CONSTRUCTING DESIRE

By

Mazen Bacha

arch 508 project design & research
advisor: prof. Jamal Abed

1996-1997

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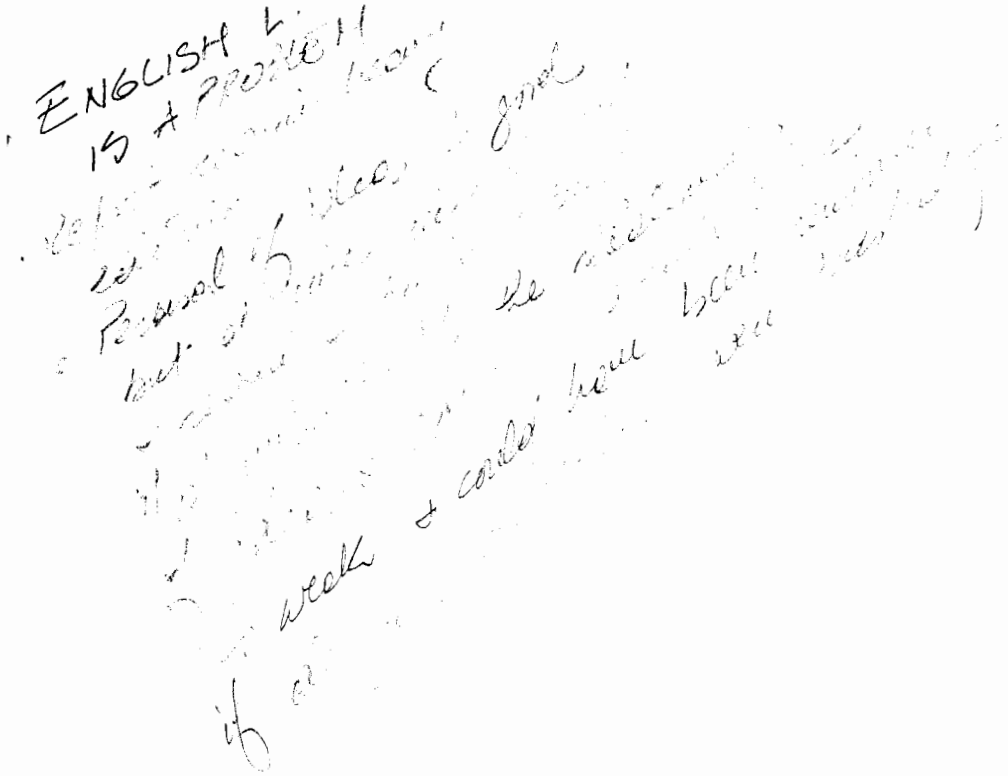

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fig.1

fig.2

8. The Beaux-Arts Ball at the Hotel Astor, New York, 23 January 1931. Scene from the pageant 'The Skyline of New York' with architects modelling their own creations. From left to right: A. Stewart Walker as the Fuller Building (Walker and Gillette, 1929); Leonard Schultze as the Waldorf-Astoria (Schultze and Weaver, 1929–1); Ely Jacques Kahn as the Squibb Building (Buchman and Kahn, 1929–30); William Van Alen as the Chrysler Building (1928–30); Ralph Walker as No. 1 Wall Street (Voorhees, Gmelin and Walker, 1931–2); D. Everett Waid, unrecognizable as the Metropolitan Life North Building (H. W. Corbett and D. E. Waid, 1931–3); Joseph H. Freedlander as the Museum of the City of New York (1931–2). This was the unadopted model for a similar scene in *The Fountainhead*.

fig.3

FORMS FOLLOWS USER *synopsis*

An architecture of Desire

The paper in general tries to investigate the architect / user fissure, be it conscious or unconscious, from all angles. The investigation was brought about by a study of the clinically depressed as a specific type of user – a user that lacks desire. And consequently the haunting question: How can I make architecture of desire for someone who lacks desire?
In an attempt to answer the question, I tried to investigate the alienation of the user in architecture from different angles.

First seeing it **in the eyes of the user** himself and all the elements pertaining to that.
The user forms an important agent in the design process, but at the crux of the matter, the architect has to deal with the client aspirations, visions and dreams- very important issues to the mind of the client. These visions and dreams emerge in the mind's eye of this client as a result of a complex compendium and deposits of past experiences, cultural, and social values. What the architect hears/receives are verbal interpretations of these dreams- representations and hence transformations of what exist in the mind's eye into a form that is constrained by language and the client's capacity to use this medium. Consequently, as pertaining to the user himself, the problem lies not only in his lack of desire, but also in his ability to use language itself. And consequently, the conversation with the architect, though the primary source of communication, can become problematic.

Second, seeing it **in the eyes of the architect** and all the elements pertaining to that.
The architect's role in this game lies in the transformation of images/thoughts formulated in the mind's eye of the user as they are displayed in words by the user into his own words and drawings/model. In that double process of transformation that includes not only a transformation within one medium but also a transformation across media, the essence of the original idea present in the mind's eye of the user himself is jeopardized. Several things interfere in the 'correctness'[1] of the architect's judgments in delivering architecture, some of these things are drawbacks inherent in the medium itself, and others are conscious and/or unconscious desires within the architect himself to exclude the user. First, I will try to investigate those desires, whether conscious or unconscious, of the architect that tries to put the user in the dark and sometimes even ignore his role in this game such desires the product of:

1. The institutional disposition of the architect.
2. The image of 'godness' attached to the architect through such paintings as Pugin's *Examples of Gothis Architecture* (Fig. 1-2), cartoons such as that of Life, stories as Ayan Rand's *The Fountainhead*, fables as Clough William-Ellis's *On the Job* (Fig. 3), and statements by famous architects such as Frank Lloyd Wright that emphasize their total authority and control in decision making, that have moved architecture away from the user.
3. The architect's abuse of language.
    a. In such an attitude of a top down relationship with the user coupled with a feeling of superiority on the behalf of the architect, the conversation / dialogue between the two parties is often marred. This is sometimes achieved by the intensive use of ambiguous words, words that are beyond the comprehension of the user.

[1] I used the word correct while fully aware to its implications and relationship to architecture. No architecture is correct as well as no architecture is wrong. However, I believe that in this context of the word correct displays the sought for meaning.

b. The way through which the architect considers the desires of the users.

4. In other instance, the alienation of the user is the product of a "photogenic" orientation of the design for consumption in the media.
    a. Stephen Harty's project as a case study.

I noticed that the problem so far is two fold, an alienation of the user on the part of the architect, and a disinterest / lack of desire on the part of the user himself. I will try to break up the attempted solution[2] of this dilemma in two parts. **First, I will look at alternatives through which the architect can behave, alternative which in their essence open the way for the incorporation of the user in the early stages of the design process, second, I will try to investigate ways through which the latent desires of the user (desires which the user at his current state is not aware of)[3] can be detected and consequently used as catalyst in the design process.**

The investigation for the latent desires in the user himself is done in several stages; the analysis incorporated a mapping of their behavioral patterns in their home and in the hospitals, which was accompanied by an understanding of the implications of these patterns so that the intervention would either disrupt these patterns in an attempt to push the clinically depressed out of his/her state of mind (in a manner similar to the way doctors do in their treatment of such cases), or build/accentuate on some of them so as to make the user more aware of them in an attempt to reach a self-healing process (also another system of treatment). This methodology of work have been influenced by a specific line of thought that does not view architecture and the user as two entities, but rather as a part of the user in architecture. Architecture becomes a way of being, just as science, art and other culture forms are. So when we come to design, describe or analyze architecture, it will not be simply a description of the production of a certain artifact, but explaining one of the ways in which we view the user and ourselves.

Investigation 1: *At Home*

Investigation 2: *In the Hospital*

Investigation 3: *Critical Study of Mental Hospitals*

Investigation 4: *Attempted Intervention*

Investigation 5: *The Site*

Investigation 6: *Programmatic Reading of the Hospital*

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[2] It is important to clarify, that what I am trying to do here is not find a solution, but rather come up with some sort of a methodology of design that might solve the problematic. And this methodology should not be seen as the one and only way of going about it.

[3] I am aware of the fact that I have already deduced that the clinically depressed people lack any desire, and basically this is the main reason for their depression, but I am also aware that the process of healing in any clinic / hospital relies greatly on not re-inventing these desires or re-discovering them, but rather through opening the eyes of the depressed to those latent desires in them. So basically what I meant earlier by the lack of desire is actually a lack of awareness of the latent desire in the clinically depressed.

FORM FOLLOWS USER

An architectural construction of desire.

*"I spent most of my time **sleeping**;*
*my **bed was my only refuge** because*
*I was always **feeling tired** and exhausted.*
My parents and sisters usually wake me up around 9:00,
*they **force me** (in a way) to get out of the bed and*
they ask me and insist on me taking a shower and get dressed –
following my doctor's order (he was a psychiatric).
They ask me to eat but in those days I lost totally my appetite,
*but **they always insisted**.*
I usually ask them to bring the food to my room
but they refuse
and ask me to go eat with them in the kitchen
but I rarely eat a thing,
and while I am eating I always ask them that I want to go
***back to my room**,*
and finally after eating I go back to my room,
I usually sit on the couch or
most often I go back to bed again.
*Sometimes they **see me walking** in the house,*
in the living room
or in the bedrooms,
so they ask me if I want to go out somewhere
*but **I always refuse**.*
During the day, they always get in to my room
because I told them so or
they get in to tell me to go sit with them in the living room and watch TV,
I usually sit –
***certainly my focus was not on the TV**.*
At lunchtime, I usually don't eat or eat something in my room.
And if somebody visits us they always ask me to go sit with them
*but **as usual I refuse**.*
In the afternoon, they take me to the balcony and
my mother or father would be always holding my hand,
*but **I felt nothing**,*
sitting at the balcony was neutral to me.
Finally at night, I take my medicine and sleep."[1]

This is a quote from an interview I have done with one of the potential users of my architecture, the clinically depressed. The clinically depressed are basically a group of people who have been burdened by life and its circumstances. There are many faces for depression, but in general all share one common aspect, *a lack of desire*.
To some architects, like Stanley Tigerman[2], "architecture is the kind of discipline wherein you are supposed to bring joy for people."
This quote discusses an experience of an architect with a user who was dying and he wanted to build a house, he asked himself: "what to do with a guy like that? What kind of house do you do?" and as a response to those questions Stanley built a

[1] An interview with Michelle N.
[2] emotion and ethic in architecture, Fountainhead, Andy Pressman

"pornographic" house that made the client laugh, and which brought joy for him. Tigerman has really tackled –in his own way-his design with a real concern of the user and the state of the user. He saw that the involvement of the user in the design is in the way the user see/the object, if it made him happy or not, if yes then the user is well understood. This to some extent characterizes my investigation of this semester, an investigation that tries to answer the questions:

How can I make an architecture of desire for someone who lacks desire? How can make an architecture that does not alienate the user?

By the mere condition of my user being, the clinically depressed, those who lack the desire, the communication and/or dialogue with the architect becomes futile, and consequently, the design arrived at would be compromised. Nevertheless, the lack of desire doesn't encompass all the problems that contribute to the alienation of the user. One of the central problems in this communication lies in the transformation of images/thoughts formulated in the mind's eye into words and drawings/model (in the case of the architect). Media used become a source of transformation. Thought and ideas are *re-presented* and hence are subject to double interpretation: The first one when the author interpreted the thought into words or drawings and the second when the reader interpreted this interpretation. Other problems may lie, as I expect that you shall argue in the text to come, in the modalities of design that may alienate the user in the first place: generic design proposals that do not address particular users (I have the hospital in mind), self-centered designers and top-down relation with client, and the institutional disposition of the education of the architect.
And I think it is a major point that every architect should take into consideration while designing, and especially in my case where I have the depressed as a user and I should also bring joy to his life...

(The **clinically depressed**: his desires, or the lack of desires, the way they are transformed into words, and the consequent problematic)

Before going deeper into the problematic, I would like to pause for a moment to explain more about **my user, the clinically depressed,** for it is they that I shall focus my design on. So who are the clinically depressed people, what do they think at, how do they behave...?

Everyone has experienced the "blues" or being "down in the dumps" several times in their life, this is what is generally called depression. There are many well-known myths about depression like: "depression is nothing but the blues", "depression is all in your mind", "depression is a character flow", and "depression is not a serious illness". But these myths are all wrong, because depression is more then just experiencing temporary feelings of sadness from time to time in our lives. When a low mood doesn't go away after a few weeks, without any reason to be depressed, this is called "clinical depression". The duration and depth of despondency, and the presence of characteristics symptoms, help distinguish depression from ordinary unhappiness.
Clinical depression is a serious illness that affects a person's mind and body. It affects all aspects of everyday life; it has an impact on eating, working, relationships, and how a person thinks about him/herself. In other words clinically depressed individuals fail to live their potential, doing poorly in school and staying on the social margin.
Clinical depression is one disease that is very misunderstood. It is called the hidden disease. Due to it is a disease that can go untreated and undiagnosed for many years, if

not for life. It affects so many people that it is often referred to as the "common cold" of mental illness".
It is not fully known what exactly causes clinical depression. There are numerous theories about causes such as biological and genetic factors, environmental influences, and childhood or developmental events. However, it is generally believed that clinical depression is most often caused by the influence of more than just one or two factors. For instance, a person whose mother had recurrent major depression may have inherited a vulnerability to developing clinical depression (genetic influence). This combined with how the person thinks about him or herself (psychological influence) in response to the stress of going through a divorce (environmental influence), may put him or her at a greater risk for developing depression than someone else who does not have such influences.
The causes of clinical depression are likely to be different for different people. Depression has different faces, and it can manifest itself in different ways in the same person. This disease has two classifications, primary depression and secondary
Primary depression: it is when a person had no previous psychiatric disorder or else any episodes of mania or depression.
Secondary depression: refers to patient with a preexisting psychiatric illness other then depression or mania.

As it is well known, depression has different types and they are categorized in the following matter:
1. Exogenous (exo,"without", genes,"body"; external or reactive): depression generated by environment matters, usually interpreted as psychological.
Endogenous ("endo", within): depression that result from internal causes (biological).
Vital (psychological): the depressed person has lost the ability to enjoy consummatory activities: food, sex…
2. Nonvital (used to be called neurotic depression): the result of reactions to set backs, disappointment, and losses. The nonvital depressive is overwhelmed by feelings of being deprived of things he desires that will never be attained; hence his effort won't improve anything.
3. Bipolar: also known as manic-depression or manic-depressive disorder. This condition is characterized by mood that alternates between periods of depression and periods of elation and excitable behavior known as mania. For people who have bipolar disorder, the depressions can be severe and the mania can seriously impair one's normal judgment. When manic, a person is prone towards reckless and inappropriate behavior such as engaging in wild spending sprees or having promiscuous sex. He or she may not be able to realize the harm of his/her behavior and may even lose touch with reality.
4. Cyclothymic disorder: a milder yet more enduring type of bipolar disorder. A person's alternates between a less severe mania (known as hypomania) and a less severe depression.
5. Unipolar: it is like the majority of the cases seen in clinical practice.
Major depressive disorder: the illness impairs a person's ability to work, sleep, eat, and function as he or she normally would. It keeps people from enjoying activities that were once pleasurable, and causes them to think about themselves and the world in negative ways.
6. Dysthymic disorder: a milder yet more enduring type of major depression. People with dysthymia may appear to be clinically mildly depressed to the point that it seems to be a part of their personality. When a person finally seeks treatment for dysthymia,

it is not uncommon that he/she has struggled with this condition for a number of years.
7. Mood disorder due to a general medical condition: depression may be caused or precipitated by the use or unknown physical medical condition such as hypothyroidism.
8. Substance-induced mood disorder: depression may be caused or precipitated by the use or abuse of substances such as drugs, alcohol, medications, or toxins.
9. Seasonal affective disorder (SAD): this condition affects people during specific times or seasons of the year. During the winter months individuals feel depressed and lethargic, but during other months their moods may be normal.
10. Postpartum depression: a rare form of depression occurring in women within approximately one week to six months after giving birth to a child.
11. Premenstrual dysphoric disorder: this is an uncommon type of depression affecting a small percentage of menstruating women. It is a cyclical condition in which women may feel depressed and irritable for one or two weeks before their menstrual period each month.

All these types are treatable, but to benefit from the treatment you have first to recognize the illness. And to recognize the illness you must know the symptoms. Here are the indicators of depression:
1. Depressed mood (blue mood): depression leads to a blue feeling that is present most of the time and won't do away. People with depression will usually feel sad, discouraged, hopeless or down in the dumps. Feeling empty or just plain blah is very common.
2. Feelings of fatigue: a common symptom in depression is decreased in energy. Some may feel tired all of the time, which a simple task may become a very big chore. A person may fell fatigued, even without much physical exertion. Everyday chores may not be completed as quickly or efficiently as normal. For example, fixing breakfast and getting dressed in the morning may seem quite exhausting, and as a result, they may take twice as long as usual to accomplish the task.
3. Appetite change: people who are depressed will usually lose their appetites. They fell as if they have to force food down. A small number of depressed people will have an increase of appetite.
4. A drop in libido: a person will experience a lack of interest in sex.
5. Loss of interest: people who suffer from depression usually lose interest in their normal activities. They may be unable to take pleasure in things they use to enjoy. A person with this illness may not feel better if something good does occur.
6. Anhedonia: it is mainly a lack of pleasure in everything.
7. Change in thoughts: thinking clearly is a problem with people who suffer from depression. They may be unable to concentrate. For example, when a depressed person tries to read a book, his or her mind may wander to thoughts of hopelessness and guilt. Such people may appear distracted and they may have memory lapses.
8. Retardation of speech: the depressed will feel unable to speak and fell as if his tongue is heavy.
9. Agitation: a person with this illness will fell sometimes tension, so he starts to act in an aggressive way.
10. Feelings of worthlessness: many people have a low opinion of themselves, but not all of them are depressed. However, feelings of worthlessness are often magnified in people with depression. Such people may illogically conclude that minor mishaps are signs of personal failure. Sometimes these feelings of guilt are taken to an extreme.

For instance, an individual may feel personally responsible for world hunger. Which self-blame is out of proportion to reality.
11. Anxiety: people with depression will experience an extreme worrying, and the feel of anxiety may also be taken to the extreme. For example, a person with extreme feeling of anxiety will feel as if the KGB is following him and they want him dead.
12. Lowered self-esteem: a person will feel extreme case of helplessness, pessimism and hopelessness.
13. Thoughts of death and suicide: this is considered the worst of all symptoms. Frequent thoughts of death and suicide are common in people with this illness. Suicidal thoughts and behaviors range from wishing to be dead to making specific plans and actual attempts, which is a scary thought, however, it is important to note here that though they experience, they might experience recurrent suicidal thoughts their actual success in any attempt if very minimal if not insignificant and this is due to the fact that the clinically depressed are often very tired and exhausted, so any attempt that involves physical activity, is rarely successful.
Suicide is the most serious consequence of depression. Over half of people with moderate to severe depression think about suicide as a way to end their pain. For most people, this goes no further then fleeting thoughts. Suicide is more closely linked to depression than any other forms of mental illness.
People who are depressed may not experience all of the symptoms listed above. Some will have many symptoms; others will have just a few. The severity of the symptoms may also be different for every person and even vary over time. However, one thing is common for all the clinically depressed; **their symptoms, no matter how many or few they may be, are all manifested in a lack of desire** to live, to eat, to wake up in the morning, to converse, to do basically anything. And it is that lack of desires that strikes me, not that it is not anticipated for, but the mere fact that the clinically depressed lack the 'desire' makes me question the architecture they 'desire' to be in.

And the question remains: ***how can I make an architecture of desire for someone who lacks desire?***

Now that I have explained about my user, the clinically depressed, I should probably clarify that I believe that **the user forms an important agent in the design process,** but at the crux of the matter, the architect has to deal with the client aspirations, visions and dreams- very important issues to the mind of the client. These visions and dreams emerge in the mind's eye of this client as a result of a complex compendium and deposits of past experiences, cultural, and social values. What the architect hears/receives are verbal interpretations of these dreams- representations and hence transformations of what exists in the mind's eye into a form that is constrained by language and the client's capacity to use this medium. And consequently, what the user delivers to the architect is yet another 'weak' re-presentation of that 'Idea', which draws us back to Plato's ideal society in the Republic.
Poets were not members of Plato's ideal society, because indulging in poetry would weaken the populace. Plato believed plays were worthless because they were "a copy of a copy": when we look out at the world around us, we see the "actual world," the material world, not the "real world." The "real world" exists in the ideal world, the realm of God. We can see the real world only in our imagination. Everything in the actual world has a prototype in the real (ideal) world. So the chair you are sitting on now is a copy of "THE Chair" that exists in the real/ideal world. Tragedy is a copy of the actual world, so in essence, it is a "copy of a copy." **It is so removed from the original which exists in the real/ideal world it is worthless**. So imitation (the Greek word for imitation

is MIMESIS) is inferior in Plato's view.
Looking at it in that frame of reference, the moment the user attempts to formulate his desires into words, **his Ideas move from the real ideal world, into the actual world**. It is in that jump that many of the qualities of the Idea are lost. However, the problematic in the dialogue between the architect and the user is even more complicated that makes one question the general validity of conversation itself. Is it efficient? Is it sufficient? And so on so forth...

Although the only social tool for the human interaction, **communication is problematic**. It is undeniable that verbal exchanges of information, questions and answers, are a primary way of getting to know one another. It is the source of mostly any shared knowledge. According to Steinar Kvale[3], conversation can be classified into several categories within which the professional conversations, which include journalistic interviews, legal interrogations, academic oral examination, religious confessions, therapeutic dialogues, and qualitative research, can be a valuable source of information. Although a primary tool, whose importance extend beyond recognition, conversation – through its materialization in words – remains fallible; thus, conversation's sufficiency in giving accurate information about any subject at hand becomes questionable. And according to Steinar Kvale, **many aspects tend to diminish the efficiency of a conversation** in drawing the full picture if not sometimes divert the essence of the idea transmitted among the parties involved be it in a social, professional, or even academic sphere[4].
First of all, conversation sometimes tend to be "individualistic", it focuses on the individuals personal problem without taking into consideration political, social and material background, which are primary elements in understanding a person. Assuming that one of the parties (a) is able to display and transmit all of his visions and dreams to the other; That process will not be complete because these visions and dreams are an accumulation of a whole matrix of conscious and unconscious reactions to the experiential, cultural, economic, and social background of party (A). When these dreams reach the end party, they are displayed as quotable entities. These entities become displaced from their 'information zone'[5] into a different context; hence any consequent reading of them would be problematic if not erroneous.
Secondly, conversation sometimes become "idealistic", it addresses the issues in the absolute, with no reference to actual situations and states of mind and the consequences of those on any given situation. This is specifically true when the conversation drifts into the generalities of things in an attempt to have a global vision. This generalization takes the conversation into an 'idealistic' or 'standardized' atmosphere.
Thirdly, it is "intellectualistic", it tends to analyze the subjects input in a very detached manner that is rarely the best solution in trying to know and understand a person better. In an attempt to understand the subject better, the other parties tend to analyze his/her input. But it is in that process of analysis that the problem arises. This analysis occurs according to standards put by the receiving end. These standards are often personal preferences on the receiving end which are not global means of 'measurements' and secondly being personal, these standards often do not relate to

[3] Author of the book 'Interviews'
[4] Although my main interest in the thesis, as will be noticed later is mainly targeting the profession realm (i.e. the user / architect relationship), I believe it is important to discuss the plausibility of 'conversation' in an absolute context first.
[5] The information zone refers to the matrix of information that tries to explain the data provided.

The Official Student Newspaper of the American University of Beirut

Outlook

...urges youth to stand up for ...cial rights

...ng Antoine Wakim ...h the ins and outs ...ial security in ...es can easily smell

develop enough until the 1960s, due to the efforts of socialists and communists in the post World War II era. The sources of social security then were medical coverage, family allocation, retirement schemes, long-term disability, unemployment insurance, and recycling institutions in the 1980s.

"Today, citizenship in Europe is based on three main rights: political, civic, and social," explained Wakim, referring to the absence of the third social right in underdeveloped countries such as Lebanon, where governments underestimate the intelligence of the younger generation and disregard their perception of social need. Along these lines, Wakim stressed the vitality of social security alongside the lengthening

St. Jude to be inaugurated in Ap

...ll Congressman Ray Lahood addressing St. Jude's medical team upon his arrival at the newly established ...ancer center

fig.4

Frontispiece: The architecture of the modern world, to an extent hardly paralleled in other periods or cultures, can be seen as the symbolic representation of ideological and political change. Ideas created buildings and ideas destroyed them. This engraving shows Baron Haussmann's workmen demolishing Ledoux's Barrière de l'Etoile in about 1860. The barrières – shining exemplars of the Age of Reason – had been erected under the Ancien Régime as control-points for the collection of taxes, and had been stormed and damaged during the Revolution as symbols of oppression. The Arc de Triomphe, behind, had been conceived by Chalgrin in 1811 as a commemoration of Napoleon's victories, but only completed in 1836 in the name of the citizen king, Louis Philippe. By about 1860 it formed part of Louis Napoleon's scheme for the transformation of Paris, Ledoux's rusticated temples being torn down to make way for the present *rond-point* – now officially known as Place Charles de Gaulle.

fig.5

the subjects way of seeing and weighing things.
Fourthly, It is "immobile" and "verbalizing", focusing on the verbal, it does not present an opportunity of observing a subject move through space, and therefore lacks all the potential information that could be deduced in that matter. That potential is clear in Moerman's study of the Lue tribe in Thailand[6]: "perhaps if you wanted to understand this people, it was not particularly useful to elicit an abstract account of their characteristics. So Moreman stopped asking 'who are the Lue?'[...] Instead he started to examine what went on in everyday situations".
Fifthly, it is "cognitivist", too abstract since it focuses more on ideas, thoughts and experiences than on action. According to Kvale, conversations are also "atheoretical" and "arethorical", they tend to disregard related theories and become collections of insignificant quotes and words. This is probably best illustrated in the newspaper. (Fig.4) I believe that the art of selling a newspaper is about those quoted, eye catching, mind teasing, large scaled headers, which when read in the context of the text itself -always printed in small letters, always too small to be read from a distance- these headers tend to become insignificant in light of the other information presented, and most often, the impetuous analysis occurring in ones mind about their reference is corrected.
Moreover, information deduced from a conversation can be very ambiguous; the subject may at instances come up with contradictory statements due to a failure in communications or even to actual inconsistencies in the subject's mind. Conversations can also be subject to changes from the subject: as the conversation goes along; the second party might change his point of view or description in the light of new ideas that come to be mentioned. A weakness in the subject's language, a lack of knowledge of vocabulary can render his input as unclear and insufficient. Conversation also has a weakness on the reader's side: interpretation is subjective and different meanings are deduced according to the person analyzing them. This critique does not mean that conversation is to be disregarded as a reading of a person's thoughts, ideas, needs, or desires. However, looking at it in a narrower perspective, "the problem is not to get out of the conversational circle, but to get into it in the right way."[7]

In short it is that last quote that I am interested in investigating yet in a more confined game context. The game context is the architectural profession. The players are the architect and the users. (Fig.5)

> *"It is highly noticeable that, while the authority of the 'author' and the activities of the 'reader' are discussed outside the architectural profession, they are absent inside the profession, which still maintains that the user is a stable, centralized, and passive subject..."*

The most appealing part in this sentence is the 'passive' adjective attached to the word user. The term 'user' itself could be problematic because of all the voluntary and involuntary associations that could be coupled with this word. However, I believe, put in the light of this scope of reference provided by the text so far, the word 'user' would be a more appropriate term than either the occupant, the occupier, or the inhabitant because it also implies both positive action, impermanence, change, and the potential for misuse.

Passive [pas'iv] adj. unresisting; lethargic; not reacting upon; (gram) denoting the

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[6] Interpreting qualitative data, by David Silverman
[7] Steinar Kvale

voice of a verb whose subject receives the action – adv pass'ively

In that scenario, the word passive indicates a subject and an object, two players in the game. And it is exactly the relationship between those poles that is under scrutiny here. The subject-object relationship and the forms of perception particularly to architecture are the central focus. I seem to agree with the notion that this relation is a one sided body referring to the architect alone. It is often the architects' visions, his interpretation, his perception of what is, and his knowledge of what will become that makes architecture. "In architectural discourse, the experience of the architecture is the experience of the architect, who lays claim to both the production and the reception of architecture."[8] At this point I have to pose to explain that I do believe in the give-and-take aspect of the relationship between the user and the architect. The user forms an important agent in the design process, but at the crux of the matter, the architect has to deal with the client aspirations, visions and dreams- very important issues to the mind of the client. These visions and dreams emerge in the mind's eye of this client as a result of a complex compendium and deposits of past experiences, cultural, and social values. What the architect hears/receives are verbal interpretations of these dreams- representations and hence transformations of what exist in the mind's eye into a form that is constrained by language and the client's capacity to use this medium. Hence, a potential problem.

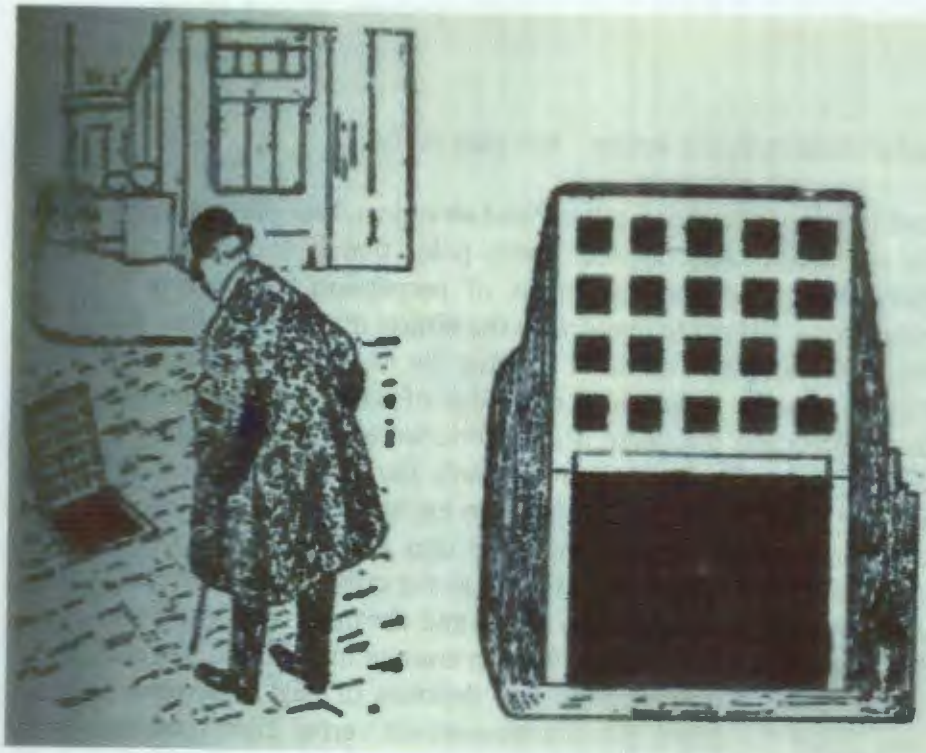
"A Klee painting named 'Angelus Novus' shows an angle looking as though he is about to move away from something he is fixedly contemplating. His eyes are staring, his mouth is open, and his wings are spread. This is how one pictures the angle of history. His face is turned towards the past. When we receive a chain of events, he sees one single catastrophe, which keeps piling wreckage upon wreckage and hurls it in front of his feet. The angel would like to stay, awaken the dead, and make whole what has been smashed. But a storm is blowing from paradise; it has got caught in his wings with such violence that the angel can no longer close them. This storm irresistibly propels him into the future to which his back is turned, while the pie of debris around him grows skyward. This storm is what we call progress."[9]

Progress! With the advent of the twenty first century and all the technological inventions, 'man' is no longer seen as a being, even in some of the books, architectural books, critics are starting to argue about the birth of the cyborg (a human-machine or is it a machine-human?) It is such attitude towards humans, that vision of humans as machines, set forth through media, science, technology, living in the city, and many more, that have helped or probably legitimized the alienation of the user from architecture. Consequently, what follows is an attempt to reach what Gillian Rose calls the 'broken middle'- where architects and users alike "confront themselves and each other as particular and as universal (and which) yields the dynamics always at stake in any comprehension of diremption – the articulation and reconfiguration of activity and passivity, norm and cognition, morality and

I recall here an extract from Manfredo Tafuri's Architecture and Utopia, an extract that discusses the effect of the city on the mechanization of 'man'.

"Poe's text [Benjamin here refers to the man of the crowd, translated by Baudelaire] makes evident the relationship of unrestrained behavior and discipline. His passer by behave as if, become like automatons, they can no longer express themselves except automatically. ... . It jostled; they bow profusely to the jostlers. ... "

[8] Occupying Architecture, Jonathan Hill.
[9] Thesis on the Philosophy of History, Walter Benjamin



69 A 1911 cartoonist's comment on Loos's Goldman and Salatsch façade (1910–11). The original caption read: 'Brooding about art, the most modern man walks through the streets. Suddenly he stops transfixed. He has found that for which he has searched so long.'

fig.6

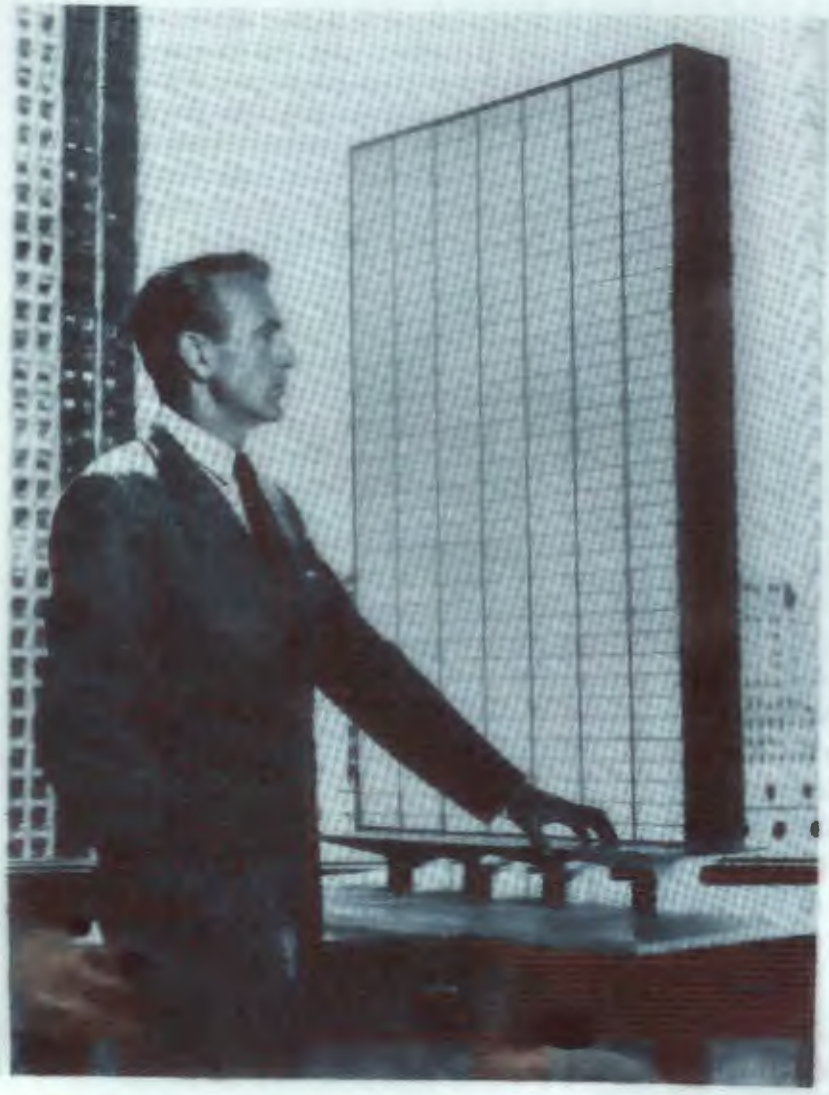


fig.7

heteronomy."[10] In short, it is an attempt **to design for my users, the clinically depressed.**

As I have said before, I believe that the architect/user relationship is problematized. I will try to analyze the situation having the architect as my frame of reference. (Fig.6). The architect's role in this game lies in the transformation of images/thoughts formulated in the mind's eye of the user as they are displayed in words by the user into his own words and drawings/model. In that double process of transformation that includes not only a transformation within one medium but also a transformation across media, the essence of the original idea present in the mind's eye of the user himself is jeopardized. Several things interfere in the 'correctness'[11] of the architect's judgments in delivering architecture, some of these things are drawbacks inherent in the medium itself, and others are conscious and/or unconscious desires within the architect himself to exclude the user. First, I will try to investigate those desires, whether conscious or unconscious, of the architect that tries to put the user in the dark and sometimes even ignore his role in this game.

(The architect: **his view towards the user**, his visions and dreams, and their interpretations)

To start with, some might argue that the fracture between the architect and the user is not the sole responsibility of the architect. It is that of the institutions he was brought up with, their system, and their visions of the world that have alienated the user. Consider for a moment Adolph Loos's argument about the failure of architecture where he says that the failure of architecture lies not in architecture as such but in the rationalization of architecture and its institutionalization and hence his comparison between the designed and the vernacular: "... The architect from the city was uprooted by definition and hence categorically alienated from the innate agrarian (or alpine) vernacular of his distant forebears... "[12] In his comparison between the designed and vernacular, Loos concludes that the designed comes as an imposition due to all the mind formation involved in the process of education.

> *"It is not the conscious of men that determine their being, but on the contrary it is their social being that determines their consciousness... Just as one does not judge an individual but what he thinks, so one cannot judge... an epoch of transformation by its consciousness, but, on the contrary, this consciousness must be explained from the contradictions of material life..."*[13]

Secondly, looking at it from this point of view, people's misleading knowledge of what it is to be an architect today becomes largely influenced by illusions of what it has been to be an architect. It is the architect's image as heroes, as geniuses that have lead to the professions destruction. The word destruction is probably too strong a word to be used, but in this context destruction is used to address a specific failure in the practice, a failure to build for the user. I believe that it is that egoistic, idealized construction of the architect's image that has in a way legitimized the freedom of design. Consider for example Ayn Rand's *The Fountainhead*, which is a celebration of the architect as hero and genius. (Fig. 7)

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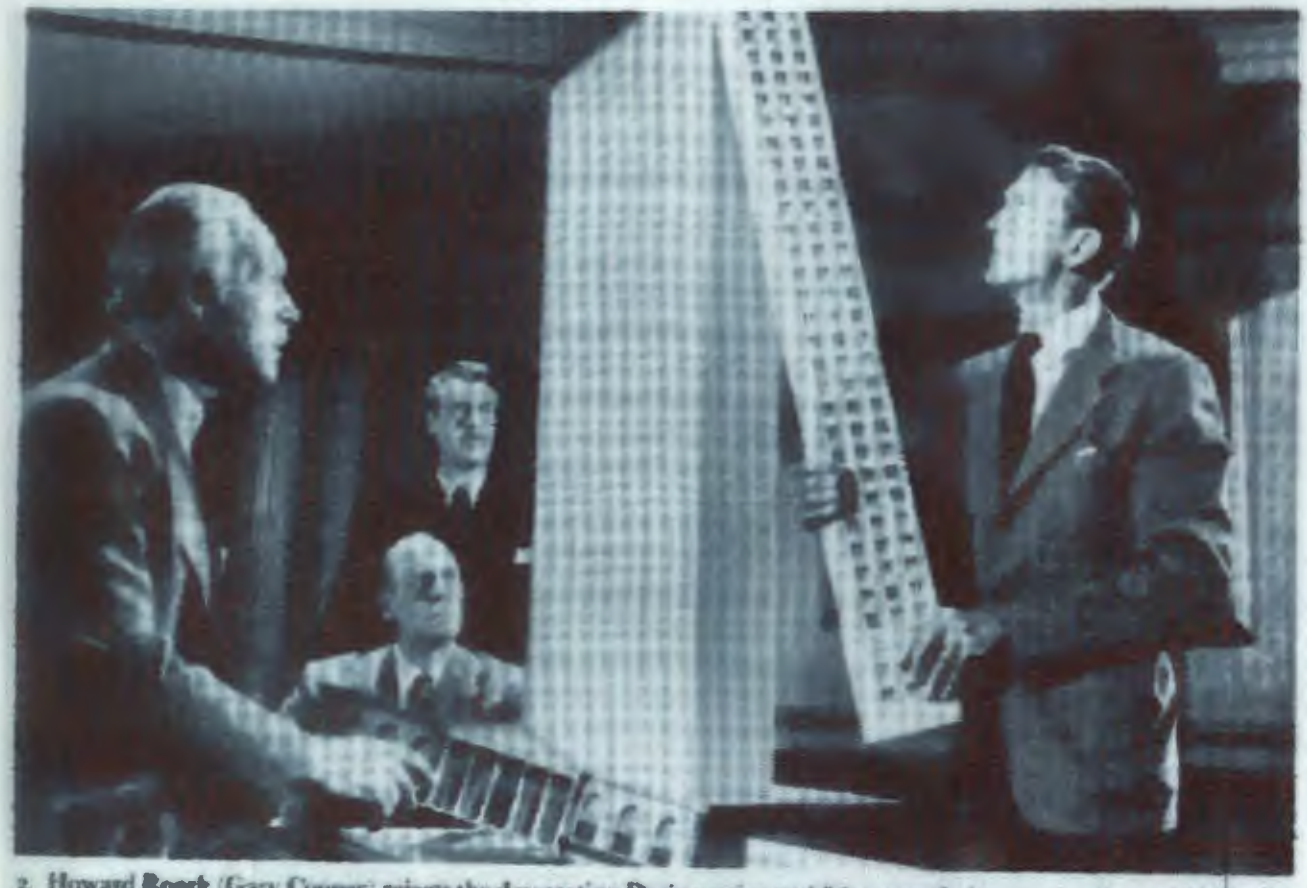
[10] Broken Middle, Gillian Rose

[11] I used the word correct while fully aware to its implications and relationship to architecture. No architecture is correct as well as no architecture is wrong. However, I believe that in this context of the word correct displays the sought for meaning.

[12] Modern Architecture, ch.8.:Adolf Loos and the Crisis of Culture, Kenneth Frampton

[13] Preface to A contribution to the Critique of Political Economy, Karl Marx.



2. Howard **Roark** (Gary Cooper) rejects the desecrating **Doric** portico and false stone facing **proposed as a palliative for his modernism** by an influential board **of directors**. **He** naturally loses the job. From ***The Fountainhead***.

fig.8

9. Cartoon from *Life* caricaturing the non-implementation of the Tarsney Act, 1894. John G. Carlisle, the Treasury Secretary, rises from his seat of judgement, strikes down Art, and instead upholds his misshapen protégé, the Supervising Architect. Idiots or convicts appear to be doing the designing, while above are sundry ham-fisted and costly post offices produced by government architects, most lately that for Buffalo. The caption reads: 'Good Architecture Be ——! Secretary Carlisle has decided that designs for government buildings shall be turned out by machinery as heretofore.'

fig.9

It basically talks about "the single minded life struggle of a young architect of genius against the architectural and social 'system' of the New York elite in the 1920's and 1930's. We see him pit his personality and powers against the strangling conventions of the day – academic classicism, the conservatism of big business, the power of the press – after any number of hard knocks he emerges spotless, his integrity and will unblemished."[14] In one of the instances the hero-architect says in his defense: "No work is ever done collectively... Each creative job is achieved under the guidance of a single individual thought. An architect requires a great many men to vote on his design."[15] It is such statements of self-evaluation driven by egoism that validate the architect's desire to take full control over his design, and in doing so the user becomes the outsider. (Fig.8) The book has been quite popular at that time, and probably even nowadays, and had it not been discussing a notion already predisposed in the mind of people, that book would have not been as successful.

That notion has been quite recurrent through out history put forth in different images from the architect as a gentleman, to the architect as professional, to the architect as a business person[16], yet all share one common denominator, the aura of power always that is attached with the architect in which ever form it was put forth. I believe it is this aura of power and an image of 'godness' that has contributed to the alienation of the user. (Fig.9). It has created a provider and a consumer. In that scenario, the architect is the provider, and the user is the consumer with total power and control in the hands of the architect.

Other images that proposed the same underlying theme are that of architectural individualism. Take for example the fictional epilogue 'On the job', "the theme of the architect as genial high priest of the great mystery and craft of house building is elaborated and updated so as to ensnare the young enquiring minds. The essentials are familiar. There is the confident architect, the old established builder with his capable foreman and the client, Mrs. Hammond. This is how the architect carries on on site:

... The top two panes of this ladder window are shown with ventilation gauze and you chaps have gone and glazed the lot. Silly. Have it put right, will you – and no extra to be charged for it either. Oh! And look here, someone's gone and fixed wooden in this scullery window to take a window board, when a tiled sill is specified. Make sure that they are taken out before the tiles are laid, or it might mean dry rot.

....

When Mrs. Hammonds turns up, the nly point of altercation concerns the window level in the nursery, which she fears may prove too high to allow her young twins to see out properly. Our clever architect avoids lowering the window and spoiling the front by promising a raised dais next to the window with a little playhouse beneath.

...."[17]

Other statements of egoism might be felt in exclamations like: "with an architect – artist in control in every town and country the face of England might be recharged with architectural significance."[18]

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[14] The Image of the Architect, Andrew Saint, Yale University Press (1983)
[15] Ibid.
[16] Andrew Saint influenced this classification.
[17] The Image of the Architect, Andrew Saint.
[18] Ibid.

It is such paintings as Pugin's *Examples of Gothic Architecture* (Fig. 1-2), cartoons such as that of Life, stories as Ayan Rand's *The Fountainhead*, fables as Clough William-Ellis's *On the Job* (Fig. 3), and statements by famous architects such as Frank Lloyd Wright that emphasize their total authority and control in decision making, that have moved architecture away from the user. But that fissure between architecture and the user is not only limited to the previous historic disposition of the image of 'goodness' attached to the architect.

Language in itself might contribute to the alienation of the user – the primary source of communication if abused can sometimes be the primary source of failure. In such an attitude of a top down relationship with the user coupled with a feeling of superiority on the behalf of the architect, the conversation / dialogue between the two parties is often marred. This is sometimes achieved by the intensive use of ambiguous words, words that are beyond the comprehension of the user. In such a system, it is erroneous that the architect should expect his words to be understood precisely as he understands them and that the language of the user should echo his own. Such an expectation is contradictory and dualistic. Consequently, the architect may start to address a fictive user, a user capable of understanding them, in an attempt to fortify themselves and their practice against any attempt to be put on trial. Consequently, the architect becomes as Plato has put it: "He is not man, he is speech". He is the one who speaks *upon* things, instead of speaking *about* them.

I recall here an extract from An Autobiography of Frank Lloyd Wright. The extract is a conversation between Wright and his friend. The conversation is discussing Wright's way of building his designs.
Ex: '... How do you get your houses built? By telling the owner what he's got to do? Or do you hypnotize them?
W: yes I hypnotize him. There is nothing so hypnotic as the truth. I show him the truth about the things he wants to do as I have prepared myself to show it to him. And he will see it. If you know, yourself, what should be done and get a scheme found on sensible facts, the client will see it and take it, I have found.
Ex: But suppose he WOULDN'T take it?
W: but by God Ray, He WOULD take it.

On the other hand, assuming that the architect and user have reached some sort of a common ground of language and that the architect was able to arrive at some understanding of the desires of the user. That process will not be complete because when these dreams reach an architect, they are displayed as quotable entities.

"*...I want a house that stands out from the other houses in the neighborhood.*"[19]

This statement, as it is displaced, may represent to a certain extent the system through which architects weigh the needs, wants, and desires of users, and act accordingly. It is such statements that I am interested in analyzing. In such a state of isolation, that statement might refer to a state of otherness. The user wants his / her house to be easily identified as different from its context, having qualities that are not only different in the sense an apple is different from an orange, but different in the sense of this apple is different from other apples. As much as what I have said now holds of ambiguity so does the statement written earlier. To stand out is not an architectural word and consequently, its implication as one provides so many diversities that one cannot really grasp. Some architects may take it literally and consequently follow

[19] This statement should not be viewed as a standard for the evaluation of any user / architect conversation, rather only as a sample of what that conversation might be.

fig. 11

fig. 10

Figure 8.3 Stephen Harty, Individual Acts of Terrorism Are Entirely Pointless But They Feel Fantastic at the Time, 1992. Photograph, Hugo Glendenning. One leg of the chair ends in a light bulb. Sitting down destroys the light and the chair topples over.

different strategies to make the building different from its surroundings (at times through height, color, use of material, form, etc...) And the strategy of differentiation followed by the architect should not be based on a subjective selection according to the preferences of the architect himself, rather according to the user's likes and dislikes. And it is here where that matrix of supplementary information of the user plays a crucial role in the design process. This is but a very straight forward simple example illustrating the need of that matrix of supplementary knowledge, although it is important to clarify that the need of that matrix is in no way limited to such a situation rather it transcends it to a more complex and sometimes even more conceptual decision making. This analysis is founded in Kant's theory about the human knowledge, and the *tabula raza* of a newly born. (Fig.10) Thinking of it this way, the visions and dreams of a user at a specific instance of time is nothing but an accumulation of a whole matrix of conscious and unconscious reactions to the experiential, cultural, economic, and social background of the user. And since two different things can induce the same reaction in a person, or reactions, which seem to be very similar, a true understanding of the background becomes important. So that when the architect transforms the visions of the user into architecture, he will be armed with all the necessary information for a just decision, and if any draw back occurs in the end product (architecture) it will not be the result of a lack of knowledge on the behalf of the architect but mostly a lack of control over the medium of transformation.

In other instance, the alienation of the user is the product of a "photogenic" orientation of the design for consumption in the media. Stephen Harty's[20] project is a chair having one leg as a light bulb. Sitting down destroys the light bulb and the chair topples down. (Fig. 11)
I believe that the purpose of this project is to declare the importance of the user in the completion of that 'grand idea' inherent in any project. In the end it is the user that will realize the idea behind the chair through that specific action of sitting. It is exactly at that moment of collision between the object and the user that the project will be complete and the concept fulfilled. Having said that, I will go back to the 'picture' of that chair. This picture is the only representation of the project. However, this picture as it is, sends different signals than the ones assumed by the architect. The picture shows the model of the chair before the intervention of the user. The picture talks about an instance in the life of the chair prior to the action of the user. It refers to that instance as the moment of completion of the project. According to the photographer, the picture was intended to commemorate the idea. The phrase *"Which idea?"* is probably the question running in the readers mind at this moment. And it is exactly this state of confusion that I intended the reader to be in. If the actual intention of the architect is to commemorate the importance of the user as an important element in the completion of the design, how come this still picture (taken in a time prior to that of the action of the user) is used to commemorate the project – the chair?
Having said that, I am great reminded by a conversation I overheard in the lobby of the architecture department once. One is an architectural student, the other a visitor. They were looking at the photos from a recent trip the architectural student took. In the course of the conversation, the visitor questioned the absence of people from all the photos. And the immediate reaction of the student was: "I guess I cannot help being an architect." This is not an isolated instance in the game of architecture; any

[20] Occupying architecture, by Jonathan Hill

quick look at one of the architectural magazines and books might confirm that idea[21].

In the former two sections I can up with basic questions, which I think will govern my line of thought in the text to come.

What is it about an architect that legitimizes his neglect / avoidance of the user?
How can I make an architecture of desire for someone who lacks desire?

The problem here becomes two fold, an alienation of the user on the part of the architect, and a disinterest / lack of desire on the part of the user himself. I will try to break up the attempted solution[22] of this dilemma in two parts. **First, I will look at alternatives through which the architect can behave, alternative which in their essence open the way for the incorporation of the user in the early stages of the design process, second, I will try to investigate ways through which the latent desires of the user (desires which the user at his current state is not aware of)[23] can be detected and consequently used as catalyst in the design process.**
Architecture in essence is very similar to Stephen Hartly's chair. Two agents produce architecture: the architect through his design, and the user through his actions[24]. The user exists through his activity. And it is through that activity that architecture ~~is~~ becomes complete. I guess what I am trying to argue here is the importance of the user in any design process and the consequent treatment of him/her/them not as a consumer agent of the end product but as a catalyst whose analysis and study will inform a great deal the end product. Consequently, my thesis will try to investigate that incorporation of the user at an early stage in the design process, the way to do it, and the consequent methodology of work; in a way to reach the idea [*form follows user*].[25] In other words, if the user is taken into consideration and his habits are mapped into the design process, then the actions induced by him will not be seen as tools of aggression on the architecture.
Roland Bathes, in his text "the death of the author" has already discussed this understanding of architecture.

> *"In his story Sarrasine Balzac, describing a castrato disguised a woman, writes the following sentence: 'this was woman herself, with her sudden fears, her irrational whims, her instinctive worries, her impetuous boldness, her fussing, and her delicious sensibility.' Who is speaking thus? Is it the hero of the story bent on remaining ignorant of the castrato hidden beneath the woman? Is it Balzac the individual furnished by his personal philosophy of Woman? Is it Balzac the author professing literary*

[21] The idea being the absence of the user.
[22] It is important to clarify, that what I am trying to do here is not find A solution, but rather come up with some sort of a methodology of design that might solve the problematic. And this methodology should not be seen as the one and only way of going about it.
[23] I am aware of the fact that I have already deduced that the clinically depressed people lack any desire, and basically this is the main reason for their depression, but I am also aware that the process of healing in any clinic / hospital relies greatly on not re-inventing these desires or re-discovering them, but rather through opening the eyes of the depressed to those latent desires in them. So basically what I meant earlier by the lack of desire is actually a lack of awareness of the latent desire in the clinically depressed.
[24] One may argue that historians, critics, and photographers/magazine, and Time are also agents that play important roles in the varied production of architecture, and I am not here to refute that, but for this exercise, I am only interested in only two agents, the architect, and the user.
[25] At this point I should probably clarify that the role of the user as a designer should be viewed as the users' inevitable interventions in the physical space and its use that bring in into the architecture matters of the everyday life.

ideas on femininity? Is it the universal wisdom? Romantic psychology? We shall never know for the good reason that writing is the destruction of every voice, of every point of origin."[26]

In his text, he argues that sometimes the text challenges the intentions of the author through the reader; whereby each reader constructs his/her own text through the act of reading. Barthes furthermore envisions a gap between the act of writing a text and the act of reading it. He came upon that conclusion through the reasoning that a text is not a single dimensional space which is and can only be read in light of what the author intended it to be, but that a text is a "multidimensional space in which a variety of writings, none of them original, blend and clash." [27] Consequently, it is the reader who gives meaning to a text. Oscar Wild has also discussed this dichotomy between the 'maker' and 'user' in his poem "The Picture of Dorian Gray" where he writes:

"All Art is at once surface and symbol
Those who go beneath the surface do so at their peril
Those who read the symbol do so at their peril
It is the spectator and not life that art really mirrors.

....

All art is quite useless.
...."[28]

In that poem, Oscar Wild concludes with the failure of art. He saw the problem, and discussed it, but failed to propose a solution. Jeffrey Kipnis in his article Forms of Irrationality also discussed the failure of architecture nowadays as insufficient. He says that this insufficiency came about from the wrongful vision that architecture "has and always will represent an idealization of its occupants"[29] while ignoring the fact that modern occupants are very different from the "anthropocentric, egocentric, phallocentric idealization of 'man' that developed from the sixteenth century through the mid-nineteenth century and that continues to be represented in architecture today."[30] Consequently, contemporary design continues to present to us an idealized view of ourselves, which proves to be inadequate. Both Oscar Wild and Jeffrey Kipnis illustrated the failure of architecture / art nowadays but it was Roland Barthes who proposed that the writer should be aware of, and indeed use, the limitations of the medium, which occurs by giving a text an author. To give a text an author is "to furnish it with a final signified, to close the writing."[31] It is by assigning an author that the text fails, and it is by assigning an author that the reader is alienated. Barthes therefore argues for the death of the traditional author and the rebirth of a new type of writer – a writer aware of the importance of the reader.

"The birth of the reader must be at the cost of the death of the author."[32]

In his view of the new writer, Barthes has in a way suggested a new architect, an architect, similar to the writer, who is aware and keen about the creative and active role of the user in architecture. Putting it in his own words, "the user [*reader*] is the space on which all the quotations that make up an architecture [*a writing*] are

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[26] Image, Music, Text , essay: The Death of the Author, Roland Barthes, The Noonday Press - NY
[27] Ibid.
[28] Oscar Wild
[29] Forms of Irrationality, Jeffrey Kipnis.
[30] Ibid.
[31] Image, Music, Text , essay: The Death of the Author, Roland Barthes
[32] Ibid.

'The characteristic arch' from *Forbidden Planet.*

fig. 12

inscribed without any of them being lost, a building's [*text's*] unity lies not in its origin but in its destination."
The text/author/reader as a matrix, a system of relationships, not as individual elements within that system, is similar and consequently comparable to the architect/building/user system. Although this is somewhat contradictory to my previous argument, I believe that what Roland Barthes suggested of the birth of a new architect [writer] is only half valid. This is so because many other elements in the design itself contribute to the alienation of the user, and the traditional -self-centered- architect is nothing but one of them, one of the others being generic design proposals that do not address particular users – I have the hospital in mind.

Roger Lewis discusses in his article "the client of many minds"[33] the problem that faces the architect while working on a project -like hospitals, schools, museums- that has a committee as client, hence the architect should take into consideration different inputs and demands which may at some point be conflicting. The problems lies in the fact that in such a circumstance, each member of the committee start to project his/her own personal preferences, likes and dislikes with little attention invested in the overall scheme, which will eventually lead to the failure of the design. This becomes an abuse of power to satisfy personal 'appetites'. I recall here the movie Forbidden Planet. Although the movie displays a highly dramatic illustration of the point, but looked at it in a more objective point of view, the argument in the movie holds true. The Krell's individual ids given the uncontrolled virtual powers to express their 'appetites' have caused the destruction of their intellectually superior civilization.

The movie The Forbidden Planet.
In the movie a scientific crew from earth ventures to another planet where they discover the still functioning physical structures of an unimaginably advanced civilization that, mysteriously, have completely disappeared. The first crew fails to maintain contact with earth and so twenty years later; a second expedition is dispatched to discover the fate of first. Upon arrival, they find that only two members of the original crew survive. The leaders of the second expedition are naturally curious about the civilization and learn from the survivors that the people were called the Krell, and they were the most intelligent and highly developed civilization ever to have existed. [...] When asked about what the Krell looked like, the scientist responded that they never depicted themselves in their art nor did they write descriptions of themselves in their literature. 'Nevertheless' he said, 'perhaps some clue can be derived from this characteristic arch.' [...] As the movie proceeds we discover that the crowning achievement of the Krell was also the vehicle of their total destruction. The Krell possessed virtually infinite intellectual power, but they felt trapped by their bodies, which limited and inhibited their considerable possibilities of expression. So, they built the largest computer ever conceived, ... Abandoning their bodies, the Krell deposited their minds into this marvelous machine that could manifest any and every intention of each individual. [...] The Krell forgot that when you deposit your mind into a machine, you deposit not only your emotional and intellectual ego, but also your personal id. [...] The Krell's individual ids, given unlimited power to express their aggressions, turned against one another, ultimately destroying the entire civilization in a single night. (Fig. 12)

Further more; in such institutions not all the members of the committee are present. To my opinion the most important members that are the key elements of the committee are always absent –the users. Let's take the hospital for example, the main client that always do the

[33] The fountainhead

conversation with the architect are the doctors or the administrators[34], whereas the main user is the patient who has never been taken into consideration in the design process nor his desires are designed for. And further more, what if I am designing a hospital for depressed people where the patient may stay for a long period of time as if I am designing a house for each and every patient of that hospital? How can I neglect them?

I am the architect (or for that matter the architect to be), my building is the hospital for the depressed, and my users are the clinically depressed. Taking into consideration, and working along the same line of thought of **Roland Barthes**, I am faced with yet another problematic: **the USER, that specific case of a user – the user with *no desire*** (the clinically depressed).

In his article 'Treating Clients as Patients'[35] Eck said:

> *"... there is less of a power struggle if the architect thinks of him or herself as a clinician. [...] It has become increasingly clear to me over the last few years of practice that architectural clients are in many ways similar to medical patients. Or perhaps put a better way, that architects might regard their clients more as patients who come to them with a health threatening problem that requires a solution [...] I'm convinced that if we instead think of a client as a patient with a specific problem, that we are more likely to produce a good building and that the desired concomitant result – a beautiful building- will also quite naturally follow"*

I think that's the way I should treat my user – the clinically depressed person. But the question still: how can I understand him? And what should be the treatment schedule-the design process? (To refer to therapy treatment = design treatment).

Jeffrey Kipnis in his article 'Forms of Irrational' tried theorize the reasons behind this problematic. In his analysis of the movie the Forbidden Planet, Kipnis come up with the conclusion that it is too difficult to fulfill the desires of a person, because architecture is limited to the physical needs, which are not necessarily compatible with his unattained desires. This dichotomy and incompatibility is brought forth by the false argument that all human architecture represents an idealized human body; therefore all architecture represents an idealization of its occupants, which might not have any reference to the actual needs, and desires of the user. Kipnis furthermore argues that this persistent need for the idealized image of the occupants is due to the continuing view of the design process as a method of achieving solutions.

In light of Kipnis arguments, I tried to formulate the work of this semester in a series of investigations that try to break down / dismantle all the factors involved in the creation of the image of my user in an attempt to understand more my user. Consequently, I have worked on several investigations that try to look beneath the surface at what the clinically depressed really want. In the line of work, I tried to analyze a day in the life of the clinically depressed. The analysis incorporated a mapping of their behavioral patterns in their home and in the hospitals, which was accompanied by an understanding of the implications of these patterns so that the

[34] This deduction have been reached according to an interview I gave done with an architectural office that was working on the design of a psychiatric hospital; where the head architect has said that the meetings only involve doctors and the owners of the hospital, never patients.
[35] The fountainhead

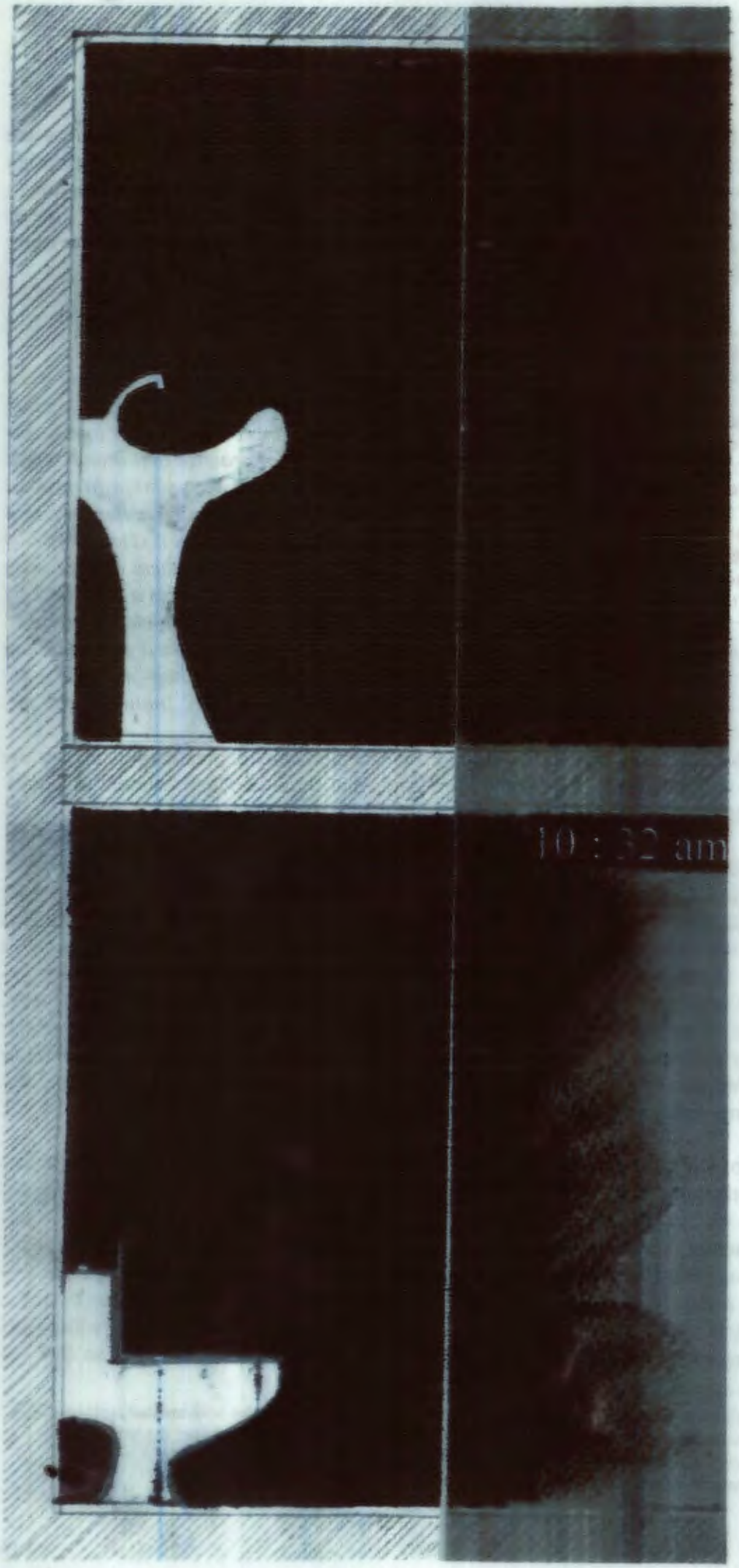

fig.16

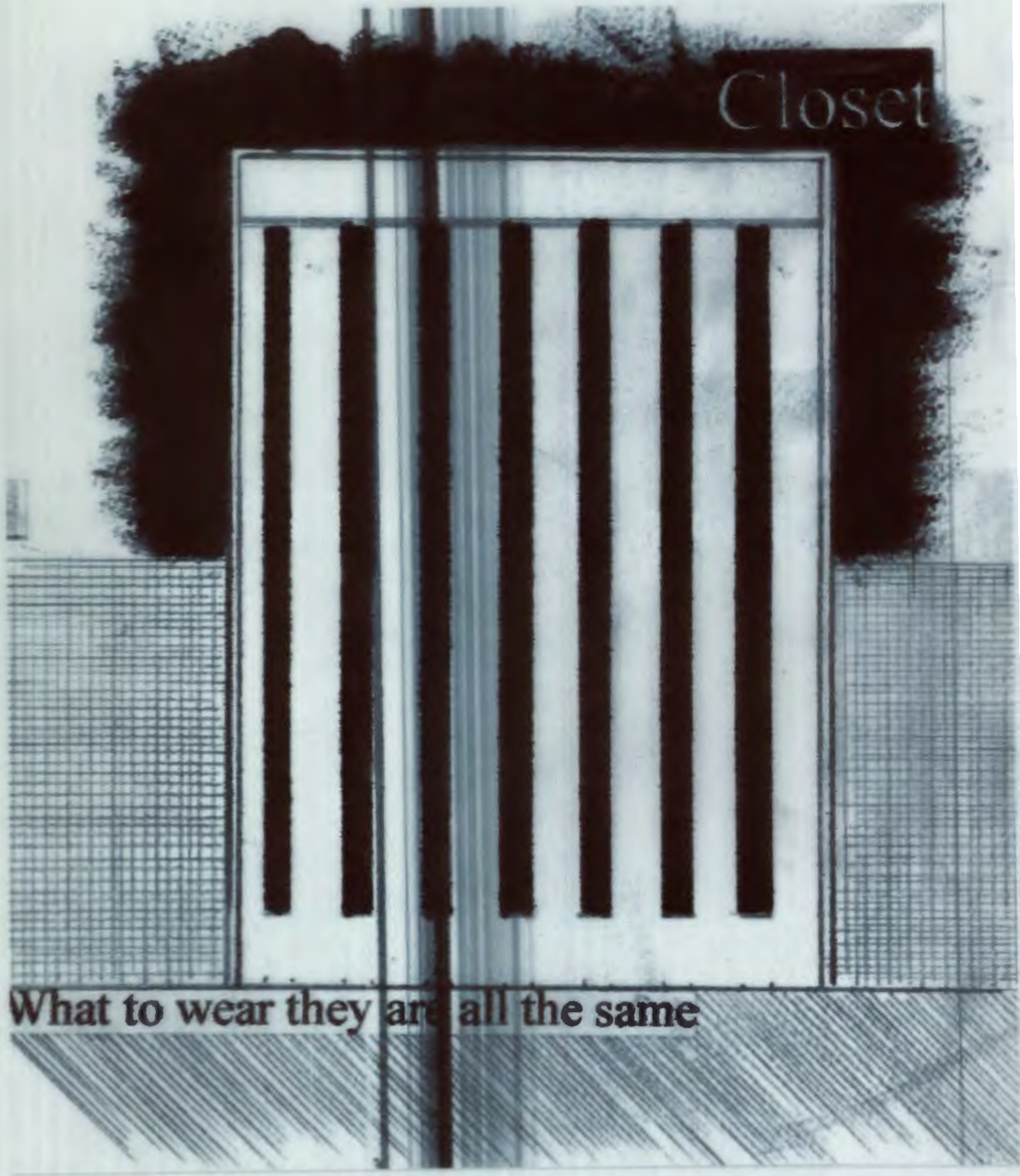

fig.15

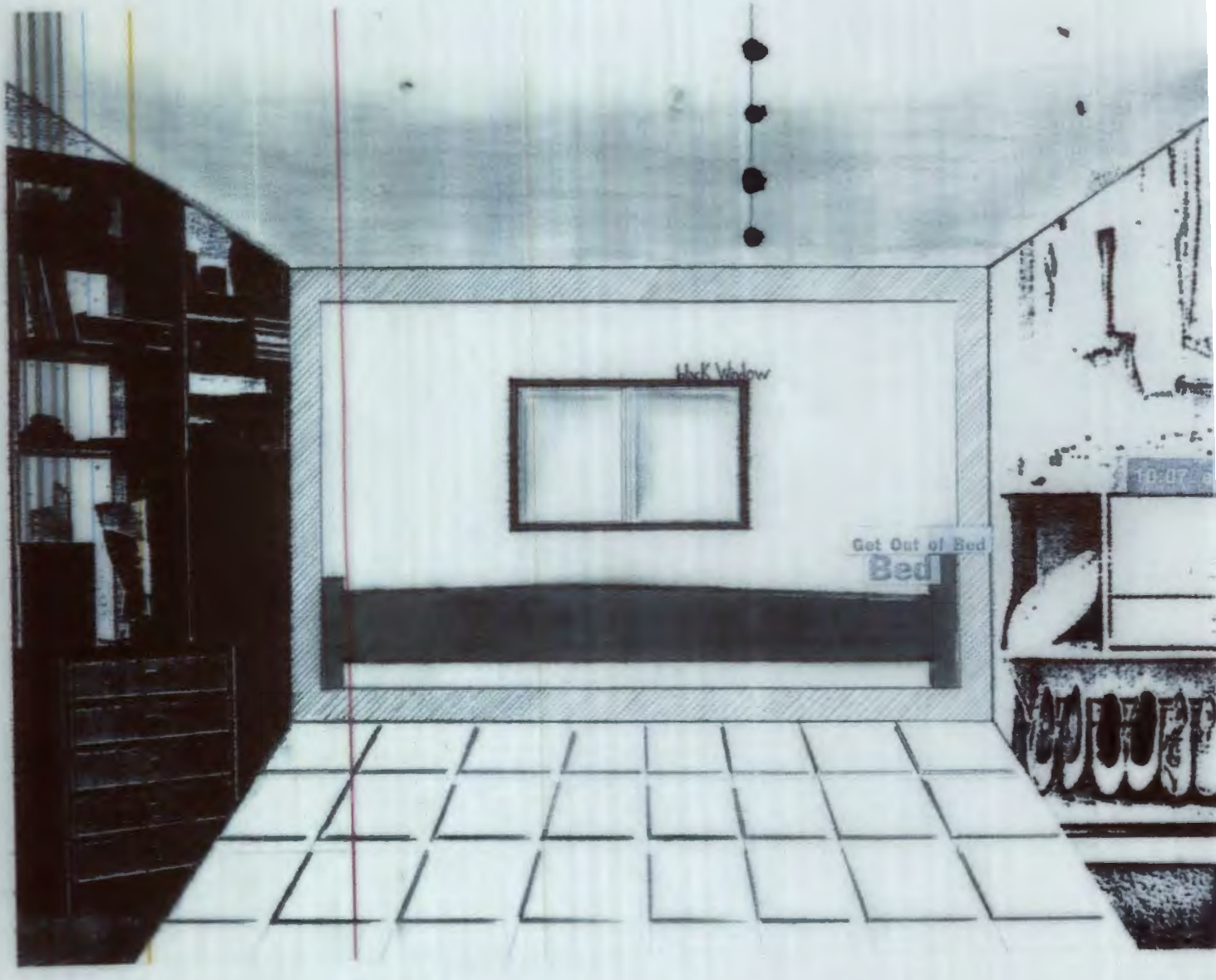

fig.14

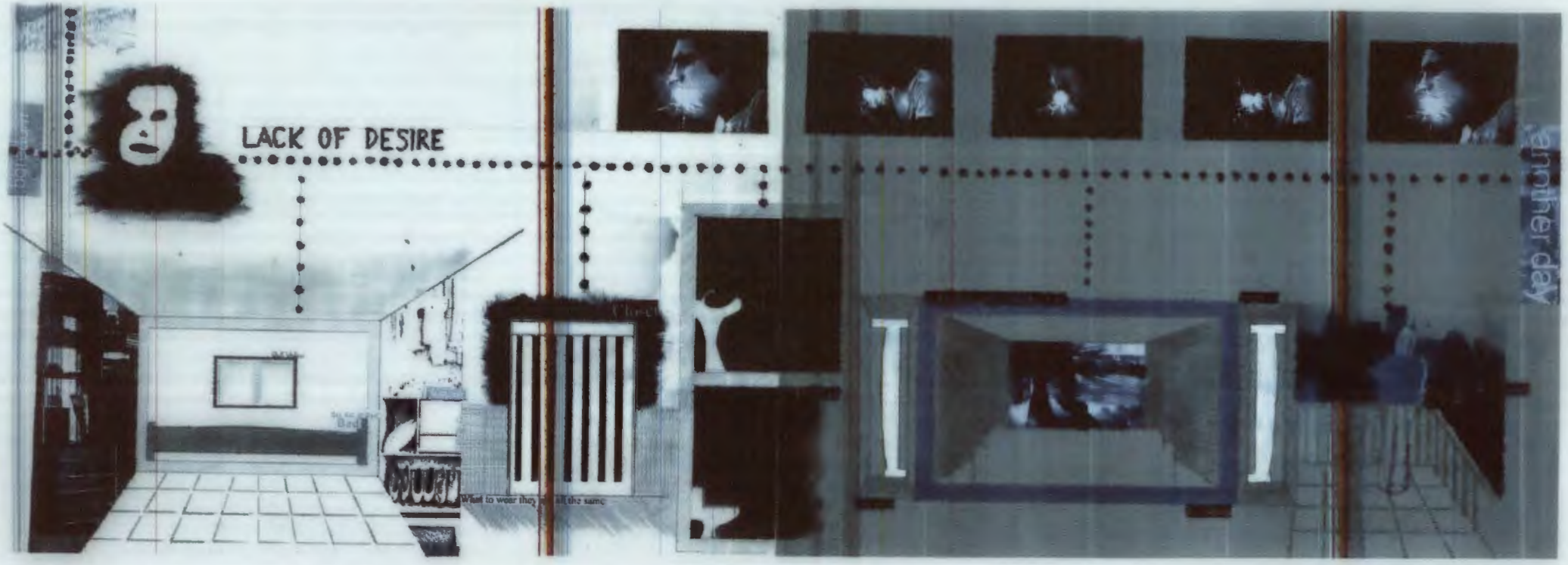

fig.13

intervention would either disrupt these patterns in an attempt to push the clinically depressed out of his/her state of mind (in a manner similar to the way doctors do in their treatment of such cases), or build/accentuate on some of them so as to make the user more aware of them in an attempt to reach a self-healing process (also another system of treatment). This methodology of work have been influenced by a specific line of thought that does not view architecture and the user as two entities, but rather as a part of the user in architecture. Architecture becomes a way of being, just as science, art and other culture forms are. So when we come to design, describe or analyze architecture, it will not be simply a description of the production of a certain artifact, but explaining one of the ways in which we view the user and ourselves.

Investigation 1: At Home (fig.13)

Before attempting to analyze their behavior at home, a survey/questionnaire[36] has been conducted. This gave me a wider perspective to the situation – some sort of a hands-on-experience that would further introduce the design.

At home, *the room* of the depressed becomes his refuge from the rest of the world, a place to hide, the only place were he views his being. The room transforms from being an entity in the house to engulf the house itself. He/she eats in his room, he/she sleeps in his room, he/she hides in the room, or simply just is in the room. The room starts to symbolize his/her own existence in the world and this detachment of the room from the rest of the house is nothing but a reflection of his/her inner feeling of detachment from the world – a solitary existence. It creates some state of isolation – a hideout.

In the room, *the bed* becomes an icon. It symbolizes sleep, which in turn symbolizes unconsciousness. The bed becomes a mean of escapism – an escapism from reality, from the now and here. This notion of the bed is reflected in this insisting urge *to go back to the bed, to go back to sleep.* For the depressed, the space of the bed becomes the main focus; it consumes the rest of the room. Everything else becomes peripheral (fig.14). It exists, it is there, but it is out of focus.

In the room, *the closet* becomes part of the wall. It means nothing to the depressed. He/she doesn't care about what clothes to wear today, what colors to wear. She does not think whether or not that scarf looks good on her, nor does he mind if the pants are too short or too long. Through out history, people were categorized by their clothes. And consequently, the closet became one of the important elements in people's life. But to a depressed person, the standards are no more the same. All the clothes are the same (fig.15); they retain their original meaning as means of shelter; tools.

In the room, *the toilet* becomes yet another tool. The depressed sees it in its basic necessity as a tool of disposing wastes. The space of the bathroom seized to exist as a space and starts to be only a tool (fig.16).

"... They get in to tell me to go sit with them in the living room and watch TV, I **usually sit - certainly my focus was not on the TV...**"

The TV room, is supposedly a place of interaction, a family get together, or simply a means of entertainment. A depressed person sits in the TV room watching, but his mind is not focused on the TV. The images start to get blurry, and even more blurry, and in a few seconds his mind would

[36] refer to appendix1,part2

fig.23

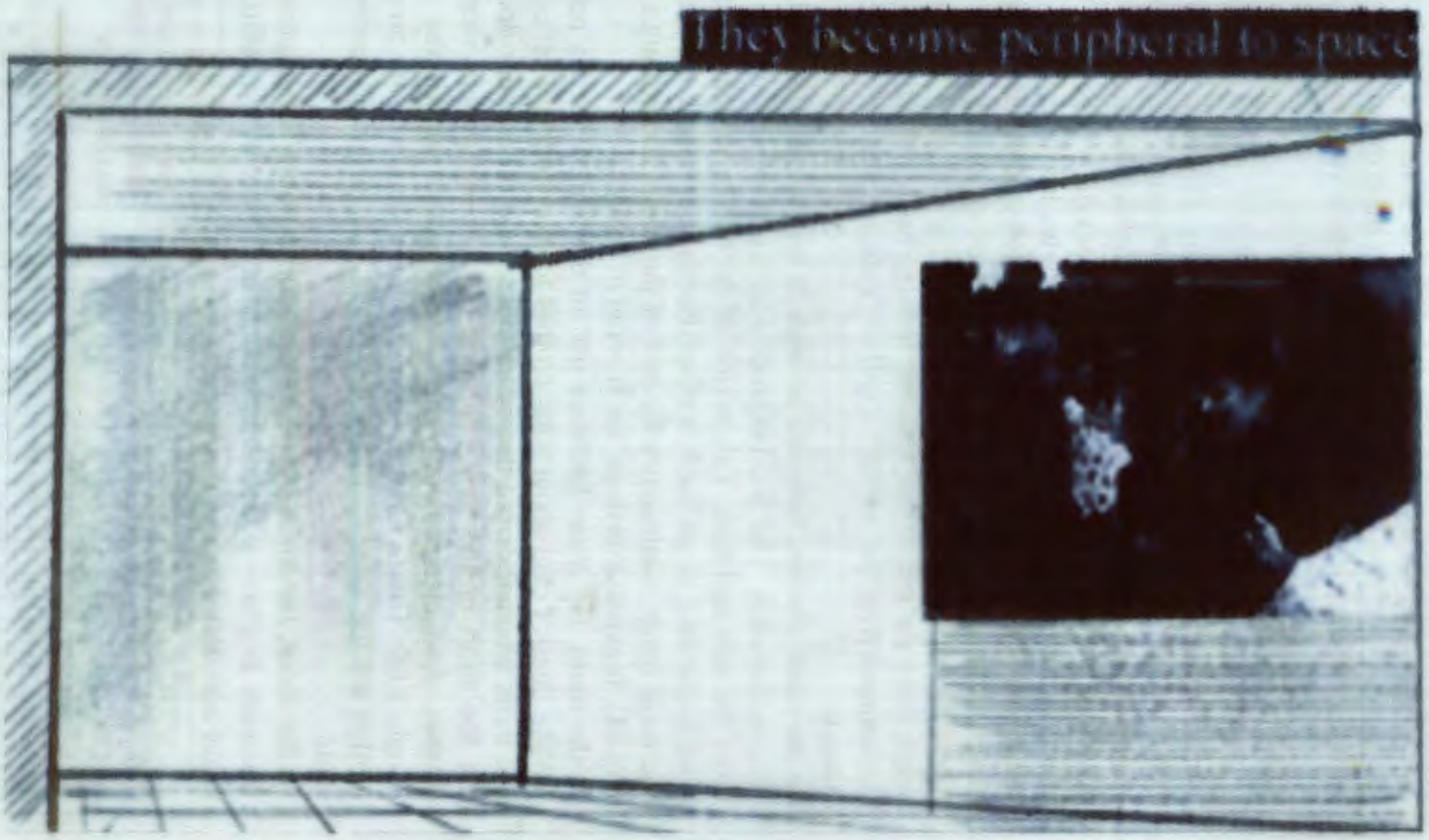

fig.24

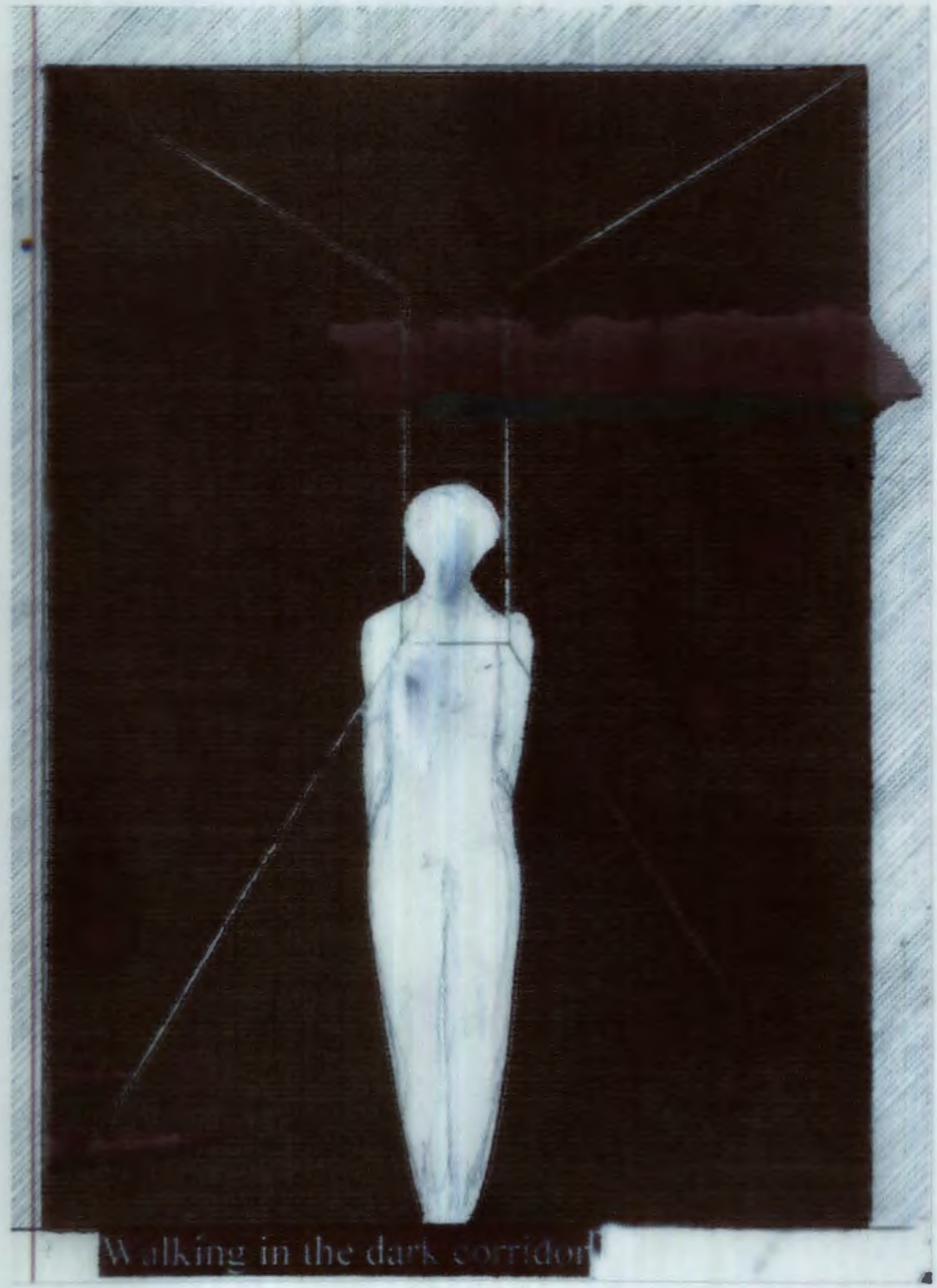

fig.22

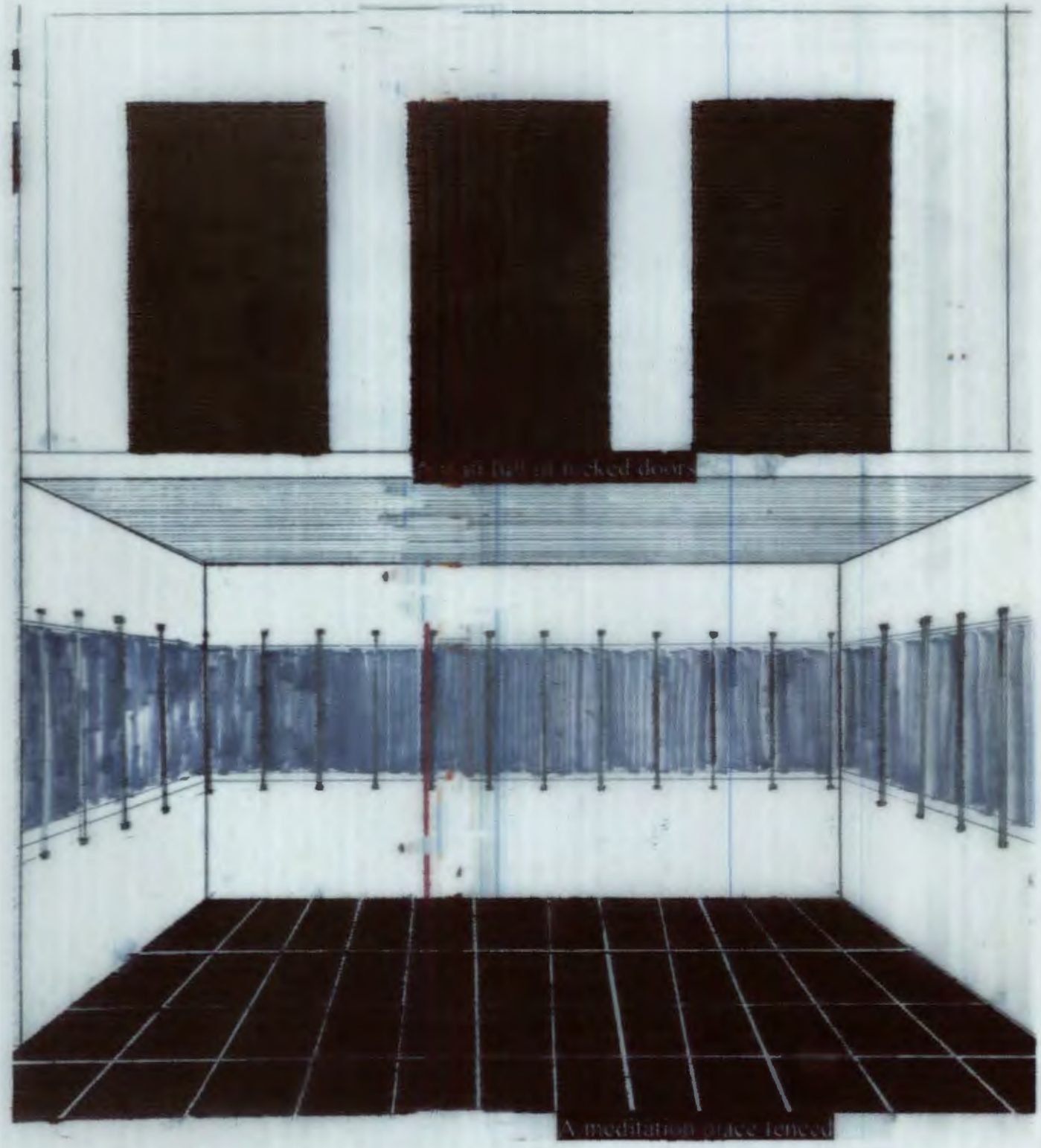

fig.21

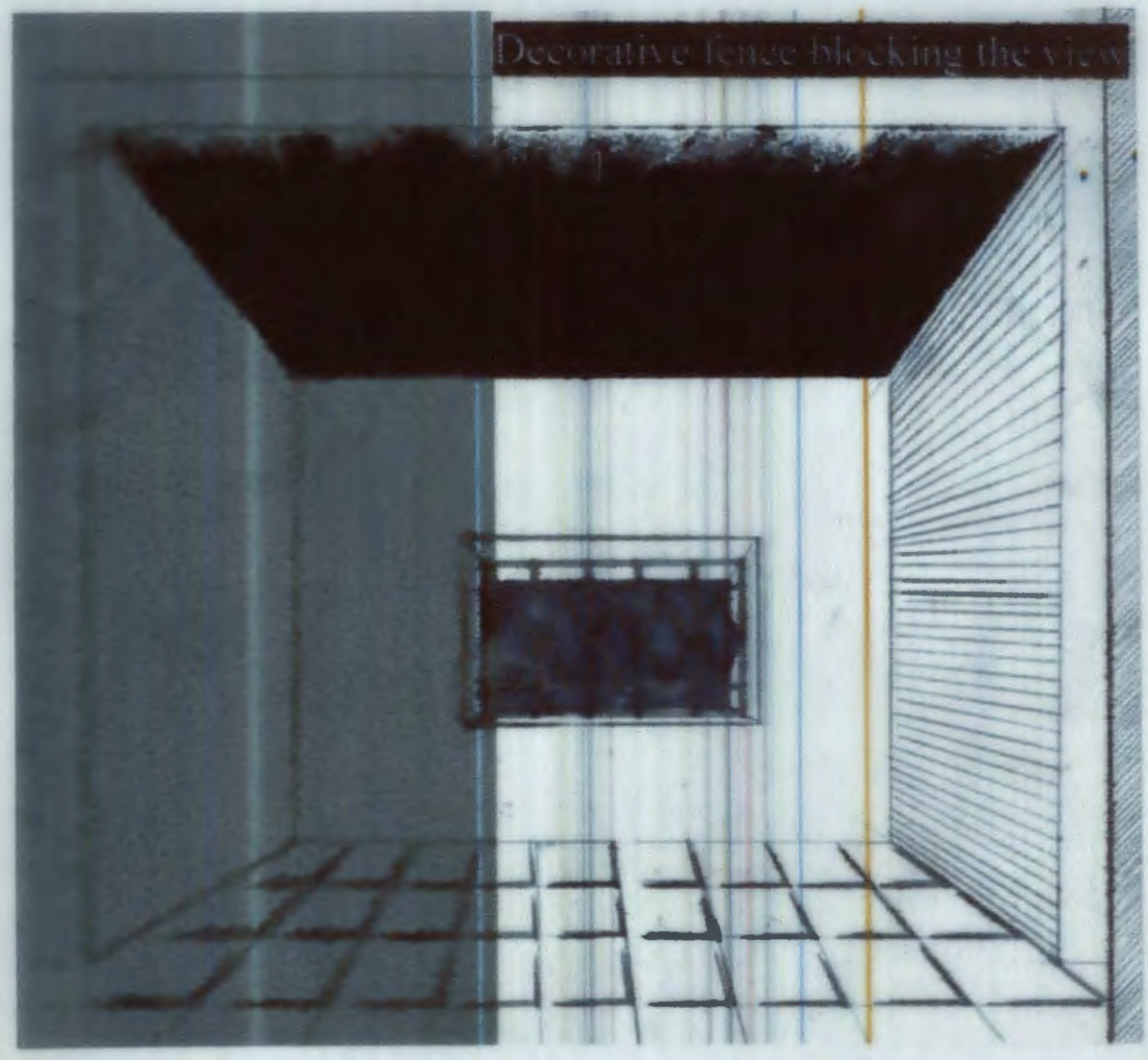

fig.20

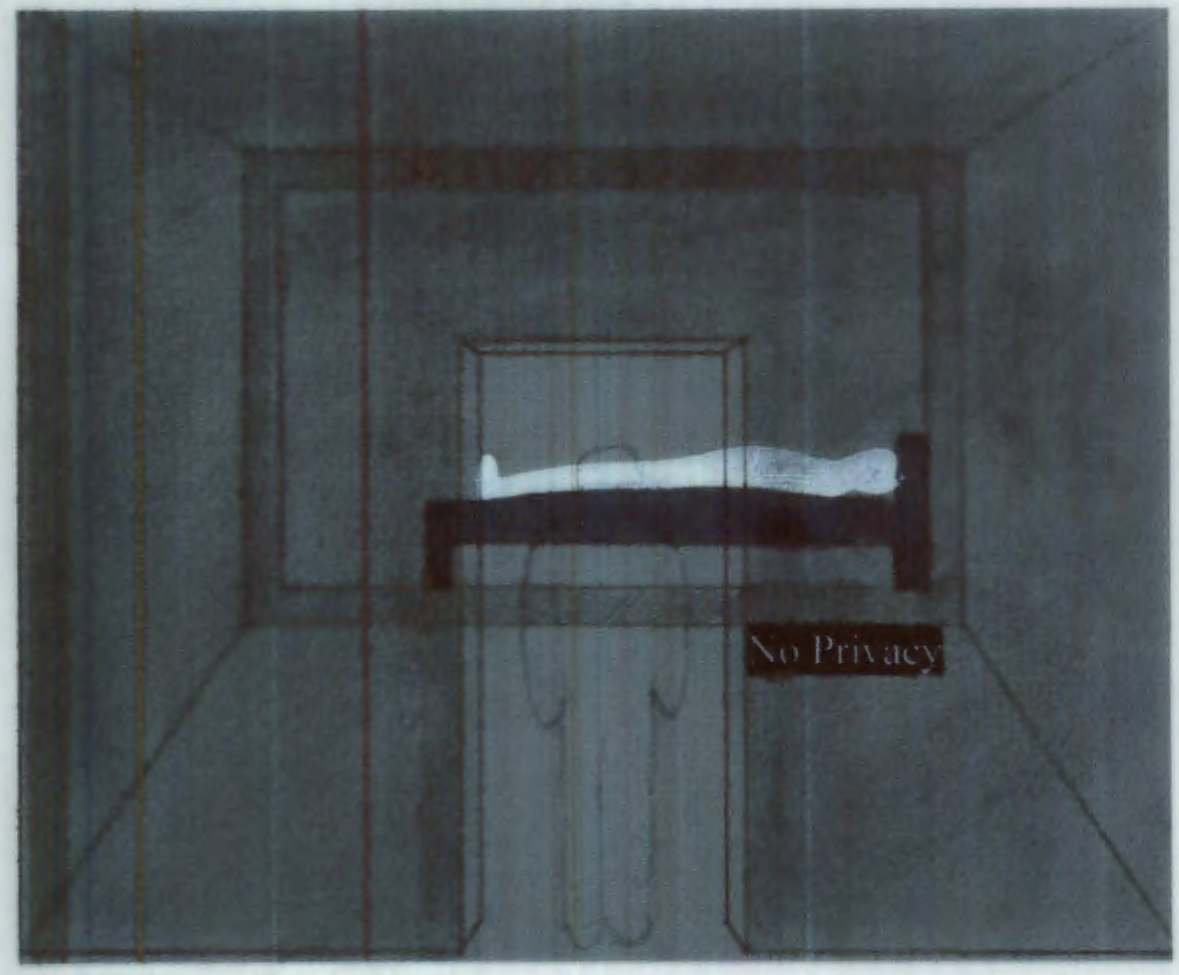

fig.19.a

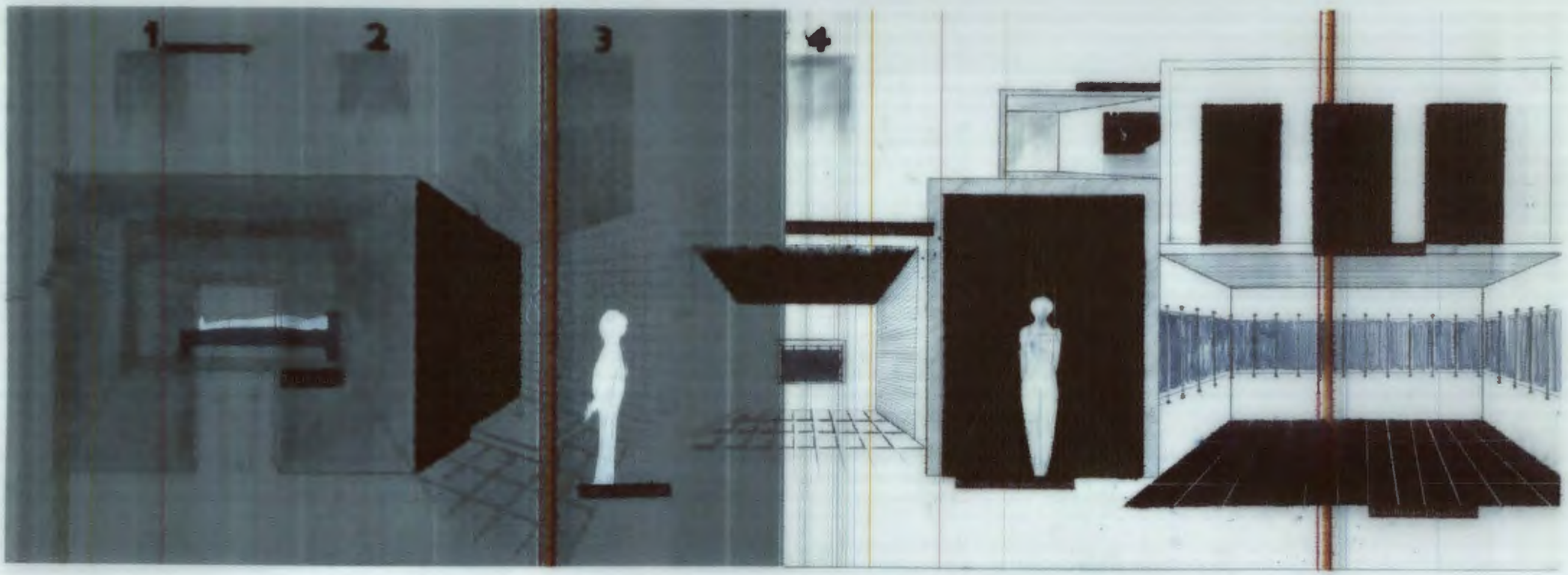

fig.19

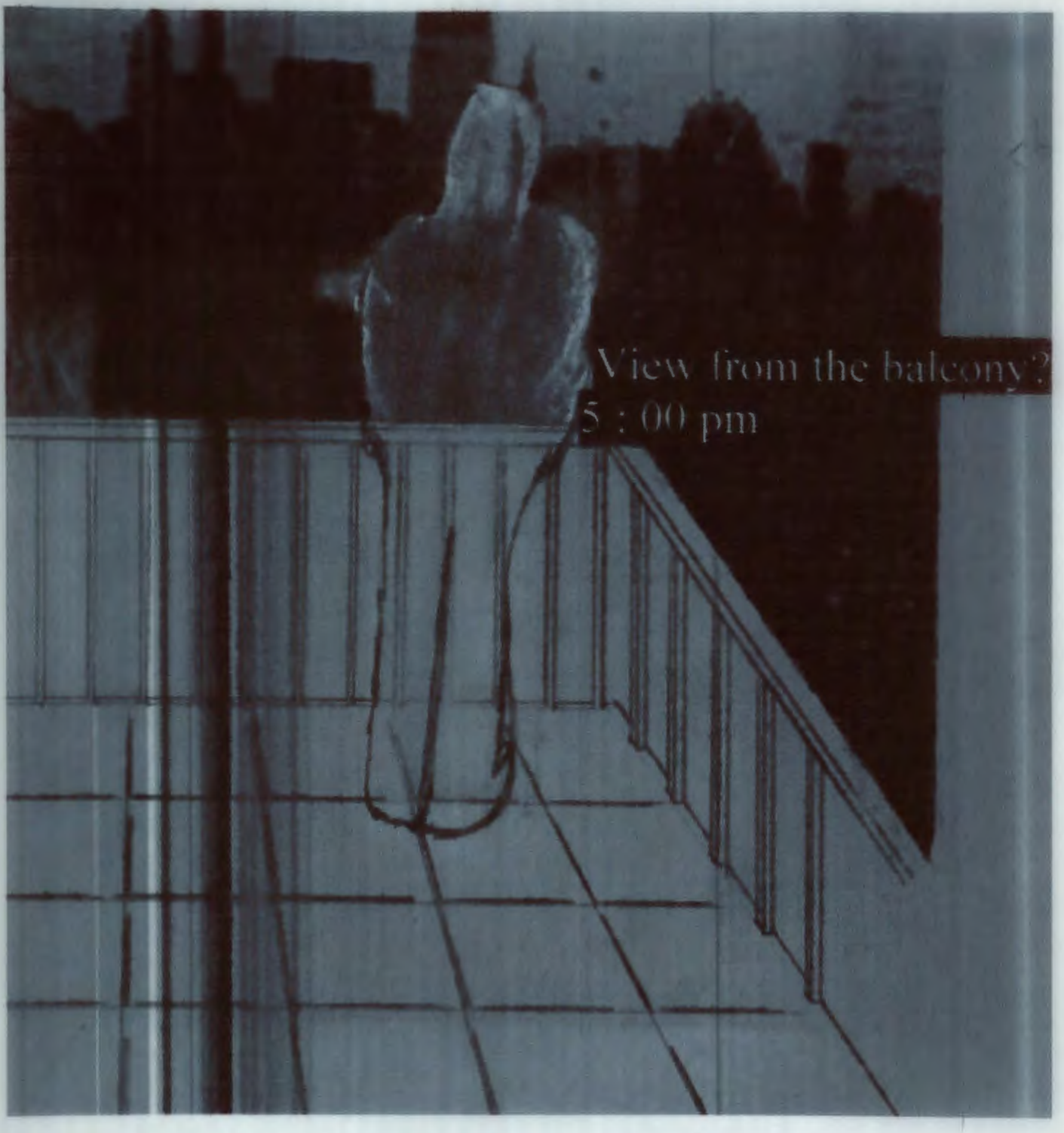

fig.18

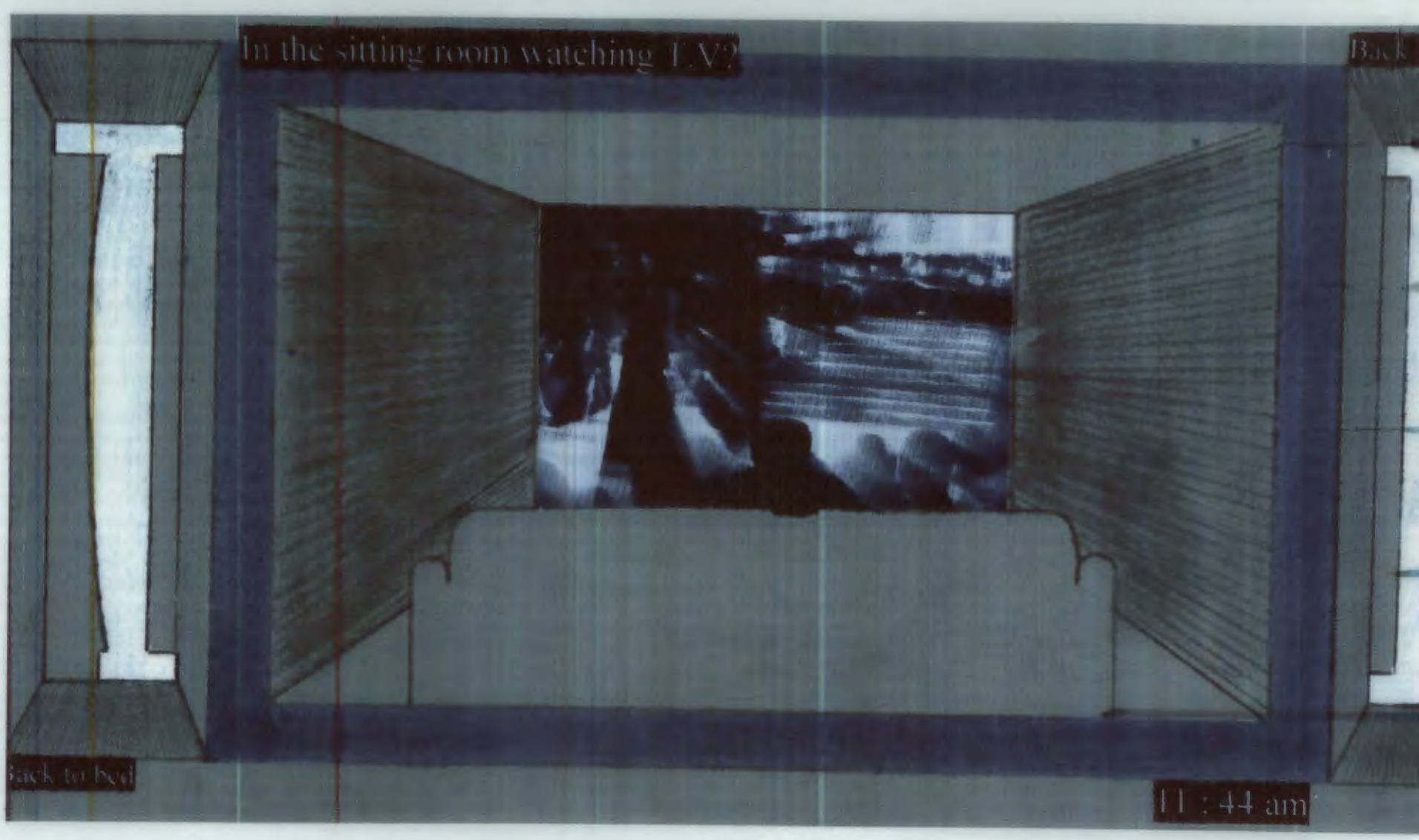

fig.17

wandering somewhere else, counting the minutes to go back to his state of isolation – to his room (fig.17).
Another attempt to entertain him/her, the family proposes a walk to the balcony, an attempt to contemplate the view, but then again, this was just like watching TV, it meant nothing to him/her, he felt neutral and sought more his state of isolation (fig.18) – back to the room.
And the cycle starts all over again the next day and the day after…

Investigation 2: In the Hospital (fig.19)

My interview with a depressed[37] and several aspects of Jacqueline's dialogue[38] proved helpful to me in analyzing the role of generic hospitals in the alienation of the user (which was discussed earlier), and to a lesser extent opened up the door for other possibilities of arrangement and gave more insight into the life of a clinically depressed person in the hospital.

Jacqueline Chapman is a former hospitalized person. When asked to talk about her psychotic episode while she was clinically depressed, she said:
"I was too terrified of death to entertain suicidal thoughts, but I was clinically depressed and somewhat **dissociated**"
"They **watched me constantly**, even while I was relieving myself and showering"
"I could not even perform a simple task like turning on a light switch"
"I became **physically exhausted**"
As the stories continue, she says: "I ended up at Thomas hospital, which had just opened therapeutic day treatment program including a community group, a therapy group, and occupational therapy. I found this a very helpful environment"

First that supervision and monitor are not always welcome by the clinical depressed. The clinically depressed feel uneasy when controlled/monitored. This notion of the panoptican - a likable solution – implemented in hospital and prisons is a two edged proposal. On the one hand, it may help doctors/nurses be more efficient and consequently, do a better job. On the other hand, such a layout might weigh down greatly on the clinically depressed – the users. It instigates feelings of insecurity, lack of independency, and a need for privacy – a condition that may contribute to a further disposition of the depressed person. A 'shadow' in my door way is what one person referred to such condition (fig.19.a). The patient in a mental hospital feels as if he is in a prison where all the openings are bared and all the doors are locked (fig.20-21). Where ever they go there is darkness and specially in the corridors (fig.22).
The life cycle of a depressed person in the hospital is similar to that of the house, however, after the interview, one can feel some sense of hostility towards the hospitals, their layout and the way they function. Statements like, I often needed my privacy are often heard, complain about the constant supervision, a haunting reminder of their inadequacy to function properly. The lack of individualism is also among the complaints; "I was treated like a machine." was one of the comments of a formerly hospitalized depressed person. "We woke up at the exact time everyday, ate at the exact time, watched TV at the exact day, and slept at the exact day." They become as numbers in the space like their units-cells- are numbered (fig.23). So they become peripheral to the space and not active entities in the space (fig.24).

[37] refer to appendix1, part3
[38] from internet, case example Jaqueline Chapman

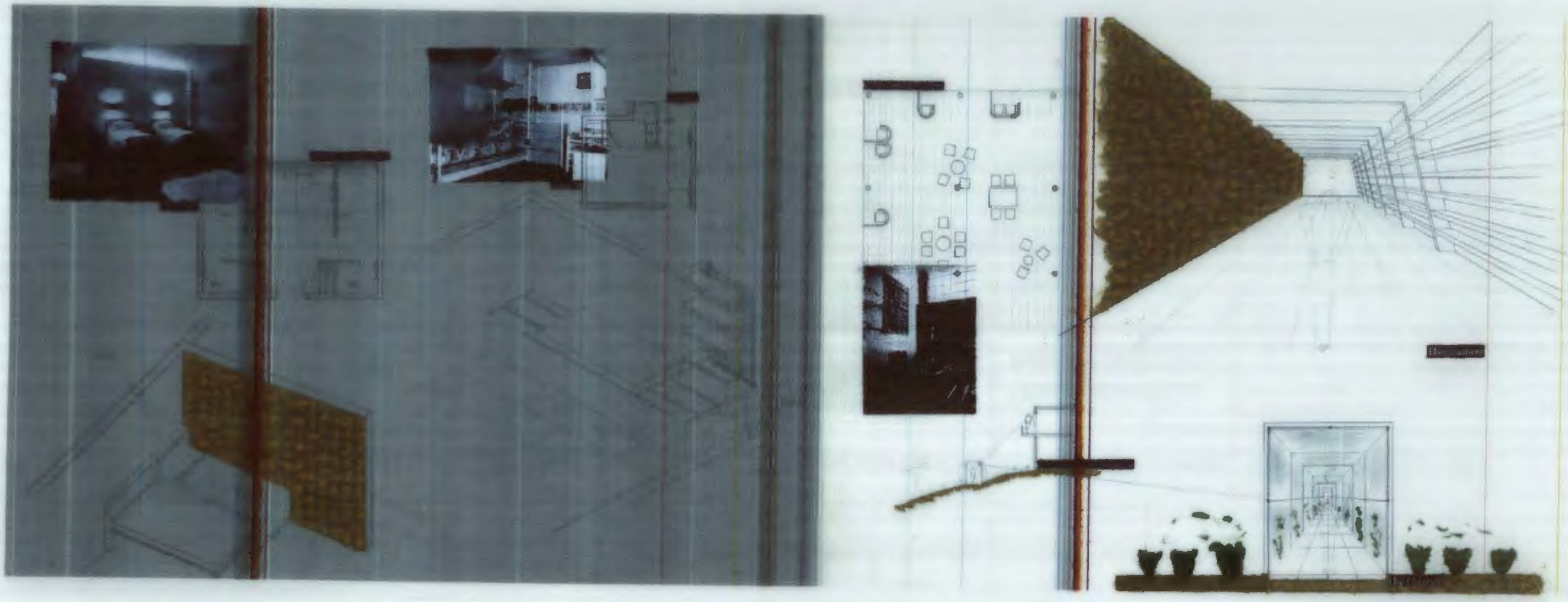

fig.31

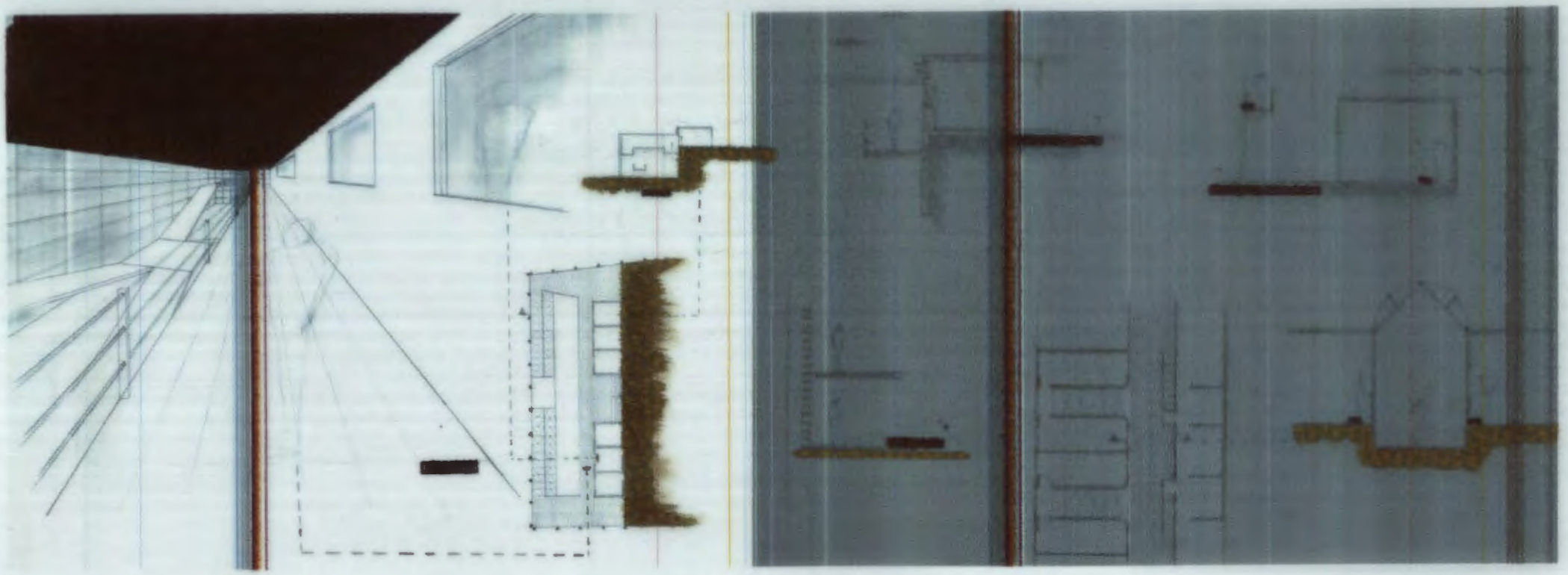

fig.30

fig.29

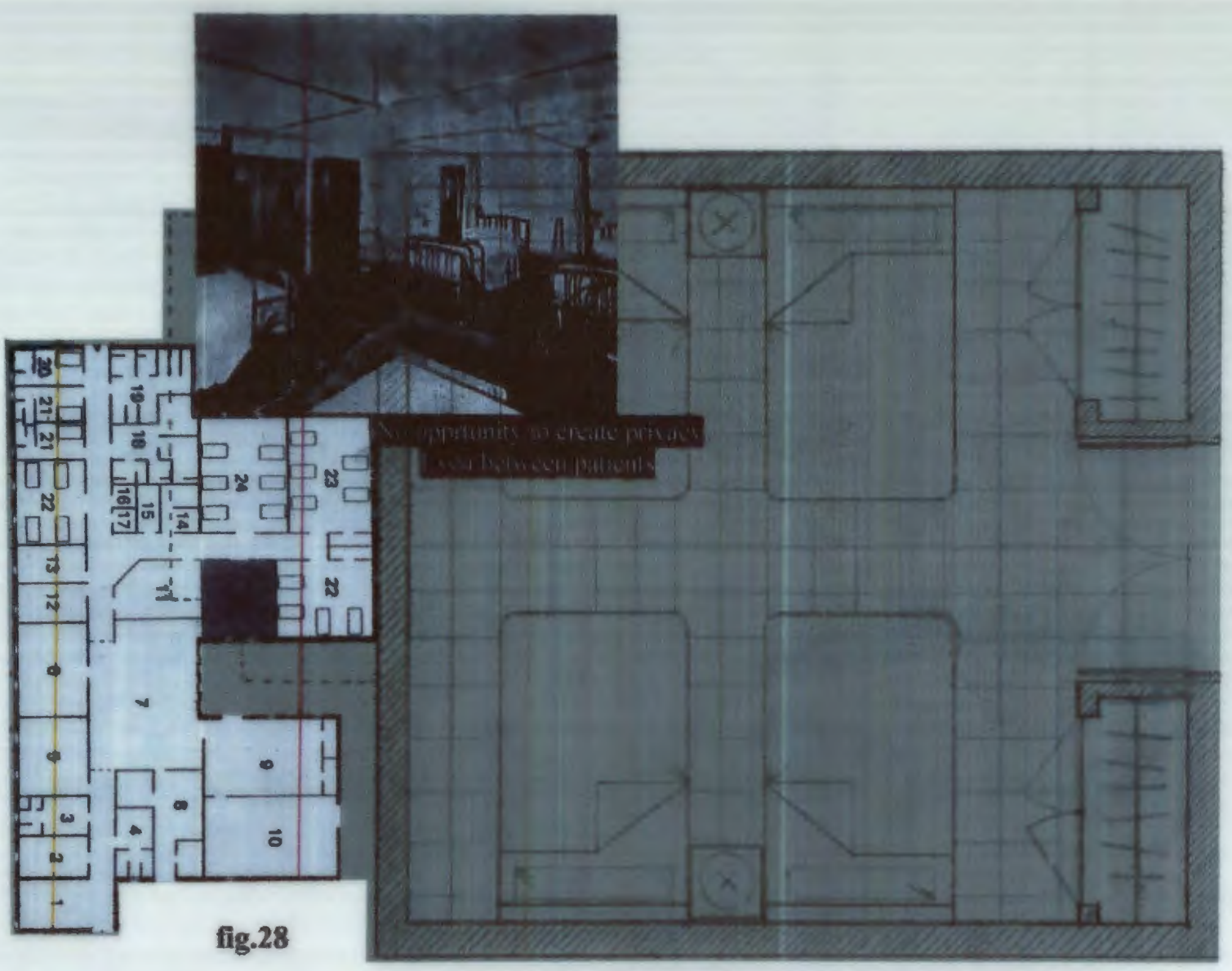

fig.28

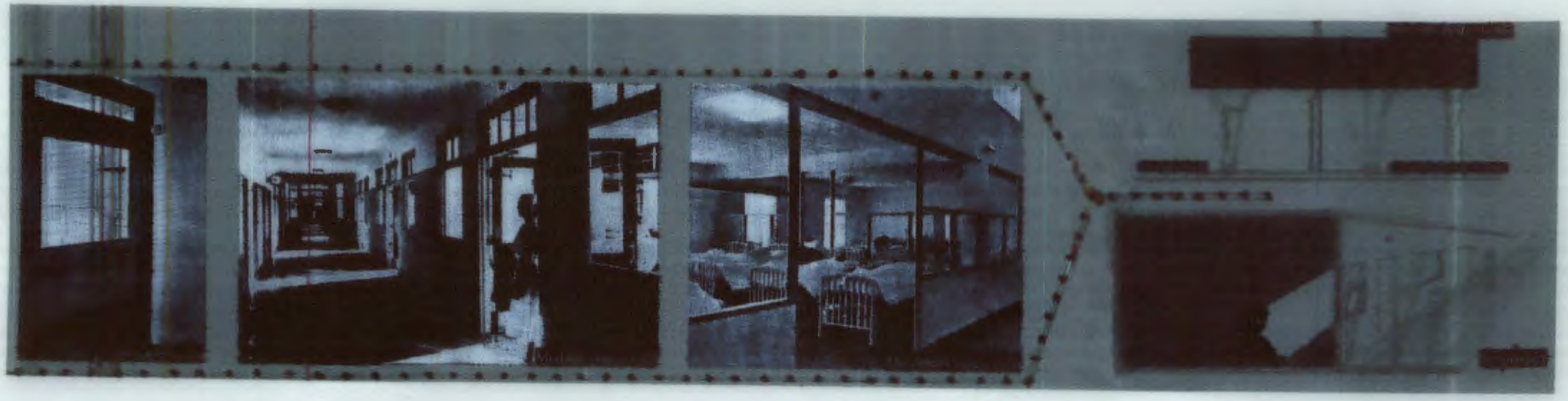

fig.27

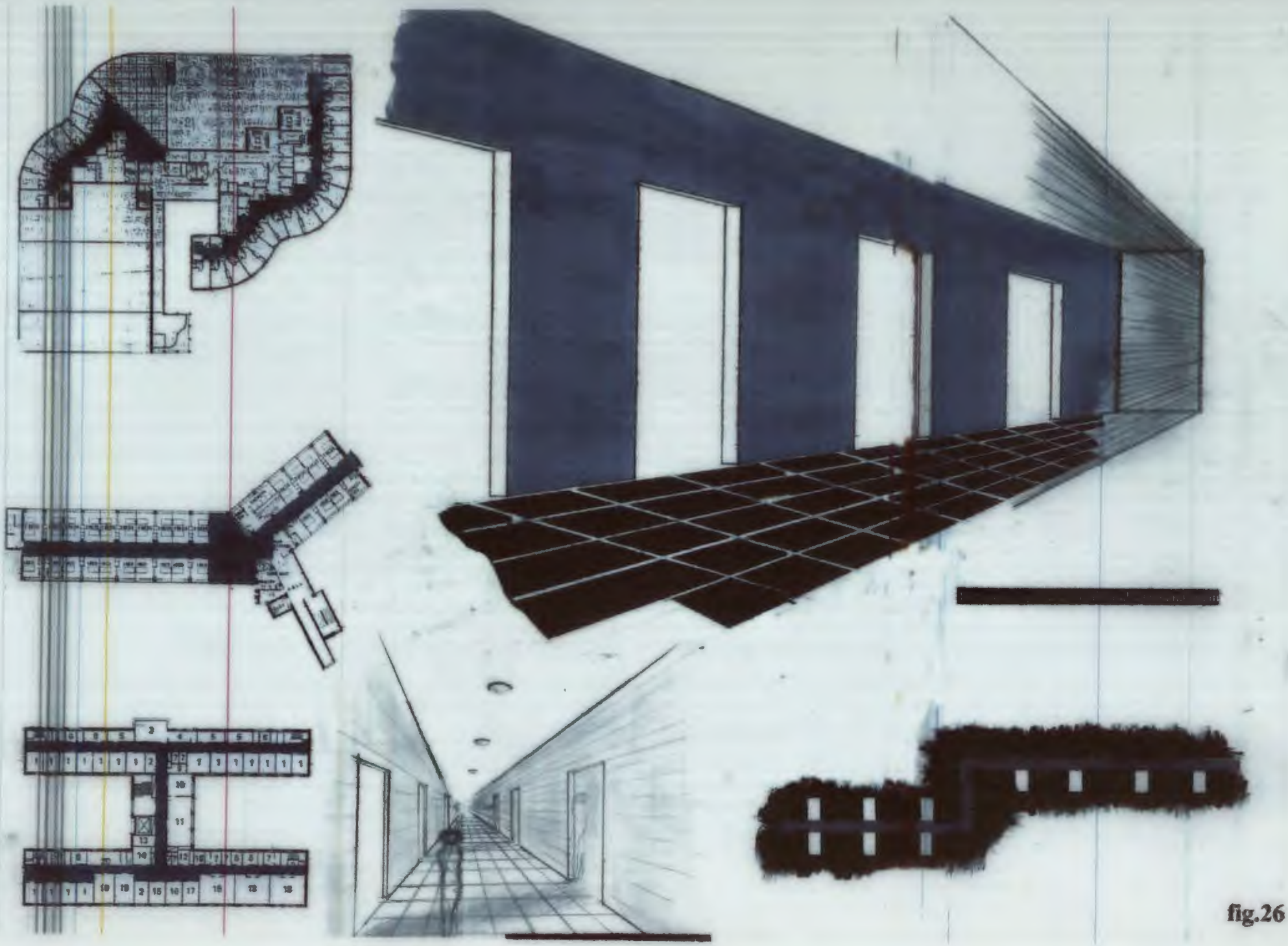

fig.26

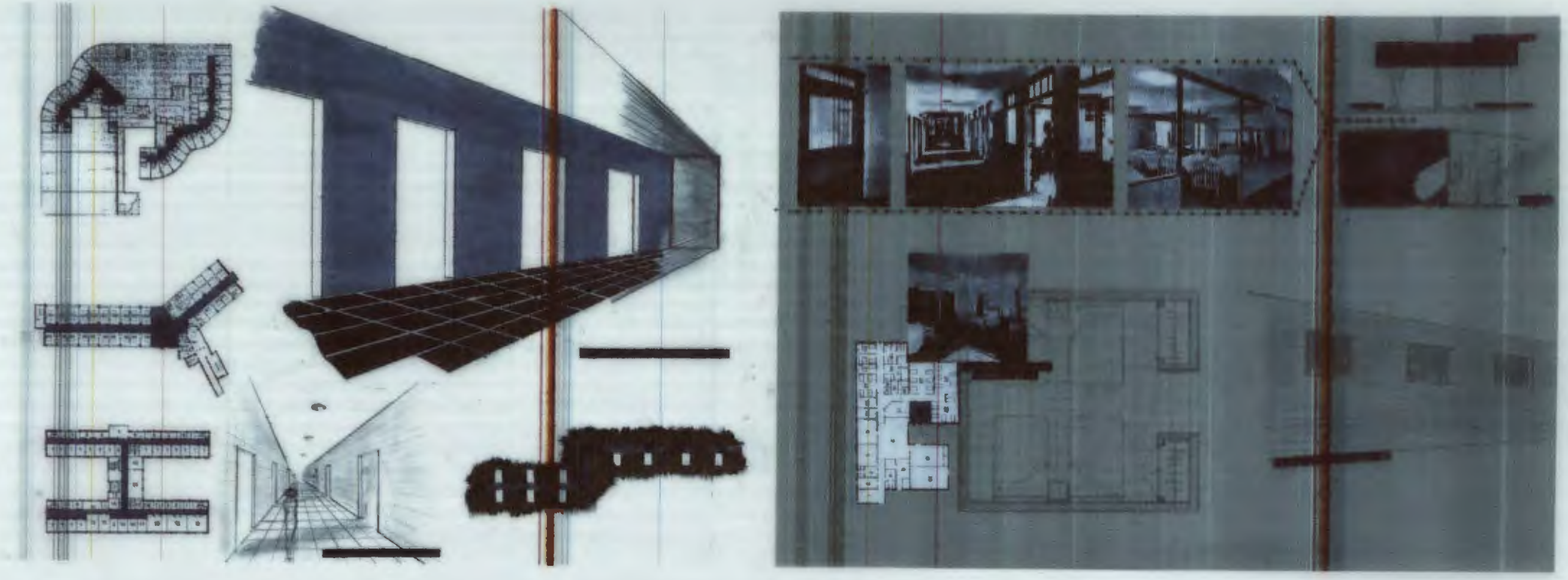

fig.25

Investigation 3: Critical Study of Mental Hospitals (fig.25)

On Sham, Vulnerability and Other Forms of Self-destruction[39], in one of the chapters in this book, there is a paper about interviews and observations done by the writer, on a psychiatric ward which contained 29 patients. The writer says:

> *"The ward studied had an attractive solarium with upholstered chairs, radio, television set, pleasant draperies, and a very large bay window. A short, rather dark corridor that contained wooden chairs and two long "hospital-style" wooden tables was situated just outside the solarium. It was far more pleasant inside the solarium than outside in the corridor."*

During the first days of his studies, it appeared to him that the ward population was divided into two main groups, the "outsider" (the ones staying outside the solarium) and the "insider" (the ones that always stay inside the solarium). After further investigation and analysis, he has noted that the illnesses of the insiders were varied, while 80% of the outsiders were diagnosed as having **psychotic depression**.
We have seen that the patients divided themselves into two different cultures in terms of the architecture of the ward, and this inform me in two ways. First that the clinical depressed people should have their own hospital, second it informs me about the way they visualize space. As I can see that the depressed patients preferred the dark corridor with wooden chairs and tables to the solarium (where you have all the entertainment and spatial needs). What follows is consequently a critical reading of the current psychiatric hospitals of today in an attempt to pin point all the factors involved in their success and or failure.
If we take similar projects (plans of mental hospitals) we can notice the same experience that repeats itself in every one of them, the experience of the corridors where the patient is faced with walls and doors at his right and left (fig.26). The rooms are designed in a way to kill the privacy of the patient; there are three categories of supervision (fig.27) but they all leads to the same effect toward the patient where he leaks privacy from the staff and from the other patients due to the horizontal cone of vision which is caused by the one leveled ground (see fig.27 left). He also leaks privacy if he is joined with other patients in the same room (fig.28).
The idea of a psychiatric hospital as a prison in terms of the panoptican layout, the metallic bars on the windows (fig.29), the reference to the patients and their consequent treatment as machines, the state of isolation of the hospital from the outside world, and so on so forth, is very prevalent. Consider the section for an instance, the central mass of the nurses is detached an isolated form the rest of the wards. It is also designed in a way to provide maximum exposure to the units of the clinically depressed. Although a dramatic picture of what a psychiatric hospital is, this image holds true for the most part of it. I believe it is this image that help alienate the users.

Investigation 4: Attempted Intervention (fig30-31)

Since a long time ago the study of drawings, painting, and sculpture produces by mentally ill patients has

"If we endeavor to compare the creations of the artist with those of the psychotic, we find an aid in some of the already developed thoughts. In the work of art, as in the dreams, unconscious contents are alive, here too, evidences of the primary process are conspicuous, but **the ego maintains its control over them**, elaborates them in its own right, and sees to it that the distortion does not go too far."

[39] Book by Jules Henry

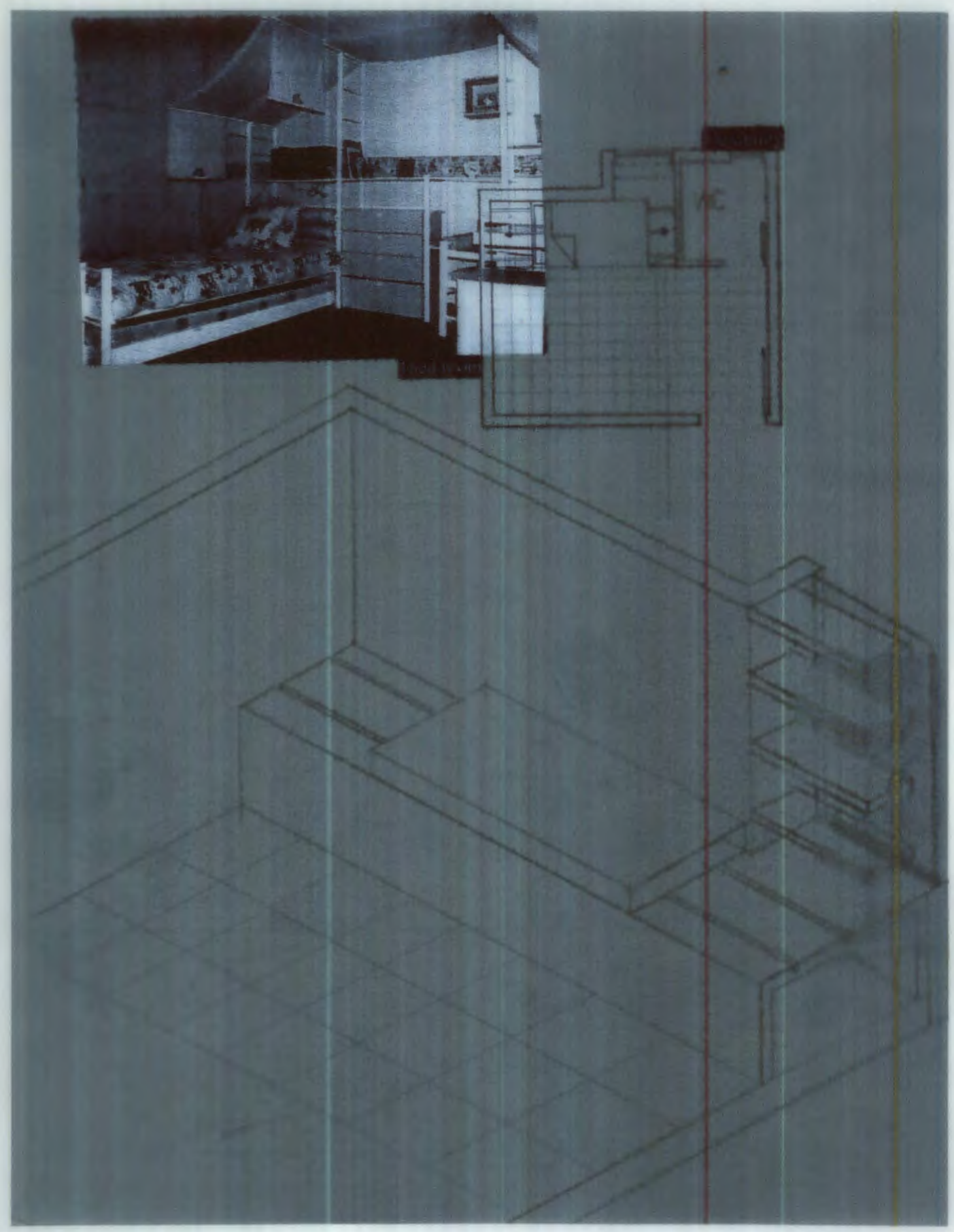

fig.32

attracted the attention of psychiatrists, it has furnished new possibilities for understanding, re-assessing, and evaluating their need.[40]
What I am concerned with this quote is the phrase: the ego[41] maintains its control over them, what we deduce from it is that every drawing or painting produced by a psychotic patient has a certain link to reality or the conscious of the patient. However, the interpretation of these painting could give me hint about their understanding of their milieu, or life or the physical entity around them, in order to come up with an appropriate design. In addition, and referring to earlier discussion about the insufficiency in discussion, the interpretation of the drawings / paintings should only be visual, hence it has been said:

> *"The works of psychotics are unintelligible-as is their speech. Depending on the extent of the disturbance, their commentary may facilitate, or may fail to further, our understanding. [...] At one point in the course of their illness some psychotic patients begin to devote themselves to creative activities. In some cases, creative activities are undertaken not only occasionally but fill a major part of the patient's life. A distinct urge to create, to utilize the most varied materials and tools, becomes manifest. Any scrap of paper, the walls or floors, may be used to draw upon; any pencil or stick may serve as a tool; bread is kneaded into figures; each piece of wood is turned into a carving, with broken pieces of glass serving as knives"*[42]

The most important hint about the mentally ill patient as presented in this paragraph by Ernst, is the importance of the object to the patient, where they start to act as designers and contributors in the transformation of things. And this gave me a start in my design investigation where the flexibility should be provided and my user –the depressed – should be a secondary designer, and what I mean by a secondary designer is that his intervention is in his activities and intervention in / on the built up space, as Jeffery Kipnis said: "an architectural object is never completed".
The interviews done with some of the physical depressed and their doctors have been insightful to me[43]. Several issues where quite recurrent, which were illustrated by the doctors as symptoms of being depressed. These symptoms manifested themselves physically in a variety of instances. For example, some depressed persons loose their physical ability. They become weakened. Their mind takes over their physical ability. Consequently, they become easily exhausted and the smallest of tasks would sometimes become too exhausting for them. As a result of which, I believe that the design should be elaborated in a way to instigate some sort of a will to perform the tasks and not allow them to surrender to their weakness which is manifested physically in their incapacities.
Consider this for example, a squarish room with a bed stucked to the wall (having the window) and sitting on rails. In that scenario, the user, my user, can easily manipulate the situation of the bed whether he wants direct light or no, according to his/her own desire (fig.32). The same can be achieved in the double bed rooms. Image a room with two walls at its third on two sides. The walls have an opening in them (the size of a bed). In a regular day the two beds of the patients are located side by side in the center of the room just next to the two walls. However, if one of the patients sought privacy in any time, all he/she needs to do is move the bed to the other side of the wall

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[40] "psychoanalytic explorations in art", by Ernst Krif
[41] Ego means the right side of the conscious in the mind.
[42] Psychoanalytic Explorations in Art, Ernst Krif
[43] refer to appendix1,2,3


INTEGRATION VS SEPERATION
SILENCE
REVERSE PANOPTICAN
FLEXIBILITY

fig.42

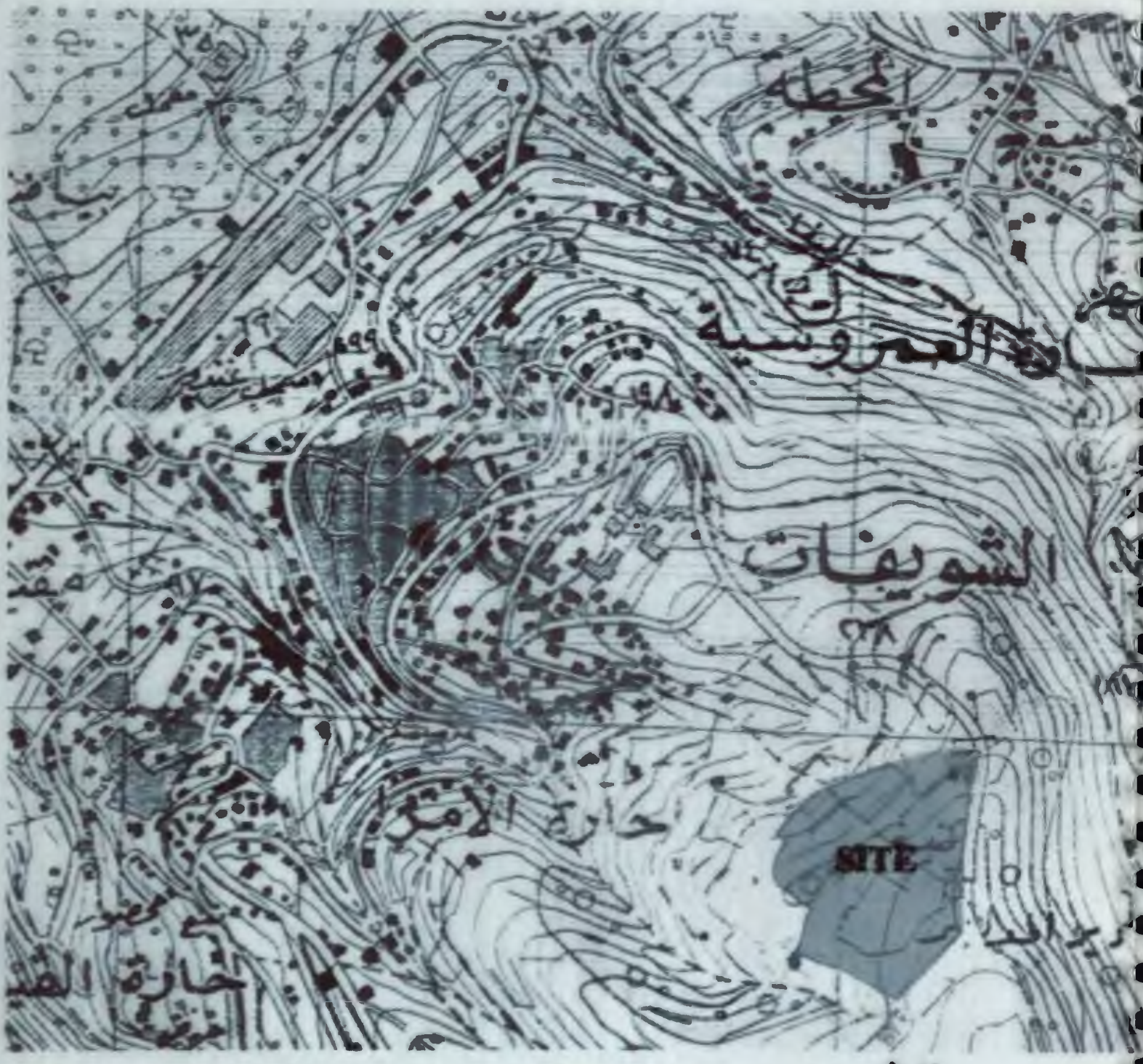

fig. 41

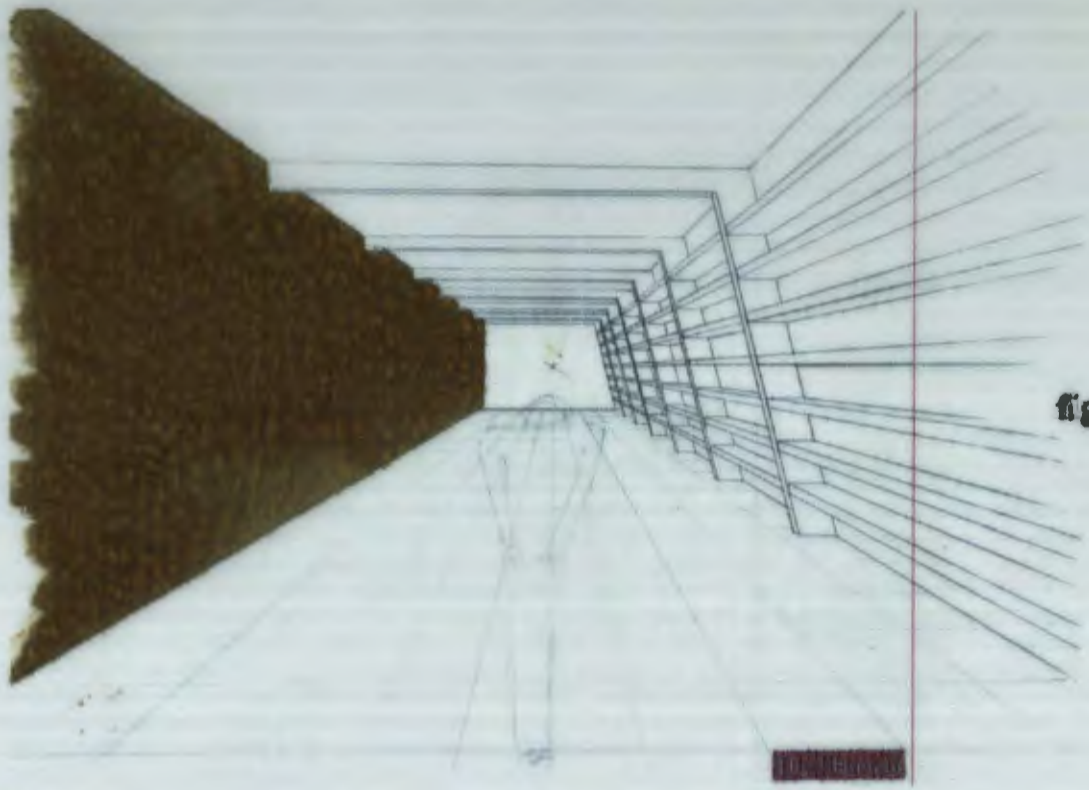

fig.39

fig.40

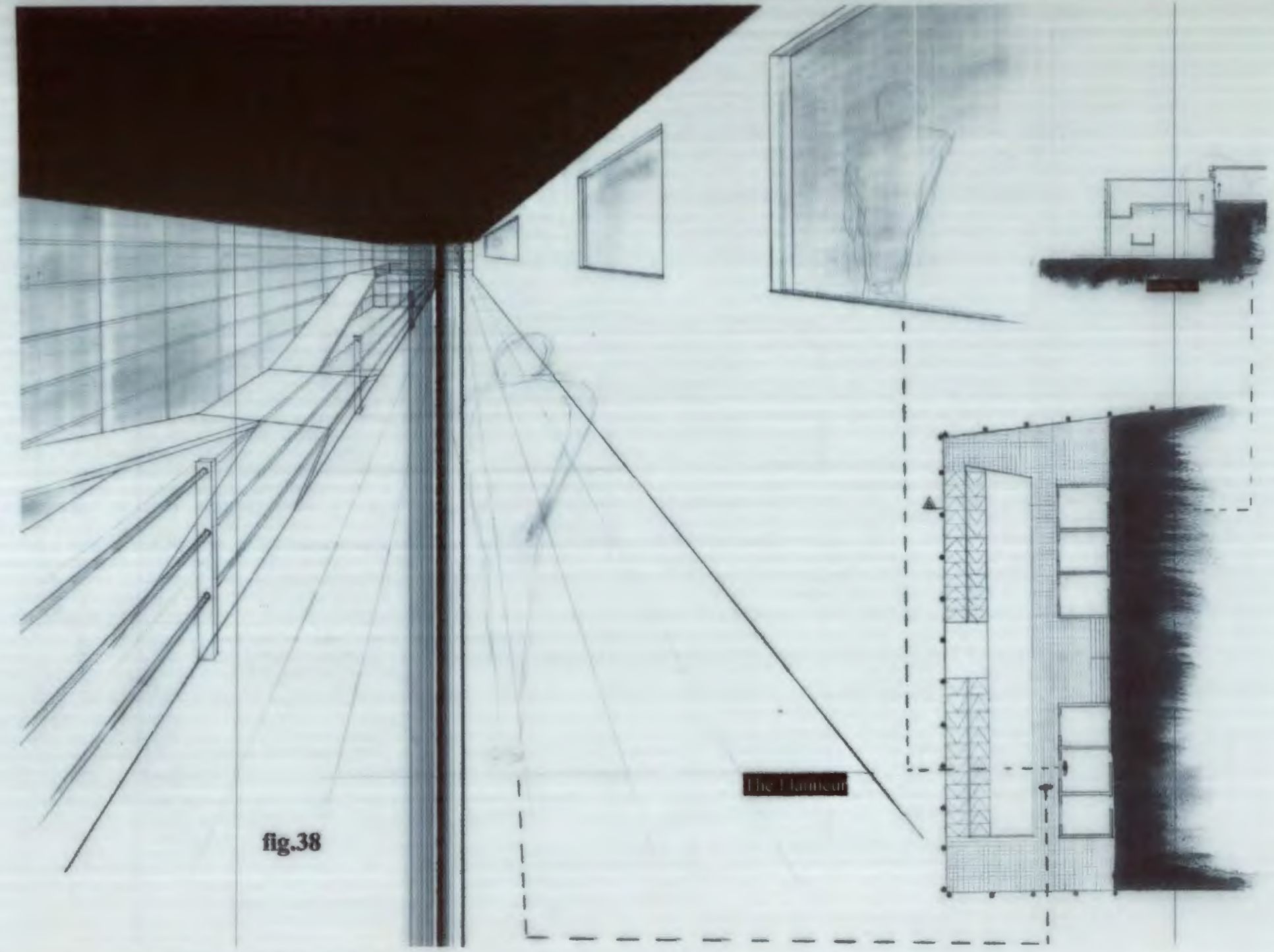

fig.38

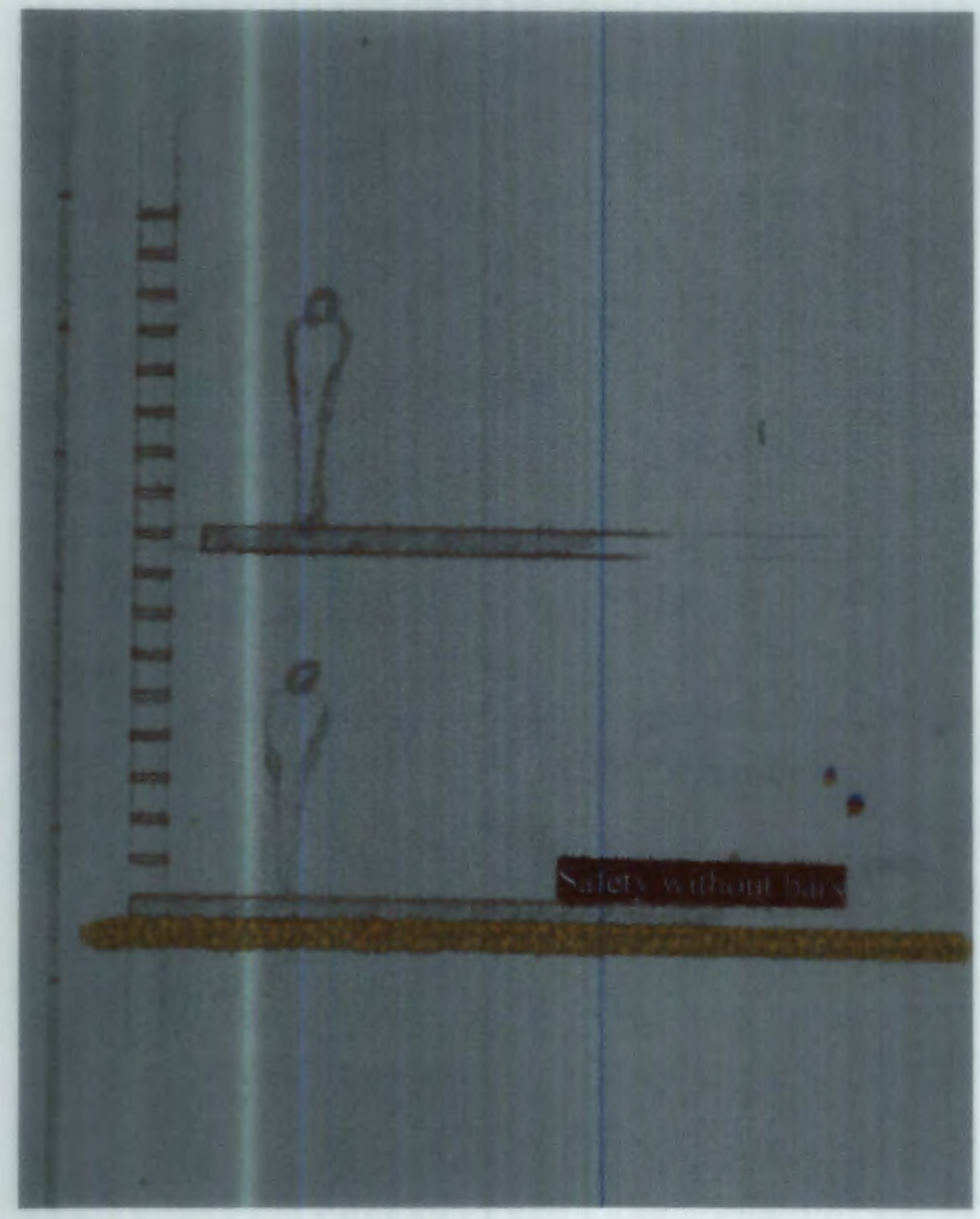

fig.37

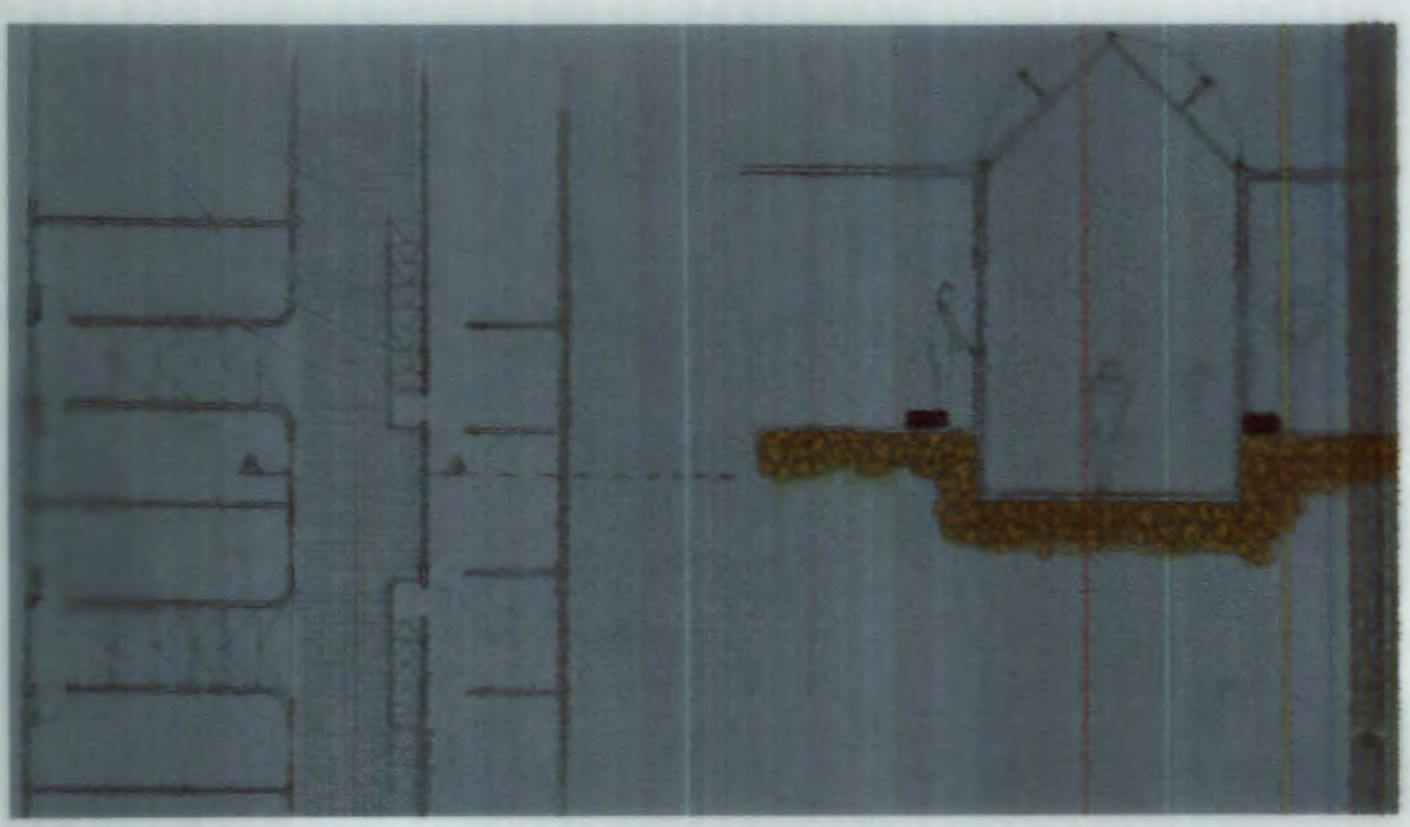

fig.35

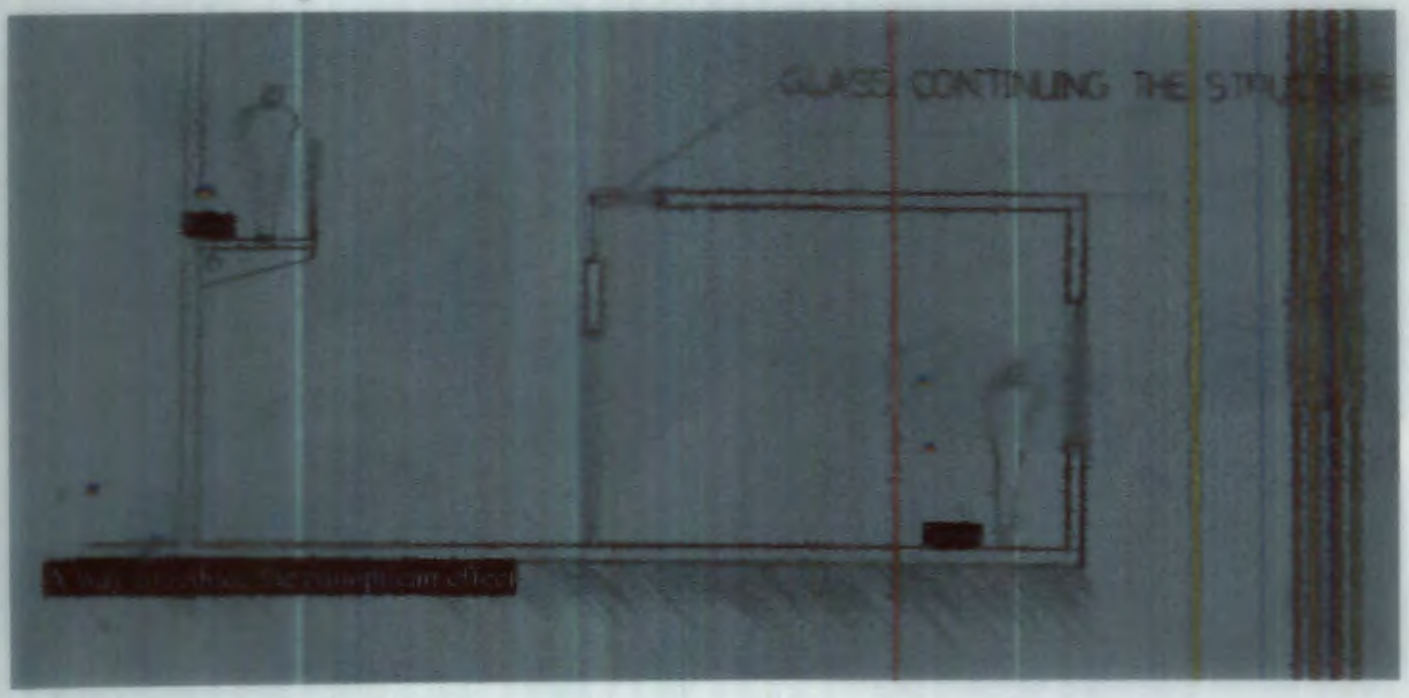

fig.36

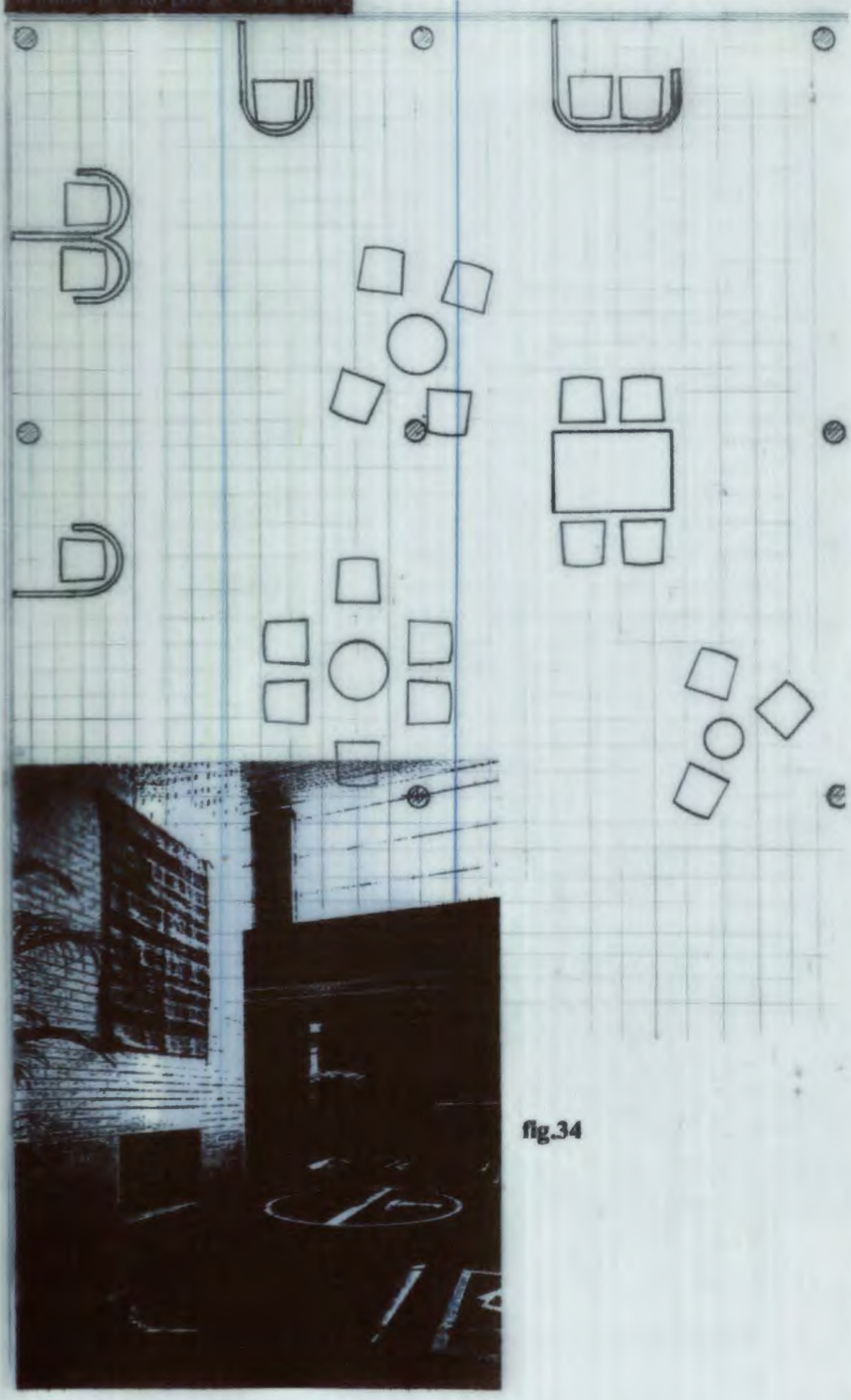

fig.34

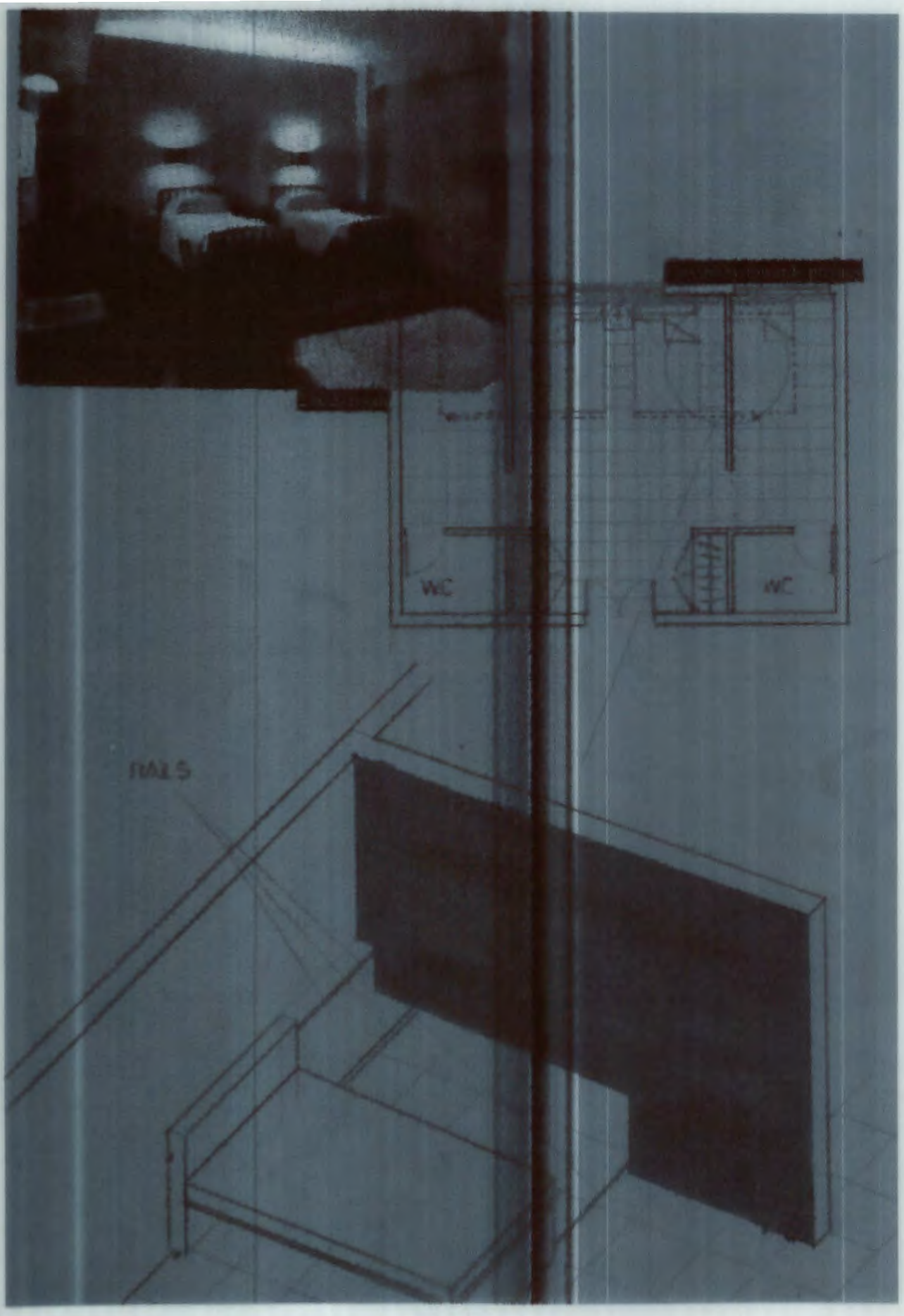

fig.33

(fig.33). At another level there should be flexibility also in other area like the sitting room for example, where the patient can create his privacy by using the chairs behind the curved doors (fig.34).
One of the problematic layouts in the psychiatric hospitals is their attempt in providing ample doctors supervision for the patients. But in their attempt to do that, the patients privacy becomes jeopardized because he/she is becomes not only supervised by his doctors but also by the other patients in the room. In one of the attempts I tried to look into this problematic. Imagine a sunk-in corridor with two sets of rooms on each side having the same level (fig.35). The patients on one side and the doctors on the other. The sunk-in corridor is the circulation space, but it becomes vertically detached from the patients' room. So although the patient is still under supervision from the doctors, his/her privacy is still maintained by a detachment from the other patients. This is on the one hand, on the other, the patient himself/herself is able to display some sign of power through his/her supervision of the passerby. In that layout, a small ramp is used to link the corridor level with the room level, which will push the patients to do some physical effort. There is also a different kind of preserving a sense of privacy which is by creating an opening in one of the corners of the room (which will look like a continuation of the frame structure of the room) allowing a diagonal supervision only by doctors or nurses (fig.36). I should also think for a way to eliminate the use of bars while preserving maximum safety, which could be addressed by using louvers (fig.37) which will be considered as architectural elements and not just bars. As I have discussed earlier, walking in corridors is not much of an experience for the patient who always refer to this activity where go for a walk aimlessly. So here it is touched upon the notion of the flanneur, so I have to come with an attempt to create different kinds of experiences (fig.38-39-40).
Moreover, the dialogue brought up an important aspect, though not architecture but it does imply some architectural / spatial arrangements: 'the cure of the depressed patient is the therapy of all kinds, which allows integration more than separation / privacy'. Consequently, the traditional vision of a seclusion / supervision set forth by the traditional layout of the hospital proves, though helpful for the doctors and/or nurses, to impair the improvement of the clinically depressed; hence the paradox.

Investigation 5: The Site (fig.41-42)

The site is another design decision, the choice of which was done according to a set of requirements brought forth by the investigations done so far. Through the semester, I tried to come up with a list of words – key words – the choice of which was the direct outcome of the interviews with both the doctors and the patients, the questionnaires, and the analysis of current psychiatric hospitals. The current selection of the site, I believe, is the one among the many investigated earlier that best fits the profile that I have already came up with. The site is in upper Shouaifat area, on the inclination of a slightly sloppy hill, and its area is around 72,000 meter square that could be divided into several pieces.
The site is characterized by:

-Extension of the reverse **panoptican** (due to its different catching views)
-Flexibility (also due to the different potential views and due to its topography)
-Integration / Separation (even though the site is located in Shouaifat which is considered a crowded city like area, the site has it is own **privacy** sine it is located on a hill, not visually but tactile also)

-**Silent** (the site has somehow the same characteristic as the depressed because the clinically depressed are called the silent mentally ill patients)
-It has an accidental path rather then a destination (which is much similar to the case of the mentally depressed, because the site has different roads that leads you to it)

Investigation 6: Programmatic Reading of the Hospital

My private hospital for the clinically depressed (that I prefer to call: "a place for curing unhappiness") has a 60 beds capacity, It is meant to receive patients of all age groups and different sexes, allowing a variety of interactions which can be very beneficial for the cure of clinically depressed (of course while designing there should be a sort if separation between the patients according to age groups and gender).My hospital will receive inpatients as well as outpatients, and will have a flexibility in dealing with both groups, patients who's illness is less severe can stay in this hospital in the day time and leave at night (they would also have their bed available at that time), they can also go to work/school at day time and come back to sleep in the hospital where they are provided with the necessary treatment. As for the rough program of such institutions:

Administrative unit:

- lobby/receptionist
- director's office and meeting room
- assistant director's office
- secretary room
- records room
- cashier
- 2 accounting offices
- toilets and janitors room

Outpatient unit:

- lobby/receptionist
- admission office
- 10 therapist's offices
- secretary room
- 2 head nurses offices
- records room
- conference room
- group therapy units(independent from the therapy units of the inpatients)
- pharmacy
- staff lounge ad cafeteria
- toilets
- janitors room

Inpatient unit/s:

- 10 . bed rooms for women and their toilets
- 10 . 2bed rooms for women and their toilets
- 10 . bed rooms for men and their toilets

- 10 . 2 bed rooms for men and their toilets
- nurses stations
- lounges
- nurses lounge
- dining room
- group therapy rooms
- 2 single therapy rooms
- janitors room
- toilets

Other facilities:

- workshops
- singing room
- painting room
- playroom for children
- library
- meditation room
- gym and physiotherapy
- swimming pool

Outside spaces:

- playgrounds (basket ball court and tennis court)
- gardens

Services:

- linen room
- laundry room
- kitchen
- workshop/storage
- 1 ambulance and an emergency room
- parking for doctors and staff
- parking for visitors

As for the area needed for such project is very much dependant on the design decision (that should be taken later) since it is a private hospital , and the general norms taken in mental hospitals are not suitable to my aims listed earlier in the thesis, thus the area could not be defined at that stage, but after calculation made from other projects, a 60 bed metal hospital needs around 20 thousand meter square as built up area including outside spaces, but as for my hospital it needs double this area which is around 40 thousands meter square.

Books:

- Rethinking architecture, by Llifchez
- The dynamism of architectural form, by Arnheim
- Signs, symbols, &architecture, by Bunt
- Speaking of sadness, by karp
- Mind, meaning and mental disorder, by Bolton&hill
- Handbook of depression in children and adolescents, by Reynolds Johnson
- How architect visualize, by Porter
- On sham, vulnerability and other forms of self-destruction, by Jules Henry
- Psycho-analysis as history, by Michael Roth
- Two Chicago architects and their clients, by Eaton
- Reconstructing the subject, by Heibel
- The fountainheadache, by Andy Pressman
- Communication in the design process, by Brown
- The complete psychological works of Sigmund Freud
- Depression (behavioral and Directive Intervention Strategies), by Clarkin Glazer
- Psychoanalytic explorations in art, by Ernst Kris
- The interpretation of dreams, by Freud
- Recovery of myself, by King
- Getting what you want, by Brecher
- The mental hospital, by Stanton and Schwartz
- Design for Health care, by Anthony Cox and Philippe Groves
- Hospitals integrated design, by Rosenfield
- Health facilities review, selected projects
- Landscape of desire, by McClung
- Occupying architecture (between the architect and the user) , by Jonathan Hill
- The image of the architect , by Andrew Saint
- Architecture and identity (responses to cultural and technological change), by Abel
- Modern architecture, by Frampton
- Academic discourse, by Bourdieu
- Interviews, by Steinar Kvale
- Interpreting Qualitative Data, by David Silverman(1993)

Interviews:

- Dr Mounir Khani, head of psychiatric department in AUH
- Dr Ahmad Ayash, psychiatrist
- Sister Ramzah, from Deir El-Saleeb
- Michelle N, ex-clinically depressed

- Jean-Pierre Mgharbani, architect

Internet sites:

http://www.allaboutdepression.com/tre_01.html
All about depression
http://www.geocities.com/angelmuzic78/depression.html
The clinical depression page
http://www.psycom.net/depression.central.friends.html
Friends and family of people with depression
http://www2.ucsc.edu/psychiatry/depression.html
Depression and suicide
http://www.virtualcs.com/blackboard/lessons/caseexamples/chapman.htm
Case example, Jaqueline Chapman
http://www.hcfa.gov/testmony/1999/991026.htm
Patient treatment in mental hospitals

Films:

Abnormal behavior: A mental hospital

Meeting with Michelle N (ex-clinically depressed):

Part 1:

Q: What was the cause of your case?
A: My case started when my brother died 3 years ago, and I felt down for a period of time then when I went to see a psychiatrist, he told that I was clinically depressed. I stayed in this period of a period of 3 months where I tried to commit suicide several times.

Q: What did you feel when you was depressed?
A: My mental ability to react or to understand was almost not present. I didn't want anything, there was nothing happy, and the life was empty and has no meaning.

Q: where did you get your treatment?
A: I visited all the hospitals present in Lebanon.

Q: did you consider the social stigma?
A: In my case and I think in all these cases of illnesses, the patient wont consider the social stigma as an important element, because he wants to be cured whatever what it takes.

Q: To what extent safety should be present?
A: Safety should be present but the most important thing is that there should be lot of care in the mental hospitals, the doctors and staff should be more close to the patient, because the depressed patient becomes like a child.

Q: Where were you getting your therapy in the hospital?
A: I preferred it in my room, but usually they meet in the doctor's office or in some rooms.

Q: What kind of spaces did you prefer then?
A: Big spaces are preferable, but this depend on the cases, but it should be friendly, nice and gentle.

Q: Did you prefer separation or integration with other patients?
A: Separation between patients is very important.

Q: What do you think that must be present in mental hospitals today?
A: Music should be present upon demand, a meditation place or yoga is very important.

Part 2:

Q: What were you doing in your days at home?
A: I spent most of my time sleeping; my bed was my only refuge because I was always feeling tired and exhausted. My parents and sisters usually wake me up around 9 AM, they force me (in a kind way) to get out of the bed and they ask me and insist on me taking a shower and get closed- following the my doctor 's order (he was a psychiatric). They ask me to eat but in those days I lost totally the appetite to eat, but they always insisted. I usually ask them to bring the food to my room but they refuse and ask me to go eat with them in the kitchen. I go to the kitchen but I rarely eat a thing, and while I am eating I always ask them that I want to go back to my room, but finally after eating I go back to my room, I usually sit on the couch or most often I go back to bed again. Sometimes they see me walking in the house, in the living room or in the bedrooms, so they ask me if I want to go out somewhere but I always refuse. During the day they always get in to my room because I told them so or they get in to tell me to go sit with them in the living room and watch t.v, I usually sit certainly my focus was not on the t.v. At lunch time I usually don't eat or eat something in my room. And if somebody visits us they always ask me to go sit with them but as usual I always refuse. In the afternoon they take me to the balcony and my mother or father always were holding my hand, but I felt nothing, sitting at the balcony was neutral to me. Finally at night I take my medicine and sleep.

Q: What was your reaction to your room?
A: As you know I am a manger of this company and I have a desk in my room having all the papers, that I always use in my normal life, but when I was sick I forgot about work and about the desk and my papers and I had only my bed or my couch and the big black window.

Q: What was your reaction to the bed?
A: It was like any bed, but I spent almost all of the time in it, and when they hear my speaking I always ask for my "bed".

Q: What was your reaction to your closet?
A: All my clothes were the same to me, I did not care about my appearance.

Q: What was your reaction to your bathroom?
A: I had a bathroom in my room but they closed it and I was obliged to use the family bathroom, but actually to me they were all the same. I used to enjoy using my bathroom, and when I get a shower or sit in front of the mirror and shave, but when I was depressed that joy went away.

Q: In general what was your reaction to your house?
A: Nothing special, the one having my case won't be concerned with the space but I can tell you that the feeling that one has toward his home was totally different during my illness period, I was almost indifferent.

Part 3:

Q: tell me about your experience in the hospital.
A: for me it was a very bad experience because I suffered a lot from the treatment and from the environment. First what I see very wrong in the hospitals today is the fact that the patient is watched constantly and his privacy is lost, what I really wanted from them was only to care for me not to supervise me like a prisoner, because I believe the depressed person becomes like a child so the staff should be close to him. In my room there was a bed and a couch and the door was always open and I had a big window but it had an ornamented steel fence, which I consider it some how disturbing and blocking the view (but anyways the view was not interesting) and in addition the building had thick walls which also are disturbing. They wake me up everyday very early in the morning and they made me put my clothes on and they accompany me to the bathroom. Then they took me to the sitting area where there is a table and we eat there with the rest of the patients, but I rarely went to this table I often ask my food to be delivered to my room or I don't eat at all. When I arrived to the hospital I was in a very severe period of my depression I tried to make suicide two times at home, but here there was a lot of supervision and a lot of safety measures, but I do remember once seeing the hose of the shower head as if it was a rope in order to make suicide, but I was not alone I was with a supervisor. During the day I usually walk in the corridors but they were very dim so I always go back to my room and to my bed. I didn't like to sit with other patients in the lobby. We are usually asked to make the conversation with the doctors in the therapy room or in their offices but I always ask to make the one to one therapy in my room. They used to ask to go for a walk in the nature but I always refuse. During my walk I am sometimes faced with some doors, I always tried to open it but they were all closed. I think yoga or a meditation place is very important but there was no place for that and it was all closed and fenced.

Meeting with Ahmad Ayash (psychiatrist)

Program questions:

Q: How many beds are needed?
A: it depends, if it is a private hospital or not. If it is a private hospital for only the case of depression the numbers of the beds should be around 60.

Q: Should the patients be grouped in one block or several blocks depending on the seriousness of their cases?
A: One block is preferable for group therapy.

Q: To what extent safety should be present? Should it be as the rest of the mental hospitals?
A: It is very important and especially in the case of the depressed, because of suicide.

Q: To what extent the patient likes the idea to be supervised?
A: I think they prefer privacy and much care hen supervision. In case of psychotic depression, he has illusions and he refuses the idea of supervision. And it is very important to take that into consideration because the patient might stay in the hospital for long period.

Q: Is the physical movement advisable for depressed persons?
What kind of outside spaces the patient need?
A: Generally the elevators should not be accessible for the patient to force them to make physical movement. As for outside spaces a swimming pool is very important and the other sports facilities, animals are important like birds and horses.

Q: Should the patient's bedrooms be integrated with the common spaces?
A: You should not make the therapy close to the bedroom, because the bedroom should be only for sleeping.

Q: Should there be special rooms for treatment? If yes, what kind of rooms?
A: Family therapy, group therapy, individual therapy (the meeting in the doctor's office for individual therapy is better).

Q: Is there emergency room? If yes for what?
A: Only one emergency room incase of an accident.

Q: Should the space be simple? Or the opposite?
He prefers the space to be enclosed or exposed?
A: It depends on his case.

Q: Does the presence of light important for the cure of the patient?
A: yes very important.

Q: Does the view really matter?

A: yes, very important and also having different views is better.

Q: To what extent colors can affect on the patient behavior?
A: It depends on the individual, but neutral colors are better.

QUESTIONS INFORMING THE THESIS:

Q: What is the percentage of clinical depressed persons as to other mentally ill persons?
A: 30% to 40% which is considered the highest rate between mental illnesses.

Q: What kind of depressed persons did u examine?
A: All kinds.

Q: Is it easy to negotiate with them about a subject?
A: No but generally they all have the same reactions.

Q: To what extent do you take into consideration his input?
A: As much as I am concerned I only take what I need to cure him just to know his specific case.

Q: Does he really reveal his needs? Or he stays in the case of repression?
A: what needs, he only wants to be cured.

Q: If you can't have a conversation with him, what are the ways of understanding him or his desires other then conversation? Are they important as much as conversation?
A: I will talk to his family, or only see his reactions or his look, or I can examine his activities or paintings for example.

Meeting with Dr Mounir Khani (head of psyshitaric department in AUH)

Q: How many beds are needed?
A: 50 beds at a maximum

Q: Should the patients be grouped in one block or several blocks depending on the seriousness of their cases?
A: Mixing is better, it is ideal. We should encourage them to be integrated.

Q: To what extent safety should be present? Should it be as the rest of the mental hospitals?
A: Safety should be present 100%, a little case could be harmful to itself.

Q: To what extent the patient likes the idea to be supervised?
A: The patient feel safe when he is supervised because he is afraid that he commits suicide, that 's mainly why he goes to the hospital , to take of the responsibility off his shoulders.

Q: Is the physical movement advisable for depressed persons?
What kind of outside spaces the patient need?
A: Yes very, all kinds.

Q: Should the patient's bedrooms be integrated with the common spaces?
A: It depends.

Q: Should there be special rooms for treatment? If yes, what kind of rooms?
A: Group therapy room, individual therapy room, electro convulsive therapy room.

Q: To what extent the shape of the building or space can affect the patient case?
A: It should be consumer friendly.

Q: Is there emergency room? If yes for what?
A: for initial treatment only.

Q: To what extent transparency is needed?
A: very important element for the admission of light and for supervision.

Q: Does the presence of light important for the cure of the patient?
A: Yes

Q: Does the view really matter?
A: the view is helpful for the cure of the patient.

Q: To what extent colors can affect on the patient behavior?
A: Bright colors can affect positively the case of the patient and dark colors negatively.