Spaced-Out in Saskatchewan: Modernism, Anti-Psychiatry, and Deinstitutionalization, 1950–1968

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SUMMARY: On the eve of deinstitutionalization, a group of professionals, including an architect, a psychiatrist, and a psychologist, joined together in pursuit of a middle ground between outright closure of long-stay hospitals and the introduction of out-patient services in general hospitals. Augmented by the use of the hallucinogenic drug LSD, these men produced a trenchant critique of modern psychiatry and the changing mental health system without subscribing to anti-psychiatry. Caught among shifting psychiatric paradigms, fiscal constraints, and political pressure to situate mental health within an encroaching system of publicly funded health care reforms, their proposed mental hospital designs failed to stem the tidal wave of post–World War II changes in mental health care.

KEYWORDS: anti-psychiatry, architecture, asylums, deinstitutionalization, Kiyoshi Izumi, LSD, psychiatry, Saskatchewan

In 1957 architect Kiyoshi (Joe) Izumi and his wife Amy tried d-lysergic acid diethylamide (LSD) for the first time. Kiyoshi and Amy relaxed and simply let the drug take its course while they sat in the comfort of their home with friends Humphry and Jane Osmond.[1] Within the first hour

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1. Kiyoshi Izumi, "LSD and Architectural Design" (by Izumi, Arnott, and Sugiyama), prepared at the request of Dr. Bernard S. Aaronson (Bureau of Research, New Jersey Neuro-Psychiatric Institute), 1967, 2–3, Saskatchewan Archives Board (hereafter SAB),

Amy became nauseous.[2] Kiyoshi, on the other hand, experienced vivid changes in his perception, including the feeling that he had regained hearing in his deaf left ear and that he could see perfectly without his glasses. He had the "indescribable feeling of hearing colours, smelling colours, seeing sound and 'seeing' texture in a form which was almost a direct tactile feeling with one's eyeball or optic nerve."[3] The effects of the drug distorted his perceptions and challenged his sense of reality. However, he described the experience as above all enlightening, and he looked forward to applying these insights to his task of designing a new kind of institution for mentally disordered patients.

Although Izumi's drug use that evening was somewhat recreational, behind it lay a more professional objective. In the mid-1950s he had been commissioned by the Saskatchewan government to conduct an assessment of the province's largest mental hospital and to make recommendations on how to improve the institutional circumstances for patients within the mental health system. LSD, according to local researchers, produced sensations that mimicked psychotic perceptions, which allowed consumers to gain a unique insight into schizophrenic perceptions.[4] This theory rested on assumptions including that the majority of individuals living in mental hospitals were suffering from psychotic disorders, or under a somewhat generic application of the term *schizophrenia*, and that this disorder was characterized by hallucinations and disordered thinking. LSD stimulated visual hallucinations (not auditory, which is a more common feature of schizophrenia) and caused some feelings of disorientation, but the overall principles behind this experiment were enough to convince policy makers, architects, and psychiatrists in Saskatchewan that the project would produce beneficial results.

A207, II.A.14. Kiyoshi and Amy were accompanied by Duncan Blewett, a psychologist with Psychiatric Services, Saskatchewan Department of Public Health, and Francis Huxley, a social anthropologist conducting research on a Commonwealth Fund grant. Francis was the nephew of Aldous Huxley, author of *The Doors of Perception*.

2. Amy Izumi, widow of Kiyoshi Izumi, interview with the author, October 10, 2003, Scarborough, Ontario. In the interview Amy recalled taking another substance to end the LSD reaction. This substance was likely niacin.

3. K. Izumi, "LSD and Architectural Design" (n. 1), 3–4.

4. For a longer description of the theory behind this idea, see Erika Dyck, *Psychedelic Psychiatry: LSD from Clinic to Campus* (Baltimore: Johns Hopkins University Press, 2008), chaps. 1 and 2.

During his subsequent study, Izumi wandered through the halls of Saskatchewan's largest mental health facility, the Provincial Mental Hospital at Weyburn, while under the influence of LSD. He noticed, for example, that corridors seemed infinitely long, echoes sounded like voices, and dark colors appeared as holes in surfaces. These kinds of observations led him to conclude that the asylum was a frightening place for psychiatric patients. Contemporary publications, Izumi's architectural sketches, and his correspondence records with local psychiatrists and policy makers reveal that he was attempting to merge features of the modernist style in architecture, which prioritized function over form, with emerging critiques of psychiatry that recognized the asylum as a symbolic representation of abusive power and social control.

Izumi's musings about therapeutic space and mental institutions were hardly novel, and several historians have described the long-standing and dynamic relationship between architects and psychiatrists.[5] Social histories of hospitals have provided a useful basis for examining the medical, political, and cultural values entrenched in a built environment, including the asylum. Long-stay mental health institutions have been regarded as a microcosm of a sterilized and often idealized or even distilled version of a society's values.[6] By the mid-twentieth century, however, asylums came under intense scrutiny, one tenet of which focused on modernizing these spaces to bring them into closer alignment with general hospitals. Rosemary Stevens, in a study of twentieth-century American hospitals, suggested that health care facilities were increasingly built to satisfy a business-like drive for technology and efficiency,[7] capturing the contemporary enthrallment with technology as a marker of progress and modernity. Adding to this debate, Peter Blundell Jones argued that post–World War II hospitals in North America were built during the expansion of the

5. See, e.g., Carla Yanni, "The Linear Plan for Insane Asylums in the United States before 1866," *J. Soc. Archit. Hist.* 62, no. 1 (2003): 24–49, esp. 24.

6. See, e.g., Thomas Markus, ed., *Order in Space and Society: Architectural Form and Its Context in the Scottish Enlightenment* (Edinburgh: Mainstream, 1982), 26. See A. King, ed., *Buildings and Society: Essays on the Social Development of the Built Environment* (London: Routledge Kegan Paul, 1980); M. Vogel, "Health Care in the Distended Society: The American Hospital in Its Social Contexts," in *The Therapeutic Revolution: Essays in the Social History of American Medicine*, ed. M. Vogel and C. Rosenberg (Philadelphia: University of Pennsylvania Press, 1979): 127–48; L. Prior, "The Local Space of Medical Discourse: Disease, Illness and Hospital Architecture," in *The Social Construction of Illness: Illness and Medical Knowledge in Past and Present*, ed. Jens Lachmund and Gunnar Stollberg (Stuttgart: Franz Steiner, 1992), 67–84.

7. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989); see also R. Stevens, "Technology and Institutions in the Twentieth Century," *Caduceus* 12, no. 3 (1996): 9–18.

welfare state and, as a result, reflected ideals of bureaucratization and public accountability. This style embraced modernism by incorporating tools of medical science and medical technology as a feature of efficiency and egalitarianism.[8] These kinds of historical studies reinforce the importance of looking at the health care environment for traces of historical sociopolitical values.

While the nineteenth-century asylum once garnered attention for its impressive palatial stature, and at times even an opulent display of state and philanthropic funding, post–World War II descriptions of the asylum more often portrayed it as an overcrowded mausoleum, in short, a shrine to the failures of humanity and scientific medicine. But while nineteenth-century participants explicitly conscripted the physical environment into their therapeutic arsenals, particularly in the form of moral therapy, scholars in the 1960s began investigating the more implicit and even deceptive ways that these institutions produced a subculture of alienated citizens, or worse, a group of disenfranchised people. More importantly, the subcultures created within asylums and penitentiaries represented a particularly grim repository for the detritus of society.

Erving Goffman leveled his critique at the asylum, which he argued represented a "total institution," one that could "be defined as a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life."[9] Elaborating on this description, Goffman suggested that the asylum functioned as a subculture that created its own rituals, rhythms, and codes of behavior. This development was most damaging for patients who lived in these institutions under the pretence of receiving therapy. Rather than providing rehabilitation, however, Goffman suggested that these kinds of institutions further segregated individuals from society physically, but moreover by acculturating them to the rhythms of the institutions, patients became less prepared to negotiate the rigors of the "real" world. In effect, the total institution served desires for efficiency over the goals of rehabilitation.[10]

Beyond these seeds of discontent that grew into an intellectual movement in the 1960s, policy makers and psychiatrists throughout Europe and North America were also becoming more reform minded at midcentury.

8. P. Blundell Jones, "The Hospital as a Building Type," *Archit. Rev.* 3 (2002): 42–43; see also B. Lawson, "Healing Architecture," *Archit. Rev.* 3 (2002): 72–75.

9. E. Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, N.Y.: Doubleday, 1961), xiii.

10. Ibid., 6.

As Gerald Grob has argued, in the postwar period the emphasis on mental health care had shifted from treatment to prevention, which transferred responsibility for mental disorders to the realm of public health. Following several administrative changes in North America, including Kennedy's Mental Health Act in 1963, "the community, not the hospital, was psychiatry's natural habitat, and practitioners had to play a vital role in creating a healthier social order."[11] Within Canada, changes in health care policy aligned psychiatry administratively with medicine during the 1960s, which David MacLennan argues contributed to the proliferation of anti-psychiatry movements. He suggests that "psychiatry's rejection of the asylum and the convergence of psychiatry and medicine are part of the same professional project."[12] In this way, psychiatry and anti-psychiatry are connected through their mutual frustration with the asylum at midcentury as well as the perception that psychiatry lacked modern accoutrements of medical technology. Meanwhile, policy makers and administrators embarked on the dismantling of the welfare state, which shuffled programs into new jurisdictions, reduced funding for frontline workers in health care, and introduced an ethos of limited state involvement in a move that initiated a reversal of postwar policies. The commitment to close or at least phase out asylums grew out of this malaise of discontentment with the modern project and was hurried along as the intellectual critique sharpened and aligned psychiatric patients with emerging human rights reforms.

Izumi's work in Saskatchewan began in the 1950s and spilled into the 1960s as the higher profile critiques gathered steam. Although his LSD-inspired designs attracted attention from the World Health Organization for embracing a new patient-centered ethic in institutional care,[13] ultimately Izumi's recognition of these principles fell out of sync with the budding anti-psychiatry movement. His work, nonetheless, appealed to psychiatrists and policy makers interested in improving designs incrementally rather than tearing down what they saw as the contemporary

11. Gerald Grob, "The National Institute of Mental Health and Mental Health Policy, 1949–1965," in *Biomedicine in the Twentieth Century: Practices, Policies, and Politics*, ed. Caroline Hannaway (Amsterdam: IOM Press, 2008): 59–94, quotation on 65**.** The author is grateful to Gerry for drawing my attention to this article and forwarding me a copy. For a clear description of the various factors that contributed to deinstitutionalization, see Grob, "American Psychiatry: From Hospital to Community in Modern America," *Caduceus* 12, no. 3 (1996): 49–54.

12. David MacLennan, "Psychiatric Challenges to the Asylum: A Theme in the Development of Canadian Psychiatry, 1918–1963," *Can. J. Commun. Ment. Health* 8, no. 1 (1989): 75–91, quotation on 80.

13. J. A. Oudine, "New Trends in Psychiatric Architecture: A Report on the First Mental Health Design Clinic," *Ment. Hosp.* 9 (1958): 31–34, esp. 32.

foundations of psychiatry. Perhaps resultantly, Izumi has been neglected as a minor or ineffectual player in the debates that gathered momentum in the 1960s. As a figure caught up in these political, architectural, and psychiatric debates, Izumi's experiences provide insight into the changing orientation of psychiatry in the 1960s and its fraught relationship with the built environment.

Using LSD to Find Patients

Far from the urban or suburban environs of postwar North America, in the small town of Weyburn, Saskatchewan, Kiyoshi Izumi embarked on his LSD-inspired study. Situated in southeastern Saskatchewan, he joined the swelling ranks of middle-class professionals who traveled to this region to participate in a set of political and medical experiments. The province had elected the first state-level social democratic government in North America in 1944 on a platform of sweeping health care reforms, including the introduction of a universal system of publicly funded health care. By the mid-1950s the provincial government's efforts were beginning to bear fruit. After establishing a regional research grants program, developing a psychiatric nursing program (the first of its kind in Canada), opening a new medical school, aggressively advertising for research positions throughout North America and the United Kingdom, and passing a law that allowed for all clinically relevant in-hospital procedures to be paid for by the state, the province began attracting a host of researchers, physicians, nurses, and other professionals to otherwise underserviced communities. Although many individuals did not ultimately make Saskatchewan their home, for nearly a decade the province sustained a crop of enthusiastic, curious, and well-connected professionals with a collective interest in contributing to health reforms.[14]

Several Saskatchewan-based researchers began experimenting with LSD in this context, convinced that their studies had far-reaching consequences for the contemporaneous reforms in mental health care. Several such individuals believed that the LSD reactions modeled schizophrenia and could therefore provide insight into the biochemical causes of schizophrenia. Establishing a biochemical explanation for the disease meant that patients could ostensibly be treated in general hospitals and thus under the new provisions for state-funded care, but in a less stigmatized and more "modern" hospital environment.

14. For a more detailed description of the way that "place" shaped this research, see E. Dyck, "Prairies, Psychedelics and Place: The Dynamics of Region in Psychiatric Research," *Health and Place* 15, no. 3 (2009): 657–63.

One of the chief proponents of this method was British-trained psychiatrist Humphry Osmond. He had arrived in Saskatchewan in 1951 and soon became the superintendent of one of the two provincial mental health facilities. Osmond's thirst for experimentation and creativity was quenched with LSD. Within a few months of his arrival Osmond began experimenting with hallucinogenic drugs, primarily mescaline and later LSD. In 1957 he introduced the word "psychedelic" to refer to the sensations he felt accompanied an LSD experience, including its mind-manifesting properties, visual hallucinations, distortion of time and space, and general increases in levels of anxiety.[15] Above all, Osmond believed that through LSD he could achieve a model psychosis, or a satisfying window into schizophrenia that had never been achieved before. Confident in his assessment, Osmond encouraged others working in the mental health field to try LSD as a means of gaining empathetic insights into the schizophrenic's world. Although Osmond considered himself to be an ethical professional, he willingly shared his supplies with nonmedical investigators when he believed the experience might somehow enhance their thinking or be of some benefit to a creative enterprise. Kyoshi Izumi became one such guinea pig.

Izumi had by then already been commissioned by the provincial government to study the local mental hospitals and to recommend improvements. Of particular concern was the gross overcrowding in both provincial institutions. The numbers had steadily increased during and immediately after the Second World War and remained above four thousand, despite inadequate accommodations. Although the total number of people living within these facilities slowly declined throughout the 1950s, the institutions remained grossly overcrowded.[16] Izumi accepted the government's invitation to examine the existing facilities under the pretence that his recommendations would be used to build a new facility in the small town of Yorkton, in the southeastern section of the province, to help ease the pressure on the existing hospitals.

When Izumi started his investigations Saskatchewan had two provincial mental health facilities, one in North Battleford servicing the northern part of the province and the other in Weyburn, which provided mental health services for residents in the south. The institution in Weyburn (Figure 1) had been modeled after nineteenth-century asylums in eastern

15. Humphry Osmond, "A Review of the Clinical Effects of Psychotomimetic Agents," *Ann. New York Acad. Sci.* 66, no. 3 (1957): 418–34.

16. Harley Dickinson, *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905–1984* (Regina, SK: Canadian Plains Research Centre, 1989), 129.

Canada. Erected in 1921, it was the last mental health facility in Canada built according to nineteenth-century design principles.[17] The result was stunning. The institution was an imposing structure on the bald Canadian prairie, complete with a bronze roof. It spread out pavilion style with work farms spanning out into its back quarters.[18] With three long wings jutting out from the central building, the Weyburn Hospital was the largest building in the community and the largest employer.

Figure 1. Saskatchewan Provincial Mental Hospital, Weyburn, c. 1920. Photograph courtesy of Soo Line Museum, Weyburn.

At the time of its opening in 1921, Saskatchewan's Department of Public Health reported that over 1,500 individuals in the province required institutional care.[19] Twenty-five years later this figure had nearly doubled, yet the capacity for accommodating patients remained the same. Desperate to control the gross overcrowding that accelerated after the Second World War, superintendents transferred patients considered "mentally retarded" temporarily into an abandoned Royal Canadian Air Force

17. A. Allen, "The Last Asylum: Weyburn, Saskatchewan," *On Site Rev.* (Summer 2000): 20–21. See also Dickinson, *Two Psychiatries* (n. 16), 21. The Saskatchewan government had followed recommendations from Dr. C. K. Clarke, superintendent of the Toronto Psychiatric Hospital, to construct a custodial institution for accommodating the province's mentally ill patients.

18. At this time, work was considered central to the therapy at mental health institutions.

19. Dickinson, *Two Psychiatries* (n. 16); "Patients on Register by Year from 1914 to 1944, SK Dept. of Public Health Annual Reports," 38.

airport until proper facilities could be built.[20] A national survey conducted in 1945 suggested that the conditions in the hospital at Weyburn were steadily deteriorating and patients were suffering, citing it as one of the worst mental hospitals in the country.[21] Allegations about the causes of deterioration ranged from insufficient resources to abusive or inappropriate therapies, a lack of trained medical personnel, and poor management policies. Chronic overcrowding compounded these stresses.[22] As a result, the Weyburn institution became routinely associated with the dark side of institutionalization.

In 1944 the Cooperative Commonwealth Federation, under Tommy Douglas's leadership, had campaigned on a platform of improving health care in the province, which included drawing concerted attention to the mental health system.[23] The resultant allure of a progressive political environment attracted people from all over the world to the province. Contemporary observers suggested that the socialist landslide, followed by successive reelections, piqued the curiosity of intellectuals, artists, and would-be politicians, among others, with an infectious optimism for constructing a socialist political culture.[24] Saskatchewan's developing cultural

20. F. H. Kahan, *Brains and Bricks: The History of Yorkton Psychiatric Centre* (Regina, SK: White Cross, 1965), 19.

21. C. M. Hinks, *Mental Hygiene Survey of Saskatchewan* (Regina, SK: Thomas A. McConnica King's Printer, 1945), 8; H. E. Sigerist, *Saskatchewan Health Services Survey Commission* (Regina, SK: King's Printer, 1944).

22. For figures, see Dickinson, *Two Psychiatries* (n. 16), 38, figure 6.

23. T. McLeod and I. McLeod, *Tommy Douglas: The Road to Jerusalem* (Edmonton, AB: Hurtig, 1987); E. Tollefson, "The Medicare Dispute," in *Politics in Saskatchewan*, ed. N. Ward and D. Spafford (Don Mills, ON: Longman, 1968), 238–79; R. F. Badgley and S. Wolfe, *Doctors' Strike: Medical Care and Conflict in Saskatchewan* (Toronto: Macmillan, 1967); C. S. Houston, *Steps on the Road to Medicare: Why Saskatchewan Led the Way* (Montreal: McGill-Queen's University Press, 2002), chap. 5, 69–76; A. Johnson, *Dream No Little Dreams: A Biography of the Douglas Government of Saskatchewan, 1944–1961* (Toronto: University of Toronto Press, 2004).

24. This sentiment was repeatedly borne out in oral interviews. Several individuals recalled in oral interviews an attraction to the region that was explicitly related to its socialist politics and the progressive research environment it fostered. Examples include interviews conducted by the author with Hon. Allen Blakeney (arrived in Saskatchewan as a Rhodes scholar and a recently graduated law student), Joyce Munn (nursing student), Arthur Allen (architect apprentice), Robert Sommer (psychologist), Frank Coburn (psychiatrist), and Arnold Funk (psychologist). These kinds of sentiments are also found in a contemporary study of the political culture: S. M. Lipset, *Agrarian Socialism: The Cooperative Commonwealth Federation in Saskatchewan, a Study in Political Sociology* (Berkeley: University of California Press, 1959). A historical examination of the political culture is D. Laycock, *Populism and Democratic Thought in the Canadian Prairies, 1910 to 1945* (Toronto: University of Toronto Press, 1990). See also E. Dyck, "Land of the Living Sky with Diamonds: A Place for Radical Psychiatry?" *J. Can. Stud.* 41, no. 3 (2007): 42–66.

institutions received an influx of cosmopolitanism as curious individuals arrived in the province to observe socialism in action, bringing with them their energy, ideas, and experiences.[25]

Kiyoshi Izumi had arrived in Regina, Saskatchewan, in 1953 for slightly different reasons. Although he may have been attracted to the politically progressive atmosphere, he also traveled to this relatively remote area to escape the stigma and racism toward Japanese people that had accelerated during the Second World War. In Izumi's native province of British Columbia, the government established internment camps in 1942 after Pearl Harbor was bombed. Although Izumi had been born in Canada and was studying abroad in 1942, he sought a new and less hostile environment upon his return to Canada in the 1950s. Izumi was born in Vancouver, British Columbia, in 1921 and trained as an architect at an impressive list of schools, including the London School of Economics, Massachusetts Institute of Technology, and lastly Harvard University, before going into private practice in Saskatchewan. His wife recalls that there were only five Japanese–Canadian families in the entire city of Regina, and although they faced bouts of racism, "Kyo" quickly made friends in government and felt safe in Saskatchewan.[26]

As the Saskatchewan government set about reforming mental health care in the province, the Weyburn Mental Hospital captured the attention of local architects interested in redesigning the facility. Izumi visited Weyburn to conduct an architectural assessment of the facility, and there he met Osmond. Over the next few years Izumi and Osmond not only developed a close personal relationship but also became professionally committed to remodeling the institution after careful consideration of its function.[27]

By 1957 another researcher joined the rising tide of professionals keen to participate in the reforms. Robert Sommer had been working as a behavioral psychologist in Kansas in the early 1950s. His work there focused on studies of personal space, including distinctions between

25. One such figure was Johns Hopkins University professor Henry Sigerist, who was invited to the province to advise the government on how to implement socialized medicine. See J. Duffin and L. Falk, "Sigerist in Saskatchewan: The Quest for Balance in Social and Technical Medicine," *Bull. Hist. Med.* 70, no. 4 (1996): 658–83; and M. I. Roemer, L. A. Falk, and T. M. Brown, "Sociological Vision and Pedagogic Mission: Henry Sigerist's Medical Sociology," in *Making Medical History: The Life and Times of Henry E. Sigerist*, ed. E. Fee and T. M. Brown (Baltimore: Johns Hopkins University Press, 1997), 315–32.

26. Amy Izumi, interview with the author, March 8, 2004.

27. Ibid. The Osmonds even became godparents to one of the Izumi children.

privacy and territory. His early work largely focused on observations of zoo animals and their responses to living in different kinds of constructed environments. Observing that the health of these animals was often directly related to the size and quality of the space allotted in the zoo, Sommer then applied this theory to notions of human health. The researcher cluster forming in Saskatchewan provided a unique opportunity for Sommer to work in a socially progressive environment and test some of his theories with the support of an interdisciplinary team. Shortly after arriving in Weyburn and meeting Osmond and Izumi, Sommer began studies of personal space as observed in the patient culture at the Saskatchewan Mental Hospital in Weyburn.[28]

Osmond, Izumi, and Sommer spent several years studying at Weyburn to deepen their understanding of how the facility functioned as a therapeutic environment. Two dominant themes emerged from their observations: (1) patients, in general, exhibited a distortion in perception (they believed that this dysfunction was the root of all mental disorders) and (2) prolonged institutionalization exacerbated the distorted perception and led to a generalized disculturation.[29] If their assumptions were correct—that is, that mental disorders were primarily a disturbance of perception—then isolation in an institution provided the worst kind of therapeutic environment. The central problem with institutionalization, as Sommer reasoned, was that it resulted in further disculturation and desocialization for the patient. The solution was to design better therapeutic environments in which the central function of the institution could repair social relationships. He argued that "the mentally ill person does not abide by the customs of society because he does not recognise them fully. In other words, people are committed to a mental hospital because they are desocialized."[30] Sommer and Osmond published these observations in 1958, a year before Erving Goffman expounded similar ideas in his more comprehensive study of St. Elizabeths Hospital in Washington, which he published in 1961.

Sommer continued, convinced that the primary dysfunction among mental disorders in general was one of desocialization, or losing touch

28. For more on Sommer, see John Mills and Erika Dyck, "Trust Amply Recompensed: Psychological Research at Weyburn, Saskatchewan, 1957–1961," *Hist. Behav. Sci.* 44, no. 3 (2008): 199–218.

29. H. Osmond, "Rehabilitation Services within the Hospital," *Ment. Hosp.* 9 (1958): 45–47, esp. 45.

30. Ibid., 45.

with the outside world.[31] He felt that as someone developed a distorted perception of reality—whether of space, time, or cultural customs—he or she became a candidate for institutionalization, which further removed him or her from the kind of environment that might actually repair the dysfunction. Although at this time he did not articulate a position that might later have been heralded as anti-psychiatric, Sommer's comments touched on some of the features that would later become major tenets of this movement. For example, by emphasizing the role of environment in shaping or even producing disorder, Sommer, and through collaboration Osmond and Izumi, interrogated the process of desocialization as a critical factor leading to institutionalization. However, Sommer and his colleagues in Saskatchewan acknowledged the presence of an underlying disorder, whether biological or biochemical, but nonetheless one that was negatively aggravated by the process of institutionalization.

To test this theory, Sommer undertook a study of letter writing in the Weyburn Hospital. This study led him to describe the "total institution," a concept developed contemporaneously by Erving Goffman.[32] In the letter-writing study, Sommer encouraged patients to correspond with family or community members in an effort to remain in contact with "the outside world." After two years of observation, he stated that "there is a point at which the patient begins to become disculturated, lost to contact with the outside world. It is important for hospital authorities to learn when this occurs, as it means that in addition to treating the patient's initial illness, the patient must be resocialized."[33] This study helped to confirm his belief that institutionalization had negative effects on the prognosis of the disorder as well as for the prospect of rehabilitation.

Osmond shared Sommer's frustrations with the traditional asylum. He suggested that these buildings had been designed to cultivate feelings of alienation and obedience, a situation in which the patient had very little power. These monuments of psychiatry, he argued, were being transformed in the twentieth century in a modernizing impulse that embraced

31. R. Sommer, "Letter-Writing in a Mental Hospital," *Amer. J. Psychiatry* 115, no. 6 (1958): 514–17.

32. See Goffman, *Asylums* (n. 9). Sommer and Goffman corresponded, and it is likely that Sommer learned of this terminology from such correspondence and then applied it to his own work. In an oral interview Sommer could not recall how he knew of this term or whether he had at that time corresponded with Goffman on this particular idea.

33. Sommer, "Letter-Writing" (n. 31), 514. Sommer also found that women wrote more letters than men, and after one year letter writing (and contact in general) tapered off substantially.

scientific reasoning, the central tenets of which included efficiency, technology, and sanitation.[34] The result, according to Osmond, was a highly depersonalized system that disregarded the fundamental function of modern hospitalization: "to do no harm to the patient."[35] Osmond argued that before Florence Nightingale's famous hospital reforms, the architectural layout harmed patients in the way that infections spread in the hospital.[36] With a greater understanding of mental illness coupled with the ability to create an empathetic experience by taking LSD, modern hospital architecture could respond to patients' needs in a more sophisticated way.

Part of the challenge in improving designs, according to Osmond, grew out of the lack of consensus within the profession about what constituted mental illness or disorder. He remained particularly concerned about psychotic disorders, which he felt were overrepresented among chronic patients within the mental health system and for which the models lagged behind those of so-called middle-class disorders. In particular, Osmond felt that middle-class patients retained a degree of independence by virtue of wealth and therefore were able to consume private services. Without consistent and universal models, diagnoses of psychotic disorders differed across regions and among practitioners, even after the publication of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* in 1952. Osmond likened annual psychiatry meetings to a "Mad Hatter's tea party."[37] The lack of appropriate models, he argued, led to a questioning of psychiatry's authority in medicine and society. Moreover, he lamented that psychiatry needed a dose of modernism itself because "starved of scientific guidance and stimulation, psychiatry fell back on the descriptive study of symptoms, dogma, system building and empiricism which is the fate of medicine without science."[38] In addition to embracing a more rigid scientific set of classifications, he felt that the contemporary challenges to modernizing medicine encouraged psychiatrists to adopt better, more sophisticated, and more scientific tools for appreciating their patients' perspectives.[39]

34. H. Osmond, "How to Judge a Mental Hospital," *Schizophrenia* 1, no. 2 (1969): 95–99.

35. H. Osmond, "The Psychiatric Premise: To Do the Sick No Harm," June 13, 1965 (draft 2), SAB, as quoted on p. 1.

36. Ibid., 1.

37. M. Siegler and H. Osmond, *Models of Madness: Models of Medicine* (New York: Macmillan, 1974), 1.

38. H. Osmond and A. Hoffer, "A Small Research in Schizophrenia," *Can. Med. Assoc. J.* 80 (1959): 91–94, quotation on 91.

39. Siegler and Osmond, *Models of Madness* (n. 37), "Introduction."

Psychiatrists, he bemoaned, collected and classified symptoms according to their existence as reported by patients but could not appreciate the severity or subtleties of experiences such as delusions or hallucinations without further communication with the patient. Patients under observation attempted to conceal their experiences from staff as a matter of privacy or if they regarded the subsequent treatment as punishment. The situation exacerbated the underlying challenges associated with communication between patients and psychiatrists, which itself was already hampered by an unequal power relationship and often a lack of common language for relating experiences. The free exchange of information between psychotic patients and doctors, as Osmond suggested, remained critical for genuine reforms in the mental health system.

In an effort to better understand patients' perspectives, Osmond and Sommer undertook a thorough examination of former mental patients' autobiographies in 1960.[40] They concluded that one of the major obstacles to promoting patient perspectives was the difficulty patients had in describing their ideas to medical experts who had no personal frame of reference for understanding distorted perceptions or disorganized thoughts. Similarly, medical experts had difficulty understanding the behavior patterns of disordered individuals, which often came across as irrational. The importance of studying patients' written descriptions of their disorders, they argued, had often been dismissed as "tiresome vapourings of paranoid and disgruntled people."[41] Osmond and others challenged this view as they collected and examined hundreds of autobiographies and discovered a rather high degree of similarity among patients' descriptions of symptoms, which often differed significantly from contemporary psychiatric language. They also discovered a high level of misunderstanding between psychiatrists and patients about issues such as "treatment." Changes to the environment also arose as an area rife with misunderstandings. For example, decorating the hospital for a festive occasion, such as a Christmas party, was particularly frightening for someone experiencing hallucinations.[42] Psychiatrists needed, they concluded, a much more sophisticated understanding of patients' experiences in addition to a list of their symptoms.

40. R. Sommer and H. Osmond, "Autobiographies of Former Mental Patients," *J. Ment. Sci.* 106 (1960): 648–62. For challenges to analyses of patient populations as coherent societies, similar to those observed in prisons, see R. Sommer and H. Osmond, "The Schizophrenic No-Society," *Psychiatry* 25 (1962): 244–55.

41. Sommer and Osmond, "Autobiographies of Former Mental Patients" (n. 40), 648.

42. Ibid., 660.

After over a decade of research with LSD, Osmond concluded that the "mind-manifesting" or "psychedelic" experience approximated perceptual disturbances as described by patients, particularly those suffering from schizophrenia.[43] He recommended that individuals working in mental health institutions, especially doctors and nurses, have an LSD experience so that they could cultivate a greater understanding of patients' behaviors. He even encouraged hospital administrators to undergo an LSD experience. One recalled that

> the room seemed in a peculiar shape with the corners somewhat rounded, the doors at peculiar angles. The far wall seemed lower and the other walls seemed to converge on it. Somewhat later the people with me seemed to acquire auras of somewhat bluish tinge. Their faces and bodies were somewhat distorted. I thought that this was quite funny but considered it impolite to laugh.[44]

Repeated experiments illustrated that LSD noticeably altered visual perceptions, but subjects also identified distortions in mood and thought patterns that often defied logical explanations. Recognizing how distortions in perception could affect behavioral responses, and believing that the LSD experience provided a relatively true representation of madness, Osmond felt confident that with the aid of LSD he, Sommer, and Izumi could create a more humane and modern mental health facility, one that combined scientific approaches with patient-friendly environments.

Izumi agreed with this idea and further suggested that "the art of architecture as a technique or form of expression is how well the architect can put together in some order not his own perceptions but the perception of those who are the actual consumers of the environment which he creates to enhance the human experience."[45] He further contended that architects must eschew the desire to create art and instead embrace analytical and scientific methods advanced by other professionals. He stated, "[T]he major hurdle it seems, is inertia and a hesitancy arising out of an unfounded fear of other disciplines usurping, or at least adulterating, the role of the architect and the artist. Architect and artist must realize that the added knowledge and insight gained is only to aid them to be more effective with their art."[46] Consistent with modernist views or the internationalist style in architecture at midcentury, Izumi emphasized

43. H. Kelm, A. Hoffer, and H. Osmond, *Hoffer-Osmond Diagnostic Manual* (Saskatoon, SK, 1967).

44. I. J. Kahan, LSD Report, July 27, 1957, SAB, A207, II.A.3, 1.

45. K. Izumi, "LSD and Architectural Design" (n. 1), 17.

46. K. Izumi, "Some Considerations on the Art of Architecture and Art in Architecture," *The Structurist* 2 (1961–62): 46–51, quotation on 51.

function over artistry.[47] As historians Verderber and Fine have shown, "by the 1960s International Style [modernism] dominated mainstream hospital design. This style was characterized by flat roofs, minimal exterior ornamentation, monolithic volumes, the use of only one color (usually white or off-white), concrete with steel and large expanses of exterior glass."[48] These features later appeared in the new hospital, but not until after considerable debate.

Izumi appears to have embraced this architectural ethic, and in his approach to designing a modern mental hospital he desired a move away from the palatial hospitals of the nineteenth century and instead welcomed an ethos of functionalism. He also, however, recognized the need to gauge function through the eyes of the hospital's consumers, in this case patients. But to do so he depended on his colleagues to assist him in developing an empathetic insight into schizophrenia.

After studying with Osmond and Sommer, and later taking LSD himself, Izumi agreed that patients suffering from mental disorders required a different kind of environment if the institution claimed any therapeutic value. He stated, "[T]o achieve architectural solutions which recognize the dynamic psycho-social phenomena requires perception of these phenomena in their 'space-time' dimensions and allowance for the peculiar perceptual distortions experienced by many of those who are ill."[49] Achieving this empathetic perspective and translating it into design terms presented the largest challenge for Izumi. He suggested that the architects' craft relied on an ability to design according to one's own perceptions, creativity, and innovation, but to design for patients suffering from disordered perceptions required a different set of priorities.[50] "The architect and artist talk about freedom of expression for themselves, but at the same time we must realize that in architecture, space and the elements in it are also a means of enhancing the emotional experience of other individuals who may or may not perceive this world in sympathy with you, and whose needs are just as important."[51] For institutionalization to benefit patients, Izumi felt that he needed to consider the therapeutic environment more

47. See also Stephen Verderber and David Find, *Healthcare Architecture in an Era of Radical Transformation* (New Haven, Conn.: Yale University Press, 2000), 17. Verderber and Find state, "The modern—that is, International Style—hospital was lauded as the apotheosis of pure functionalism," 17.

48. Ibid., 17.

49. K. Izumi, "An Analysis for the Design of Hospital Quarters for the Neuropsychiatric Patient," 8, Centre for Addiction and Mental Health Archives (hereafter CAMH Archives), Arthur Allen papers.

50. Letter from Izumi to Bruce Koliger, May 4, 1966, 2, SAB, Izumi Correspondence.

51. Izumi, "Some Considerations" (n. 46), 46.

deeply. This meant removing stimuli that commonly produced feelings of fear or paranoia. He needed to effectively utilize space in a manner that encouraged positive social interaction. The central function of the new institution had to involve the development of what he called therapeutic "psychic space."

Psychic space was a concept that encapsulated the recognition of disordered perceptions and codified the patients' authority in the resultant spatial organization. During Izumi's first LSD experience he developed an appreciation for his "psychic environment." He stated that the "environment involved your emotional, intellectual, conscious and sub-conscious state which was affected by the 'psychic' qualities of the people."[52] The psychic space was further affected by physical stimuli. For example, "[A] corridor was further elongated. . . . [T]he acoustical rhythm of the building would be affected by the usual building noise such as the hum of motors, fans, footsteps, typewriters, cleaning equipment. . . . [H]ence a comfortable room was a room that had a rhythm appropriate to its spatial, visual and tactile qualities."[53]

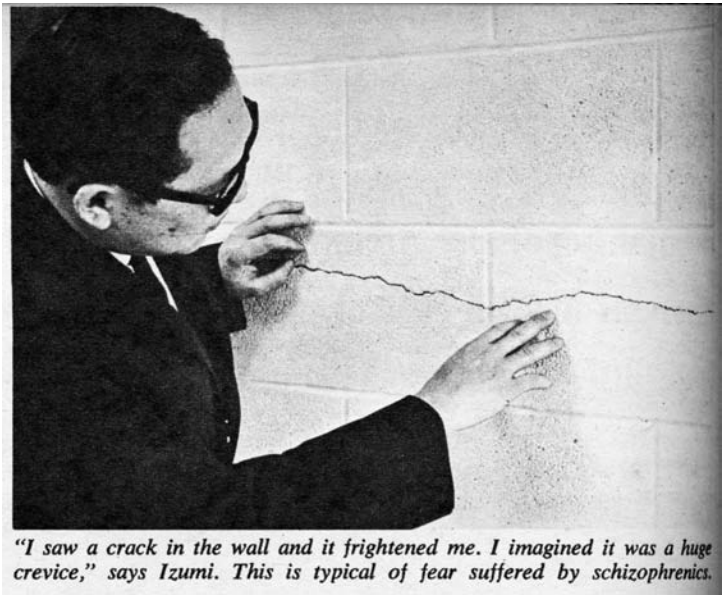

Figure 2. Kiyoshi Izumi, as featured in the *Weekend Magazine* in "The Demented World of Kyo Izumi," February 28, 1966. Reproduced with the permission of Library and Archives Canada.

52. K. Izumi, "LSD and Architectural Design" (n. 1), 6.
53. Ibid., 6.

Izumi's own experience matched descriptions from patients and provided insight into the ways that feelings and perceptions were communicated from patients to doctors (Figure 2). He combined his firsthand observations with LSD with anonymous patients' descriptions of various institutional environments.[54] For example, Izumi's experience confirmed a patient's account of "how a room 'leaked' and this related to perceiving your body become a very geletenanious [*sic*] and fluid form and 'seeing' yourself flow and ooze out through cracks and other openings that are distinct from the accepted openings such as doors and windows."[55] Further observations revealed the relationship between psychosocial behavior and stimuli such as colors, tile arrangements, mirrors, room designs, and hallways. Beige, for example, was a common color for institutional walls, but patients commented that it produced feelings of "immobilization."[56]

Izumi's notes also contained statements and observations that he collected from patients at the Weyburn Hospital. One schizophrenic patient commented on the need for additional space to feel comfortable. He explained to Izumi that he needed "social and emotional freedoms to co-ordinate the body to the environment in a manner which protects freedom to make decisions without interference."[57] This patient continued by suggesting that other people may see the schizophrenic patient as simply fast or slow, ambitious or lazy, and so on, but he explained that his behavioral reactions were related to comfort in the decision-making process, which Izumi interpreted as the need for safe "psychic space."[58]

Sommer picked up on some of these observations and designed a set of behavioral experiments to test some of the spatial arrangements. He firmly believed that institutional designs reinforced feelings of imprisonment, surveillance, and subservience.[59] To interrogate the effects of spatial organization he devised a series of tests where he observed seating arrangements and the subsequent socialization of student volunteers and later institutionalized patients with schizophrenia. In both sets of experiments Sommer prearranged the furniture, monitored the seating choices of individuals, and followed up the experiment with a debriefing interview

54. Patients in this study were referred to Izumi from the local institution in Weyburn and from the research hospital in Saskatoon (under the direction of Osmond and Hoffer).

55. K. Izumi, "LSD and Architectural Design" (n. 1), 6.

56. Ibid., 6.

57. Ibid., 7.

58. Ibid., 7.

59. R. Sommer, *Design Awareness* (San Francisco: Rinehart Press, 1971), 8.

with each of the participants. His studies revealed vast differences in the perceptions of personal space and desired seating arrangements between the student volunteers and the patients.[60] The students, for example, preferred more distance between individuals and moved chairs or couches to achieve optimum personal space and comfort. In contrast, the patients with schizophrenia conversed in closer proximity to one another but did not move the furniture under any circumstances.

Variations on these experiments revealed even more dramatic differences when observing a mixed group of students and schizophrenic patients. As patients sought to engage in conversations they moved closer to the students, who often moved further away. When Sommer conducted follow-up interviews, patients admitted that they felt rejected by the students. Students by contrast claimed that they had tried to expand their personal space when they felt threatened by the patients' advancements.[61] As he analyzed these outcomes, he introduced a number of new complicating factors, such as differences between long- and short-term patients, graduate and undergraduate students, males and females, and other combinations of individuals. His continued studies began to illuminate how ideals of personal space were affected not only by environment but also by perceptions of power relationships. His conclusions reinforced the notion that the traditional institution did not adequately consider the importance of distorted perceptions and their effects on behavior, mood, and thought, or the resultant impact that these features had on power dynamics within the hospital.

Although their combined studies did not readily provide an antidote to the asylum-style acculturation, Izumi remained under pressure from the provincial government to produce an appropriate design for the expanding mental health system. He drew from the multilayered and interdisciplinary studies that Sommer and Osmond had been involved with and ultimately proposed a circular design for the new hospital that he called a "socio-petal" model (Figure 3). He felt that based on his observations of disculturation within the institution, its main therapeutic function, as aided by its design, needed to rely on creating space that was conducive to social interactions. In other words, the mental hospital required an architectural layout that fostered community.

60. R. Sommer, "Studies in Personal Space," *Sociometry* 22 (1959): 247–60, esp. 252–53.

61. R. Sommer, "The Distance for Comfortable Conversation: A Further Study," *Sociometry* 25 (1962): 111–16, esp. 114.

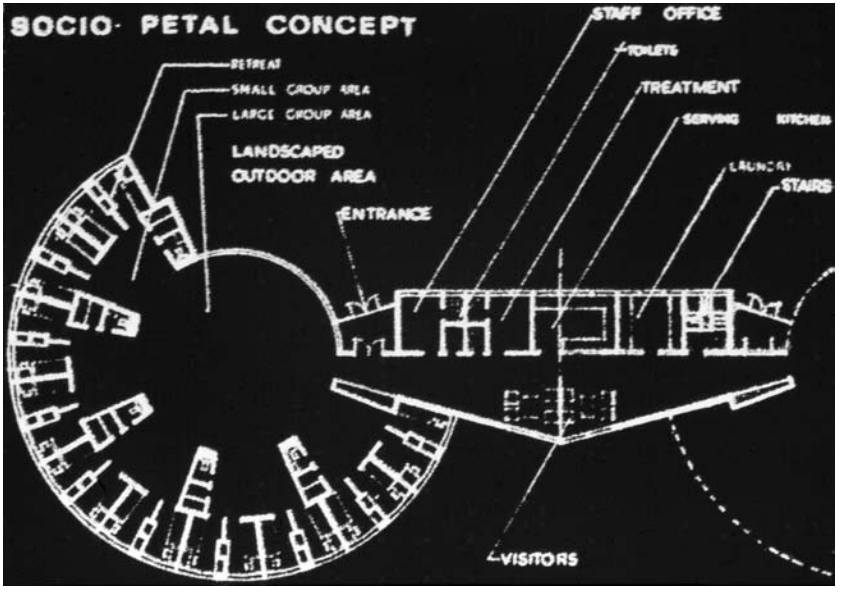

Figure 3. Draft of socio-petal design. Published in Fannie Kahan, *Brains and Bricks: The History of the Yorkton Psychiatric Centre* (Regina, SK: White Cross Publications, Division of the Canadian Mental Health Association, 1965). Copyright permission from Barbara Kahan.

Socio-Petal Design

The initial socio-petal design recommended by Izumi incorporated features of modernism and austerity alongside a desire to build the hospital for the patients rather than for its staff. His proposed circular design provided private spaces for patients along the perimeter of the building and expanded space for social contact as one moved outside one's private space. The extra barriers or buffers, he felt, would create unambiguous divisions in the hospital and allow for an unobtrusive entrance into a room or, similarly, an escape into privacy.

Inside the facility, he avoided long corridors that, according to patients and LSD subjects, echoed and reinforced feelings of paranoia and depersonalization, which made the transition from one space to another a frightening experience. In an attempt to limit the feeling of being under surveillance, he removed the central nursing station. Unlike a panopticon-style building, Izumi suggested that hospital staff have a relatively separate, rectangular area off to the side of the patient-oriented space.

He suggested that this kind of design offered a model for addressing the need for various kinds of "psychic space."[62] Although he was later criticized for retaining features of surveillance through his use of circular designs, Izumi resented these accusations and suggested instead that those spaces were designed with patients, rather than staff, at the center.

He also paid attention to the interior designs in the institution, in which he continually retained his core objective that the institution should foster a design that facilitates the building and rebuilding of social relationships. For example, Robert Sommer had paid close attention to floor tile designs with respect to appropriate coloring, texture, and arrangement. Conscious of the ways that colored tiles could create illusions of distance, security, and gaps or holes in the floor, Sommer carefully chose patterns in common spaces that created a sense of security in a home-like environment. Conversely, he resisted arrangements that created solid lines and might therefore suggest barriers.[63]

He gave similar attention to seating arrangements, an idea he borrowed from Sommer, so as to maximize the likelihood of social contact. Rather than expect individuals to initiate contact in a large group setting, he arranged seats in small groups to create more comfortable environments for initializing conversation. Here again he effectively made use of different colored floor tiles to mark spaces and to encourage the flow of traffic into comfortable social spaces, organized to maximize face-to-face contact.

Although his designs were minimalist to the point of austerity, he nonetheless chose interior design details carefully in an effort to create a home-like environment without incorporating ambiguous decorations. For example, he discarded the idea of using grainy wood paneling after considering the frightening effects it could have for someone experiencing hallucinations. He took extra care to ensure that colors and textures clearly marked spatial separations. He chose dark colored frames for exterior windows to outline the separation between glass and wall. In spite of the space inefficiencies, he recommended that clothes closets remain freestanding wardrobe-style containers rather than installing closets in the walls. Otherwise, he felt that these structures might leave an impression or illusion that the wall was fluid or malleable, capable of creating a hole. In spite of nurses' complaints that the beds were awkward to move or that

62. "An Analysis for the Design of Hospital Quarters" (1955), "Some Architectural Considerations," and K. Izumi, "Explanation of Socio-Petal Building Design" (n.d.), CAMH Archives, C. Pleasance File.

63. R. Sommer, "Floor Designs Can Be Therapeutic," *Hospitals* 34 (1960): 54–56.

patients were too low, Izumi suggested that the beds be lowered so that the patients could more easily reach the floor while lying in bed to avoid the frightening feeling of being suspended or falling.[64]

When he first published his architectural model, along with some of his interior design ideas, he encountered a mixed reception. The published responses and correspondence remained fairly favorable, and many correspondents agreed with the general principles behind his socio-petal model. The journal *Mental Hospitals* devoted a special issue to discussing the socio-petal building. In it, superintendents, architects, and psychiatrists commented; responses from psychiatrists ranged from discarding the concept as "fanciful" to embracing it as "a fresh breeze of new thinking."[65] Many contributors to this volume applauded the use of an interdisciplinary team to devise this new model. Architects responded somewhat less enthusiastically. Many of them pointed out that the round building presented significant challenges such as added expenses and the need to develop an appropriate roof to suit a radial structure. They provided few details on these kinds of costs, and no consensus emerged. The Saskatchewan-based team showcased their work in this capacity, not only as an example of an alternative to traditional asylum-styled care but also as the product of collaborative research efforts conducted under progressive political conditions.

Results

In the early 1960s the province of Saskatchewan had seemed ready to act on Izumi's final recommendations and to begin construction. By this time, however, circumstances had changed in the region. Tommy Douglas, who had led the Cooperative Commonwealth Federation (CCF) to victory on a health reform agenda in 1944, left the province to lead a new national party. His successor, Woodrow Lloyd, remained committed to passing legislation on publicly funded health care, but he now faced an aggressive lobby from the medical profession. The ensuing debate, and

64. F. S. Lawson, "Saskatchewan's First Regional Mental Health Facility: The Yorkton Psychiatric Centre," and K. Izumi, "Special Considerations of Design," in *Ment. Hosp.* 8, no. 3 (1957): 19–23.

65. "Sociopetal Building Arouses Controversy," *Ment. Hosp.* Architectural Suppl. 8 no. 5 (1957): 25–32, esp. 25–26. These specific comments came from Alfred Paul Bay, superintendent of Topeka State Hospital, Kansas, who described the plans as "fanciful," 25. Karl Menninger of Topeka, Kansas, stated that the designs represented a "fresh breeze of new thinking," 27.

ultimately a doctor's strike in 1962, focused political and bureaucratic energy on this contentious issue, which overwhelmed considerations for the new mental health facility. The 1960 provincial election functioned as a referendum on publicly funded health care, and Lloyd retained power with a narrow victory. Four years later, in 1964, the Liberals defeated the CCF on a platform that promised to dismantle the health care reforms and that decisively withdrew funding for the Yorkton initiative.[66]

Izumi's recommendations for the new mental health facility became collateral damage in the highly contentious debates over health care reforms. Izumi's connections to the previous government made his plans an easy target for a new government seeking to distance itself from the previous policies. In part of the Liberal government's approach to charting a new policy toward mental health, it engaged in a dramatic and aggressive process of deinstitutionalization. Rather than adopt a program of gradually releasing individuals into the community and establishing corresponding support systems, by the mid-1960s the mental hospitals in Saskatchewan were being rapidly depopulated. For example, the population of the mental hospital in Weyburn had an in-patient population of 1,202, but after this change in policy that number dropped by over 30 percent to a total of 796 in a single year. The following year, 1965, it fell another 30 percent, reaching a population of 553 patients.[67] Although the drop in patient population was augmented by the introduction of new psychopharmaceuticals (chiefly chlorpromazine), the drug therapies did not operate alone. The shift in attitude toward a policy of deinstitutionalization became an engrained feature of the new government, as it attempted to carve out its own health reform agenda, distinctive from the CCF. Within Canada, the confluence of new medications and political will made Saskatchewan the first province to embark on a large-scale policy of deinstitutionalization.[68]

Izumi's proposed facility was built in 1964, in spite of these changes. His colleagues, Osmond and Sommer, had left the province. Osmond

66. See C. David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911–1966* (Montreal: McGill-Queen's University Press, 1986); Malcolm G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions That Created the Health Insurance System* (Montreal: McGill-Queen's University Press, 1978); Allen Blakeney, "Fulfilling the Douglas/Lloyd Vision," in *Medicare: Facts, Myths, Problems and Promise*, ed. Bruce Campbell and Greg Marchildon (Toronto: James Lorimer, 2007), 42–45.

67. Dickinson, *Two Psychiatries* (n. 16), 180.

68. Patricia Sealy and Paul Whitehead, "Forty Years of Deinstitutionalization of Psychiatric Services in Canada: An Empirical Assessment," *Can. J. Psychiatry* 49, no. 4 (2004): 249–57, esp. 256.

returned to England briefly in 1961 and later took a position at the Neuropsychiatric Institute in Princeton, New Jersey. In 1962 Sommer moved to Alberta and a year later returned to the United States as an associate professor of psychology at the University of California, Davis. With his closest research colleagues gone and his political allies out of power, Izumi seemed unable to sustain sufficient support for constructing the new facility according to his original designs.[69] Forced to reduce costs but keen to retain essential features of his model, Izumi restructured his hospital plan and gave it a more conventional look. Ultimately, Izumi designed a rectangular building with a flat roof and concrete walls, an institutional structure much more befitting of the modernist style. Although the final product incorporated some of his recommendations for interior design concepts, Izumi felt that the Yorkton Psychiatric Centre prioritized efficiency and technology for hospital staff over communal, therapeutic space for patients.

The Yorkton Psychiatric Centre represented a triumph of modernism in both architecture and psychiatric treatment. The austere style of the building combined with changes in patient care meant that few patients used the facility as an in-patient residence. The majority of patients were out-patients, and of those the majority received a regimen of drug therapies. The ensuing out-patient care that dominated this environment also meant that a discernable patient community did not develop, as Izumi had hoped. Newsletters, letters, and records from the patients themselves were not created or have not survived, save for a few remnants reported in more traditional venues.

Despite numerous requests, mostly from Izumi, the provincial government did not commission a follow-up study of the Yorkton Psychiatric Centre.[70] Izumi nonetheless offered his own informal observations:

> I cannot say as to what extent the design has contributed to the program in any definitive sort of way. In general, the comments by both staff and patients who have experienced other kinds of institutional environment such as North Battleford and Weyburn, the older psychiatric hospitals in the province, are that Yorkton is much more comfortable and patients are much more relaxed. A visiting staff member commented that "it was much easier to be kinder in

69. For a more detailed explanation of the political debates behind this decision, see Greg Marchildon, "A House Divided: Deinstitutionalization, Medicare and the Canadian Mental Health Association in Saskatchewan, 1944–1964" (paper, Open Doors Workshop, August 2009). I am grateful to Greg for providing me with a copy of this paper.

70. Izumi to Director of Research (The Foundation for Mind Research), New York, 1968, SAB, R45 3–18(e) S.S.H.C.

> the Yorkton Center." In short, what I felt that they meant was that the Yorkton environment was much more conducive to their own well-being which in turn reflected upon their attitude and treatment of the patients.[71]

Newspaper reviews of the Yorkton Psychiatric Centre provided a more optimistic view of its significance, reporting a general satisfaction among patients and staff at the Yorkton facility.[72] A nurse who had worked in the Yorkton Centre claimed that its unique design helped the staff overcome the depressing and spirit-numbing mood that is often found on psychiatric wards; the layout of the institution helped staff focus on the individual.[73] She continued by commenting on how the facility combined modern technology with a strong emphasis on developing social relationships. In a comparison of patient activities in the Yorkton Psychiatric Centre, the Weyburn Mental Hospital, and the University Hospital in Saskatoon, nurses defended the Yorkton Centre, claiming that patients there seemed more relaxed and regularly engaged in activities in the common spaces. A patient who had stayed at both the Munroe Wing at the Regina General hospital and at the Yorkton Psychiatric Centre wrote about her experiences in a letter to the Saskatchewan Health Minister. She explained, "[T]he atmosphere at Yorkton Mental Clinic is a complete contrast to Munroe Wing. I would recommend that you check the two clinics and see if certain modern trends couldn't be introduced in Regina."[74]

Conclusion

Although the Izumi–Osmond–Sommer design was never fully realized, their in-depth discussions about the role of the mental institution in modern society tapped into broader international trends: namely, modernism, anti-psychiatry, and deinstitutionalization. Their concerns about the new mental hospital began before anti-psychiatry had blossomed into a recognizable movement. Their cosmopolitan experiences and collaborative work produced a rather unique expression on the Cana-

71. Izumi to Dr. R. E. L. Masters, July 31, 1968, 1–2, SAB, A207, Izumi Correspondence.

72. "'Madness' Drug Helps Architect," *Globe and Mail*, May 10, 1965, 10; "Ancient Urban Renewal," *Globe and Mail*, December 4, 1965, 9; "Just Plain Sense," *Globe and Mail*, August 29, 1969, 25.

73. "And Then There's Yorkton—A Giant Step Forward," *Calgary Herald*, February 2, 1968.

74. Marjorie Dybvig to Minister Steuart, May 24, 1966, SAB, R45 80(904), Psychiatric Services Miscellaneous Correspondence.

dian prairies that predated the work of players such as Erving Goffman, Michel Foucault, and Thomas Szasz. Those authors would later feed on these kinds of sentiments of disillusionment and develop more stringent and focused critiques of modernism as the thrust of their stance against psychiatry. While these relatively unknown characters might not quite fit the profile of the 1960s-style postmodernist or anti-psychiatry figure, their work nonetheless suggests that these kinds of ideas had been percolating for some time.

By the mid-1960s a number of scholars had published critical treatises that offered more focused analyses of the problems with progress, modernism, technology, and bureaucracy. Izumi shared many of the anxieties expressed in these works. For example, in 1968 he published a short essay with the Canadian Mental Health Association, which demonstrated his growing frustrations with the modernizing world, one that he believed devalued personal relationships.

> The environment is becoming ever intensely impersonal, depersonalizing, disculturating and dehumanizing. Sheer physical proximity, the attendant lack of even basic privacy and the jungle-like, competitive techno-politico-economic milieu, has increased the amount of enforced and unwanted social intercourse, not only with friends, social and business associates but with strangers and even our antagonists, to a point of saturation which leaves little or no energy and even desire for those more essential dialogue[s] and social relationships with our wives, husbands, parents and children. As our tolerable limits are approached, we tend to retreat psychologically and become indifferent and apathetic.[75]

In this lengthy excerpt, Izumi borrowed terms from his earlier work with Osmond and Sommer, such as "deculturation" and "depersonalization," and applied them to what he recognized as a larger phenomenon of modernization, which included inevitable by-products of increased bureaucratization and urbanization. Moreover, he felt that these urban trends incubated mental disorders, thus fueling their growth and expression. In the face of such strong sociopolitical currents, he argued, desocialization is more likely to occur as familial relationships are strained and more individuals are alienated from traditional support systems. As a result, they may seek, or be encouraged to seek, refuge within the mental health system. The mental health system, therefore, must be prepared to respond appropriately with forms of early detection and the ability to provide

75. K. Izumi to Canadian Mental Health Association, May 16, 1968, 1, SAB, A207, Izumi file.

treatment that repairs socialization. Traditional institutionalization had failed in this respect, and, for what seemed like obvious reasons to Izumi, care in the community was not a viable option as it was the very environment that produced alienation in the first place.

Izumi has never been recognized as a player in the intellectual movements of the 1960s, and yet his description of the kind of supersaturation of humanity borne out of modernity suggests that he shared many of these sentiments. Using the midcentury mental hospital as a site of historical investigation provides a rich resource for examining how contemporary ideas toward institutionalization, progress, and disorder captured the zeitgeist of both a 1950s-style faith in scientific progress and its 1960s-style critique.

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