

# Obituary for a Psychiatric Centre and its Shopping Mall

by Seth Denizen

Just as the sleeper—in this respect like the madman—sets out on the macrocosmic journey through his own body, and the noises and feelings of his insides, such as blood pressure, intestinal churn, heartbeat, and muscle sensation (which in the waking and salubrious individual converge in a steady surge of health) generate, in the extravagantly heightened inner awareness of the sleeper, illusion or dream imagery which translates and accounts for them, so likewise for the dreaming collective, which, through the arcades, communes with its own insides. [...] Of course much that is external to the [individual] is internal to the [collective]: architecture, fashion—yes, even the weather—are, in the interior of the collective, what the sensoria of organs, the feeling of sickness or health, are inside the individual. And as long as they preserve this unconscious, amorphous dream configuration, they are as much natural processes as digestion, breathing, and the like. They stand in the cycle of the eternally selfsame, until the collective seizes upon them in politics and history emerges.

—Walter Benjamin, *The Arcades Project*

Built in 1977 in downtown Baltimore, the Walter P. Carter Center began with a clear mandate to get the mentally ill out of prisons and emergency rooms, off the streets, and into community-based treatment programs. Named for the local civil rights activist who conceived of this approach, the building was intended to act as an enormous switchboard within which the uninsured urban poor could be connected to mental health services provided by the state, or by specialized non-state providers, housed on one of its seven floors. Its original plans included a shopping mall full of restaurants and shoe stores on its ground level that would create a porous border between the Carter Center and the city, allowing patients to venture out and the city to enter in.<sup>1</sup> Each level of the building would be organized in order of increasing acuity, with the most disturbed patients on the seventh floor, where they could enjoy the view from the hydro-therapy pool. More than just a hospital, the Carter Center would fill a huge and growing gap in the city's social services and, for the first time, give the police something to do with the mentally ill other than incarcerate them. Its porous borders would extend into the legal system, and in this way the poor and predominantly Black and Latino communities of Baltimore would have an institution

that would be awake at night, sentinel-like, keeping their family members out of harm's way, and out of the prison system. Every obituary should begin with the dream of the deceased.



Walter P. Carter Center,  
1977-2009  
Photo: Seth Denizen

Walking through the building just before its closure in 2009, it was clear to me that the twentieth century had been hard on this dream, which was itself already fragile and full of contradictions.<sup>2</sup> The building seemed to keep a good record of these contradictions simply in the way it had been constructed, renovated, and occupied. The ground floor, intended originally as a shopping mall, was occupied by a small lobby and a large methadone clinic. The series of generous balconies that marked the exterior of the building turned out, upon closer inspection, to be roofs inaccessible even to the staff. The centralized climate control system was notoriously out of step with reality, and since the windows

on the wards could not be opened for safety reasons, there was nothing that could be done to moderate the indoor temperature. Just underneath the mechanical room housing this system, a long forgotten branch of the Jones Falls River was discovered, which occasionally escaped its pipes and flooded into the basement.



Walter P. Carter Center,  
balcony constructed as a roof  
Photo: Seth Denizien

The most bitter defeat of all, however, was that the Carter Center had become the prison it meant to replace; the evidence of this transformation could be seen clearly in the seemingly endless *ad hoc* retrofits that the building had endured since the 1970s. As if under siege, metal bars had been welded onto exterior fences, small gaps had been sealed with concrete, Plexiglas had been added to the inside of windows, and a metal cage had been placed over the outdoor patio after a patient broke his legs trying to escape. The “clients”<sup>3</sup> were all actually serving time in one way or another.



Walter P. Carter Center,  
outdoor patio  
Photo: Seth Denizien

Most were awaiting the results of a pre-trial competency evaluation, meaning that a judge would decide whether or not they were mentally competent to stand trial. If the crime they were being tried for was minor, such as breaking a window, loitering, or assault, they were sent to the Carter Center for evaluation.<sup>4</sup> In 2009, the average length of stay for clients awaiting this evaluation was 49 days.<sup>5</sup> If they were found competent to stand trial and convicted of an offense, the time they spent in the Center would be subtracted from the sentence.<sup>6</sup>

If clients were not found competent, and instead in need of psychiatric services, then the judge could order their return to the Center until they recovered. Once recovered, they could then be sent back to trial and made to serve time for the original offence. Within this logic, recovery is not considered a cure, but rather an abatement, or diminishing, of one’s acuity level, which means a return to some kind of stable state.<sup>7</sup> By the time it closed its doors, the only legal differences between the Center and a prison were that at the former clients could be forced to take medication involuntarily, and they could also be denied a request for solitary confinement, which in prison can be requested for safety reasons.<sup>8</sup>

Looking back on the life of the Carter Center and its slow decline into a more nineteenth-century form of confinement, it is important to notice how the abandonment of the shopping mall as a model marks a significant transition. Standing in the patio on the seventh floor, the idea that the normative symbolic order and all the affective tricks of a shopping mall would be enlisted to blur the border between reason and un-reason, inside and outside, with the intension of creating an indeterminate space of new social encounters, seems remarkably utopian. Or more precisely, it seems as utopian as the golden toilets of Thomas More’s *Utopia*, wherein a double reversal of symbolic meaning creates the implicit promise of new social relations. The mall may or may not have created new social relations, but at the very least, its design was optimistic about the way the city might be made available to the mentally ill and cannot, on these grounds, be accused of the cynicism that arrived later.



Walter P. Carter Center,  
relaxation room with water theme  
Photo: Seth Denizien

The dream of a shopping mall that makes no distinction between the mad and the nonmad, the asylum and the city, consumption and treatment, was clearly not real-



Eastern Shore Hospital Center Treatment Mall. Left to right: Food Court, Main Mall corridor, and Snack Bar. Photography is not allowed at ESHC, images are from Maryland Department of Mental Health and Hygiene website: <http://dhmh.maryland.gov/eshc/SitePages/treatment.aspx>

ized by the Carter Center. However, it is far from forgotten in the State of Maryland Department of Health and Mental Hygiene. Twenty-four years after the Center was opened, the new, \$22.8-million-dollar Eastern Shore Hospital Center became the first state hospital in the country to successfully design and build a mall for the *explicit purpose* of psychiatric treatment.<sup>9</sup> Hailed as a national model at the time, each of its linear residential wards opens at one end onto a mall that organizes every aspect of daily life at the hospital.<sup>10</sup> At 9:30 a.m., the mall opens and the clients can leave their ward to begin shopping for group therapy. Each group therapy session takes place in a room located off the main mall promenade. Examples of group therapy sessions include: “Understanding My Diagnosis,” “Relapse/Recovery,” “Money Management,” and “Mall Walking.” Clients can shop for therapy by looking in the doors and windows of the Treatment Mall, or simply temporarily trying out a session. Clients then earn a wage by attending group therapy, which is dispersed in “Mall Money,” based on their “Group Participation Average” (GPA). This metric is not based on mental ability but rather on performance, which is relative to the client and rated on the basis of nine criteria. This rating is then electronically communicated to the pharmacy, which can use it to alter dosages in the client’s medication. Mall money is redeemable in the food court and gift shop, which also accepts cash that the clients can withdraw from the Treatment Mall Bank. Food and snacks are most frequently bought in the food court, whereas phone time and AA batteries are popular items at the gift shop. Fifteen-thousand dollars is raised each year to pay the wages, in Mall Money, of the clients; this fundraising is accomplished through a “Walk-and-Run” in the Fall, and a golf tournament in the Spring, both organized by volunteers.

The differences between the shopping mall at the Carter Center and the one realized at the Eastern Shore Hospital Center are important. In the former, the mall was transplanted without modification, whereas in the latter it has been reinterpreted from within, almost beyond recognition, to give expression to entirely new social forms. Perhaps any resemblance between the two malls is superficial, an irrelevant overlap in dream imagery. The main evidence that the two shopping malls are related comes from the fact of their shared paternity in the community-based treatment model developed in the mid-1960s, which continues to shape the language used by the psychiatric profession to explain the adoption of the American mall as a therapeutic space: “The goal was to create pleasant, community-like spaces and destinations within the mall, through which participants could move safely and as independently as possible, with the least amount of staff intervention.”<sup>11</sup> The creation of “community-like” spaces within the institution continues to be the “heterotopic” project expressed in the literature on treatment malls, which emphasizes the double benefit of having to spend less time directly monitoring patients while simultaneously providing therapy.<sup>12</sup> The therapy is an architecture which approximates the kind of exchanges the clients will have to engage in outside of the institution—the *world as mall*—and creates the conditions under which the clients can habituate themselves to those kind of exchanges while on medication—the *world as ward*.<sup>13</sup> The hope is that clients will become capable of living within the new rhythms introduced into their life by their medication, in a kind of psychopharmacological *dressage*, and that these rhythms will be strong and stable enough to maintain their temporal integrity against the rhythms and structures of life outside the institution.<sup>14</sup> At this point the state would no longer need

to pay their hospital bill—a shift in fiscal responsibility which has effectively replaced “the cure” as the end goal of treatment. That the architecture of the American shopping mall was the chosen approximation of reality for these state psychiatric hospitals to help produce the essential set of rhythms for the mentally ill to master needs to be accounted for if the dream of the treatment mall is to be interpreted.

It seems clear that the treatment mall finds its affinity with the American shopping mall not simply because of its formal resemblance. While its familiarity is clearly important to practitioners at the Eastern Shore Hospital, there also seems to be a more fundamental hypothesis at work: mental illness is essentially a problem of exchange. The hypothesis is a compelling one. According to British psychotherapist Adam Phillips, “madness is when you can’t find anyone who can stand you, [and] if you can’t find anyone who can stand you, you can’t find anyone who believes you’ve got anything they want.”<sup>15</sup> If “madness” designates a category of people from whom we want nothing—with whom there can be no exchange—as Phillips insists, then the forms of exchange offered by the Treatment Mall are revealing of the way in which state psychiatric centres dream of how we might one day want something from the mentally ill, thereby offering them a moment of normative recognition. This dream consists of three forms of exchange: consumer choice, wage labour, and performance pay. Through them, Eastern Shore offers its clients two moments of recognition: first as an employee, and then a consumer; the architecture of the American mall offers the shortest possible distance between these two subject positions. Physical distance is no small architectural concern at Eastern Shore: in order to make a phone call, clients must first attend group therapy to make money, then go to the bank to withdraw the money earned, then go to the gift shop to buy a phone card, and then use the phone card in the designated phone room. This is probably why Mary K. Noren, CEO of the Eastern Shore facility, emphasizes the relation between architecture and activity: “We wanted the building to reflect our treatment program.”<sup>16</sup>

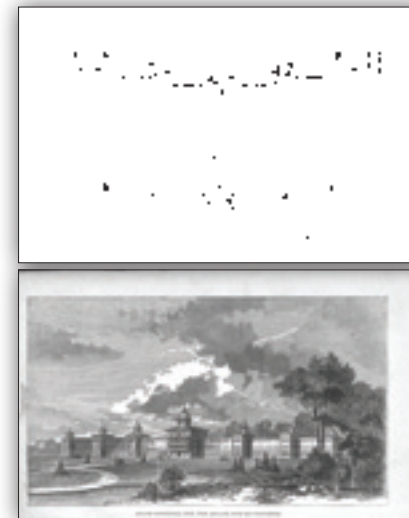
Given the architectural requirements of this approach to treatment, it is difficult to imagine how any part of this program

could have been realized in their former building. Just a few miles down the road from the new Treatment Mall, the former Eastern Shore State Hospital for the Insane, built in 1915, consisted of separate pavilions arranged along the shoreline of the beautiful Choptank River. In order to fund the construction of the Treatment Mall, in the mid-1990s the state sold the waterfront property to Hyatt, who developed it as a 400-room hotel, 24,000 square-foot conference centre, 18-hole golf course, and 150-slip marina. “We ended up with a first-class resort and a state-of-the-art hospital,” said Maryland Governor Parris Glendening.<sup>17</sup> That this kind of scenic beauty could have been reserved for the “insane” in 1915 is an indication of the magnitude of the differences that lie between the two treatment programs.



Postcard of Eastern Shore State Hospital for the Insane, built in 1915, showing the location of the Choptank River  
Image from: [www.asylumprojects.org](http://www.asylumprojects.org)

The original Eastern Shore Hospital was built to take advantage of its view of the river, its picturesque woods, and first-class farmland. In the nineteenth century, madness came from civilization, or the social conditions and everyday rhythms that had come to characterize life in a European city.<sup>18</sup> The location was crucial for its cure, as the “inalienable nature of reason” in the patients of the nineteenth-century asylum “slept beneath the agitation of their madness.”<sup>19</sup> Treatment was to awaken this slumbering reason by relocating the mad to the natural beauty of the countryside in order to sever their relationship with the social conditions and everyday rhythms of life in the city. According to American medical historian David Rothman, if there was ever some doubt among European doctors in the nineteenth century as to whether civilization was the cause of madness, this doubt simply did not exist in the United States, whether in the general public or among American medical superintendents,



The Kirkbride plan, from *On the Construction, Organization and General Arrangements of Hospitals for the Insane*, by Dr. Thomas Story Kirkbride (1854).

prior to the Civil War.<sup>20</sup> As the cause of insanity was understood to be environmental, the solution that presented itself in the Jacksonian era was architectural.<sup>21</sup>

The result was that professional publications of the period, such as the *American Journal of Insanity*, were largely devoted to architectural questions. No detail of the new asylum was beyond medical scrutiny. The definitive work on the Jacksonian asylum, *On the Construction, Organization and General Arrangements of Hospitals for the Insane*, written by American medical superintendent Dr. Thomas Story Kirkbride in 1854, is divided equally between the architecture of the building and its management; that is, between the width of corridors, location of pipes, ventilation ducts, gas works, speaking tubes, and dumb waiters in the first half, and the management of physicians, supervisors, seamstresses, farmers, carriage drivers, and night watchmen in the second.<sup>22</sup> The plan Kirkbride pioneered took the distinctive form of a long, linear, double-loaded corridor that stretched across a ridge or vantage point. Known as the linear plan asylum, Kirkbride’s design is still a familiar form in many American cities, with somewhere between 38 and 41 buildings still in existence; as many as 32 have been demolished.<sup>23</sup> The linear form of the building was intended to provide each patient with a view of the countryside, which would itself treat both the causes and symptoms of insanity. According to Kirkbride:

The building should be in a healthful, pleasant and fertile district of country, [...] the surrounding scenery should be of varied and attractive kind, and the neighborhood should possess numerous objects of an agreeable and interesting character. While the hospital itself should be retired and its privacy fully secured, it is desirable that the views from it should exhibit life in its active forms, and on this account stirring objects at a little distance are desirable.<sup>24</sup>

The Eastern Shore State Hospital for the Insane was built on these basic principles, with one exception: by 1915, the general opinion was that the most violent patients should be physically separated from the others, rather than kept in the same corridor, and this meant splitting up the wards. The treatment program of the first Eastern Shore hospital, as it was designed in 1915, continued the Jacksonian commitment of caring for the mentally ill in a therapeutic landscape of beautiful scenery, “stirring objects,” and agricultural rhythms.

Eastern Shore State Hospital for the Insane, built 1915, showing the location of the Choptank River and separate wards  
(Sanborn Map from 1930)



While Kirkbride and the American medical superintendents were debating the design of buildings in the landscape, contemporary figures like Andrew Jackson Downing and his protégé Fredrick Law Olmsted debated how to build the landscape that would provide the therapy. Some of the clearest explanations for how views of the countryside cured madness came from Olmsted as he tried to convince city governments of the effectiveness of his landscape designs. These were principles he would apply equally to his design for Kirkbride’s Buffalo State Asylum for the Insane (completed in 1871), and New York’s Central Park (completed in 1873). From Olm-

sted's explanations for his work in the context of the history of the Eastern Shore Hospital, it becomes clear the extent to which the mall in the new hospital was a complete reversal of everything the first building sought to achieve:

Of this class of evils [of town life] there is one rapidly growing in Boston, in contention with which nothing has yet been accomplished. It is an evil dependent on a condition involved in the purpose of placing many stacks of artificial conveniences for the interchange of services closely together. It may be suggested if not explained (for evils of this class are seldom fully explainable) in this way. A man's eyes cannot be as much occupied as they are in large cities by artificial things, or by natural things seen under obviously artificial conditions, without harmful effect, first on his mental and nervous system and ultimately on his entire constitutional organization. [...] An influence is desirable, however, that, acting through the eye, shall be more than mitigative, that shall be antithetical, reverse, and antidotal. Such an influence is found in what, in notes to follow, will be called the enjoyment of pleasing rural scenery.<sup>25</sup>

Standing in the relaxation room of the Walter P. Carter Center, it seems clear that the twentieth century has thoroughly discredited this view as a treatment for madness. It is also clear that the twentieth-century strategy of filling asylums with artificial conveniences for the exchange of services would have deeply shocked Olmsted and the American medical superintendents of the Jacksonian era. Nevertheless, these two diametrically opposed moments in the history of treatment, separated by some 150 years, share a common belief in the power of architecture to *produce* subjects, a view completely abandoned in the intervening years. The resurrection of architectural solutions to problems of mental illness comes at a time when this belief is at an all-time low outside of the medical profession. Very few architects today are willing to claim that their designs could make people better, wiser, more reasonable, or sane. During the height of the psychopharmacological turn in the mid-twentieth century, the medical establishment was unwilling to make this claim about their buildings. Instead, the mad

were largely warehoused during the first half of the century, and then made homeless by deinstitutionalization in the latter part of the second. In this sense the Treatment Mall is a return to the point where the Jacksonian asylum left off, once again filling its own professional psychiatric literature with architectural plans and sections.<sup>26</sup>

Despite the appearance of sophisticated drugs and management techniques for their administration, the return of architecture in the production of sanity is a return to the same alliance that medical superintendents have always made with design: with the power of walls and doors comes repetition, and repetition is a fundamental aspect in the production of subjectivity.<sup>27</sup> The ways in which one repeats, the things one does over and over again in the asylum, are not the same activities witnessed in the nineteenth-century facility; more fundamentally, the transcendental power of this repetition to produce a "cure" no longer shapes the ideal subject the asylum is tasked with producing. The shared insight of both operations, however, is that the spaces people inhabit give meter to the diverse rhythms that form their lives, rhythms within which ideas about the meaning and consistency of life are formed. The changing architecture of asylums is thus a continuing conversation between medical practitioners over how best to design the outcome of this process. The power of architecture to shape the rhythms of our life is a power to determine the ways in which we reproduce social relations. If it was so clear to the CEO of the Eastern Shore Hospital that the architecture of the building needed to change in order to reflect her treatment program, it was because the repetitions her patients lived out in that building were not the ones needed to survive without the support of the state at this historical moment. The rhythms that the present generation is faced with mastering are exactly the ones identified by the mall at Eastern Shore, and the subjectivities that are made in this historical moment will always confront the employee and consumer on this unequal ground. That this unequal ground is an outcome of design is well worth remembering in an obituary for the death of a psychiatric centre and its shopping mall.✕



Left: Bartolome Esteban Murillo, *Boy with a Dog* (1650) Right: Salvatore Rosa, *Landscape with Man and Tree* (c.1649) In *Treatise on the Theory and Practice of Landscape Gardening* (1850), Andrew Jackson Downing gives a helpful explanation for how the picturesque was also a psychology:

"Some of Raphael's angels may be taken as perfect illustrations of the Beautiful. In their serene and heavenly countenances we see only that calm and pure existence of which perfect beauty is the outward type; on the other hand, Murillo's beggar boys are only picturesque. What we admire in them (beyond admirable execution) is not their rags or their mean apparel, but a certain irregular struggling of a better feeling within, against this outward poverty of nature and condition."

#### Endnotes

- 1 The original plans have been lost. This description comes from an interview conducted by the author with Walter P. Carter social workers.
- 2 The Carter Center was closed in October of 2009, due to state funding cuts.
- 3 The psychiatric profession now prefers the term "clients" to "patients."
- 4 People accused of more serious crimes were sent to the Clifton T. Perkins maximum-security facility in Jessup, Maryland.
- 5 Archie Wallace, former Carter Center CEO, personal communication, 2009.
- 6 According to Wallace, 49 days is frequently a longer amount of time than the average prison sentence his clients receive in court.
- 7 Archie Wallace, personal communication, 2009.
- 8 Safety is a serious issue in mental health facilities. There have been two murders of patients by other patients reported at the Perkins facility since 2010. Since the closure of the Carter Center, Perkins is the only state facility for completing competency evaluations available to the city of Baltimore. See Justin Fenton, "Patient Killing at State Psychiatric Hospital is Second Since 2010," *The Baltimore Sun*, 22 October 2011.
- 9 Maryland Department of Health and Mental Hygiene, Treatment Mall Program, <http://dhmh.maryland.gov/eshc/SitePages/treatment.aspx>.
- 10 "This is a national model for innovative mental health care," Maryland Governor Parris Glendening, quoted in Chris Guy, "Mental Health Center Eyes New Treatments on Eastern Shore," *The Baltimore Sun*, 16 August 2001.
- 11 Steven L. Webster, Susan H. Harmon and Betty T. Paesler, "Building a Treatment Mall: A First Step in Moving a State Hospital to a Culture of Rehabilitation and Recovery," *Behavior Therapist* 28 (April 2005): 71-77.
- 12 It is heterotopic in that these community spaces produce an "elsewhere" within an institution which is already an "elsewhere." For Foucault's six principles of heterotopia, see Michel Foucault, *Of Other Spaces*, trans. Jay Miskowicz, *Diacritics* 16, no. 1 (Spring 1986): 22-27.
- 13 For a glimpse at the small but growing literature on treatment malls, see F. A. Ballard, "Benefits of Psychosocial Rehabilitation Programming in a Treatment Mall," *Journal of Psychosocial Nursing and Mental Health Services* 46, no. 2 (February 2008): 26-32; Joy Holland, Clotilde R. Prandoni, Michael R. Fain, Jacqueline E. Richardson and Paul Montalbano, "Moving Beyond Ward-Based Treatment: A Public Mental Health Hospital's Transition to a Treatment Mall," *Psychiatric Rehabilitation Journal* 28, no. 3 (Winter 2005): 295-297; K. A. McLoughlin, T. Webb, M. Myers, K. Skinner and C. H. Adams, "Developing a Psychosocial Rehabilitation Treatment Mall: An Implementation Model for Mental Health Nurses," *Archives of Psychiatric Nursing* 24, no. 5 (October 2010): 330-338; and, Ste-

- ven L. Webster and Susan H. Harmon, "Turning the Tables: Inpatients as Decision-Makers in the Treatment Mall Program at a State Hospital," *Psychiatric Rehabilitation Journal* 29, no. 3 (2006): 223–225.
- 14 For a rhythmanalysis of dressage, see Henri Lefebvre, *Rhythmanalysis: Space, Time and Everyday Life*, trans. Stuart Elden and Gerald Moore (London: Continuum, 2004).
- 15 Adam Phillips, *Equals* (New York: Basic Books, 2003), 87.
- 16 Mary K. Noren, personal communication, May 2009.
- 17 Guy, "Mental Health Center."
- 18 See Michel Foucault, *History of Madness*, trans. Jonathan Murphy and Jean Khalfa (London: Routledge, 2006).
- 19 *Ibid.*, 473.
- 20 "Before the Civil War, practically no one in the United States protested the simple connection between insanity and civilization. Despite the tenuous quality of the evidence, Americans accepted the conclusion without qualification. [...] American medical superintendents demonstrated none of the circumspection of their European counterparts. The connection of civilization to insanity fit well with their preconceptions and perspectives." David Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little, Brown and Company, 1971), 113–114.
- 21 According to Rothman, these years amounted to a "revolution in social practice," in which the building of penitentiaries and asylums became for the first time (and perhaps since) a large-scale public project. Prior to 1810, Virginia was the only state to support a public asylum, whereas by 1860, 28 of 33 states had public institutions for the insane. *Ibid.*, 130.
- 22 Thomas S. Kirkbride, *On the Construction, Organization, and General Arrangements of Hospitals for the Insane* (Philadelphia: Lindsay and Blakiston, 1854).
- 23 For a list of cities with Kirkbride buildings, see Ethan McElroy, "Kirkbride Buildings," [www.kirkbridebuildings.com](http://www.kirkbridebuildings.com).
- 24 Kirkbride, *Hospitals for the Insane*, 7.
- 25 Frederick Law Olmsted, "Boston Parks and Parkways—A Green Ribbon, Seventh Annual Report of the Board of Commissioners of the Department of Parks for the City of Boston for the Year 1881," in *Civilizing American Cities: A Selection of Frederick Law Olmsted's Writings on City Landscapes*, ed. S. B. Sutton (Cambridge, Mass.: MIT Press, 1971), 24–28.
- 26 See, for instance, the speculative design in A. D. Dvoskin, S. J. Radomski, J. A. Olin, R. L. Hawkins, L. A. Dotson and I. N. Drewnicki, "Architectural Design of a Secure Forensic State Psychiatric Hospital," *Behavioral Sciences and the Law* 20 (2002): 481–493.
- 27 Gilles Deleuze, *Difference and Repetition*, trans. Paul Patton (Columbia University Press, 1994).

Bio

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