2007

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Hoey, Brian A.
2007 **Therapeutic uses of place in the intentional space of community**. *In* Therapeutic Landscapes. A. Williams, ed. Geographies of Health. Hampshire, England: Ashgate.

Chapter 18

Therapeutic Uses of Place in the Intentional Space of Purposive Community

Brian A. Hoey

Introduction

This largely historical chapter is positioned at the intersection of anthropology and human geography where, with sociology, psychology, architecture and public health, an integrated science of human health is forming. The role of environment in shaping quality of public health and civic life is at the center of merging academic and applied interests (see Jackson, 2003). Although public health, and especially environmental health, has long considered the *negative* effects and risks to the physical person associated with places such as industrial sites, there has been comparatively little consideration of the health-*promoting* role of place in physical and mental health (Frumkin, 2001; 2003). In terms of public policy, change is evident in the growing number of local, state and federal initiatives such as the United States Centers for Disease Control and Prevention's 'Healthy Places,' which supports '... the design and development of built environments that promote physical and mental health by encouraging healthy behaviors, quality of life, and social connectedness' (CDC, 2006). This chapter will explore therapeutic use of place to promote health and well-being while focusing on deliberate use of geographic place, architectural space, and the dynamic interplay between both employed in an intentionally created community setting.

The chapter provides an overview of the historical context for construction of the Northern Michigan Asylum in the second half of the nineteenth century, as well as its present adaptive reuse as 'neo-traditional' community. The term neo-traditional, employed by local planners, is typically used more or less synonymously with that of 'new urbanism'. New urbanism is a relatively recent community design reform movement recognized by its emphasis on bringing together mixed uses in an attempt to recapture the presumed vibrancy and stability in urban neighborhoods of an idealized American past. The Asylum's massive redevelopment takes place after nearly 20 years of uncertainty and possible demolition following its closing in 1989. The Northern Michigan Asylum is an especially interesting case as it is not only an ideal expression of nineteenth-century asylum reform but also, in its redevelopment, an expression of the ideals of new urbanism. Both movements entail not only a basic communitarian ideal but also an environmental, or spatial, determinism. The

history of reformist idealism in design of the purpose-built mental asylum based on principles of 'moral treatment' provides a lens for my discussion of contemporary reimagining of the past for present purposes seen in new urbanism. Having this perspective is especially important given how new urbanism is being embraced by growing numbers of local governments and applied to numerous community planning projects around the United States and elsewhere.

While looking at therapeutic landscape, both implicitly and explicitly understood and operationalized in ideologically related projects, I extend application of the construct from consideration of the nineteenth-century asylum to the recent new urbanist movement and its design prescriptions for the post-modern 'village.' I will argue that the initial design and early operation of asylums such as Northern Michigan share a set of critical motivations, ideals, and objectives with the contemporary planning prescriptions called for by new urbanism. At the center of these movements is a commitment to using place therapeutically, that is, with curative, restorative and remedial goals, within purposively created community. The chapter suggests how the therapeutic landscape may be connected to public health and policy debates on the subject of design, community planning, and regional development in the United States. It attempts to reveal enduring resonances between major health and design reform movements of two arguably similar historical periods of great social and cultural change – the Industrial Revolution and our current post-industrial restructuring.

Setting and Fieldwork

Roughly 250 miles northwest of Detroit, Michigan's Grand Traverse region is a one-hour drive from the nearest highway. The area consists of four adjoining counties: Grand Traverse, Leelanau, Antrim, and Benzie, which have a combined population of approximately 140,000 persons according to US Census 2000 figures. Together they comprise an area extending roughly 25 miles from the region's economic and social hub at Traverse City (population 14,500). Census figures show that population increase in these counties ranged between 20 and 28 percent during the period from 1990–2000 with in-migration contributing four times the amount attributed to natural increase.

As with many rural places in the United States dependent on natural resource extraction during the nineteenth century, rapidly diminishing stocks of timber, fish and other commodities threatened the local economy. Shrewdly reading trends, business and political leaders created new purpose for the area, reframing many picturesque hills, towering sand dunes and miles of lakeshore as enchanting objects of reflection with power to promote health and well-being. The region was revisioned as a restorative sanctuary in two temporally separate but thematically related projects. The first of these is the construction of an institution for the mentally ill. Responding to local lobbying, the State of Michigan built a mental hospital in Traverse City completed in 1885. While the area was relatively remote, the competitive site selection process was not driven by a desire to distance this facility from centers of population for a common good. Rather, siting was determined by the conviction

of reformist asylum planners that patients would benefit from the abundant fresh air, clean water, wholesome food, and natural splendor afforded by distance from increasingly congested and polluted population centers. Some 40 years later, the region was again marketed as refuge but to a growing middle-class eager to seek quiet retreat from the hustle and bustle of life in a rapidly urbanizing and industrializing America, by journeying to places of great beauty and real or imagined remoteness (Hoey, n.d.; cf. Aron, 1999; Löfgren, 1999; Sears, 1989).

More recently, the theme of place as refuge has again emerged in local 'place-marketing,' including promotion of Northern Michigan Asylum's redevelopment (see Kearns and Philo, 1993 on the historical marketing of place). Like many rural places once only seasonally attractive for short-term stays, the region now finds itself a destination not only for vacationers but also migrants who seek year-round retreat (see, for example, Bonner, 1997; Jobes, 2000; Murdoch and Day, 1998; Pindell, 1995). In my fieldwork over the past seven years, I have examined utopian family projects enacted through middle-class refuge-seeking behavior, where people relocate to personally meaningful geographic places as a way to intentionally refashion lives according to 'moral narratives of self' with greater emphasis on personal fulfillment, work/family balance, belonging to community, and affective attachment to place (see Hoey, 2005; 2006; cf. Bellah et al., 1996 on 'therapeutic quest'; Halfacree, 1998, 203; Murdoch and Day, 1998; cf. MacIntyre, 1984 on narrative 'quest' and the unity of a life). For these migrants, Grand Traverse is a therapeutic landscape. Here they construct personal moral geographies in which they attempt to negotiate challenges to identity precipitated by the effects of economic restructuring on work and family life.

Until recently the concept of therapeutic landscape was applied more or less exclusively to sites that facilitated recovery from illness and achieved a reputation for healing properties including spas, places of pilgrimage, and retreats. Some scholars now extend application to everyday memories and the experience of outwardly mundane but personally meaningful places (see, for example, Conradson, 2005; Gastaldo et al., 2004). These often taken-for-granted places 'have an attraction which gives [persons] a certain identifiable sense of well-being' (Jackson, 1994, 157–8) much like what I document with urban-to-rural migrants I call 'life-style migrants' (Hoey, 2005, 2006). Their story is important not only as a research context for my current project on the therapeutic use of place, but also for the fact that their numbers and common desire for a certain experience of place and longing for community creates a demand for local new urbanist projects like the Asylum's redevelopment into the Village at Grand Traverse Commons.

Introduced to the Northern Michigan Asylum by manner of proximity, initially it served simply as trope. In writing about both literal and figurative asylum, I discussed themes of refuge-*seeking*, in the behavior of urban-to-rural migrants, and refuge-*creating*, in both the 'social construction' (Low and Lawrence-Zúñiga, 2003, 20) of the symbolic landscape of the Grand Traverse region, and in individual and social responses to uncertainty and anxiety in the wake of profound cultural, economic, and structural change. By virtue of local debate on how best to redevelop the site, if at all, the Asylum emerged over time in the unfolding story as a character in its own right. This chapter is a product of that shift. It is a preliminary overview

for future ethnographic research on the Asylum's redevelopment and a speculative essay on ideological and practical connections between two reform movements in purpose-built community design and use of the therapeutic landscape concept to better understand them.

Therapeutic Landscape – Therapeutic Community

While the idea that place may be restorative to human health and well-being is by no means new, the therapeutic landscape concept is a recent social science construct conceived as a way for academics to frame both real and imagined connections between place and human health (Gesler, 1992). Since its introduction, it has become an important theoretical contribution to health geography (see Williams, 1999). Health geography's emergence parallels a related turn by cultural anthropologists away from the limiting perspective of place as merely physical landscape or material context for cultural processes.[1] Rejecting the notion that place is a largely neutral setting or container within which social and cultural life unfolds, ethnographies within medical anthropology, for example, present a dynamic, relational view of human physical and mental health. This view holds that health involves complex interactions between people and their social, cultural and material environments at different points in history (see, for example, Devisch, 1993; Fadiman, 1997; Martin, 1994).

Studies in the anthropology of health such as these present us with rich conceptualizations of place akin to the study of landscape. As used by anthropologists, cultural geographers, and environmental historians, 'landscape' is understood as a cultural production, a symbolic transformation of the natural world (Cosgrove, 1983; Cronon, 1995; Jackson, 1994). Such an understanding takes into account humans, their anthropogenic environment and the manner in which this environment is conceptualized, constructed, experienced, and symbolized in different places and times (cf. Cosgrove and Daniels, 1988; Hirsch and O'Hanlon, 1995; Meinig, 1979). Similarly, landscape is used in health geography as a metaphor for a complex layering of cultural understandings, history, social structure, and built environment that converges in particular places (Kearns and Moon, 2002; cf. Williams, 1999).

Although with notable applications in nursing and palliative care (for example, see Andrews, 2002), *therapeutic landscape* has remained a largely academic concept. That of *therapeutic community*, however, derives from an almost entirely applied context. Encompassing place-based treatment and healing processes, it focuses attention specifically on important social relationships and the total milieu of social life (Jones, 1968; Kennard, 2004; Main, 1983). It emphasizes how community may be subject to design and intent to use the social collective within a particular place for healing purposes. While the therapeutic community construct is perhaps encompassed by that of therapeutic landscape, with its broad conceptualization and application, it provides a useful way of connecting my use of the terms 'community'

1 For consideration of the changing treatment of place in anthropology, see, for example, Lawrence and Low (1990).

and 'landscape.' The concept distinguishes therapeutic forms of community from other types, or specifically other places of institutional treatment, through its emphasis on intent and design within a social and physical setting, that is, 'the way in which [an] institution's total resources ... are *self-consciously* pooled in furthering treatment' (Jones, 1968, 85–6, emphasis added).

As legacy of the treatment approach that founded Northern Michigan Asylum, therapeutic community emphasizes the potential for healing in carefully cultivated social relationships, meaningful work, and the quality of physical environment within which individual development and social life takes shape (see Kennard, 2004). These same themes resonate with idealistic aims of new urbanist planners in developments such as the Village at Grand Traverse Commons. One of the aims of this chapter is to show how, within different historical contexts, reformist asylum planners of over a century ago and present-day new urbanists intend to *create community* for curative and restorative purposes. But what does it mean to intentionally create community?

The varied senses and many emotional layers attached to the word and idea of 'community' in popular discourse suggest that its meaning must go beyond geography or local practice alone. Within common sense understanding in the United States, we find 'an expectation of a special quality of human relationship' (Bender, 1982, 6; cf. McMillan and Chavis, 1986; Plas and Lewis, 1996). My own definition depends on the affective and experiential dimension suggested in this understanding rather than on reference to particular physical place or social assemblage. Speaking elsewhere on the topic of intentionally created community, I have argued that while the characteristics of physical space may be planned, community is something that must be experienced. Community, or perhaps 'sense of community,' may or may not be achieved through the intent of those who plan for it (Hoey, 2003). At the same time, I agree with psychologists Jeanne Plas and Susan Lewis (1996; cf. Talen, 1999) that it is possible to objectively design and create physical environments conducive to intermediate factors associated with the subjective experience of community. I use the term *intentional space* of purposive community in order to call attention to the important distinction between ideal and real – intent, imagination, and actual placed-experience.

New Urbanism

> Simply put, we wish to improve the world with design ... We believe that the physical structure of our environment can be managed and that controlling it is the key to solving numerous problems ... We believe that design can solve a host of problems and that the design of the physical environment does influence behavior (Elizabeth Plater-Zyberk, founding member of the Congress for New Urbanism, quoted in Marcuse, 2000).

> New Urbanism is at the core of a broad process of social change and institutional reorientation in which one can see a redefinition of 'community' as a practical ideal, a reworking of the way that social order and significance are registered visually in spatial arrangements and architectural form, and a reconfiguration of our ability to recognize moral order in our visual and practical experience of the built environment (Brain, 1999).

A reformist, even activist, design movement that emerged in 1980s community planning (see Duany et al., 2000; Katz, 1994), new urbanism's aim to transform all aspects of community design from new or 'greenfield' developments to urban infill and the redevelopment of existing structures or 'brownfields' such as Northern Michigan Asylum. At the core of new urbanist reform is a call to create 'healthy neighborhoods' defined by walkable scale, open spaces for public recreation, a range of housing options and businesses in 'mixed use' design, and cultivated 'sense of place' (Duany and Plater-Zyberk, 1992; Calthorpe, 1993). New urbanist doctrine asserts not only that it is possible to plan for community, but that community can be purposively created in order to have a therapeutic effect on both the individual and social level. With its communitarian ideals, new urbanism has become a key part of the debate over how to improve both civic life and public health in the United States (see, for example, Brain, 1997; 1999; Calthorpe, 1993; Krier, 1991; MacCannell, 1999; cf. Bellah et al., 1991, 1996; Etzioni, 1998; cf. Putnam et al., 2003).

New urbanism furthers assumptions essential to the reform asylum that intentional, purposeful design of the spatial order can serve as foundation for a new moral order (see Gans, 2002; Harvey, 1996; 1997; cf. Talen, 1999 on 'spatial determinism').[2] Varied expressions of purposive community-building reflect the challenges and opportunities of their respective historical periods. These range from reformist asylums to communitarian projects that include nineteenth-century intentional communities, New Deal era 'subsistence homesteads' (see Berry, 1992; Lord and Johnstone, 1942), and new urbanism's neo-traditional developments. Nineteenth- and early twentieth-century reform asylums and contemporaneous communitarian experiments were calculated reactions to widespread and transformative social, cultural and economic changes taking place in the larger society (Rothman, 1971; Zablocki, 1980). This seems true of today's new urbanism. A common axis upon which these diverse movements turn is shared intent to provide a holistic plan for community life where everyday routines performed within carefully designed spaces create more balanced, complete persons and stronger social collectives. In so doing, they self-consciously create models of harmonious living for a society seen as out of balance. Their shared dedication seems founded on a core belief that the intentional space of purposefully created community may be utilized as a therapeutic milieu and imagined haven against an increasingly heartless world (see Hawkins, 1991).

Locating the Northern Michigan Asylum in History and Place

The Northern Michigan Asylum is a product of the reformist 'moral treatment' plan that characterized a mid- to late-nineteenth century institutional approach to mental illness (Grob, 1973; see also Edginton, 1997; Hunter et al., 1986; Williams, 1999). Built at the dawn of modern psychiatric treatment, during a period of sweeping social, cultural and structural changes in late nineteenth-century America, the Northern Michigan Asylum was founded on the approach of Thomas Story Kirkbride. His plan

2 In this way, new urbanist practice perpetuates core aspects of the architecture and planning style of modernism that the movement's principal figures claim to reject (see Gans, 2002; Harvey, 1997; cf. Talen, 1999 on 'spatial determinism').

was to construct largely self-sustaining communities where the built environment and landscape became not only a sanctuary from social disorder but also healing instruments employed to restore individual balance while projecting social harmony. Kirkbride promoted a way of life designed to attain certain therapeutic goals within an asylum community, as well as to serve as an example of harmonious living for the greater society.

Seen from the vantage of contemporary medical science, treatment regimens for psychiatric disorders common at the time of Northern Michigan Asylum's opening in the 1880s, appear as based on little more than faith in the curative power of natural surroundings, carefully cultivated parklands, and well-designed architecture (see Gesler, 1992; Dear and Wolch, 1987; Hunter et al., 1986; Edginton, 1997; Williams, 1999). Given the nearly barren pharmacological cupboard of this period, limited to measures including opium derivatives such as morphine, and reliance on practices such as cupping and purging, we might conclude that this faith was born of necessity alone. In fact, the commitment of asylum reformers to the therapeutic landscape was an innovative approach and departure from earlier models which borrowed wholesale from the penitentiary. Their new approach was a reflection of important intellectual currents of the age (Edginton, 1997, 91; Sears, 1989; Tomes, 2001). During this historical period, American artists, writers, health reformers, and community planners all pointed to the ability of certain environments to exert a powerful, restorative influence on the material and non-material self (Albanese, 1990; Glacken, 1967; Macy and Bonnemaison, 2003; Whorton, 1982).

Central figures to the relatively young field of landscape architecture, notably Frederick Law Olmsted who designed New York City's Central Park and served as first Secretary General of the United States Sanitary Commission, designed many of the period's mental hospitals (see Beam, 2001; Hawkins, 1991). Writing in 1865, Olmsted asserted that taking in the scenery of carefully designed landscapes 'employs the mind without fatigue and yet exercises it, tranquilizes it and yet enlivens it' (Olmsted in Ranney, 1990, 504–5). Olmsted's teacher, the influential architect and landscape designer Andrew Jackson Downing, found inspiration through his admiration for moral treatment asylums. Downing's approach to landscape design was a blend of arguments and goals of both the emerging parkland and sanitary reform movements (Taylor, 1999). Writing mid-nineteenth century, Downing noted that 'it is somewhat curious, but not less true, that no country-seats, no parks or pleasure grounds in America are laid out with more care, adorned with more tastes, filled with more lovely flowers, shrubs and trees, than our asylums' (Downing, 1853, 269). His praise demonstrates a shared confidence with reformist asylum planners in the therapeutic power of place. Sharing their cultural critique as well, Downing pointed to rapidly changing social, cultural and economic conditions as a principal source of emotional imbalance and nervous disorder (Hunter et al., 1986, 1037). The condition most often cited as a source of mental illness was at that time the 'progress of civilization' (Hunter et al., 1986; cf. Doerner, 1981, 80).

The application of Kirkbride's model of moral treatment materialized during rapid industrialization and urbanization in the mid- to late nineteenth century at the same time as communitarian projects of the Utopian Socialist period (Sutton, 2004). The widespread shift from highly independent lifestyles to the decidedly

regulated and routinized lives of wage laborers in the service of strict overseers was a wrenching change at the individual and societal levels (Gillis, 1996; Hilkey, 1997; Zunz, 1990), which brought responses ranging from the asylum reform movement to a fluorescence of intentional communities (McEwen, 1980). The actions of reformist leaders across these various social movements reflect deeply held beliefs in the power of place realized through the careful design and execution of institutions within the built environment to affect change in personal development, health and well-being and, eventually, the broader society (cf. Hayden, 1976; Sutton, 2004).

For example, the historian Nancy Tomes (1994) has noted that utopian sects such as the Shakers and the Oneida community used building plans and other spatial arrangements to both embody and advance their vision of a more perfect social collective.[3] McEwen (1980) suggests that because both voluntary and involuntary forms of intentional community are subject to control and purposeful design, they are attractive at certain times in history when other social processes appear to be in relative chaos. Assessing the historical record, McEwen has found that interest in communitarianism occurs at times when traditional total institutions, such as the asylum, are in transition.[4]

As noted by David Rothman (1971), medical superintendents of reform asylums located the roots of mental disease in the changing nature of American society and, in particular, what they perceived as the increasing fluidity, openness and loosened bonds of community life. Moral treatment was intended as an intervention into the psychological burden and crisis of personhood generated by the chaotic effects of a rapidly changing world. Asylum reform in the United States was part of a broad effort in mid-nineteenth-century Jacksonian society to encourage a new moral order to compensate for what appeared to be a steady undoing of the fabric of American society (Rothman, 1971; McEwen, 1980, 174; Sears, 1989, 92–3). Asylum reform was intended to methodically correct deficiencies found in the greater community, create stability in the day-to-day life of individuals, and balance the indiscretions of the broader society with the aim of rehabilitating victims of a disjointed social system.

3 As in Kirkbride's case, Lawrence Foster (1997, 254; 269) notes how the Oneida community's founder, John Noyes, was born at a time in the early nineteenth century when the United States was undergoing a 'disquieting' range of social, political and religious changes. During this time, the young republic was leaving behind elements of a relatively more cohesive colonial past and moving into a new era of 'rough-and-tumble' nineteenth-century capitalist individualism. Underlying Noyes' communal experiments, Lawrence asserts, was his concern for overcoming 'the social and religious disorder that he perceived around him.'

4 The sociologist Erving Goffman (1961, xiii) defines a total institution as 'a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life.' Rose et al. (1977) refer to total institutions as 'controlled environments' to emphasize their intentionality and broaden the term's scope of application.

The Kirkbride Plan of 'Remoralization'

While recognizing the importance of practical design matters, including low ward density, adequate lighting, circulation of fresh air, and ample drainage for providing sanitary conditions and facilitating patient recovery, Kirkbride emphasized the restorative and redemptive potential of individual experience of the therapeutic landscape. A founder of the Association of Medical Superintendents of American Institutions for the Insane (now the American Psychiatric Association) over 150 years ago, Kirkbride authored the organization's first official standards for hospital design in 1854. Although pivotal to the exercise of the Kirkbride Plan, highly detailed landscape, architectural, and logistical plans basic to the care of patients were only part of his treatment model.

Kirkbride promoted a therapeutic modality focused primarily on the 'remoralization' of patients. While this may suggest patient indoctrination into prevailing middle-class mores, the category of 'the moral' had a different set of meanings in Kirkbride's time. The moral was understood to encompass the mind, emotion and character, thereby distinguishing it from material aspects of personhood. Although independent of a physical body, Kirkbride believed that this 'non-material' self could be shaped through a patient's sensory and emotional impressions. Kirkbride's goal was to engender a 'healing sense of place' in patients (cf. Gesler, 1993: 2) through attention to individual experience of place, the way in which a person would encounter their surroundings in day-to-day practice (cf. Tomes, 1994).[5]

As superintendent of the Pennsylvania Hospital for the Insane, Kirkbride wrote that within the intentional space of the asylum's purposefully created community, 'every object of interest that is placed ... every tree that buds, or every flower that blooms, may contribute in its small measure to excite a new train of thought, and perhaps be the first step toward bringing back to reason, the morbid wanderings of a disordered mind' (Kirkbride, 1880 [1854], 47; cf. Steele and Hains, 2001). Moral treatment reformers assumed that the moral could be influenced through careful manipulation of spatial order. As noted by Barry Edginton (1997, 94, emphasis added; cf. Godkin, 1980 on 'rootedness' and mental health), the focus of treatment was thus 'not on the patient but the *attachment* of the patient to the healing ability of natural and social environments' (see, for example, Altman and Low, 1992 on the idea of 'place attachment').

By removing the patient from potentially harmful routines enacted in physical and social surroundings that may support such habits, remoralization in the course of moral treatment was thought to promote psychological and emotional healing.

5 This is consistent with his concern for both moral and material aspects of personhood; questions that scholars now characterize as having to do with 'embodiment.' Theories of embodiment are concerned with the lived experience of a person's own body and specifically the way in which individuals negotiate their everyday lives through their own bodies, and how they mediate, interpret, and interact with a physical and social environment (see, for example, Csordas, 1990; Scheper-Hughes, 1994; Van Wolputte, 2004). For a discussion of embodiment and disablement see, for example, Crooks and Chouinard (2006).

The regime put to work in the Kirkbride Plan thus recognized the socially and spatially constructed nature of persons. His plan acknowledged how, through the mundane and taken-for-granted routine of everyday practice, social actors are shaped through unconscious repetition and internalization (cf. Bourdieu, 1977 on 'habitus'). Kirkbride believed that the purposively constructed environment of the asylum removed afflicted persons from potentially self-destructive habits of lives unmoored and spun out of control by the sheer force of profound social and cultural changes to which he was witness. Remoralization amounted to an environmental intervention into the personal rituals of everyday life shaped by a person's social and physical setting.

Refuge, Rehabilitation, and Restoration in the Therapeutic Landscape

> The Village will not be a gated community (Minervini Group, 2004, redevelopers of Northern Michigan Asylum).
>
> The Village is a place where we come together to create, exchange, inspire and innovate in an environment of historic permanence and pastoral beauty. It is a 'sense of place' that encourages creative participation and expression, in all its forms, and where interaction flourishes. The Village is a renewable resource of creative experiences that traverse social, economic, cultural and artistic ideologies (Ray Minervini, quoted by ArtServe Michigan, 2007).

Although the Northern Michigan Asylum has been closed for over twenty years, the Grand Traverse region continues to provide asylum to those who seek refuge. As already noted, my research with lifestyle migrants documents how the area has become a place of refuge to the downsized and downshifting worker. Long officially sanctioned as asylum for the mentally ill, it serves today as a place of retreat for those with a variety of disabilities, including drug and alcohol addiction. Dave, a middle-aged participant in my project on urban-to-rural migration, ran a rehabilitation center located not far from the old asylum. The clinic served a range of clients, including referrals from the State of Michigan's Alcohol Treatment Services. He described for me how addicts sought treatment here rather than in hometown programs within the depressed, deindustrializing urban areas of Flint, Saginaw, and Detroit. Many clients were downsized autoworkers whose life plans were thrown into chaos when they lost self-defining jobs. They believed themselves more likely to recover if distant from familiar but personally harmful routines. In many cases, recovering addicts opted to stay after treatment rather than return home, having apparently found more than mere distance from past habit.

The region's history as host to an institution for the mentally ill and as virtual asylum for a range of people in need of convalescence from the travails of modern life has left a deep impression in the local ethos. This continues to shape the construction of its symbolic landscape. Recent practice affirms a long-standing local perception that this particular geographic place is capable of healing. One especially notable instance occurred immediately following acts of terrorism on September 11th, 2001 in the United States. A group of some 60 local health care professionals and civic

leaders, calling themselves the Healing Community Response Team, spearheaded a community-wide effort to reach out to New York City firefighters. Their unique proposal was to offer a place of restorative refuge where traumatized families could come to find respite and possibly some measure of personal recovery within the therapeutic landscape.

Within this context of ongoing social construction of this particular geographic place as refuge, the old Northern Michigan Asylum is undergoing a kind of redemption through which it appears to return to the fundamental ideals of Kirkbride's moral treatment. Having become a reluctant symbol of the Welfare State's decay during the later half of the twentieth century, after years of neglect the brownfield site reemerged as a 'Renaissance Zone' established by the State of Michigan in the late 1990s to encourage investment of physical and social capital. With the blessings of hundreds of local activists who had long struggled to save the Victorian-era buildings, an early member of the Congress for New Urbanism (and a local builder) was granted permission to perform his ambitious redevelopment.[6]

Workers busily engage in giving the vast 388,000 square foot main complex an architectural rebirth over many years, with self-contained sections being worked on gradually as they can be sold. Restoration of a blighted site, burdened with the stigma imparted by contemporary views on institutionalized care, promises conversion of the old asylum into an integrated community. Residential, commercial, and recreational spaces, the realms of work and home and domains associated with the material and moral respectively, are brought together in what new urbanist developers promise will be a harmonious, even Kirkbridian, blending. Like Kirkbride, they attempt to achieve this through careful attention to the ways in which people encounter and relate to their surroundings in day-to-day practice.

The old asylum is starting over, architecturally reborn through a program of adaptive re-use and uniquely re-imagined as sanctuary in a (post)modern envisioning of the past for present purposes in an attempt to return to a 'cherished American icon ... a compact, close-knit community' (Katz, 1994). A glossy brochure asks would-be community members to 'Picture a mixed-use, walkable village environment that will offer a chance to live, work, and play in the "Central Park" setting of the Grand Traverse Commons ... Picture a New World approach to creating an Old World neighborhood. Picture "The Village of Grand Traverse Commons" (Minervini Group, 2001).[7]

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6 As of late 2006, 20 residential units had been finished and sold and thirty more were being completed. These units range from 280 to 3,500 square feet. Thirty-eight businesses now operate within the renovated portions of the asylum, including a restaurant, bakery, winery, art gallery, yoga studio, and several non-profits. A Montessori junior high school also occupies part of the renovated space. An estimated 15 percent of the total building stock of the asylum property has been renovated.

7 In its reference to Central Park, the Minervini Group invokes Olmsted as the famed park's designer. At the same time, it no doubt unwittingly evokes not only his contributions as landscape architect but also his less glamorous role as first Secretary General of the United States Sanitary Commission. In this way, calling on Olmsted appropriately connects the Asylum's story to the history of zoning laws, with roots in the work of early sanitary engineers. Alongside broad health reforms in the context of asylum design, zoning laws were

Lifestyle migrants relocate to the region longing to fulfill 'family fantasies' (Aitken, 1998), ideals of family life that underlie enduring notions of 'the good' in American society (Hoey, 2005; 2006). Here in the intentional space of purposively created community, families seeking refuge and a sense of belonging gather to fulfill personal dreams of a more balanced and integrated lifestyle. In their attempt at self-fulfillment, they may help realize the communitarian vision of new urbanist planners while embracing a faith basic to moral treatment that the therapeutic landscape can affect personal change through purposeful planning of the material conditions of everyday life.

Conclusion

As noted by David Rothman (1971, 133), nineteenth-century medical superintendents believed the asylum would offer a means to 'correct within its domain the faults of the [broader] community and, through the power of example, spark a general reform movement.' Within intentional space, a therapeutic quest or ideal entails not only consideration of individual health and well-being, but also attending to the perceived ills of the broader society through promising a model of harmonious living. This is an ideal shared by proponents of new urbanism who express their belief that a carefully constructed spatial order can be used to shape the moral order.

In responding to post-9/11 anxieties in US society, however, planning prescriptions set out by new urbanists and others may lead to the excessively ordered, 'purified' communities of a sort critiqued over three decades ago by Richard Sennett (1970). Although the Minervini Group appears to anticipate an accusation in their proclamation that 'the Village will not be a gated community,' planned communities conceived in a prevailing climate of fear do risk becoming the actually or virtually enclosed places that are widely criticized for furthering unhealthy class and racial homogeneity and promoting social isolation (see, for example, Blakely and Snyder, 1997; Low 2003). Such an outcome is clearly anything but the therapeutic, moral antidote to a variety of chronic social ills that stem from rampant individualism, economic disparities, and racial difference. It would be a shame if the contribution of new urbanism amounted to little more than an aesthetic improvement over modernist forms of community planning and so-called sprawl. David Harvey (1997) asserts that new urbanism's emphasis on creating community can appear oblivious

meant to address challenges of rapid industrialization and urbanization by segregating land uses to distinct geographic areas within communities (Peterson, 1983). In the late nineteenth century, undifferentiated density in urban areas, where residential and industrial uses were seldom separated, led to a variety of risks including spread of infectious disease and contact with obnoxious and potentially dangerous industrial processes. Well intended at their establishment, according to new urbanist thought, zoning laws have long contributed to the high 'deconcentration' at the root of 'sprawl,' which now vexes many communities beset by snarled traffic, dwindling open space and diminished opportunities for public recreation (see Duany et al., 2000; Frumkin, 2003; Jackson, 2003). Because of new urbanism's interest in high density and mixed use, its developments often require exception from current zoning regulations.

to 'the darker side' of its communitarian impulse. Harvey explains that 'community' has always been a key site of social control and surveillance, akin to the managed material and moral order of the asylum as total institution. As such, a prescribed, institutionalized form of community can impede the conflict and creativity that arise from expressions of diversity in favor of a more comfortable parochialism.

This chapter joins other work at a crossroads where fields of anthropology, human geography, and public health unite around mutual consideration of the role of intentionally constructed, purposive community in human mental and physical health. Building on the discussion presented here, together with previous work with lifestyle migration, I plan to conduct research focusing on the Village at Grand Traverse Commons. I plan to examine everyday life and the divergence between an ideal and the real. I will explore the social construction of place, place marketing and, ultimately, the social production of place as therapeutic together with its consumption.

Through the lens provided by a moral treatment asylum and its redevelopment, this chapter extends application of the therapeutic landscape construct from consideration of the intentional space of community in the reform asylum to new urbanism and its design prescriptions for a neo-traditional village. Other scholars might consider my use of this construct for suggesting how a broad range of places may be examined or re-examined. These might include intentional spaces of purposive community in cases such as retreat centers and diverse enclaves defined by shared commitment to a particular lifestyle, connection to a particular geographic location, and cultivated sense of belonging.

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Chapter 19

The Therapeutic Landscape of Dementia Care: Contours of Intersubjective Spaces for Sustaining the Person

Athena McLean

Introduction: The Historical Landscape of Dementia Care

In *Culture Against Man*, anthropologist Jules Henry (1963) decried the horrific conditions elders faced in US nursing homes, where they were warehoused to die. Neglect, poor sanitation, restraints usage, and needless deaths led by the late 1980s to federal reforms promoting improvements. Since Henry wrote his eye-opening work, the landscape of dementia care has undergone profound change, inspired by rethinking nihilistic assumptions that nothing could be done to help the afflicted. New spatial designs shedding institutional facades, and caregiving approaches centered on the person, hoped to improve life for institutionalized elders. These changes were shaped by institutional and regulatory practices within a larger social, political and economic landscape.[1]

By the 1970s, concerns had led to altered physical spaces and staff-intensive caregiving aimed at preserving residents' functioning (cf. Liebowitz, Lawton, and Waldman, 1979). When these later became seen as 'cost inefficient,' institutions redirected priorities to more efficient maintenance care tasks. Even visionary caregiving facilities gradually reverted to these standard practices (McLean, 2007, 71–7). By the 1980s, researchers voiced concerns about the neglected 'person' with dementia and environments for improving her well-being (Kitwood, 1989). Competing fiscal pressures (rising costs and reduced federal and state subsidies) and regulatory demands that institutions extensively document care, have nonetheless continued to favor the task over the person.

In response to the persistence of institutional approaches and the growing literature directing attention to the *person* (Kitwood, 1997), a 'Culture Change' (CC) movement since 1995 has focused on transforming the therapeutic landscape of

1 I use 'landscape' here similarly to Eric Hirsch (1995, cited in Low and Lawrence-Zúñiga, 2003, 16), as a site of tension involving both an 'idealized or imagined' background and foreground of lived everyday experience. Even more apt to the issues discussed here are Setha Low's distinction between the processes of *social production* of the structural features of the landscape versus the *social construction* of its symbolic features to those who live and frequent it (Low, 2000, 128; Low and Lawrence-Zúñiga, 2003, 20).

Published by
Ashgate Publishing Limited
Gower House
Croft Road
Aldershot
Hampshire GU11 3HR
England

Ashgate Publishing Company
Suite 420
101 Cherry Street
Burlington, VT 05401-4405
USA

Ashgate website: http://www.ashgate.com

British Library Cataloguing in Publication Data
Therapeutic landscapes
1. Medical geography 2. Landscape - Therapeutic use
3. Landscape - Health aspects 4. Environmental health
I. Williams, Allison, 1965-
615.5

Library of Congress Cataloging-in-Publication Data
Therapeutic landscapes / edited by Allison Williams.
p. cm.
Includes bibliographical references and index.
ISBN-13: 978-0-7546-7099-5
ISBN-10: 0-7546-7099-6
1. Landscape--Therapeutic use. 2. Landscape--Health aspects. 3. Medical geography. 4. Environmental health. I. Williams, Allison, 1965-
[DNLM: 1. Geography. 2. Therapeutics. 3. Environment Design. 4. Holistic Health. WB 700 T398 2007]

RA792.T455 2007
613--dc22

2007020564

ISBN 978 0 7546 7099 5

Printed and bound in Great Britain by MPG Books Ltd, Bodmin, Cornwall.

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