

Architecture as Therapy: A Case Study in the Phenomenology of Design

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*My paper is an analysis of the use of the drug LSD as methodological tool to enter the phenomenological lifeworld of schizophrenics and design a place for their treatment. If the user has a completely different lifeworld (individuals with mental or physical disability), then how do we envisage the space they inhabit? It would be useful for the researcher, then, to embody the perception of the schizophrenic to create a space that would, at best, assist in healing and, at worst, not exacerbate their illness. This is like understanding the perceptions of someone from a different culture and, at the same time, reproducing that material culture in a way that would be understandable to individuals of that culture. Schutz, in *The Phenomenology of the Social World*, argues that an 'intersubjective understanding' of an individual's perception is not isolated in individuals but is embedded in their social relations. He argues that 'we put ourselves in the place of the actor and identify our lived experience with his [sic]'. The researcher would not only have to be schizophrenic but also have to experience the interactions among people and space as a participant in the lifeworld of the schizophrenics. The use of LSD as a chemical technology allowed for 'sympathetic embodiment'. The bodies of the researchers, on LSD, would act as a bridge between their 'being' and their patients' 'world'. 'Osmond and Izumi experienced "space" . . . not [as] an abstract set of relations within which the lifeworld is structured [but] rather [as] the lived experience of the body-in-space . . . [i.e.] the primary relation from which all conceptions of space are constructed' (Dovey 1999, p. 39). Researchers can then view (experience) their surroundings while understanding the institutional setting in which patients are treated and also understand the knowledge used by the patient to understand the 'institutionally appropriate rules of conduct'.*

Keywords: 1960s—architectural theory—architecture—Canada—LSD—Yorkton Psychiatric Centre

Introduction

It is most important to review the history of the care of the psychiatric patient and hospital design so that we are not retarded by habit, custom, tradition [or] design.

—Kiyo Izumi

Dr Humphrey Osmond and architect Kiyo Izumi, working in post-war Saskatchewan, Canada, were intrigued by the use of hospital design as a technology for healing, that is, the use of architecture as a method of treatment. They wished to understand mental illness, not only to effect better treatments or possible cures but also to understand it as a way of providing a healthful place for treatment. Their work attempted to decode the behaviour of the mentally ill through observation within the context of their place of treatment, that is, how environment affects behaviour.¹ They asked, 'how could one build an institution of healing that embodied in its patients a sense of salubrity?' By implicitly, and sometimes explicitly, using the methodology of phenomenology, they attempted to answer this question.

To place themselves within the experiential world of the patient and use their patients' perceptions as a guide, they would use a new technology: an experimental

drug.² They believed that this new drug (LSD³) allowed them to simulate the perceptions and feelings of their patients and sense their surroundings as their patients would sense them.⁴ They would study their patients' 'experience' of the environment first hand. Since they thought that the patients' behaviour was directly affected by their perception of the environment, any attempt to understand the behaviour of the mentally ill had to come from the perspective of the patient. Thus, a change of perception and thinking was needed to see the world in a different way, that is, from the inside. LSD, then, became the chemical technology, a technical bridge, since it allowed for this shift in perception.

To incorporate these ideas into a research project, the Province of Saskatchewan, especially the Weyburn Hospital, which housed 2,600 patients in 1946,⁵ became the site of the world's largest LSD experiments during the 1950s.⁶ Prior to Osmond's work, warehousing patients in extremely large institutions without any form of therapy, save routine and discipline, was the norm. Now this all changed: 'It was an Age of Bold Experiments. Tommy Douglas' CCF [provincial government] was in power . . . The pioneering spirit went beyond art and medicine, though: it dared to explore the brain, the psyche and dimensions that passeth all understanding'.⁷

By 1965, Osmond and Izumi announced that they had designed the new Yorkton Psychiatric Centre (YPC) with the aid of psychedelic drugs. This facility would have 150 beds for all types of mental illnesses; there would be cottages of twenty to thirty-four beds, a central administration building, and dining and living rooms. The site would enable access to the community and approximate the normal conditions of patients' everyday lives.⁸ Even so, in designing this facility,

. . . it was not possible to interview the patients and get their views since they were too disturbed and would have had difficulty in describing their perceptual worlds. [Izumi] therefore decided he would become a volunteer, take LSD, and spend time on the ward of the hospital at Weyburn under Dr. Osmond's supervision and also on the ward of the University hospital in Saskatoon.⁹

This deliberate attempt to transform their perceptions of space by 'sympathetically embodying'¹⁰ the perception of the patient would, they thought, aid in understanding the schizophrenic's lived experiences. They would have to learn to speak from the social 'standpoint' of the patient. 'The object was to understand some of the experiences and problems of the mentally ill, so these problems could be considered in the building design'.¹¹

Using the design of the YPC as the object of my investigation, I will delve into how Izumi attempted to enter the everyday perceptual 'lifeworld' of the mental patient to construct a new treatment environment, that is, how the design was interacting, as a non-human actant, with patients whose perceptual reality was influenced by their illness.¹² I will also discuss the ideas and perspectives of these reformers/builders and how their methods were transferred to architectural form. My purpose is not to judge whether this design worked as a means of treatment (i.e., 'did it cure the patient?') but rather to understand how this particular design developed.

Background

In 1951 fall, Dr Humphrey Osmond was appointed the clinical director of the Saskatchewan Hospital at Weyburn. Osmond left England because his work with Dr John Smythies, on the possible use of mescaline as a treatment for schizophrenia, was 'rudely rebuffed'¹³ by his superiors and he was looking for a place to freely pursue his interests without professional interference. Osmond claimed that he

took charge of a decrepit hospital with a demoralized staff.¹⁴ He brought to the position at the overcrowded hospital an energetic new plan of patient-focused treatment.¹⁵ Osmond thought that ‘the mental hospitals themselves were a major cause of chronicity’¹⁶ and that their size and design were contributors to an ‘iatrogenic effect’. Seclusion, violence, sexual abuse, locked units and lack of privacy were but a few of the problems that plagued the enormous hospital [1]. These experiences, and their associated place, became damaging for treatment and exacerbated its patients’ conditions.

On 19 January 1965, Dr Sommer,¹⁷ a researcher at the Weyburn Hospital, wrote in the *Regina Leader Post* on how institutional life affects the behaviours of patients. Dr Sommer, a psychologist, proposed that the lack of privacy, separation, loss of individuality and purposelessness of the institution burdened the health of the patients. Through his research, he saw that the routine of the hospital was there for the convenience of the staff and not for the benefit of the patients. Patients were not only confused as a result of their condition but also confused by the lack of information and further confused by the hospital’s design.

As director, Osmond wanted to know how patients felt during their treatment and wanted to convert the hospital to a place of safety. He was convinced that the feelings of the patients contributed to their well-being and cure.

From his work in England, he ‘brought with him the idea that certain [chemical] compounds produced schizophrenic-like states in normal volunteers’;¹⁸ therefore, during the 1950s, Osmond used mescaline and then LSD to treat alcoholic patients. In this case, however, LSD was not used as a treatment for mental illness at this time since biochemistry was in the process of becoming the mode of treatment and was slowly replacing psychotherapy as the treatment of choice.

While treating his alcoholic patients with LSD, Osmond noticed that they experienced psychedelic episodes. These episodes became obvious after attempting hundreds of experiments (fifteen of which were on himself) and were thought to produce or mimic schizophrenic symptoms.¹⁹ Dr Abram Hoffer, a colleague of Osmond’s, states the following: ‘Since the LSD and schizophrenia experiences were so similar, I reasoned, perhaps this compound would also appear in the bodies of schizophrenic patients’.²⁰ Osmond finally came to the realization that LSD might be used in some way when finding the cure for schizophrenia.²¹ The use of LSD became more than a new drug for the treatment of an illness; it was a technology to change perception.

Fig 1. The Weyburn Hospital (Diener, R. and S. Wolfson, *Weyburn: An Archaeology of Madness*, 3rd Eye Media Productions 2004, cover)



LSD was a means of experiencing alternative forms of consciousness and creating an inner journey to the self. For the researcher, any understanding of a patient's experience must start with self-knowledge of the researcher. Osmond initiated this journey in a meeting with Aldous Huxley in 1953 and through their correspondence continued his exploration of alternative forms of consciousness over the next decade.²² LSD became the door of perception, or a technology to 'sympathetically embody' the schizophrenic experience—since LSD was linked to schizophrenia in the research at the time.²³ LSD was to be taken not only by the patients but also by the staff in controlled settings to gain insight into the patient's world. 'Hoffer and Osmond realized that many volunteers actually enjoyed the LSD experience'.²⁴

Here in Saskatchewan workers in the mental hospital field, and in one case a journalist, have been able to learn how a mental patient feels by taking a drug [that] made them temporarily schizophrenic, . . . [researchers] have drawn aside the curtains that hide a dark world.²⁵

From 1951 to 1961 a number of researchers, both locally and internationally, joined together to understand the relation between schizophrenia and the newly developing set of drugs called psychedelics.²⁶ With his colleague, Dr Abram Hoffer, director of psychiatric research in Saskatchewan, Osmond participated in research focusing on the biochemical cause and cure of schizophrenia. Osmond also corresponded and met with Timothy Leary,²⁷ Albert Hofmann²⁸ and others during his tenure at Weyburn. The Saskatchewan researchers were involved—with the best of intentions and methods of scientific research—in work that would alleviate their patients' everyday confusion and the anxiety brought on by the experience of a particular place of treatment.²⁹

The work of Osmond, as superintendent of the Weyburn Hospital, brought him into direct contact with conditions that influenced his views on treatment of mental illness. Daily, he saw the effect of place: how an antiquated overpopulated institution influenced the lives of those afflicted with mental illness. For Osmond, the hospital was custodial, 'turning those suffering from schizophrenia into zombies'.³⁰ Although it was assumed that the type of therapy used for the primary treatment of mental illness had a chemical base, he also envisioned an architectural solution to the problem of custodial care.

Osmond, as reformers before him, saw the need to reform the treatment of mental illness by providing a new type of institution: one that would assist in the healing process. He looked to the creation of a particular form of space in which healing would occur and sought out an architect, Kiyo Izumi, who would be able to transform this vision into a built environment [2].



Fig 2. YPC preliminary sketch (Archives, Province of Saskatchewan, Regina, RB 5131)

The idea

In an article titled, 'Buildings Can Drive You Crazy, But Can They Restore Your Mental Health?', in *Metropolis*, Philip Nobel³¹ poses the question, 'can architecture heal?' Does the building's design have the ability to provide a space within which the mind/body can heal itself, stabilize relationships and calm the experience of the patient?

The design of the YPC was to represent health; it was not to represent the particular conditions of those who occupied the building. Izumi understood that there was a significant aesthetic impact on the patient and also realized that the design had to take patients' accounts seriously.³²

The researchers at Weyburn were all too familiar with the effects of institutional life on the patient.³³ The new institutional environment would be cheerful and homely and would not only be healthful but would also be understandable to those with perceptual difficulties caused by their illness, thus catering to the patient's past, or 'stock of knowledge'. This 'cheerful' atmosphere would give 'the patients living conditions that were as near those of domestic living as possible'.³⁴ Ambiguity and uncertainty had to be reduced so as to limit the chances that a patient would suffer from anxiety about the meaning of the surroundings.³⁵ The meanings of the design had, then, to relate to the world of the patient directly. These ideas reflected the general trend in thinking about hospital design at the time. For example, in 1957, John Oudine writes that organization and design need to be based on socialization and acculturation by foreseeing the increase of stable interpersonal relationships between hospital patients through the use of small groups. These interactions can occur in 'face-to-face' groups; yet, the patients must have a retreat, which is made possible by the plan. The aim of the project was, then, to uncover the commonalities within which the patient lived and uncover the meanings of the patients' environments.

The YPC would incorporate in its design the information on schizophrenia that Osmond and Izumi gathered from their research and years of experience. Their attempts to simulate the experiential world of the patient through LSD experimentation assisted in their quest: 'changes in perception resembling those found in some schizophrenic people can be produced experimentally'.³⁶ Their attempts to mimic the patient's senses would provide an aesthetics of health that related to the patient's perceptual and emotional experiences of the space. Izumi makes this point when discussing the need to consider carefully the aesthetics of the design: 'The problem, as I see it, is how to design a physical space with its visual elements which serves a purpose for each and every person using it, and at the same time reflects and enhances the most desirable aesthetic experiences expressing this purpose'.³⁷ To identify with the patients, Osmond and Izumi would have to sense their world as would a schizophrenic. These were Izumi's experiences of his foray, or trip, into this world:

The tiles on the wall glistened eerily, thereby projecting hideous fantasies that sprang at him from the cracks. The recessed closets seemed to yawn like huge, dark cavities, threatening to swallow him alive. The raised beds were too high for a patient to sit on . . . There was no privacy, and the time sense was nil . . . The bars on the windows were a constant reminder of incarceration. But worst of all were the long, endless corridors leading into more of nowhere.³⁸

A phenomenology of place

Fundamental to the phenomenological position . . . is that one cannot presuppose a world prior to our lived experience of it.³⁹

The real is what you can feel, smell, taste and see . . .⁴⁰

In designing the YPC, Osmond and Izumi knew they had to experience the world as a schizophrenic would experience it. Using the phenomenological perspective, the researcher would understand the subjective meanings of particular acts and feelings of the subject and use these to institute a programme of research.⁴¹

Since the schizophrenic perceived the design and organization of the hospital space in a particular way,⁴² Osmond and Izumi would have to translate those experiences into a particular built form. The 'lived body' of the schizophrenic would then mediate the perceptions about his or her external reality (the building or environment as an interacting agent).⁴³ Assuming as Izumi and Osmond did—that the design influenced the patient's lifeworld—then the researcher must mimic the perceptions of the schizophrenic to understand the effects of their designs. But what are the subject's lifeworld experiences? Osmond and Izumi followed Herbert Blumer's axiom that 'if the scholar wishes to understand the action of people it is necessary for him [*sic*] to see their objects as they see them'.⁴⁴

The researcher, then, had to embody the perception of the schizophrenic or have the experience of deep inner meaning or physical sensation to create a space that would, at best, assist in healing and, at worst, not exacerbate the patient's illness. Osmond states that this is like understanding the perceptions of someone from a different culture. In the same way, the hospital as an artefact of material culture would have to be presented in a way that would be understandable to individuals of that culture. As with the phenomenological position (e.g., Schutz), each individual perceives the worlds from the standpoint of their own experiences while bringing to that perception a particular stock of knowledge gleaned from the culture at large. Schutz, in *The Phenomenology of the Social World*, argues that an 'intersubjective understanding' of an individual's perception is not isolated in individuals but is embedded in their social relations.⁴⁵ He argues that 'we put ourselves in the place of the actor and identify our lived experience with his'.⁴⁶ The researcher would not only have to be schizophrenic but also have to experience the interactions, with people and space, as a participant in the lifeworld of the schizophrenics.

In Seamon's view, Osmond and Izumi followed the key steps of a phenomenological methodology.⁴⁷ First, they involved themselves with direct contact with the thing they were studying—they immersed themselves in the environment of the mental patient. Second, they assumed no knowledge of the way in which the phenomenon would be experienced—Osmond wrote many times of the different culture and language of mental illness that he had to learn. And third, they used themselves as instruments of research by taking LSD.

The use of LSD as a chemical technology allowed for 'sympathetic embodiment'. Their bodies, while taking LSD, would act as the bridge between their being and their patients' lifeworld. 'Osmond and Izumi experienced "space" . . . not [as] an abstract set of relations within which the lifeworld is structured [but] rather [as] the lived experience of the body-in-space . . . [i.e.] the primary relation from which all conceptions of space are constructed'.⁴⁸ Using these methods, researchers can encounter their surroundings while understanding the institutional setting in which patients are treated and can also understand the stock of knowledge used by the patient to understand the 'institutionally appropriate rules of conduct'.⁴⁹

Another example of this type of phenomenological research is what might be called first-person accounts. The work of Toombs, a researcher with multiple sclerosis, shows how design enables a person with a disability. Toombs writes on how phenomenology assists the researcher in understanding the 'profound disruptions of space and time that are an integral element of changed physical capacities'.⁵⁰

Although the design of the YPC did not conform exactly to the original plan (according to Izumi, external constraints affected the way the building took shape),

it did fit a number of principles that Izumi developed during his research on Weyburn and while taking LSD. His plan, however, would develop a 'psycho-social structure which supports the patient and which may be enhanced by an appropriate architectural setting'.⁵¹ An appropriate architectural setting would modify the environment of the patient in relation to his/her perceptions of self, others, space and time.⁵² The design of the buildings ensured privacy, social interaction, adaptability and alternatives for interaction.⁵³

Abram Hoffer remarks that Izumi's design of the YPC provided for the most important aspect of treatment - privacy. 'Privacy can be attained by careful design of space'⁵⁴ that would provide for freedom from invasion into an individual's visual, auditory, tactile, taste and olfactory spaces.

The Yorkton hospital consists of small, cottage-like clusters of rooms, thirty to a unit, joined together by underground passageways . . . There are many windows, low and unbarred, eliminating the old, dismal barn-like aspect of mental hospitals. The walls are painted in pleasant, flat colors, and each patient has his [*sic*] own room in one or another of the clusters, rather than a bed in an austere ward. The beds are low to the floor, and the rooms are furnished with regard to making it easier to define the floor as a mere floor, not a pit . . . The emphasis throughout puts patient needs foremost, without sacrificing utility.⁵⁵

LSD became the vehicle for Osmond and Izumi to experience the space of the hospital. The design of the YPC was based on these experiences and resulted in a model of special design. The origin for this model was their experiences in the Weyburn Hospital and their sympathetic understanding of the perceptions of those confined there.

Sociopetal design

[Osmond's] hospital was one of the first in which the relationship between semifixated feature space and behavior was clearly demonstrated. Osmond had noticed that some spaces, like railway waiting rooms, tend to keep people apart. These he called sociofugal spaces. Others, such as the booths in the old-fashioned drug store or the tables at a French sidewalk café, tend to bring people together. These he called sociopetal.⁵⁶

The sociopetal⁵⁷ model envisioned by Osmond and constructed for the YPC by Izumi⁵⁸ came directly from their experiences with LSD. Izumi states that: 'It was not until I made experiments under the influence of LSD, to try to simulate certain perceptual experiences of mental patients, that I became aware of the psychophysiological forces with which they were trying to cope'.⁵⁹ These experiments showed him the distorted perceptions of patients. He realized that the assumed insignificance of particular sights, sounds and smells to a sane person could become insurmountable fears to the patient.⁶⁰ These include self-perception, perception of others, space perception and time perception. He goes on to say that 'all of the senses, including those that transmit impressions of temperature, humidity, taste and sound' need to be allowed for in the design.⁶¹ These bodily sensations are accommodated in the design of the building by accounting for space relationships, a lack of extensive corridors, smaller room size, a retreat and an 'attempt to bring spaces into relative scale and shorten distances'.⁶²

The sociopetal design is related to how phenomenology understands the body in place as a knowing subject. For both, there is the consideration of the subjective world or conscious retreat of the patient, the physical world in space and place

(stock of knowledge) and, finally, the interactions of the patient in the social world.⁶³ Spatial experience is, then, mediated by the situated place of the lived body within a given space [3].

In his work on the YPC, Izumi paid careful attention to the patients' lifeworld in an attempt to structure and stabilize their perceptions with the built environment. 'Architecture has a certain power to stabilize both "being" and "world," to defend us against the "terror" of both space and time: "Architecture is an act of self assurance"'.⁶⁴ Also, Izumi acknowledged in his work the relation between the design of space and the ability that space had to structure social relationships. In other words, the space became an active participant in the patient's lifeworld, an integral part of the interaction: a non-human interactant.

Izumi used this knowledge to rewrite the standards for designing mental hospitals. In his paper presented in 1967 he states:

... there is much need for greater research and the major problem is how to extrapolate objective standards for the many subjective experiences. However, in the main, it is thought that these can be reduced to definite design principles or at least directives as generally, even though the degree of perceptual distortion experienced is difficult among individuals [,] the direction of the distortion is fairly consistent. For example, in the case of apparent size, the consistent tendency for paranoids, psychopaths, [and] schizophrenics is [to be] larger. Though, there are not enough definitive studies of this nature to be dogmatic, based on the observation of other psychologists, nurses, psychiatrists in existing mental hospitals and my own observations, and research among mentally ill patients, *assisted by the experience stimulated through drugs such as LSD* [emphasis added].⁶⁵

Izumi began his thinking on the design of the YPC with the idea that a person has three levels of association.⁶⁶ As outlined in [3], these levels were defined as intimate, small group and larger group. These levels of interaction would structure the

THREE LEVELS OF SOCIAL RELATIONSHIP

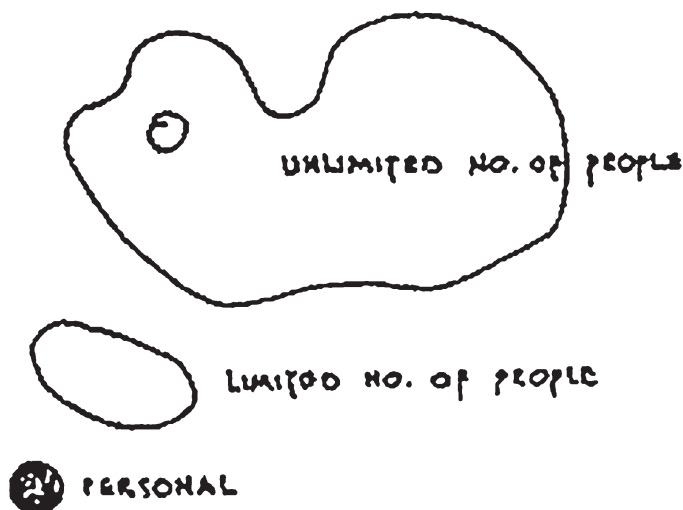


Fig 3. The original idea for the design (Archives, Province of Saskatchewan, Regina, RP 69.1019, p. 15)

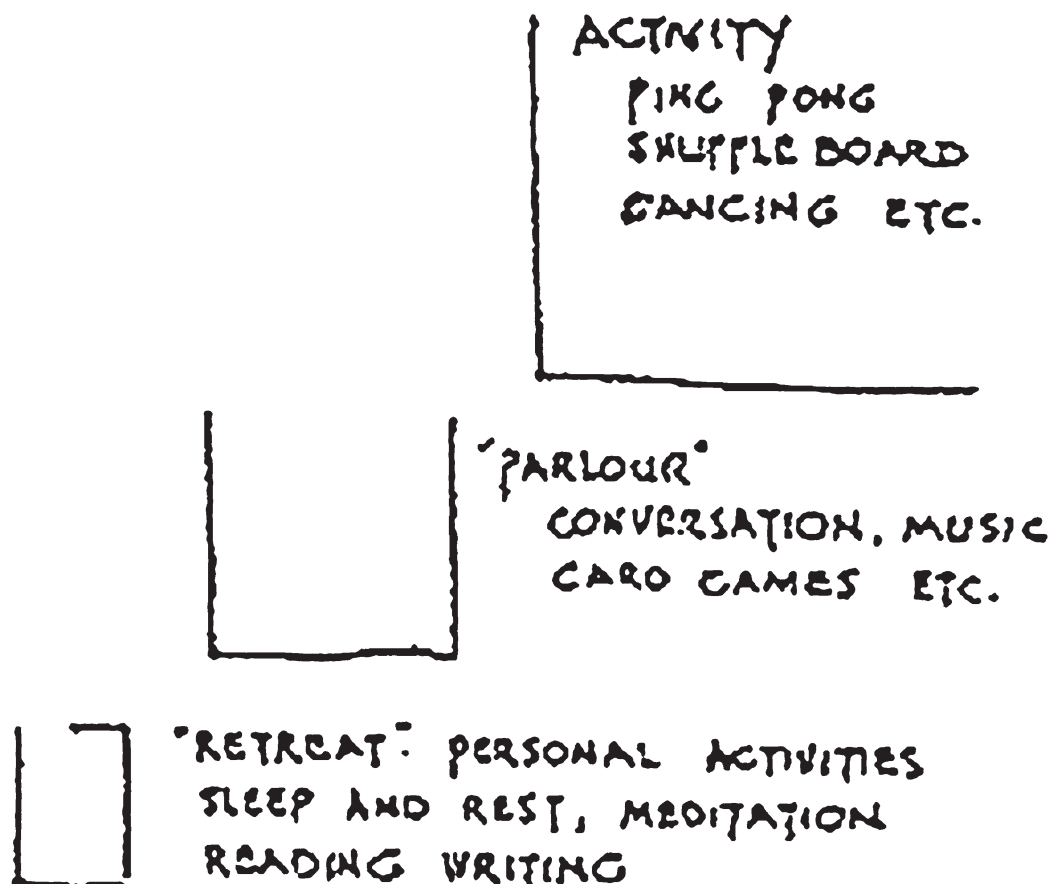
patient's interaction with other patients, the staff and their own condition. The patient could freely move through these spaces to find a comfortable situation in which they would feel at home. These spaces would then act as a buffer, allowing the design to avoid exacerbating the patient's perceptions.

He then moved these groupings to types of activities that would occur within each level of interaction, with an eye to the space in which these activities would take place. He imagined how the space would interact with the patient and how the patient would experience the space. The space (see below) was not only organized by the type of activity but also organized in relation to the size of space and design references associated with that space, for example, windows, doors, lobbies, door frames, closets, floor design, material textures, toilets and nose level. There would be a level of comfort in this space that allowed for social interaction with some privacy.

Fig 4. Translation of the idea into design (Archives, Province of Saskatchewan, Regina, RP 69.1019, p. 15)

The personal space acts as an 'intimate retreat [with] a bed, locker, possibly a chair and table or desk, and storage for some clothing [4].⁶⁷ Izumi lists certain types of designs to avoid, types to enhance and other designs to encourage, in particular, a

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sense of privacy, all based on his experiences as he mimicked the schizophrenic's lifeworld. Here, the patient would be alone but still safe. Location of plumbing, treatment rooms and fans needed to be considered in relation to the retreat. The head of the bed was to be placed in the room as desired by the patient.

The next space, the parlour, has 'wall hangings and a normal complement of furniture such as tables and chairs, book shelves and other equipment'.⁶⁸ Furniture was to be arranged so as not to replicate a waiting room in a hospital but to have the same arrangement as a family room in a home. The design needed to avoid all levels of ambiguity. The design of doorways, panelling, trim, paint lines, hardware and baseboard design needed careful consideration.

The last, the activity space, had 'a sense of integration with the outside through large window areas and should convey the feeling of expansiveness'.⁶⁹ The attachment with the environment would give the patient a sense of the calm of nature, connect their actions with those of an environment surrounding the hospital and break the monotony of the view within the hospital.

In designing the different spaces, Izumi gave particular consideration to how the space would affect the visual perceptions of the patients.⁷⁰

No doubt anybody who has taken LSD would be particularly appreciative of the need for obliterating anything in the way of unusual, excessive or unnecessary visual cues among psychiatric patients.⁷¹

Since visual perception was one of the predominant senses noticed by researchers while taking LSD, there is a considerable need to reduce 'ambiguity and uncertainty'⁷² through design aspects such as window placement. Izumi placed the bedroom windows symmetrically in the exterior wall 'to maintain privacy, and yet to maintain the sense of enclosure'.⁷³ 'As one moves into the areas of common territory, the window space becomes more open, reflecting the less private nature of these areas [5].'⁷⁴ Private windows also face the expanse of nature so that patients would not see the building from their windows, as is more obvious in the circular design.

These design ideas were translated into a circular form [6]. The circular design, since it was symmetrical, would support the sociopetal idea and focused interaction towards the centre, while private space would be on the periphery. This

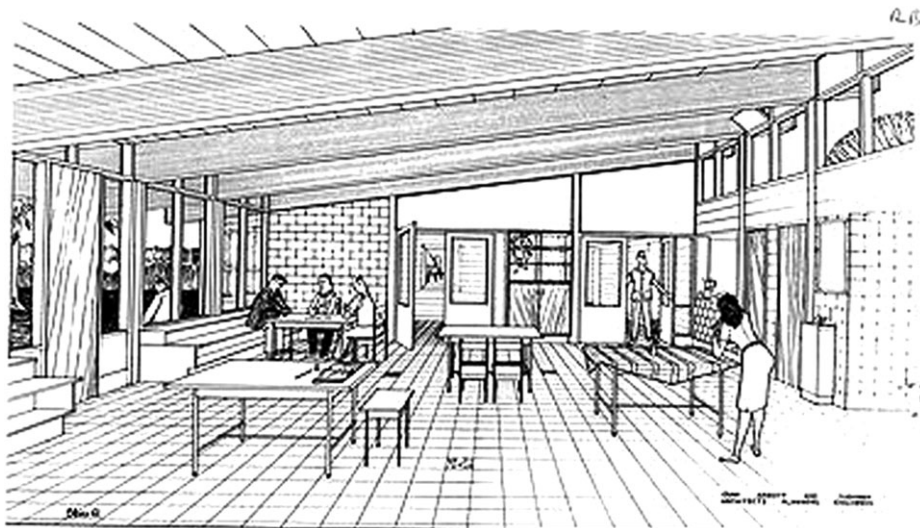


Fig 5. Preliminary sketch of the common room (Archives, Province of Saskatchewan, Regina, RB 4917)

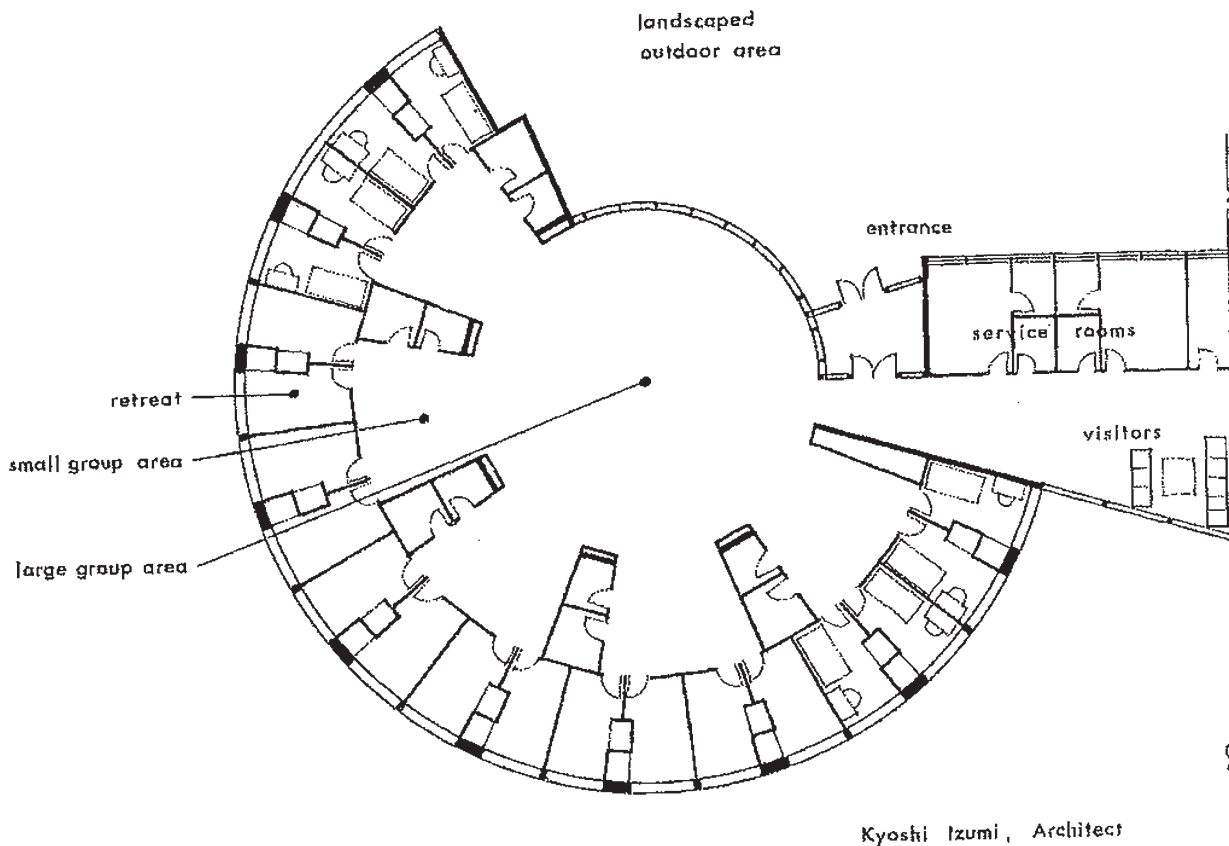


Fig 6. Circular plan (not built)
(Archives, Province of
Saskatchewan, Regina, RP
69.1019, p. 15)

design allows for social interaction, communication and activity to be drawn away from the patient's retreat. The patient, then, would have a certain power (ability to choose) over his or her surroundings that was directly mediated by the design of the space. As Dovey puts it, '[the] built form can orient, disorient and reorient its subjects through the spatial framings of everyday life'.⁷⁵

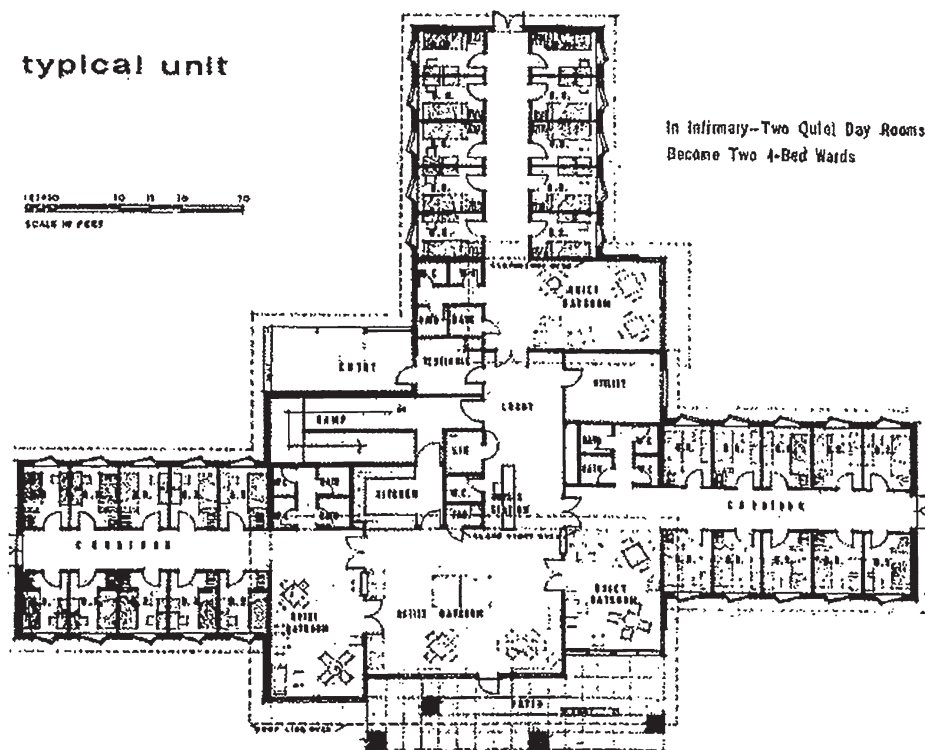
No external governmental standards were followed in the sociopetal drawing (above) and because of the architectural standards⁷⁶ needed for grant proposal funding, this design was not built, as it did not fit those requirements. Dickinson writes:

Federal construction grants would have amounted to \$4,386,000. This money would only be forthcoming, however, if the existing building codes, fire regulations and hospital construction standards were satisfied. As a result, the architectural design underwent further modification.⁷⁷

Certain architectural limitations were incorporated into the design and therefore the design became rectilinear, with some corridors. As a result it looks like a cottage [7].⁷⁸

This new plan still incorporates the sociopetal model while compromising some of the privacy issues discussed above.⁷⁹

Even before its erection, the YPC's design was controversial. In the May 1957 architectural supplement of *Mental Hospitals*,⁸⁰ there was considerable reaction to the sociopetal design proposed by Izumi and Osmond. Dr Walter Barton, a hospital superintendent, agrees with the principles that motivate those interested in



reforming hospital design: a need to guard against overcrowding, to have adequate staffing and social relationships and to provide a 'path of retreat to some privacy'. Barton, however, doubts whether a building, in itself, can provide these needs. To him, the design has little effect, if any. Dr Paul Bay, another hospital superintendent, said in support of the sociopetal design, that too many architects and superintendents were wedded to their own designs and saw this new approach as 'fanciful' rather than as a chance at general hospital-design reform. Moreland Griffith Smith, an architect, is critical of specific elements of the initial circular design [6]. He argues that Izumi's plan actually defeated the purpose of privacy and therapeutic groups by opening the rooms to a larger recreational space. He also states that there should be more traditional experimentation on patients to understand their reactions to colour, sound and individuality of their space. Mr Smith's solution was to have 'a small unpretentious community of buildings, possibly connected by passages opening into courts, [which] would achieve the desired results of producing a familiar and reassuring living situation'. Actually, this recommendation was very close to the final design [7].

Fig 7. Functional design of the final floor plan (Izumi, 'Special Considerations of Design', *Mental Hospitals*, 1965, p. 89)

Besides all the reaction and controversy, the YPC was built and initially cared for patients. Through the subsequent era of deinstitutionalization, however, outpatient treatment became the norm and any means of assessing the impact of the design on patient's lifeworld was lost.⁸¹ After many years of the failure of the de-institutionalization movement, there is new life in the idea that there are still individuals who need institutionalized care, be they the mentally ill or the aged. An analysis by Cherulnik shows that the generic use of the sociopetal model developed in Saskatchewan was a positive step in the design of hospital wards. In his discussion of ward design, he shows that the design increases sociopetal spatial arrangements, which in turn lead to the replacement of passive, solitary, non-social patient behaviour by purposive, engaged social interaction.⁸² This is where the research of Osmond and Izumi is of importance today. We need to revisit the

general discussion of how the place of treatment *is* the treatment: that is, a discussion of architecture as therapy.

Summary

In this article, I have used the concepts of sympathetic embodiment and lifeworld to explore how Kiyo Izumi and Humphrey Osmond entered the everyday sensory experience of the mental patient to construct a new treatment environment. With LSD as the chemical bridge, they empathized with their patients' experiences in designing a building that would assist in healing. LSD was used in an effort to assist in their research since Osmond firmly believed that the institution, the building itself, made schizophrenia worse.⁸³ Izumi's sociopetal concept was not without its critics, however, and many had doubts as to whether this radical new form could accomplish the results hoped for.⁸⁴ It might be said, however, that the use of LSD in this instance fitted the age-old desire of the architect to see the world through the eyes of those who would inhabit the place or built environment. Also, since this project to create an alternative space for institutional treatment was abandoned, there was no way to access the potential of the design. In contrast, the concepts of sociopetal and sociofugal, developed with the assistance of LSD, have been the mainstay of environmental psychology, environmental behaviour research, hospital and school design, and proxemics.⁸⁵

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Notes

- 1 H. Osmond, 'How to Judge a Mental Hospital', *Schizophrenia*, vol. 1, Second Quarter, 1969, pp. 95–6.
- 2 'Sandoz Pharmaceuticals spent over \$3-million in developing the drug and handed sample doses of LSD to hundreds of reputable investigators' (P. G. Stafford & B. H. Golightly, 'LSD—The Problem Solving Psychedelic', *The Psychedelic Library*, 2003, ch. 1–4, p. 5. <<http://www.psychedelic-library.org/staf2.htm>>.
- 3 H. Osmond and his colleague J. Smythies saw the structural similarities between mescaline and adrenaline in 1952. They thought that schizophrenia results when the brain releases a hallucinogen derived from adrenaline. Thus, the use of LSD, similar to mescaline, would simulate schizophrenia in a sane person (M. Blumenfield & L. Glickman, 'Ten Months Experience with LSD Users Admitted to County Psychiatric Receiving Hospital', *New York State Journal of Medicine*, vol. 67, no. 13, 1967, pp. 1849–53 and E. Dyck, 'Prairie Psychedelics: Mental Health Research in Saskatchewan', in *Mental Health and Canadian Society*, J. Moran & D. Wright (eds.), McGill-Queen's University Press, Montreal, 2006).
- 4 Osmond in *Hofmann's Potion* (C. Littlefield, director, & K. Martin, producer, NFB, 2003) states that many of the staff and researchers took LSD to gain the experience of being a patient and empathize with their condition.
- 5 *Regina Leader Post*, 19 August 1965, p. 2.
- 6 There were also LSD experiments on patients in Britain and in the USA (D. Black, *Acid: A New Secret History of LSD*, Vision Paperbacks, London, 2001) as well as Dr Ewan Cameron's brain-washing experiments in Montreal that were funded by the CIA. Also, there were a number of patients in Britain given LSD as a method of treatment (C. Dyer, 'Patients Given LSD May Be Able to Claim Compensation', *British Medical Journal*, 1995, vol. 311, no. 7014, pp. 1185–6). Nonetheless, this is the only example of the researchers using the drug, not as a method of treatment but as a method of understanding. This difference is examined by Blumenfield & Glickman, 1967, and J. Markoff, *What the Dormouse Said*, Penguin, London, 2005.
- 7 *Western Living*, 2001, p. 43.
- 8 *Regina Leader Post*, 29 January 1960, p. 23.
- 9 A. Hoffer, *Adventures in Psychiatry*, KOS Publishing, Ontario, 2005, p. 155.
- 10 Abram Hoffer said that they had to get inside the 'skin' of the patient and search for a clue to treatment (*Hofmann's Potion*).
- 11 K. Izumi, 'LSD and Architectural Design', in *Psychedelics*, B. Aaronson & H. Osmond (eds.), Schenkman Publishing Co., Cambridge, 1971, p. 381.
- 12 'The lifeworld refers to the tacit context, tenor and place of daily life to which . . . people give no reflective attention' (Seamon 2002, p. 5). This is people's experience of the empirical world, about which he asks the question, 'how would a more comprehensive architecture accommodate an experience of all the senses?'
- 13 Hoffer, *Adventures*, op. cit. p. 47.
- 14 *Hofmann's Potion*, op. cit.
- 15 In 1944, the capacity of Weyburn was 1,040 and its population was 2,488. This design was comparable to asylums in England (J. Taylor, *Hospital and Asylum Architecture in England 1840–1914*, Mansell, New York, 1991) and the USA (C. Yanni, *The Architecture*

- of *Madness*, Minnesota, London, 2007) in the nineteenth and early twentieth centuries.
- 16 H. Dickinson, *The Two Psychiatries*, Canadian Plains Research Centre, Regina, 1989, p. 147.
 - 17 To understand the perceptions of the patients at Weyburn, Dr Sommer states that he took LSD along with others working there (personal correspondence).
 - 18 The British mental health establishment did not accept Dr Osmond's work at St George's Hospital, London, on the use of drugs such as mescaline and LSD (D. Martin, 'Humphrey Osmond, 86, Who Sought Medicinal Value in Psychedelic Drugs, Dies', *The New York Times*, 22 February 2004, p. 25, and F. A. Kahan, *Bricks and Brains: The History of the Yorkton Psychiatric Centre*, CMHA White Cross Publications, Regina, 1965, p. 5).
 - 19 Hofmann's *Potion*, op. cit., and Hoffer, *Adventures*, op. cit.
 - 20 Hoffer, *Adventures*, op. cit., p. 116.
 - 21 'By 1960 the biochemical unit of the psychiatric research program in Saskatchewan was gearing up to investigate any possible relationships to the schizophrenias. One of the studies involved examining the urine for several fractions and comparing the urine of patients under controls. We were then treating many alcoholics using psychedelic therapy . . . It occurred to me that inasmuch as LSD produced something very similar (but not identical with) schizophrenia, perhaps it might also generate in the body of a person (not a schizophrenic) the same type of biochemical abnormality which we thought was present in the patients' (A. Hoffer, 'The Discovery of Kryptopyrrole and Its Importance', *Journal of Orthomolecular Medicine*, vol. 10, no. 1, 1995, pp. 1–2).
 - 22 It was Dr Osmond who gave LSD to Aldous Huxley and became his supplier for future sessions (M. Horowitz & C. Palmer (eds.), *Moksha*, Park Street Press, Vermont, 1999).
 - 23 'During the 17 years of research before it [LSD] was severely restricted in the late Sixties, over 3,000 scientific and popular articles were published [on the benefits for research into mental illness]' (Anon., 'Lysergic Acid Diethylamide (LSD)' <http://www.Serendipity.li/dmt/ptl_lsd.html> accessed 16 March 2003).
 - 24 *Western Living*, 2001, p. 46.
 - 25 *Regina Leader Post*, 20 January 1960.
 - 26 Humphrey Osmond coined the term 'psychedelic' in 1957 at a meeting of the New York Academy of Sciences to name the new group of mind-altering drugs (see letter from Huxley to Osmond, 30 March 1956 (Horowitz & Palmer 1999, p. 107)).
 - 27 Timothy Leary was one of the primary subculture figures of the 1960s and 1970s. He popularized the psychedelic movement with his often-quoted philosophy: 'Tune in, Turn on, and Drop out'.
 - 28 Albert Hofmann was a Swiss chemist who discovered the use of LSD in 1943.
 - 29 The use of LSD for research ground to a halt in Canada in the early 1960s as requirements for its use became increasingly rigid (Hoffer 2005, p. 120). Nonetheless, research today shows that the use of LSD as a model-psychosis does have legitimacy in understanding the chemical base of schizophrenia (D. E. Nichols, 'Hallucinogens', *Pharmacological Theory*, vol. 101, no. 2, February 2004, pp. 131–81 and E. Gouzoulis-Mayfrank et al., 'Psychological Effects of (S)-Ketamine and N,N-Dimethyltryptamine (DMT): A Double-Blind, Cross-over Study in Healthy Volunteers', *Pharmacopsychiatry*, vol. 38, no. 6, November 2005, pp. 301–11).
 - 30 Cited in Kahan, op. cit., p. 46.
 - 31 P. Nobel, 'Buildings Can Drive You Crazy, But Can They Restore Your Mental Health?', *Metropolis*, October 1999. <http://www.metropolismag.com/hml/content_1099/oc99aom.html> pp. 1–3.
 - 32 Osmond in Hofmann's *Potion* 2002 and H. Osmond, 'The Witness: A Schizophrenic Patient's Experience and Its Relevance to Psychiatry', *International Journal of Parapsychology*, vol. 8, no. 3, 1966, pp. 445–64. There is an interesting contrast here between the YPC and the Brutalist design of the Lindemann Psychiatric Center in Boston by Paul Rudolph, which were built at the same time.
 - 33 D. Kordes ('The Arts of Care in an Asylum and a Community 1925–2004', Ph.D. thesis, Australian National University, Canberra, 2009) discusses the period of 'herd care' that emphasized a particular architectural design and had particular effects on patients (see also, *Regina Leader Post*, 1960, p. 9).
 - 34 Kahan, op. cit., p. 27.
 - 35 H. Osmond, 'Function as the Basis of Psychiatric Ward Design', *Mental Hospitals*, April 1957, pp. 23–27.
 - 36 Osmond in Kahan, op. cit., p. 61.
 - 37 Izumi in Kahan, op. cit., p. 48.
 - 38 Stafford & Golightly, op. cit., pp. 14–5.
 - 39 K. Dovey, *Framing Places: Mediating Power in Built Form*, Routledge, London, 1999, p. 39.
 - 40 Morpheus, *The Matrix* 1999, screenwriters Larry and Andy Wachowski.
 - 41 B. Werlen, *Society, Action and Space*, Routledge, London, 1993, p. 76. Without using this specific method, there are architects, Pierre Riboulet, for example, who spend considerable time with the users of the buildings they designed to understand how the space is seen through their eyes (Hoyet 2001–2002).
 - 42 There is no evidence that these researchers differentiated between a 'person with schizophrenia' and a 'schizophrenic', that is, a first-person versus a third-person approach (see O. Gambini, V. Barbieri & S. Sarone, 'Theory of Mind in Schizophrenia: First Person vs. Third Person Perspectives', *Consciousness and Cognition*, vol. 13, no. 1, March 2004, pp. 39–46). This discussion within phenomenology would have to account for the particular 'stock of knowledge' of the person. D. Seamon ('Phenomenology, Place, Environment, and Architecture: A Review of the Literature', *Phenomenology Online* <www.phenomenologyonline.com/articles/seamon1.html> 2002) states that there are common architectural elements that are experienced by individuals in their life-worlds, an architectural 'stock of knowledge'. For example, walls, roofs and floors have the experience of inside/outside where weight, substance and motion clarify these structural elements. Do persons with schizophrenia have that same stock of knowledge?
 - 43 The body is the place that the agent takes in the physical world (Werlen 1993, p. 159).
 - 44 Cited in C. Calhoun et al. (eds.), *Contemporary Sociological Theory*, Blackwell, Oxford, 2002, p. 68.
 - 45 Schutz quoted in Calhoun et al., op. cit., p. 28.
 - 46 Schutz in Calhoun et al., op. cit., p. 33.
 - 47 Seamon, op. cit., pp. 11–2.
 - 48 Dovey, op. cit., p. 39.
 - 49 Burger and Luckmann cited in Calhoun et al., op. cit., p. 49.
 - 50 S. K. Toombs, 'The Lived Experience of Disability', *Human Studies*, vol. 18, 1995, pp. 9–23.
 - 51 K. Izumi, 'Some Architectural Considerations in the Design of Facilities for the Care and Treatment of the Mentally Ill', Second draft of a paper presented for the American Schizophrenia Foundation, 28 April 1967, p. 6.
 - 52 Izumi, 'Some Architectural Considerations', op. cit., p. 7.
 - 53 Izumi, 'Some Architectural Considerations', op. cit., pp. 8–17.
 - 54 A. Hoffer, 'Building Values into the Community', mimeo, CAMH Archives, n.d., p. 9.
 - 55 Stafford & Golightly, op. cit., p. 15.
 - 56 E. T. Hall, *The Hidden Dimension*, Doubleday, New York, 1966, p. 101.
 - 57 'Sociopetal space encourages social interaction and supports activities that provide the bases for gathering and interaction. Conversely, sociofugal space discourages social contact by not facilitating the establishment of eye contact or initiation of conversation' (A. Lawrence, 'Learning about Human Spatial Behavior', *ISDESIGNET*, September 1998, pp. 3–5). This form of setting orients individuals to a central focal point as sociofugal

- settings orient individuals towards the periphery (Hall 1966, p. 101). Sociofugal spaces are easier to control.
- 58 K. Izumi, 'Perceptual Factors in the Design of Environments for the Mentally Ill', *Hospital and Community Psychiatry*, vol. 27, no. 11, 1976, pp. 802–6.
 - 59 Izumi, 'Perceptual Factors', op. cit., p. 805.
 - 60 L. W. Robinson, 'Hearing Color, Smelling Music, Touching Scent; Bizarre Reactions Become Normal Under the Influence of LSD', *New York Times Magazine*, 22 August 1963.
 - 61 Izumi, 'Perceptual Factors', op. cit., p. 803.
 - 62 K. Izumi, 'The (in)human(e) environment', Transcripts of 6 TV Lectures, Ottawa, Ministry of State and Urban Affairs, Document C. 73.3, n.d., p. 6.
 - 63 Werlen, op. cit., p. 75.
 - 64 Harries in Dovey, op. cit., p. 41.
 - 65 Izumi, 'Perceptual Factors', op. cit., p. 5.
 - 66 Yorkton Psychiatric Centre Plans, Archives of Saskatchewan, RP 69.1019.
 - 67 Ibid.
 - 68 Ibid.
 - 69 Ibid.
 - 70 K. Izumi, 'Special Considerations of Design', *Mental Hospitals*, February 1965, p. 86.
 - 71 Ives in Izumi, 'Special Considerations', op. cit., p. 88.
 - 72 Osmond, 'Function as the Basis', op. cit.
 - 73 Izumi, 'Special Considerations', op. cit., p. 88.
 - 74 Ibid.
 - 75 Dovey, op. cit., p. 15.
 - 76 Izumi, through his work on this project, had an effect on revising the architectural standards that are placed on mental hospital design (K. Izumi, 'Architectural Considerations for Mental Health Facilities', section 10, part 11, *Canadian Building Standards and Guide Material for Hospitals and Health Facilities*, Department of National Health and Welfare, Ottawa, 1965, pp. 39–44).
 - 77 Dickinson, op. cit., p. 154.
 - 78 Izumi, 'The (in)human(e)', op. cit., p. 7.
 - 79 It is interesting that history repeats itself, as the final design is very similar to the design of The York Retreat built in 1796 as the first model of humanitarian patient care (B. Edginton, 'The Design of Moral Architecture at The York Retreat', *Journal of Design History*, vol. 16, no. 2, 2003, pp. 103–17).
 - 80 M. G. Smith, 'Sociopetal Building Arouses Controversy', *Mental Hospitals*, Architectural Supplement, May 1957, pp. 25–6.
 - 81 C. Lipscomb, 'The Yorkton Psychiatric Centre: A Five-Year Review', *American Journal of Psychiatry*, vol. 127, no. 2, August 1970, pp. 232–7.
 - 82 P. Cherulnik, *Applications of Environment-Behavior Research*, Cambridge University Press, New York, 1993, p. 146. It is a mystery why Cherulnik's chapter on the research by Sommer, Osmond and Izumi fails to mention the use of LSD.
 - 83 Osmond, 'The Witness', op. cit.
 - 84 Anon., 'Sociopetal Building Arouses Controversy', *Mental Hospitals*, Architectural Supplement, May 1957.
 - 85 Hall, op. cit., pp. 101–4.

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