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The Design of Community Mental Healthcare: Nicole Sonolet in Postwar France

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What role can architects play in the delivery of care? Is there a theory of care provision in architectural form that does not resort to behaviorism? How can care spaces be programmed? Designs for two mental hospitals and a body of theoretical work from the 1950s to 1970s by the French architect Nicole Sonolet (1923–2015) offer potent and understudied responses. Rather than imagine that architectures of care would themselves directly produce healing, Sonolet believed that careful programming, collaboration among architects, patients, doctors, and staff, and an understanding of architecture's potentials and limits would improve spaces for care.

Sonolet's hospitals were developed in the context of institutional psychotherapy (IP). Elaborated by the Catalan psychiatrist François Tosquelles in the 1940s at the clinic of St. Alban, further developed by Frantz Fanon in the context of colonial Algeria and, much later, by Jean Oury and Félix Guattari in postcolonial France, IP sought to decarceralize the provision of mental healthcare and empower patients to direct more of their own processes of healing. [1] This would be done by allowing both patient and analyst to rethink the relationship between the patient and the institution, activating the creativity of both doctors and patients in this process to understand the social forces at work on the patient. Institutional psychotherapists considered that not only doctors and nurses but also care workers, staff members, other patients, family members, and even the spaces of care themselves could intervene in a process of healing. This would assist patients in obtaining care according to their own needs, rather than following patterns of care predetermined by overly rigid treatment protocols or even the state. As Meike Schalk, Susana Caló, and Godofredo Pereira have discussed, the focus on space in processes of treatment in IP opened important avenues for understanding the roles that architecture can play in mental healthcare more broadly. [2] What is particular about Sonolet's design and theory work in this context is its explicit focus on designing and theorizing care (*"soin"* in

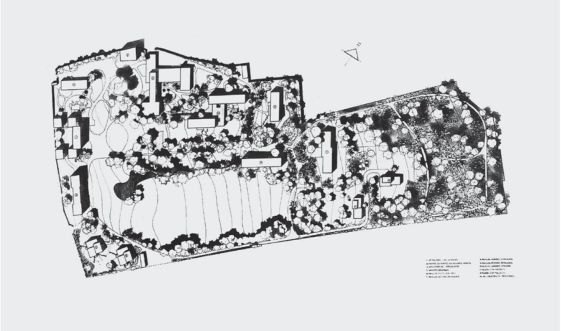
1 See Valentin Schaepelynck, *L'institution renversée: Folie, analyse institutionnelle et champ social* (Paris: Eterotopia, 2018); and Camille Robcis's new intellectual history of the movement, *Disalienation: Politics, Philosophy, and Radical Psychiatry in Postwar France* (Chicago: University of Chicago Press, 2021).

2 See, in particular, Meike Schalk, "The Urban Mental Hospital and the State of Research," *SITE* 2 (2002), 15–16; and Susana Caló and Godofredo Pereira, "CERFI: From the Hospital to the City," *London Journal of Critical Theory* 1, no. 2 (May 2017), 83–100. An analysis of Sonolet's work in the 1960s and 1970s appears in Meredith TenHoor, "State-Funded Militant Infrastructure? CERFI's Équipements Collectifs in the Intellectual History of Architecture," *Journal of Architecture* 24, no. 7 (2019), 999–1019, https://doi.org/10.1080/13602365.2019.1698638. In addition, Julie Mareuil has recently completed an excellent master's thesis on the architectural history of l'Eau Vive in which she reads not only archival material but also building permits to document its construction history. Julie Mareuil, "Une clinique-pilote de la sectorisation psychiatrique: L'hôpital de l'Eau Vive et son évolution de 1959 à 1977" (MA thesis, ENSA Paris-La Villette, 2020). Work on the architectures of community-based care in other national contexts is developing as well. For a UK-based history, see Christina Malathouni, "Beyond the Asylum and before the 'Care in the Community' Model: Exploring an Overlooked Early NHS Mental Health Facility," *History of Psychiatry* 31, no. 4 (December 2020), 455–69. For a US-based history, see Joy Knoblauch, *The Architecture of Good Behavior* (Pittsburgh: University of Pittsburgh Press, 2019).

French). Some of the most crucial formulations of that term in IP emerged through her collaborations from the late 1950s until the early 1980s with the psychiatrist Philippe Paumelle. Sonolet designed two hospitals directed by Paumelle: l'Eau Vive residential mental hospital in the Parisian suburb of Soisy-sur-Seine, which opened in March 1963 after five years of planning and construction; and the Center for Mental Health of the Association de Santé Mentale 13 (or ASM 13) in Paris, which Sonolet designed conceptually during the 1960s before collaborating on site with architects Maria Baran, Olek Kujawski, and Tristan Darros from 1973 to 1982. This article focuses on the former, as it is an important yet underrecognized prototype for this new form of hospital.

Sonolet became involved with architectures for mental healthcare as somewhat of an expert. A close family member had been hospitalized, and she knew intimately the architectural and organizational challenges of the French mental healthcare system. As a student at the École de Beaux-Arts in Paris during the Second World War, she had studied modernist design with Henri Larrieu, André Leconte, and Georges-Henri Pingusson, and her thesis project was a design for a psychiatric hospital with three hundred beds, which she completed after resuming her studies in 1954. In the early years of her career, she was, through her thesis research, in conversation with many leading figures in the institutional psychotherapy movement, and these conversations helped her to develop her own ideas for how new complexes for mental health services could be designed. [3]

In these years, mental health in France was in a state of crisis, with patients confined to overcrowded asylums. During the Vichy regime, some patients had been subject to deliberate neglect and starvation. [4] There were too few beds for too many patients; patients were housed in asylums far from where they lived and thus severed from communities that could assist with healing; outpatient facilities were uncommon and preventative treatment even more so. Beyond these material conditions, patients were stigmatized. The sheer number of people who needed treatment, coupled with a lack of doctors, meant that care was often routinized, with patients and their families disempowered to intervene in the course of treatment. IP emerged as an alternative. Institutional psychotherapists wanted to offer care outside the context of the asylum and to do so, whenever possible, in outpatient settings in the patient's own communities.



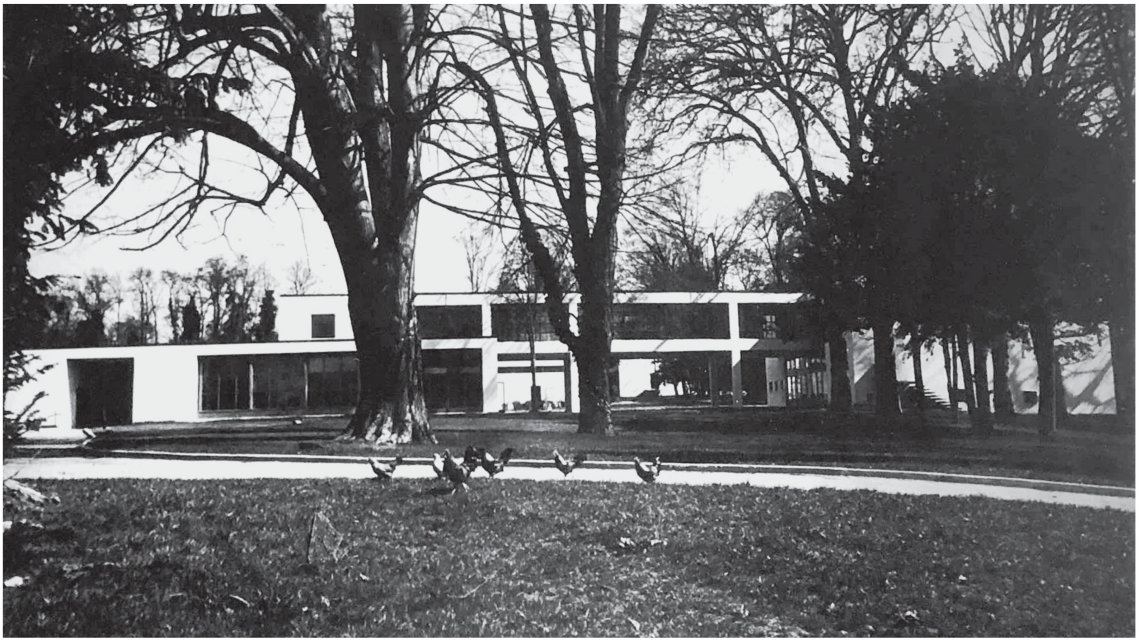
3 My research on Sonolet draws on interviews with her family members and from her personal archive of letters, plans, pamphlets, and notes, shared with me by her family. I am deeply grateful to Christine de Bremond d'Ars, without whom this work would be impossible. Because Sonolet's work was not collected by the primary architectural archives in France, and because Sonolet herself was not particularly concerned with self-promotion, her work is not as widely known as that of many male architects who have realized a similar quantity of projects.

4 Philippe Paumelle was particularly critical of this and contributed a strong condemnation of the state of French psychiatry to *Esprit*, publishing under a pseudonym: Philippe Langlade [pseud.], "Qui sommes-nous?," *Esprit* 197 (December 1952), 797–800. For more on this text, see Serge Gauthier, "Philippe Paumelle, homme de pensée et d'action, et la fondation du Treizième," in Colette Chiland, Clément Bonnet, and Alain Braconnier, eds., *Le souci de l'humain: Un défi pour la psychiatrie* (Toulouse: Érès, 2010), 9–30.

fig. 1 Nicole Sonolet, plan of the grounds and buildings of l'Eau Vive hospital, Soisy-sur-Seine, France, 1960s. Archives of Nicole Sonolet, collection of Christine de Bremond d'Ars

After years of agitation from doctors and patients, laws reforming mental healthcare in France were passed in the early 1960s, which broke up the asylum system into locally organized "sectors" and facilitated a transition to more locally directed care with consistent teams of doctors for residents in a given geographic area, as well as other reforms in the treatment of patients.

Community-based care was particularly important to Paumelle. Starting in the mid-1950s, he began to organize urban mental health services in Paris, hoping to provide people with access to intensive psychiatric services within their neighborhoods. The system of community-based care he envisioned would include outpatient psychotherapy and free clinics, as well as occupational and movement therapies, and would provide support to patients and their families before and after hospitalization. With funding from a donor who wanted to improve treatments for alcoholics, he founded the Association de Santé Mentale 13 (ASM 13), intended to serve the population of the 13th arrondissement in Paris. Thanks to this funding, starting in 1958 Sonolet and Paumelle were able to work together to plan l'Eau Vive, which was intended to be an experimental pilot project that would test the strategy of sectorization, allowing care to shift from its previous "hospital-centrism" to a more open model. [5]



figs. 2 and 3 Exterior views of l'Eau Vive hospital, Soisy-sur-Seine, France, 1960s. Archives of Nicole Sonolet, collection of Christine de Bremond d'Ars

5 Simone Paumelle in the brochure *1963–2003: Les 40 ans de l'eau vive* (ASM 13, June 2003), 6.

While Paumelle had hoped to be able to establish a hospital within Paris and to explore the possibilities for designing urban mental healthcare centers, he accepted the opportunity offered to develop one in Soisy, a small suburb south of the capital, as a first and crucial step in improving care for Parisian residents. Following tenets of community-based care, he imagined a hospital where patients would be seen by a consistent team of doctors, nurses, and caregivers rather than switching from

clinician to clinician. He planned for an open campus where patients of different genders could interact rather than be segregated and in which patients would not be confined to their rooms, as if in a prison, but would be free to move around the grounds. At Soisy, patients, families, and doctors would also be able to collaborate in developing a course of treatment. Over several years, Sonolet and Paumelle worked together to develop plans for the hospital. Sonolet's design for the complex integrated a few extant buildings and ten new pavilions in the 5-hectare, park-like setting of a former theological center. fig.1

The hospital was designed to accommodate 175 patients suffering from either alcoholism or psychological challenges. These patients were organized into treatment groups of seven, who were to be monitored by one consistent nurse rather than a rotating team of staff, as Paumelle and Sonolet believed that

deeper and more therapeutic relationships could form with consistent staff and doctors. They also recognized that every relationship a patient had—whether with other patients or with staff at the hospital—would be part of the patient's recovery. This was an essential tenet of IP dating from Tosquelles's work at St. Alban: all interactions with people, objects, and buildings could be opportunities for patient-initiated exchange that could untangle the relationships between patients and their social and political environments, and these interactions could assist with resocialization and reintegration. At Soisy, the staff would consist of artists and craftspeople who would work with patients in studios; people in charge of animating the collective life of patients; physical therapists; and housecleaners, all of whom would be involved with therapeutic interaction.

Processes of Healing

Sonolet's designs for l'Eau Vive were modernist and elegant: a series of long, low pavilions, often raised on pilotis, with long expanses of windows opening onto verdant grounds. **figs. 2 and 3** These buildings were formally and materially similar to the architectural designs of her Corbusian-inspired professors at the École de Beaux-Arts and to "organicist" modern architects such as Alvar Aalto and Aino Aalto, who, in the 1950s and 1960s, similarly designed concrete and steel-framed buildings with abundant use of natural materials in their interiors, and whose work Sonolet admired. Like these precedents, Sonolet's pavilions could be economically built with flexible floor plans, wood and stucco on the interior, and were planned with great consideration of how patients, doctors, and staff would move through them. Yet Sonolet's designs went far beyond design logics that privileged the economical use of materials, organized circulation or movement through space, or highlighted views between interiors and landscapes. They also exceeded Alvar Aalto's attempts to bring physical comfort to patients through careful calibration of ergonomics, materials, and light. Sonolet's focus at l'Eau Vive was on *processes of healing*.

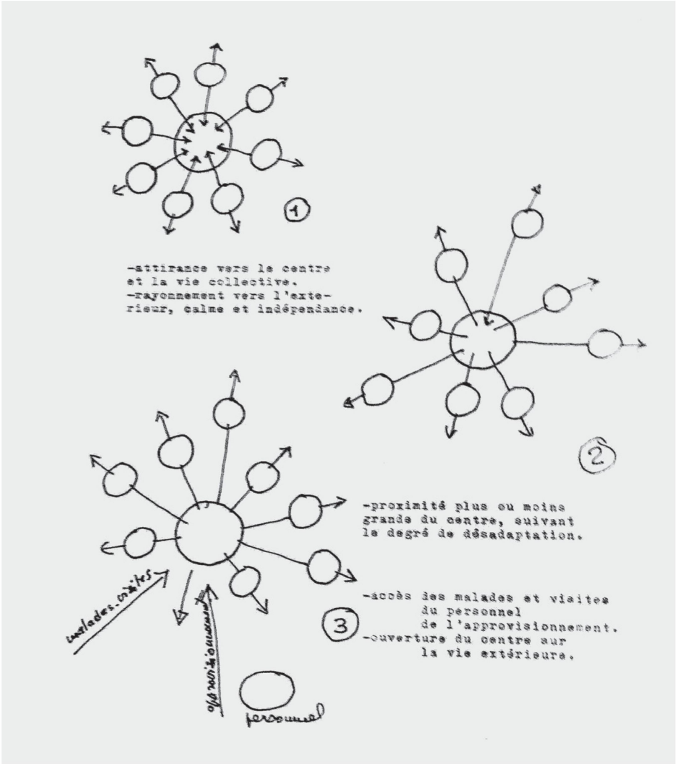
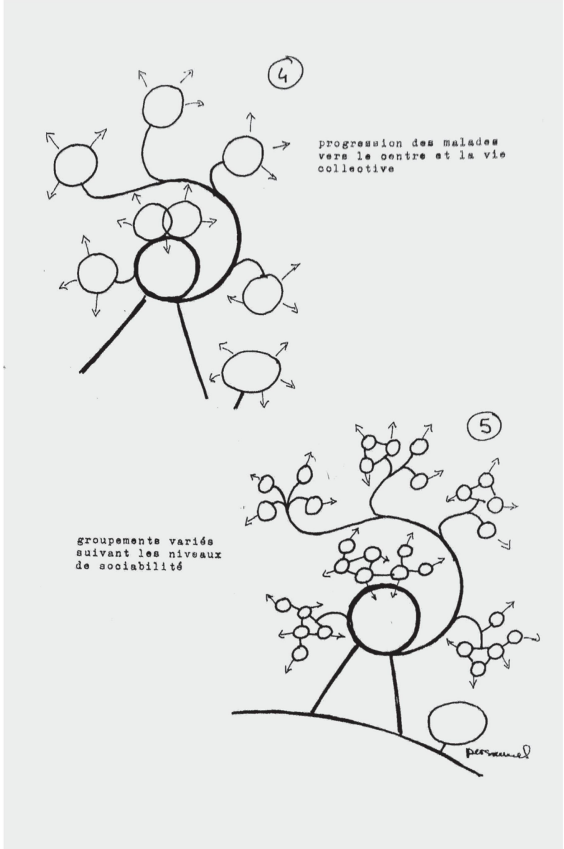


fig. 4 a, b Nicole Sonolet, diagrams of socialization patterns in mental hospitals, ca. 1964. Archives of Nicole Sonolet, collection of Christine de Bremond d'Ars

The degree to which patients desired and were capable of socializing with others in the course of their treatment was a major driver both of Paumelle's treatment strategy and of Paumelle and Sonolet's conception of the hospital. Diagrams based on notes Sonolet compiled on care and architecture conceptualize different ways that social interactions — orientation toward or away from others — might inform the organization of space. Sonolet considered not only the staff's need for access to and distance from the patients **fig. 4 a** but also the various needs of the patients **fig. 4 b** whose groupings were far more fluid and intermingled because they would vary depending on where they were in the course of their treatment. Yet Sonolet's diagrams were not intended to be directly spatialized. Instead, they were a conceptual tool for

understanding how the space(s) could be planned. To render her diagrams in built form, Sonolet carefully planned a variety of services (*équipements*)—for food preparation and eating, for gathering, for quiet repose, for treatment, for enjoying nature—and distributed them throughout the complex. These were intended to support not only patients but also visitors and staff.

While some programmatic components for patients were fixed, others were intended to be as flexible as possible, built with the understanding that one space might have to serve multiple purposes and that the patient's ability to transform that space could also be an instrument in the patient's healing. Describing her understanding of this process in notes she took on the planning of the clinic, Sonolet wrote that architectural and interior design might help to "condition" spaces to provide a variety of experiences: of openness to the world or of enclosure; of stimulation or of repose; of warmth or of coolness. The staff and the patients would orchestrate movements through these variously conditioned spaces as a way to provide therapeutic experiences, which would either help them maintain ties to communal life or gradually prepare them to reintegrate into their communities. Photographs of the interior of the hospital show Sonolet's attention to the design of communal spaces: chairs could be grouped and regrouped to offer flexible possibilities for socialization, for example. They comprised an active environment intended to be used in the course of treatment. **fig.5**



In Paumelle and Sonolet's programmatic plans for l'Eau Vive, patients would not be segregated according to gender, as they often had been in asylums, and would have more ability to choose whom to spend time with. Doctors would not use straitjackets or tranquilizing "neuroleptic" drugs that rendered patients inert or catatonic, and they hoped to avoid closed doors that would evoke prisons. As patients recovered, those ready for reintegration into collective life could have social experiences at Soisy; those who were not ready would have spaces for solitude and repose. In a text she wrote on mental health consultations,

Sonolet underscored the importance of privacy, noting that it was especially important in waiting areas in the clinic's entry, where patients would be nervous as they entered the complex. She recommended the construction of several private waiting areas, and designed the bedrooms to offer patients visual privacy even when their doors were open. She wanted patients to have quiet corners that they could be comfortable in, where they could observe but not be observed. Most of all, she insisted that patients had the right to evolve—not to be fixed in one space in the hospital or in one fixed mental state or diagnosis.

fig. 5 Patient lounge at l'Eau Vive. Archives of Nicole Sonolet, collection of Christine de Bremond d'Ars

Sonolet's conception of patient evolution was also concerned with visual and aural dimensions of the hospital. Patients might sometimes want to see the park-like landscape at Soisy, to have an experience of expansive openness, but at other times they might prefer to be in enclosed interior spaces. In the hospital, she designed light wells that would at once illuminate interiors and also signal the presence of other social worlds in the building. These views could also presumably help staff keep an eye on patients in a less obtrusive manner. **fig. 6** While the light wells hinted at the presence of others, their presence could be modulated. The possibility of community was suggested but not insisted upon at every moment. Sonolet's attention to the social interactions and social sensations enabled by varying light, dimension, texture, and spatial organization reflected her intention to allow patients and caretakers to manage their sensations, moving between enclosure and exposure, bright and filtered light, pattern and stillness. Spaces would have clearly different qualities, ones Sonolet called "hot" or "cold," which could correspond to patients' moods and desires. Overall, the hospital would have a kind of legibility that would be important for patients who might feel nervous upon entering and whose perceptual capacities might be altered due to their illness. Sonolet insisted that patients should feel oriented in the hospital: they should know where nurses and doctors were, and these caretakers should be accessible. In this sense, the building would allow patients to care for themselves through their use of different spaces, but it could also model a world with more accessible forms of care—a place where people offering care would be responsive and available, with this availability facilitated through the design of the building.

Soisy's organizational schema—one where patients move through different spaces to become progressively more socialized

in the course of their treatment—became more widely used later in the 1960s, as community-based case services were developed in the United States, the United Kingdom, as well as in other European countries. After the passage of the 1963 Community Mental Health Act in the United States, for instance, national funding and support were made available for a similar process of deinstitutionalization and for community-based facilities. As Joy Knoblauch documents, architect Clyde Dorsett was put in charge of coordinating and supporting the development of architectural typologies for community mental health for the US National Institute of Mental Health. [6] Dorsett and Sonolet were friendly colleagues, visiting each other's families and projects in Washington, D.C., and in France and exchanging yearly cards and letters. After the construction of l'Eau Vive, several of the schemes Dorsett helped promote were explicitly designed to support socialization processes in ways similar to those Sonolet had earlier designed. Hospitals he supported used various materials, lighting, color, and other techniques of spatial differentiation. This was especially true of a 1967 plan by Kiyoshi Izumi for the Rice Design Fete in which, as Knoblauch describes, "diverse residents could be encouraged, slowly, to interact with each other in increasingly larger groups." [7] This gradual exposure to social interaction was not invented by Sonolet, but she was one of the first architects to translate these goals into architectural form. She published commentary on her experiences at l'Eau Vive in international psychology journals in 1966 and 1967, drawing from her work designing the facility to explain how urban mental health complexes, including the one she and Paumelle would later build in Paris, should be planned. [8] Because l'Eau Vive was one of the first community mental health centers to be realized by IP practitioners in France, Sonolet became known in community mental health circles as the French expert on the architecture of IP. She consulted on international projects throughout the 1960s, sharing many conclusions derived from her work, especially about the role of spaces conditioned for various forms of sociability in the design of mental health centers.

fig. 6 Light wells at l'Eau Vive. Archives of Nicole Sonolet, courtesy of Christine de Bremond d'Ars

However, Sonolet did not have a mechanistic understanding of the hospital's impact on socialization. She did not believe that the hospital itself would guide socialization but rather that the hospital would make it possible for patients to use different

6 Knoblauch documents the architectural dimensions of this work in great detail. I am grateful to her, as well as to my father, William TenHoor, who worked with Dorsett in the 1970s, for discussions about the architecture of community mental health centers in the United States during this period. See Joy Knoblauch, "Better Living through Psychobureaucracy? Community Mental Health Centers," in *The Architecture of Good Behavior*, 57–96.

7 Knoblauch, "Better Living through Psychobureaucracy?," 69–71.

8 Nicole Sonolet, "Un centre de santé mentale: Point de vue et proposition d'un architecte," *Information psychiatrique*, no. 6 (June 1966), 527–32; and Nicole Sonolet, "An Urban Mental Health Center: Proposal for an Experimental Design," *Social Psychiatry* 2, no. 3 (1967), 137–43, https://doi.org/10.1007/BF00578330. These texts also describe Sonolet's forthcoming urban projects.

spaces as techniques or *dispositifs* in their own healing. The spaces offered by the hospital were enabling rather than prescriptive, following the thinking of IP practitioners. [9] Sonolet's conceptual models for hospitals show how hierarchical models of care common in past asylum designs could be replaced with the more fluid arrangements promoted by practitioners of IP, where social interactions with anyone physically present in the clinic would offer an opportunity for social support. The clinic would become a kind of city in miniature, or a model for the city, a space of potentially healing social interactions that would be available for patients as they were ready for them. Just as community-based clinics would make mental healthcare a standard part of the city, Sonolet's plans made the clinic into a space of socialization. This was an important departure from the more behaviorist readings of architecture espoused by the American architects who developed the field of environmental psychology in subsequent years and would search for standard bases for architectural sensations or, more flagrantly, argue that urban design decisions shaped things like crime statistics in cities. [10] Sonolet did not believe that care could be guaranteed through architectural plans. Rather, careful research and programming and the deployment of spaces attuned to the psychology of patients could make the experience of hospitalization less frightening and more healing.

Sonolet's concerns about privacy and socialization were also reflected in the aspects of her designs focused on supporting the hospital's staff by improving their working conditions both materially and psychologically, which was also a preoccupation of Paumelle's. This was reflected in her designs for each pavilion's facades, which were oriented to different uses or types of patient. Some entrances were designated for staff, away from the view of the patients, whereas another side of the building might offer patients open views onto the park, and still others would offer enclosed spaces. For example, in the entry building located closest to the street, one facade features a guardian's quarters, garages, and spaces for occupational therapy, while gathering spaces facing the street occupy a separate facade. While separation of functions along the facade was common in other forms of hospital design, the facades at Soisy were organized according to the specific needs communicated to Paumelle and Sonolet by those working at the clinic. Sonolet's extensive interviews with hospital staff made clear to her that she needed to offer workers relief from constant interaction with patients. The staff would have use of a chateau, which already existed on the site, with dormitory-style bedrooms, teaching rooms, and a laboratory, and some could access special larger living quarters. Two houses for doctors

9 Michel Foucault, in an interview with Paul Rabinow and Gwendolyn Wright in these years, came to a similar conclusion: the architecture of the panopticon reflected techniques of power, but ones that depended on use. Architecture alone did not guarantee freedom. "Liberty is a practice," he argued. See Paul Rabinow and Gwendolyn Wright, "'Space, Knowledge and Power' [Interview with Michel Foucault]," *Skyline*, March 1982, 16–20.

10 One could trace this tendency in Christopher Alexander's work, and Oscar Newman's work was widely received in this manner, leading to the development of the theory of "crime prevention through environmental design," which delineated design features that would supposedly deter criminals. See also Joy Knoblauch, "Defensible Space and the Open Society," *Aggregate* 3 (March 2015), https://doi.org/10.53965/AKNV9163.

had their own gardens and were separate from both the patients and the staff quarters, allowing for additional privacy. Over time, it became clear that staff at the center needed spaces to rest from providing care, spaces separate from those of the patients, and further accommodations were organized a few kilometers from the hospital. Some of Sonolet's plans were meant to gently push doctors to provide better care: she planned one central cafeteria for all staff, as this would require doctors to interact and work together, thus preventing them from assuming too much unchallenged power over their small domains within the hospital. [11] Sectorization promoted consistent care but made exchanges between doctors and staff even more essential. Since Soisy was also a teaching hospital, spaces for staff sociability would ensure that it was a place of learning and discovery.

Like all designs, Sonolet and Paumelle's work was modified over time. Chronic underfunding of mental health services meant a shortage of hospital beds in the 1970s and 1980s , and the number of beds at Soisy was increased, which changed the character of the hospital, eliminating many of the spaces for solitude that Sonolet had planned. And as patients with less debilitating conditions began to receive treatment in Paris in newly-built day clinics, l'Eau Vive began to serve more seriously ill patients. While the hospital was planned so that patients would never be forcefully isolated, after this change some patients apparently requested or required a "closed" pavilion for their own healing, and one was established in the early 1970s. Paumelle had strongly opposed this idea and put himself in charge of this pavilion (whose door was designed to give the sense of enclosure without being truly carceral) to ensure that patients in it were well cared for and could leave if they were able to, though after his death in 1974 the character of this pavilion did change. [12] The violence of some psychotic patients also required procedural modifications. After a patient brought a gun to a different clinic, the staff at l'Eau Vive decided to create procedures to gently search patients before they entered Soisy, though not in a "police-like manner." [13] Patients and activists have also raised concerns about how one prominent doctor in the hospital treated transgender patients. Though this has little to do with the architecture of the clinic, it shows that the rhetoric of liberation at l'Eau Vive was not always in alignment with what patients and activists demand for their own communities. [14]

Research as Care

In the mid-1960s, as Sonolet completed planning of l'Eau Vive, she continued to work with Paumelle to plan an urban mental health center in Paris, the Center for Mental Health, and began to publish

11 Paul Béquart, the first medical director of the clinic, underscores this point. See *1963–2003*, 28.

12 Béquart writes that some patients chose this space in pavilion 7, but I cannot substantiate this. See *1963–2003*, 25. In spring 2022, a former patient relayed to me how traumatic the experience of isolation was at l'Eau Vive, and I hope that future work on the history of this clinic can include testimonials from patients.

13 *1963–2003*, 25.

14 Colette Chiland, one of the doctors who worked at the hospital for many years, has been criticized by Act-up Paris and the group Activiste Trans for imposing binaristic and regressive definitions of trans identities not based on trans experiences, especially in her book *Changer de sexe* (Paris: Odile Jacob, 1997). The website Transgender Map documents the critique of Chiland in greater detail: https://www.transgendermap.com/politics/psychiatry/colette-chiland/ (accessed March 1, 2022).

her findings from years of research on mental health facilities. [15] Writing for IP-focused psychology journals, as well as the more widely read *Esprit* (for which she wrote an article on social housing, which she had designed during the 1950s and 1960s) and, later, for the journal *Recherches*, Sonolet described how health-care facilities could be planned. Whereas care *practices* could be flexible and attuned to the patient, architecture could not be made infinitely changeable; a firm and fixed understanding of the requirements and qualities caregivers desired for patients was necessary. Accordingly, while some of Sonolet's recommendations could be derived from data about desired doctor/patient/space ratios and the populations of each sector, others were more ineffable. They had to do with how care spaces could inflect and allow access to social and natural environments, altering phenomenological qualities of space so as to create a varied palette of spaces for treatment, as Sonolet had done at Soisy. In her texts, Sonolet clarified that these two sets of knowledge were necessary to consider when building a community mental health center.

The other part, however, could be elicited only through conversations with those using the clinic themselves: patients and doctors. For Sonolet, then, both of these forms of research—understanding architectural typologies and possibilities, then undoing and modifying them based on feedback from users—were forms of care. Speaking at an event celebrating forty years of l'Eau Vive, Sonolet clarified this process:

"Doctors explain what they want as a mode of life for their patients, what they need. Architects try to find types of space and connections between spaces that favor care—in the life of patients and of the staff. It is evident that architecture isn't care, but it can support or inhibit care (a very good team in bad spaces is better than a bad team in good spaces). You need a constant back and forth between proposals and critiques between doctors, architects, social assistants, and nurses." [16]

These feedback loops between programming and design had parallels with the patient-specific treatment protocols that doctors involved with IP developed as they worked against the idea of a uniform and standardized formula for treating different illnesses. Sonolet seemed to modify the psychoanalytic practice of providing care to derive a process for designing the hospital. Following the principles of IP, this would yield designs that were guided by a set of common principles but were specific to each situation and team of staff members and also to the community from which they issued. Designing these spaces required close collaboration between architects and doctors. Simply creating a formula that would directly translate health into space was

15 Sonolet, "An Urban Mental Health Center"; Nicole Sonolet, "Un centre de santé mentale urbain: Proposition d'une expérience," in "Programmation, architecture et psychiatrie," special issue, *Recherches* 6 (June 1967); Sonolet, "Un centre de santé mentale: Point de vue et proposition d'un architecte"; and Phillippe Paumelle and Nicole Sonolet, "Le dispensaire d'hygiène mentale," *Techniques hospitalières* 12, no. 133 (1956), 51–53.

16 These talks were later published in a pamphlet. See *1963–2003*, 39 (author's translation).

impossible. This irreducibility to type helps to account for the formal variations in Sonolet's work, as well as the careful intentionality of her designs. Ideally, Sonolet implied, the kind of care that generated variety might be deployed in the planning of all collective facilities.

The importance of variety is a theme of Sonolet's text for *Esprit*, published in 1969, in which she argues that collective housing should be made more humane and that different qualities of spaces should be created by enabling more forms of programming and human interaction in collective social housing developments. [17] Indeed, Sonolet's understanding of l'Eau Vive as a variously programmed space in which patients could comfortably live while receiving treatment aligns well with her understanding of an ideal form for residential projects. IP attempted to make mental healthcare less carceral—the opposite of which was to make it more domestic—but Sonolet did not maintain this opposition, understanding that even the most domestic spaces could themselves be carceral if not based on a design process organized around experience, desire, and need. The best escape was liveliness and the possibility of unexpected and felicitous interaction, if so desired, or safe repose if not. [18]

In 1967, the Centre d'études, de recherches et de formation institutionnelles (CERFI, led officially by Guattari and practically by Anne Querrien), a research institute devoted to investigating the politics and potential designs of collective facilities, received a state-funded contract to investigate the relationships between architecture and psychiatry, the results of which were published in an issue of CERFI's journal *Recherches*. [19] Guattari, already friendly with Sonolet, tapped her as a key protagonist in the meetings and discussions about this project, centering her work at Soisy as essential to understanding how collective facilities for mental health could be designed. Sonolet's contribution reprised those she published in *Social Psychology* and *Information psychiatrique*, outlining challenges, processes, and formal considerations when programming hospitals, along with a menu of programmatic possibilities and several charts explaining how such a scheme could work under different population densities. She stressed that long-term success (rather than flexibility that would be impossible in architectural design) could be achieved only after considerable research and conversation. [20] A few years later, Sonolet participated in another Guattari-led CERFI project about planning mental healthcare in French New Towns. A transcript of a colloquium on this topic was preserved in a CERFI report. [21] Sonolet, along with the architect Alain Schmied, resisted creating fixed typologies for hospitals, working against the idea of creating a

17 Nicole Sonolet, "Logements Sociaux?," *Esprit*, no. 385 (October 1969), 464–74.

18 Sonolet's focus on the user and on animation in social housing parallels critiques of French housing projects from the 1950s and 1960s that Kenny Cupers documents in *The Social Project: Housing Postwar France* (Minneapolis: University of Minnesota Press, 2014). Sonolet was in conversation with many of the protagonists (alas, mostly male and, in the world of postwar French architecture, thus better documented) in Cupers's book.

19 "Programmation, Architecture et Psychiatrie," special issue, *Recherches* 6 (1967). For more on this aspect of Sonolet's work, see TenHoor, "State-Funded Militant Infrastructure?"

20 A brief analysis of this text appears in Caló and Pereira, "CERFI: From the Hospital to the City," 95–97.

21 CERFI, *La programmation des équipements collectifs dans les villes nouvelles (Les équipements d'hygiène mentale): Rapport sur l'exécution de la convention d'études entre le CERFI et le Ministère d'équipement et du logement (Direction de l'aménagement foncier et de l'urbanisme) du 4 mai 1971* (Paris: Centre d'études, de recherches et de formation institutionnelles, 1972).

standardized and repeatable architectural "solution" to a problem. While a gospel of mechanization and architectural standardization was part of Sonolet's architectural training, and certainly a technical interest of hers as someone who had to create public buildings on tight budgets, Sonolet did not feel that standardization would work in the case of programming, which she argued needed to emerge in response to the specific needs of a community and the specific practices of doctors. During these years, Michel Foucault, who worked on CERFI-funded projects and was very much part of the conversations about psychiatry, power, and planning that Sonolet helped to shape, argued that French liberalism was based in part on biopolitics; that is, calculations about the value of life. By theorizing care as an incalculable practice, one valuable in and of itself, CERFI and Sonolet developed an antibiopolitical understanding of how the state could tend to mental health needs by destigmatizing care and allowing for healing to happen through multiple channels. The IP model might itself appear neoliberal to modern ears, with its focus on individualizing patient desires and letting these desires drive healing processes, but when viewed in the context of midcentury French mental healthcare overall, which was one of great austerity and underfunding and alarming routinization of care, this turn toward the individual can clearly be seen as corrective rather than paradigmatic.

In plan and facade, in the design of interior spaces and exterior gardens, Sonolet's architectures for IP offer a simultaneously detailed and open-ended model of how institutions can be designed to support the provision of care and how they can become one of many therapeutic media through which patients might interact as they shape a path toward recovery. Architecture could assist in the practice of IP, and architects, Sonolet demonstrated, could adapt some of the conversational practices of IP to drive design research.

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