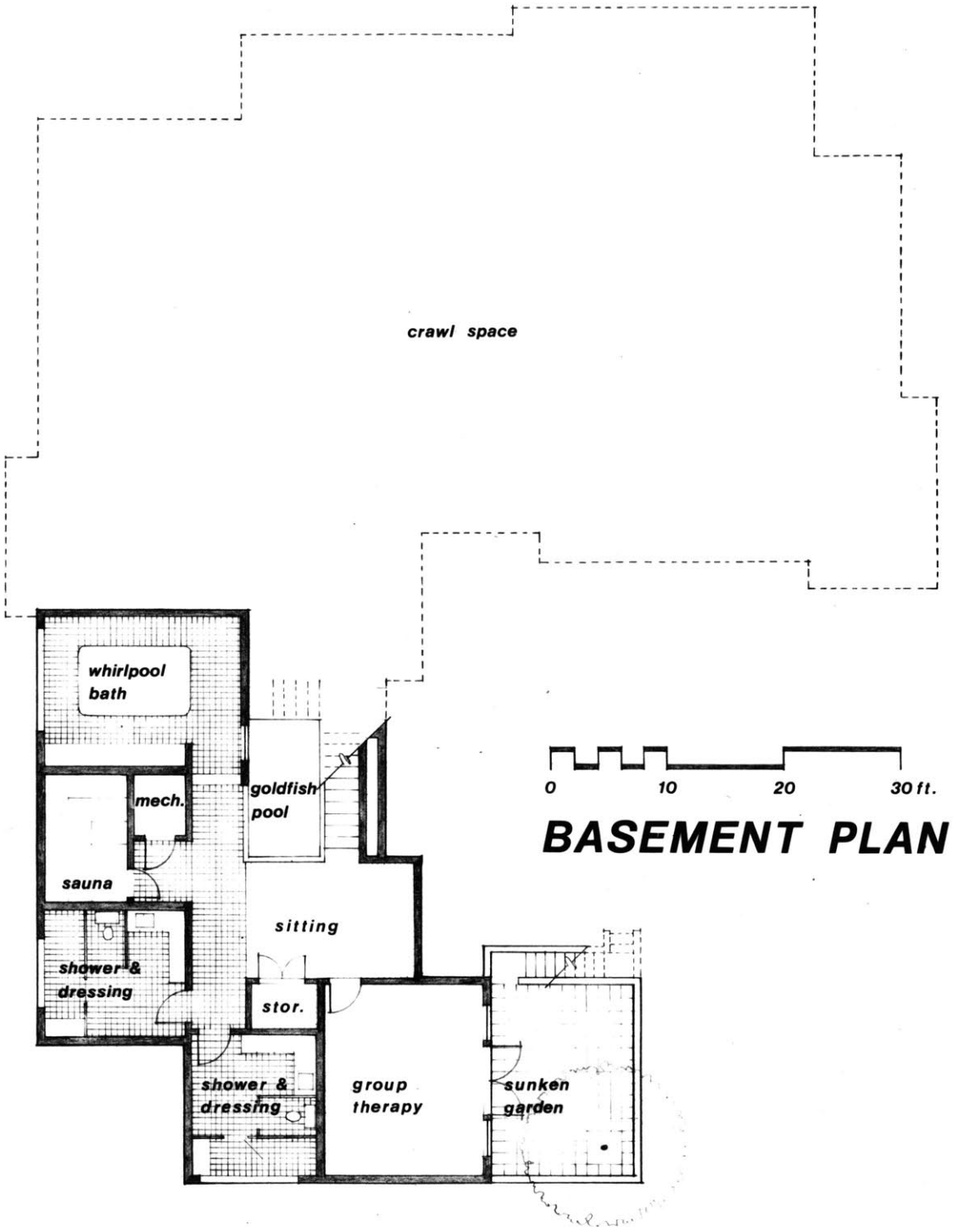
Separate sinks for ease of communal use

RINDGE AVENUE

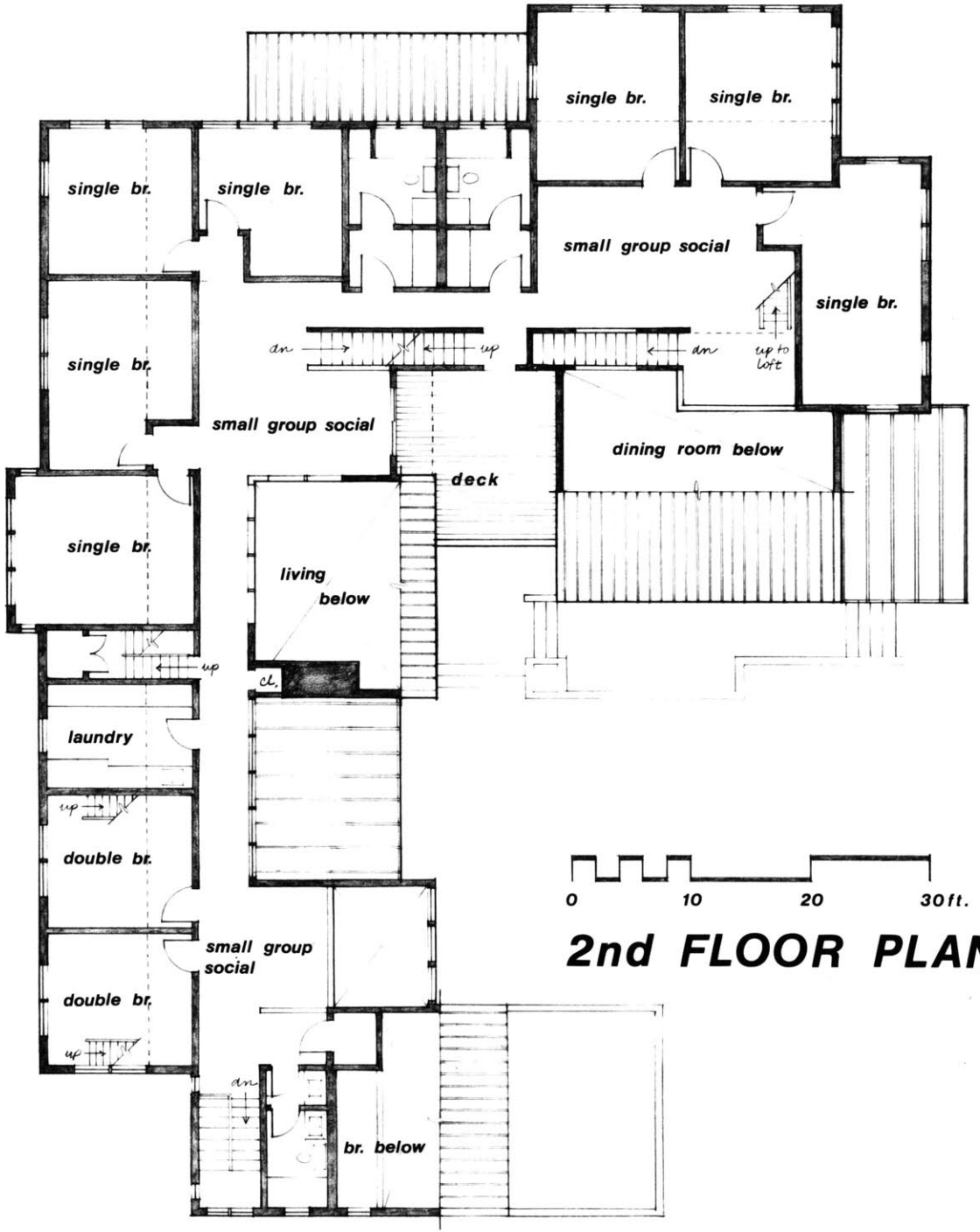


0 2 4 6 8 10 20 30 ft.

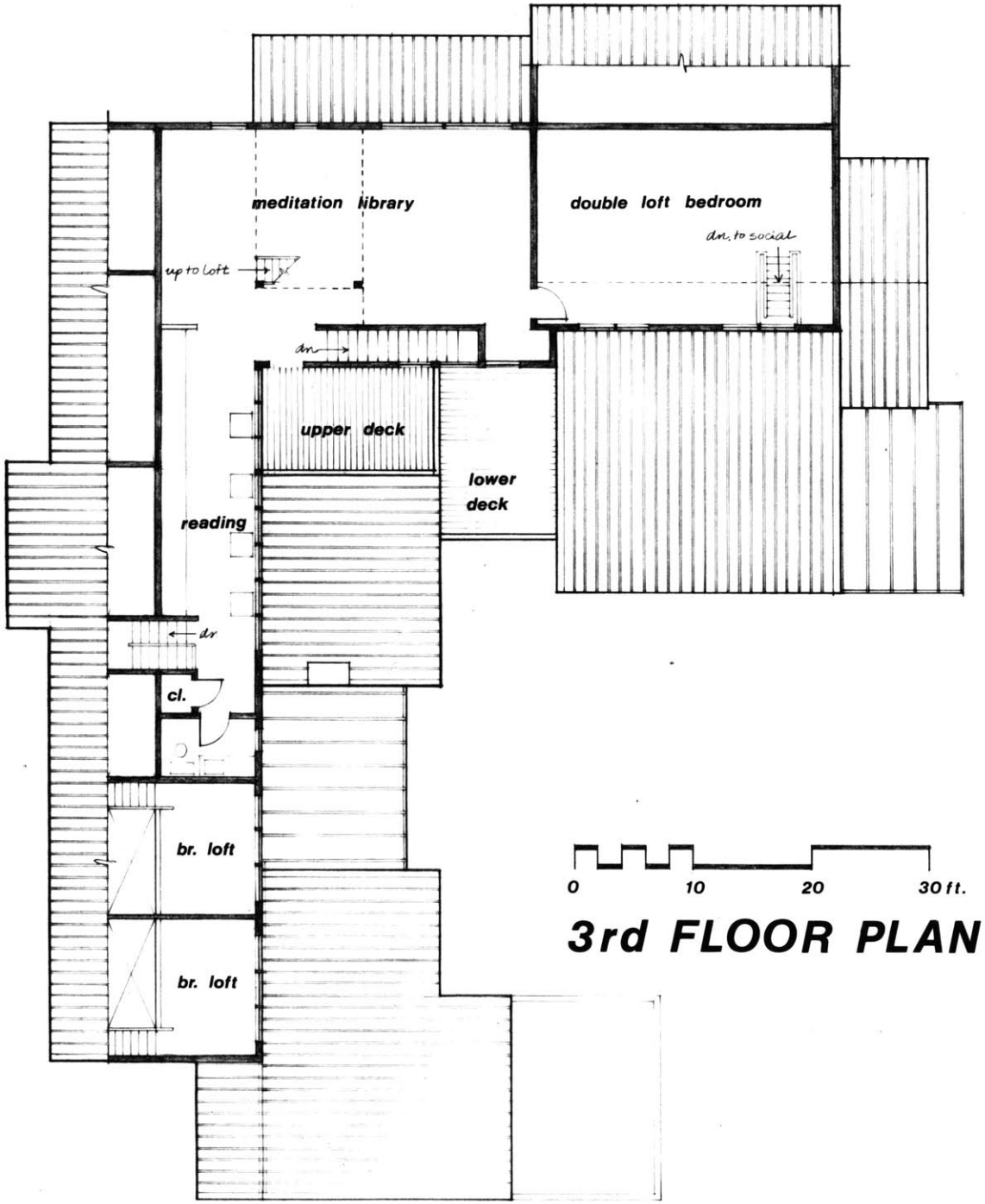
SITE PLAN



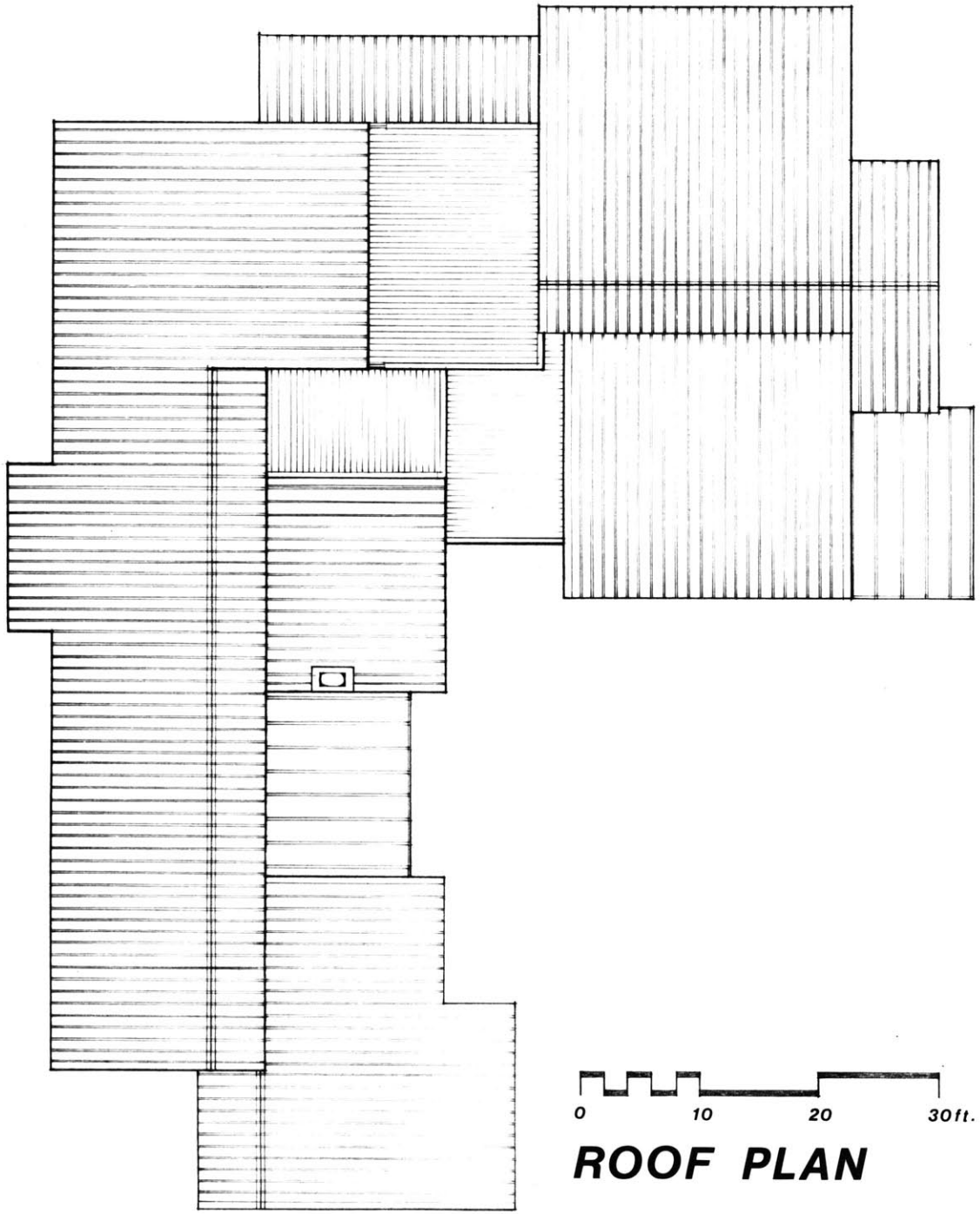
BASEMENT PLAN



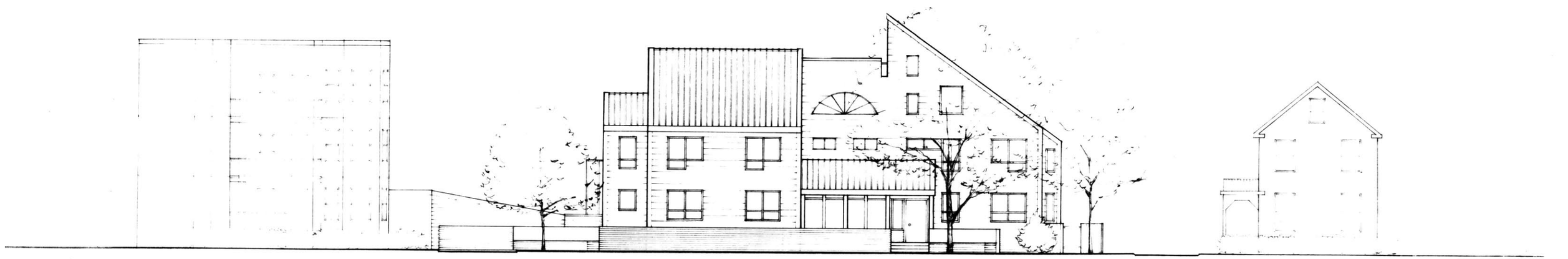
2nd FLOOR PLAN



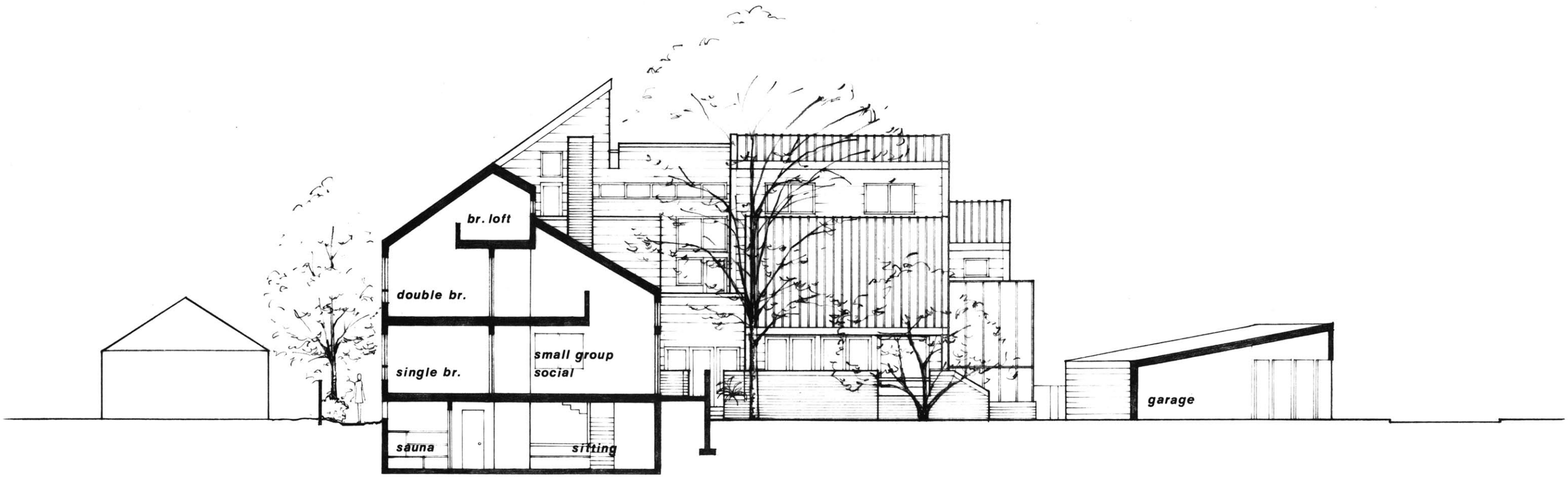
3rd FLOOR PLAN



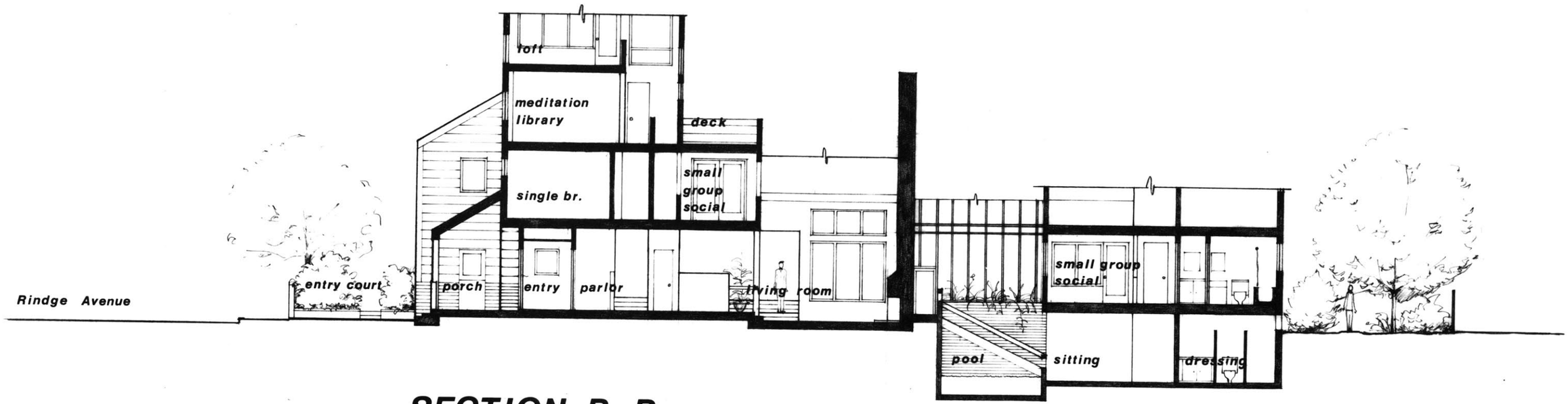
ROOF PLAN



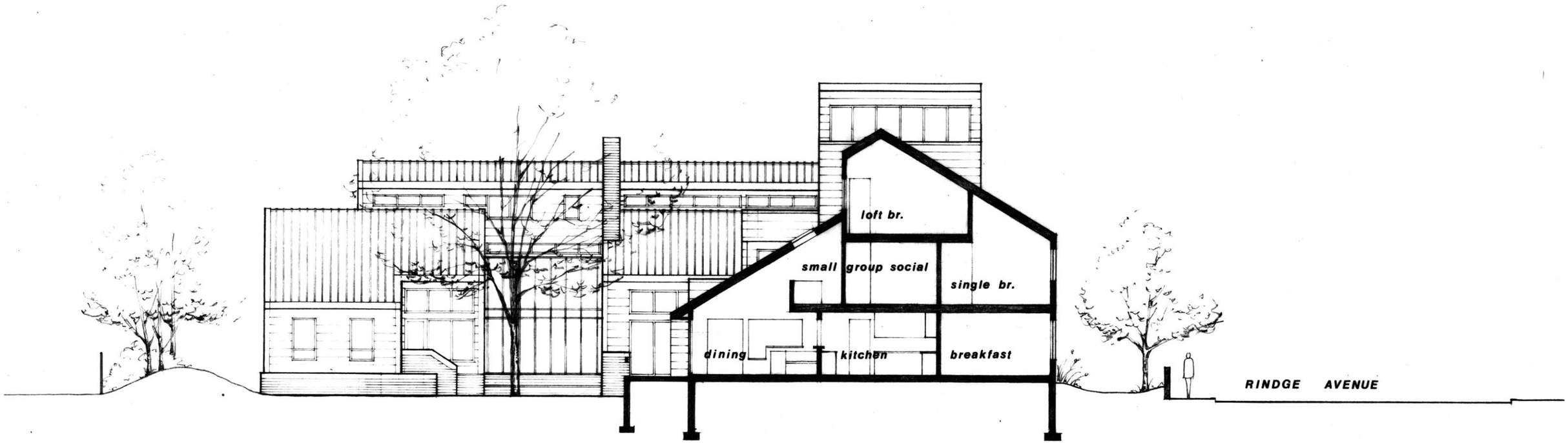
RINDGE AVENUE ELEVATION


br. loft
double br.
single br.
small group
social
sauna
sitting
garage

SECTION A · A


loft
meditation
library
deck
single br.
small
group
social
Rindge Avenue
entry court
porch
entry
parlor
living room
small group
social
pool
sitting
dressing

SECTION B·B


loft br.
small group social
single br.
dining
kitchen
breakfast
RINDGE AVENUE

SECTION C · C

DESIGN ISSUES

The dominant organizers of this design were sun path orientation, the existing street frontage (setbacks and scale of other buildings), the existing school and its driveway down the left side of the site, and the "intimacy" and "stimulus" gradient principles discussed in the thesis body.

Sun:

The mass of the building is pushed over to the front and the right of the site so that the L-shape is open to the sun's path and embraces the largest amount of lawn area. This L-shape allows the building to make a frame around a large (about 50' in height and spread), existing tree located in the central area of the site.

Existing street frontage:

The street setback of the other houses and buildings is somewhat variable, but this design maintains what would be about an average for the block. In order to respond to an average building width, the massing of the new design is broken up into two parts on the Rindge Avenue side, with the entrance area pushed farther back to make a transition zone or entry court,

happily marked by another large, existing tree.

Existing driveway and school:

Taking advantage of the existing driveway, the seven-car garage for the therapeutic household and the delivery area and service entry are located on the left side of the site. The garage structure provides a buffer between the noisy school children who pour down the driveway twice a day and the back yard of the house. Pushing the mass of the building to the front and right of the site allows the living areas the maximum distance from the school building to the rear. The earth berm and plantings to the rear of the site form a screen between the yard and the school building.

Intimacy and stimulus gradients:

With the back yard holding such importance in the massing of the building, and with the L-shape of the masssing, the active communal areas of the house had to be located within the crook of the "L". The lively character of these areas and their need to be observable by residents in other areas of the house dictated that they be centrally located and have higher and more dynamic ceiling forms.

The outer edge of the building is designed to have a

more regular form to lend formality to the public face and to make the building appear to be more appropriate for the existing neighborhood character. This regularity is also more appropriate to the North side with its lack of sun and cold winter winds. The inner edge on the back yard side, though, has a more varied, lively aspect to respond to the relaxation of the private realm and to trap as much sun as is reasonable. This differentiation of the inside and outside facades, the position of the major outdoor activity area, the ease of placing dynamic forms to the center of the "L", and the need to create the intimacy gradient, dictated that the bedrooms be located on the second and third floors to the outer edge of the building.

Briefly, the design responds to the design considerations discussed in the body of this thesis in the following ways:

Image:

Of course, the design is non-medical and non-institutional in its image; it simply appears to be a large house. Much is made of the roof to emphasize the feeling of shelter. The shed and gable forms are roofed with corrugated aluminum which would be blue

in color to attract attention to lively form and to reflect the color of the sky (the great sheltering dome above). The roof comes down lower in the back of the house and is higher and more regular in the front, except that a separate low section forms the main entry to the house.

Choice:

Major circulation spines run through the building from side to side and from front to back to make the layout of the plan easily comprehensible to residents. These paths run through a sequence of choices of places to enter or observe.

As discussed above, the intimacy and stimulus gradients were major organizers in the design. For the most part, these two overlap - what is private is usually less stimulating; what is communal is usually more stimulating. There is a hierarchy of social spaces from the lively common areas in the center (the living and dining rooms) to the overlooking intermediate areas in the center of each bedroom grouping to the private bedrooms themselves located, for the most part, at the outer extremities of the house on the second and third levels. The lively common areas are of a more spatially continu-

ous nature and offer many foci of interest and possibilities for leaving and entering. The ceilings of these two areas slope down from a two-story height in order to incorporate the views from the intermediate social areas above and to bring the building mass down to a low scale in the yard area. The stairs down from the two front bedroom clusters culminate in a small sitting area between the living and dining rooms where residents might observe the larger areas before deciding whether to join in or not.

Less dynamic social areas such as the kitchen, breakfast area, TV room, conference room, and crafts room are located on the first floor around the exterior of the house so that their ceilings might be lower and more regular in form.

There are many different kinds of bedrooms to choose from and bedroom clusters each have their own focus.

Two special areas - the water room and the meditation library - are located at the upper and lower extremities of the house to emphasize their psychological meanings of delving into the unconscious (water) and lifting the spirits in contemplation (meditation-library).

Privacy:

As stated above, the bedrooms are placed at the outer edge of the house on the second and third floors, except for the back cluster which is allowed to come lower to the ground because of the greater quiet at the rear of the site. Thus, in three-dimensional form, the intimacy gradient is preserved. The bedrooms are to be perceived as areas of retreat.

In some of the double bedrooms, the ceiling slopes up enough so that a loft can be built along the higher side of the room. This loft provides private areas for the two occupants of the room - the loft space itself which might be used for sleeping, and the space below which becomes a kind of bed alcove.

Outside, the rock basin area at the end of the botanical walk and the places in amongst the trees and shrubs at the rear of the site form private hideaways.

Interaction:

Special places form relational settings. Some of these are the big kitchen, the laundry on the second floor, the greenhouse, the fireplace area, the goldfish pool, the sauna and bath, the vegetable garden, and the botanical walk. In these places there would be special

things to do or to talk about outside of the personal relationship of two people.

The design forms a comprehensible hierarchy of socialization areas with options for walking alongside of these areas to have the chance to observe without committing oneself. Intermediate social areas have views onto greater common areas - the dining room (front left cluster), the living room (front right cluster), or the outdoor patio (the rear cluster).

Enhancement:

Texture: The exterior materials provide an interesting variety of textures from the brick ground form to the horizontal wood siding to the corrugated aluminum roofing. Special attention was paid to the landscaping of the outdoor areas to include textural variations, especially on the botanical walk, the path of which is like a Japanese garden with a progression from gravel to small, rough-edged stones, to longer pieces of stone with one machine-cut edge. Plantings would be chosen in part for their textural interest, such as trees with outstanding bark, plants with berries, and different leaf patterns and sizes.

Color: Color cannot be shown here but the design would

allow for flexibility in creating the mood of the place. The communal areas might be painted in a warm white to allow plants and decorations to set the mood in color. The water area would be painted in blues and greens, the meditation library in pristine white or light blue (for expansiveness). The bedroom painting would, of course be left up to the choice of the various residents. The roofing material would be of a deep blue color, as mentioned above, to emphasize the roof forms, to lend playfulness to the building's aspect, and to reflect the great dome of the sky above.

Light: As discussed above, sunlight was one of the major organizers of the desing. With all other factors considered, the bedrooms could not be uniformly placed on the eastern side of the building (for "rising with the sun"), but the intermediate social areas tend to that side (although the one above the dining room would have a skylight only). Lively common areas are to the south for the greatest amount of sun (with sun controls, of course). The kitchen and breakfast areas are to the east for morning light. The greenhouse gets sun all day, except perhaps on late summer afternoons. A special lighting effect would occur for the water room in that a resident would walk down from the very

bright, glassed-in area at the ground level to the dark, cool, watery environment below.

Natural settings: It may be inappropriate that a therapeutic household be isolated from the mainstream of society in a rural settings, but every effort should be made to create a microcosm of the countryside on the available land. The elements of this landcape plan include 1) the major sweep of green lawn from the back patio area to the gently sloped berm at the back of the lot - the building, garage, berm, and plantings create a sense of enclosure and privacy; 2) the botanical walk, a special pathway from the front entry court to the rock basin and bench area at the back of the lot - this walk would provide a delightful sequence of blooms and berries and fall color changes - a bit of magic!; 3) the rock basin area, a small, contained area for meditation and one-to-one meetings 4) the sunken garden outside the therapy room, providing a controlled view of the outdoors in order that concentration might be better maintained in the meetings - during nice weather, the group might meet in the garden itself; 5) the vegetable garden, providing a way for residents to find meaningful employment within the household - horticultural therapy has obvious healthful

benefits; 6) the greenhouse which would allow residents to continue their horticultural activities in the colder months and so to be reassured of the continuity and renewability of life.

Fire: The vertical rise of the fireplace, as an existential symbol of creation and existence, is given the place of central importance in the high part of the living room. It marks the place as one place with people linked together in faith in their living experiment.

Water: Water was made much of in the design with a large area below grade given over to the goldfish pool (which signals at the base of the stairs the kind of place one is entering), sauna, showers, and communal bath.

Movement :

Many of the opportunities for manipulation of the environment would be in the moving of furniture and decorations, and in the adjustment of lighting, which are not shown in the drawings.

Directional symbolism has been discussed above: one goes down into the cave and the water of the unconscious, up into the territorially marked bedroom clusters above, and farther up into the lofty meditation library of

spiritual and intellectual growth. More minor level changes occur on the first floor as, for instance, between the parlor and the hallway to the kitchen and to the stairs for the second-floor living areas.

Dancing and movement classes might be held in the dining room (the table could be disassembled and stored in the large hall closet designed for that purpose), on the patio, or out on the lawn.

Transition:

Much attention was paid to the entry sequence. One proceeds from the sidewalk where there is a low brick wall around the front and side of the site, to a break in the wall where a large, existing tree marks the entrance, to the entry court (defined by a change in paving material) with its bench facing the street and its small social area just down from the porch, up some steps to the front porch which is defined by its own low roof, to the weather-locked entry with mailboxes off to one side, and finally into the parlor and the center of the circulation system of the house.

THE AGE OF THE ASYLUM

Western society has seen two great periods of interest in the design of special facilities for the housing and treatment of its behaviorally deviant, mentally disturbed, or "insane" members - from the late 1700's with the birth of the insane asylum in Great Britain and France and not again until the 1960's with the Community Mental Health Center movement. Before the end of the 18th century, society had made little distinction between the mentally disturbed and any other behaviorally deviant persons or social welfare cases. The mentally disturbed were often kept in their families' homes; otherwise, they roamed the village streets, living on hand-outs, or they were imprisoned in the local poorhouse, workhouse, or jail. Bethlehem Hospital in London, which later came to be known as "Bedlam" and which inspired the modern-day meaning of that word, was one of the few institutions founded before 1790 for the express purpose of caring for the "insane". Bedlam was a place of last resort where men and women were herded together, often chained to the walls, scantily dressed and poorly fed. These poor souls became objects of diversion for London citizens who could pay a penny for the excitement of walking the viewing galleries of the

Fig. 19
In this 18th century painting by William Hogarth from a series called "The Rake's Progress", the rake finds himself locked in Bedlam Hospital, surrounded by patients behaving in bizarre fashions. In the background stand two upper class women who have paid admission for the excitement of viewing the "lunatics".

hospital.

With the Enlightenment, there arose a "cult of curability", an emphasis on humane, "moral" treatment of the insane, and an enthusiasm for the widespread founding of asylums, the special design of which was considered to be of the highest importance. Nineteenth century medical superintendents were pioneers with a missionary zeal, believing that a specially designed and administered setting or community would not only rehabilitate or redeem the inmates, but would serve as an example of right and moral living for the larger society. In the United States, the Association of Medical Superintendents of American Hospitals for the Insane (AMSAII - today, the American Psychiatric Association) appointed a committee which discussed the minute details of asylum site selection, construction, water supply, sewerage, drainage, materials, lighting, and so on. Thomas Kirkbride, who was president of AMSAII for eight years, was most influential in the spreading of ideas for the proper design and administration of insane asylums with his book, On the Construction, Organization, and General Arrangements of Hospitals for the Insane. Kirkbride recommended that all patients have single rooms except for those who might be afriad to sleep alone or who were suicidal. Rooms were to be grouped

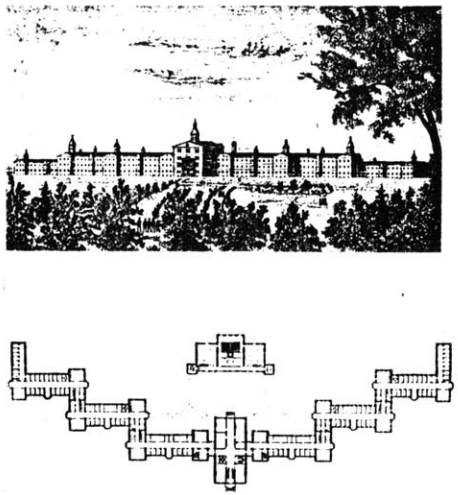


Fig. 20
Thomas Kirkbride's design for the Pennsylvania Hospital outside of Philadelphia became the most influential model for state "lunatic" hospital design in the United States. The central section was to house the administration and the wards for the patients ranged out on either side, offset from each other to allow light and air into the corridors.

together with an average of fifteen persons per ward. Double-loaded corridors were to be about 14 feet wide with the idea that they might then become areas of socialization as well as circulation. As for the quality of the place, Kirkbride wrote:

> "A hospital for the insane should have a cheerful and comfortable appearance, everything repulsive and prison-like should be carefully avoided, and even the means of effecting the proper degree of security should be masked, as far as possible, by arrangements of a pleasant and attractive character. For the same reason, the grounds about the building should be highly improved and tastefully ornamented; a variety of objects of interest should be collected around it, and trees and shrubs, flowering plants, summer-houses, and other pleasing arrangements, should add to its attractiveness."[1]

The "Kirkbride plan", with its central rotunda and symmetrical ward wings ranging out on either side, can still be seen as the most prevalent type of state mental hospital building today.

1. T. Kirkbride, On the Construction, Organization and General Arrangements of Hospitals for the Insane, p. 11.

THE COMMUNITY MENTAL HEALTH CENTER MOVEMENT

Thomas Kirkbride and the other people who helped to usehr in the "Age of the Asylum" did much to ameliorate the conditions of the insane, but within about thirty years

of the original reform fervor, the belief in the curability of insanity began to wane, the asylums became seriously overcrowded, and patients began to suffer the theretofore unpredicted effects of long-term institutionalization. The state mental hospitals (the latterday "insane asylums") continued as insular, largely self-supporting institutions, regarded as places of last resort for the custody of chronically insane populations. Although most of these hospitals still function today, the major thrust of mental health care plannint in the United States is tending towards a community orientation, a development which was given impetus in 1963 when President Kennedy sponsored legislation which provided for the establishment of a network of community mental health centers. These community-based facilities were to offer short-term, intensive care and so, hopefully, would avoid institutionalization of mental patients in the anti-functional environments of the state mental hospitals. Just as the original insane asylums had been founded as a reform of conditions in which people were abused in their families' homes, on the streets, or in county institutions, the community mental health center movement was initiated as a reform of conditions in which people were locked in the state hospital "snake pits" or back wards.

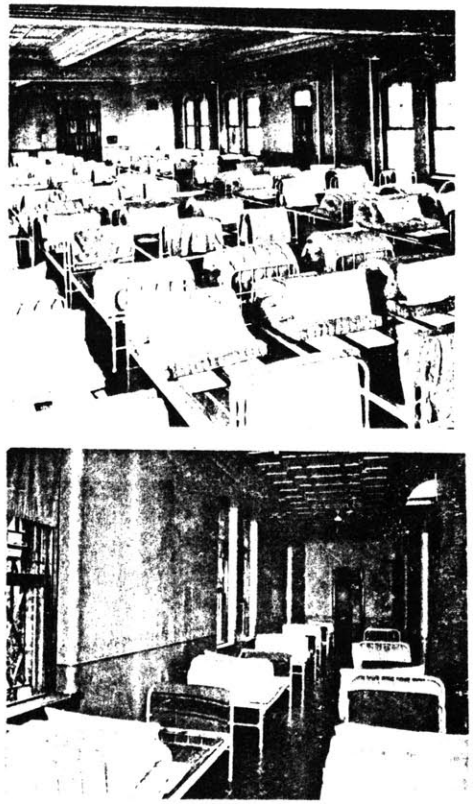


Fig. 21
Within about 30 years of the original reform fervor, the belief in the curability of insanity began to wane and the asylums became seriously overcrowded. Originally intended for circulation and socialization, the wide corridors became sleeping space for many more patients.

The most significant abuse perpetrated by the state hospital system was considered by community mental health care proponents to be its ignorance of the individual. It was pointed out how state mental patients were denied most of the accessories commonly recognized as expressions of individuality, were dressed in uniform clothing, were mass transported, and mass fed. Even bathing and toilet facilities offered no privacy. The state hospital was typically located in remote areas with ample surrounding grounds which seemed to be designed keep patients in and the community out, although in actuality, they had been included to afford the patients a beneficial, natural environment for relaxation and exercise. The buildings were large, multi-story, unadorned edifices with conspicuous features such as window screens or bars, heavily grilled sunporches, and interminable corridors which would certainly depress and further disorient the patients and affect staff and community attitudes as well.

After more than a hundred years of dormancy, then, enthusiasm over the quality of the treatment environment flared again in response to the community mental health center legislation. A new field of architectural or environmental psychology took form, and psychiatrists and architects banded together much as they had in the early

19th century with the belief that good design is intimately related to effective therapy. Numerous books and journal articles were published between 1963 and 1969 which attempted to relate psychiatric treatment philosophy to architectural design rationale.[2] These publications dealt with design considerations which would presumably avoid the abuses of and anti-functionality of the state hospitals by responding to the special needs of the mentally "ill" in a humane manner. A therapeutic milieu was to be established in the community mental health center through a coordination of treatment and architectural design programs. The recurring topics of consideration in these discussions of architecture for the community mental health center include the following:

1) Order and clarity of form and space.

   In response to the schizophrenic's frequent perceptual distortions and changes in thinking, it was believed necessary to emphasize the proper separation of the different use spaces and architectural elements and to organize them with some easily discernible logic so that the patients might go from one area to another without difficulty or apprehension.

2) Change and variety.

   At the same time that order and clarity were stressed, so too was the need for a variety of sense stimuli and a choice of activities and size

2. L. Good, S. Segal, and A. Bay, Therapy by Design; Architecture for the Community Mental Health Center; "Planning, Programming, and Design for the Community Mental Health Center"; etc.

of activity groups. The community mental health centers were to enhance one's experience of life.

3) Individuality.

The place was to constantly acknowledge the patient's individual worth, dignity, and right to privacy. His body image and self perception were to be bolstered, his initiative mobilized, and his energies motivated to realize his potential for creativity and productiveness.

4) Sense of community.

The community mental health center was to facilitate realistic and meaningful communicative interchange amongst the patients themselves. Small living groups of from four to eight persons were believed to lessen fears of social interaction, provide for support, and stabilize mood swings. It was acknowledged that one patient might well have the capacity for helping his fellow patients so that spontaneous interactions and a sense of interdependence were encouraged.

5) Community integration.

The community mental health centers were to complement existing social and cultural agencies' services, not replace them. The physical facilities were to integrate well with the surrounding buildings so that the outside community might welcome the Center in its midst. Hopefully, the occurrence of mental "illness" would lose its social stigma and former mental patients might readily acclimate themselves to life on the outside.

MENTAL HEALTH CARE PLANNING IN MASSACHUSETTS TODAY

In spite of community mental health legislation, Massachusetts in 1975 still allocated 80% of state funds for mental health care to the state mental hospital system.[3] In the last five years, though, planners in the community mental health system have been pushing for comprehensive community-based services with hospitalization only as a last resort. The Massachusetts Department of Mental Health advocates extensive social and vocational rehabilitation programs, half-way houses and group homes for the previously hospitalized, and even "counter-culture" crisis centers. In other words, a network of various decentralized forms of mental health care is planned to take the place of most of the existing state hospitals, some of which have actually been closed down now.

3. Task Force on Community Mental Health.

The high cost of hospital services is frequently sited as a major reason for limiting their use to the following circumstances:

". When the patient's medical needs require diagnostic or treatment facilities available only in hospitals
. When the security of the patient, his or her family, of the community requires 24-hour care
. When the patient's treatment can be adequatly controlled only in a hospital setting (e.g. medication

or physiological emergencies such as seizures)
. When no other facility is appropriate for around-the-clock supervision."[4]

The largest group of people said to require 24-hour hospital care is described as adults whose "mental illness and emotional problems are manifested by psychosis, suicide attempts, severe depression, episodes of confusion, etc." Within this group are two sub-groups: 1) those patients currently residing in state hospitals (ambulatory patients with predominant medical problems, ambulatory patients who are psychotic, ambulatory non-psychotic patients who are institutionally dependent, and acutely psychotic patients who require short-term hospitalization) and 2) adult patients newly admitted to private, voluntary, and public hospitals.[5]

Community residences for the mentally "ill" are now required as an essential service in comprehensive area-based programs of mental health care. Although these residences are a relatively new resource, their numbers have increased at a geometric rate so that by 1974, there were 60 such programs in Massachusetts. Viewed as less traumatizing, less alienating, and less costly than traditional hospitalization, community residences are recommended for utilization by several groups of people:

4. Task Force on Community Mental Health, p. 55.

5. Task Force on Community Mental Health, p. 55.

". Individuals in crisis, coming directly from the community who require short-term, intensive non-medical supervision and support (many of whom are now cared for in state hospitals)
. Individuals ready to leave a hospital after short-term care but not yet ready to assume the full responsibilities of independent living
. Individuals who after long periods of hospitalization are capable of personal care but lack social skills and competencies."[6]

6. Task Force on Community Mental Health, p. 55.

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