



KEY POINT SUMMARY

OBJECTIVES

To focus on the role that the built environment plays in psycho-environmental dynamics so that beneficial effects can be emphasized and negative effects avoided in architectural design.

DESIGN IMPLICATIONS

By taking into account the specific types of mental illnesses afflicting patients, designers could make informed decisions about which medical spaces and equipment could help create a more positive living and healing environment.

Lost in space: the place of the architectural milieu in the aetiology and treatment of schizophrenia

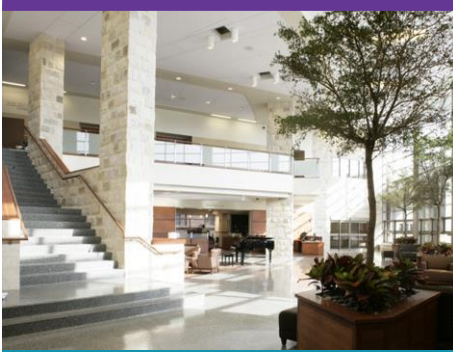
Golembiewski, J. 2013 | *Facilities* Volume 31, Issue 9/10, Pages 427-448

Key Concepts/Context

This article is a theoretical discussion concerning how designed and constructed environments can be significant factors in the psychogenesis of mental illnesses, particularly with non-affective psychoses. The authors believe that the current body of literature is lacking in resources that could help direct design decision-making to positively influence the well-being of mentally ill individuals. Discussing this matter may help identify specific qualities of the built environment that appear to be aetiologically related to psychosis.

Methods

The author draws on research from published works in neurology, psychology, and epidemiology in order to explore the dynamics between psychotic illnesses and built environments. Extracts from these sources are synthesized into several topics of discussion. First, there are categories of different “affordances,” which attempt to elucidate the complex issue of understanding the experience of living as a psychotic individual. Affordances are defined as opportunities to engage and act in well-learned or instinctive ways, and are discussed under the subdivisions of “emotional affordances,” “hedonic affordances,” “physical affordances,” “identification affordances,” and “narrative affordances. The essential idea underlying each of these topics is the idea that most humans have automatic reactions, or certain patterns of behavior within these different spheres of thought and action. The topic then shifts to “selective attention,” which describes the difference between “bottom-up” attention and “top-down” attention. Bottom-up attention describes a tendency to be drawn towards unexpected, seemingly random stimuli, whereas top-down attention is given to expected or intended phenomena.



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Findings

The author notes that both “bottom-up” attention and “top-down” attention appear to be moderated by dopamine (a neurotransmitter that is dysfunctional in schizophrenia), and that facility designers should be aware of the nature of patients’ conditions. Individuals with bottom-up attention deficits will be very prone to accidents and will be largely unaware of aesthetic concerns such as time constraints or artistic beauty. However, environments that do not provide those exhibiting bottom-up attention with opportunities for aesthetic stimulation or discovery risk causing further atrophy of bottom-up attention. The author recommends as a general rule of thumb uniform and bright lighting with occasional variation to reinforce diurnal rhythms.

Limitations

This paper contains no original research and focuses on presenting the dynamics of mental illness rather than making concrete suggestions for design. Many of the primary sources used in the paper similarly deal with concepts behind the diagnosis and description of mental illnesses rather than aspects of healthcare design.

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