

# The Spatial Organization of Psychiatric Practice

A Situated Inquiry into 'Healing Architecture'

Simonsen, Thorben Peter

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**THE SPATIAL ORGANIZATION OF PSYCHIATRIC PRACTICE: A SITUATED INQUIRY INTO 'HEALING ARCHITECTURE'**

PhD Series 03.2020

Thorben Peter Simonsen

# THE SPATIAL ORGANIZATION OF PSYCHIATRIC PRACTICE

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Doctoral School of Organisation and Management Studies

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**CBS**  COPENHAGEN BUSINESS SCHOOL  
HANDELSHØJSKOLEN

# THE SPATIAL ORGANIZATION OF PSYCHIATRIC PRACTICE

A situated inquiry into ‘healing architecture’

Thorben Peter Simonsen

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# Preface

This dissertation is written as a paper-based dissertation. While four papers were written as part of the research conducted for this dissertation only three are included here.

1. ‘Rummets Grammatik: Helende arkitektur i psykiatrien’ is co-authored with Holger Højlund from the Department of Management, Politics, and Philosophy, Copenhagen Business School and has been published in *Politik* (2018 (2):22–42). The paper is written in Danish and is for this reason not included in this dissertation. An early version of the paper was presented at the 33<sup>rd</sup> EGOS Colloquium, Copenhagen, Denmark, July 6-8, 2017.
2. ‘The spatial organization of psychiatric (dis)order’ is aimed for publication in the journal *Space and Culture*
3. ‘Unfulfilled promises? Staff reactions to the ‘healing architecture’ of psychiatric inpatient wards’ is aimed for publication in the journal *Social Science and Medicine*.
4. ‘Healing architecture and psychiatric practice: (re)ordering work and space in an inpatient ward in Denmark’ is co-authored with Cameron Duff from the Royal Melbourne Institute of Technology. The paper was accepted for publication in *Sociology of Health and Illness* on September 3<sup>rd</sup>, 2019. The layout of the paper has been adapted to fit the dissertation, but the contents are completely the same as in the accepted paper.

Due to the requirements of the targeted journals, all three papers are written in UK English, while the remainder of the dissertation is written in US English.

# PART I

## CHAPTERS 1 – 5

Head-nurse: Well, in the first instance it all sounds really nice and I would have liked more words to have been used [by the architects to describe what ‘healing architecture’ is] because, to me, when they say ‘healing architecture’ it means a lot. What’s actually healing about it? Do they mean the colors? Is it the interior design they mean? Is it the transparency they mean? Well, I don’t know, but I can guess that this is perhaps some of what they mean, but I don’t know, so it would be unfair if I started to make inferences about it, no?

Interviewer: Well, are there any of the things that you have mentioned that you feel make a difference in any way?

Head-nurse: They make a difference but I am not sure that it’s healing.

# 1. Introductions

We shape our buildings and afterwards, our buildings shape us

- Winston Churchill

This dissertation is about the spatial organization of contemporary psychiatric practice - about 'healing architecture' in psychiatry. While spaces may be primordially given, the organization of space is not. For this reason, I take 'healing architecture' to represent a particular effort to spatially and materially organize contemporary psychiatric practice. The problem motivating my inquiry is not about how architecture and space mediate health outcomes and promote patient recovery, what 'healing architecture' is or should be, but rather, what it actually *does*. How architecture in health care settings contributes to the ordering of space and interaction, enabling certain practices, while constraining others is, I argue with Moser (2017), largely eclipsed in the social science literature - a mystery (Alvesson and Kärreman 2007), if you will, and something to be investigated further. My inquiry, therefore, is brought to bear on a purpose-built psychiatric hospital in Slagelse, Denmark, opened in late 2015. With 'healing architecture' and the idea of recovery literally built into the bricks and mortar of the building, the new hospital in Slagelse is considered the vanguard of contemporary hospital design, representing the future of psychiatric inpatient facilities. As such, the Slagelse Hospital can be understood as a paradigmatic case (Flyvbjerg 2006) for considering the spatial organization of contemporary psychiatric practice.

In the last decade, there has been a significant upsurge in both research on (e.g., Connellan et al. 2013; Curtis et al. 2007; Gesler et al. 2004; Jovanovic, Campbell, and Priebe 2019; Long et al. 2011; Papoulias et al. 2014; Reavey, Harding, and Bartle 2017; Shepley et al. 2017) and investments in contemporary mental health facilities, corresponding with broader changes in general health care developments. An interest in the therapeutic value of the physical properties

of the built environment, including architecture, interior design, and landscaping, has been re-examined and utilized in many contemporary health care developments. The *Private Finance Initiative* (PFI) in the UK has, for example, sought to upgrade or completely replace public psychiatric hospitals no longer fit for purpose within the NHS, subsequently delivering what are considered state of the art facilities across the country. Similarly, in Denmark, approximately 5.5 billion euro is currently being devoted to the development of new hospital facilities, with forty-one construction projects underway, six of which are psychiatric hospitals. Together with the psychiatric hospital in Slagelse, many of these projects are funded through the Quality Fund, which was established in 2007. This wave of new hospital developments has also spurred considerable debate concerning design, with previous generations of mental health facilities criticized for being more concerned with clinical functionality than with well-being and recovery, generating calls for closer consideration of hospitals as civic architecture, having social and symbolic significance as well as clinical impact (Curtis 2010:195).

It is against this backdrop that the notion of healing architecture has become a prominent feature of contemporary hospital and health care design, a design concept that contends that particular spatial and material features of the built environment have a positive impact on patient experiences, recovery, and psychiatric practice (Frandsen et al. 2009; Lawson 2010; Nickl-Weller and Nickl 2013). This is expressed through sensory stimulations like the quality of light, color, and sound, and through spatial dispositions, such as having access to green areas and the possibility for patients to withdraw into rooms that offer a sense of privacy and security (Frandsen et al. 2009:v; Frandsen, Gottlieb, and Harty 2012:1068). The concept of ‘healing architecture’ is heavily influenced by evidence-based design, a scientific method developed on the principles of evidence-based practice, which in turn originates from scientific fields such as neurology, evolutionary biology, and immunology (Frandsen et al. 2009:7)<sup>1</sup>. The ideas found

---

<sup>1</sup> This approach is typically attributed to the work of Ulrich (1984; 2008, 2010), who has argued that light, views to nature, and an overall sense of control contribute positively to health outcomes. His paper *View through a window may influence recovery from surgery* (1984) on the impact of a view to natural scenes on postoperative recovery has had a significant impact on this stream of research in general and on the development of the idea of healing

within evidence-based design can be traced back to the Enlightenment, where hospital design became avant-garde due to the conviction that designed environments were effective tools for improving health and well-being (Nickl-Weller and Nickl 2013). Here, we see an attempt to establish, more or less, causal links between design and health outcomes, a sort of environmental determinism that has been criticized for taking a largely passive view of the way clinical practice can be shaped by space (Frandsen et al. 2012; Lundin 2015).

The proverbial modernist dictum that form follows function seems to have been invoked in relation to the upsurge of the use of evidence-based design in developing ‘healing architecture’, making it hard not to see the contemporary psychiatric hospital as being conceptualized as “a machine for living in” (Corbusier 1986:4) or as a tool for treatment. While Le Corbusier’s famous maxim might be a rather hyperbolic interpretation of the current state of affairs, it does, however, enable me to point to the fact that psychiatric facilities, and hospitals in particular, are being designed to *work*: to promote patient recovery and healing by (re)imagining inpatient settings as therapeutic environments (see Gesler et al. 2004). As such, the imposing structures of the Victorian asylums of yesteryear are gradually becoming antiquated, replaced by modern transparent buildings with open and flexible spatial dispositions, reflecting contemporary models of care (McGrath and Reavey 2019). Through a synthesis of functional demands and sensory impressions, the emergence of ‘healing architecture’ is certainly transforming the institutional spaces of psychiatric practice, producing what the German philosopher Peter Sloterdijk (2016:468) might recognize as the development of a novel alphabet of forms (see also Simonsen and Højlund 2018).

Investigating such novel spatial forms, and studying the role ‘healing architecture’ might play in everyday psychiatric practices within the psychiatric hospital in Slagelse, is central to the

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architecture in particular. Since Ulrich’s influential study, multiple factors have been included and implicated in improved outcomes on general health care including single rooms, ambiance, sunlight, views to nature, way-finding and personal control over the immediate environment (Lawson 2010; Ulrich et al. 2008).

research interests of this dissertation. This interest runs parallel with recent investigations of so-called caring architecture, where Nord and Högström (2017b:10), for example, call for a focus on the “everyday practices performed by architectural space and other matter in cooperation with the people who live and work in institutions for shorter or longer periods” in order to advance our understanding of what is happening in institutional care in light of contemporary architectural developments.

The opening quote by Churchill captures a significant tension between the design and development of buildings and the subsequent use thereof by stating that we shape our buildings and afterwards they shape us. Churchill famously proclaimed the above in 1943 in relation to the rebuilding of the Chamber of the House of Commons due to its previous destruction by incendiary bombs during the *Blitz*. He was referring to the importance of retaining the Chamber’s adversarial and, in a sense, combative rectangular form in order to maintain the practice of British parliamentary democracy. While Churchill’s statement does indeed say something about the relationships between buildings, people and society - an insight that has motivated me throughout the conception and production of this dissertation - it does not, however, represent a fundamental truth about these relationships. While clinical spaces may indeed frame treatment, care practices, and medical encounters, and, as such, be constitutive of a variety of social relations, they cannot simply be determined or understood by the physical and spatial properties that demarcate their boundaries, although these undeniably make a difference for movement, interaction, and, thus, care. Perhaps form does not simply follow function (Kornberger and Clegg 2004). For these reasons, the dissertation sidesteps any assumptions about the causal relationships between a building and its proposed effects, and instead seeks to come to terms with what ‘healing architecture’ does by considering the relationships between space and interaction as mutually constituted.

In the remainder of this introduction, I continue to sketch out some initial trajectories relevant to the overall assumption that architecture, space, and the built environment actually matter.

While Foucault's (1961) excavation of the relationships between epistemology and materiality in psychiatry have been instrumental for understanding how and why mental health spaces were shaped as they were, his 'history of insanity in the age of reason' does not inform us about how such spaces subsequently shaped their occupants in practice. For this reason, we need a different analytical point of entry to study what 'healing architecture' does. Following these initial trajectories, through which I consider the relationship between architectural order and social action, I introduce the research questions of the dissertation and clarify the direction and interests of the research, before I continue to outline the content and structure of the dissertation.

## **Architectural order and social action**

We are always already *in* some place, housed by buildings, embedded in environments, moving through spaces. This is, perhaps, rather obvious. But what the implications of our spatial circumstances are, how they shape, infringe upon, organize, enable or constrain us is not just a matter of course. How buildings come to shape us cannot be predetermined. This fundamental proposition is particularly relevant in relation to the profession and practice of psychiatry, as architecture, space, and the built environment are believed to modulate the conditions of possibility for treatment and recovery, as well as ordering relations, and shaping the activities of its inhabitants in relation to particular health trajectories and health outcomes. Architecture, space, and the environment are, in other words, designed, built and intended to make a difference. Foucault's (1961, 1973b, 1973a, 1977) work has been especially salient in this regard as it theorizes how the initial enclosures of mental ill-health were enacted. While not advancing architectural determinism, his descriptions of the panoptic mechanism, for instance, rested on an understanding of the built environment as something that configures and arranges possible avenues of action, supports or hinders the ways in which one can freely move around, assigns roles and identities, and makes surveillance and security possible. This is not to say that architecture in itself can resolve social issues and determine organizational synergies, let alone heal psychiatric patients, but it can, as Foucault (1984b:246) notes in an interview with Paul

Rabinow, produce positive effects when the liberating intentions of the architect coincide with the real practice of people. Intentionality inscribed in the spatial disposition of a building by the architect's design can, in other words, play a significant role in configuring organizational and social relations in everyday patterns of action.

Architecture is here seen as an element of support in the distribution and canalization of people in space, but should also, Foucault goes on to elaborate, be thought of as “a plunge into a field of social relations in which it [the architecture] brings about some specific effects” (Foucault 1984b:253). Consequently, we do not live in a void inside which people and things are just placed, but rather we live inside a set of relations that delineates sites which are irreducible to one another and absolutely not superimposable on one another (Foucault 1984a). Architecture does not order practice in any predetermined way. It can produce unintended effects and serve other ends, which is why the interconnections, and not the primacy of this over that, become the interesting thing to study (Foucault 1984b:254). Foucault (1984b:246) captures this nicely when he reflects that “it is somewhat arbitrary to try to dissociate the effective practice of freedom by people, the practice of social relations, and the spatial distributions in which they find themselves”, because, as he continues, “each can only be understood through the other.”

It is not given how we come to terms with the interconnections between the practices of people, the practices of social relations, and the spatial circumstances within which they take place. Foucault's (e.g., 1961, 1977) work demonstrates that the spatiality of any given situation is subject to various historical transformations within a public order of discourse and technology (Lynch 1991:54), making the architectural representations of a time contingent upon these. The design of psychiatric facilities has in this sense always reflected dominant perceptions about mental illness (Prior 1988). While history might have formed who we are and how we understand ourselves it is arguably not consistent with the many ways in which we interact and conduct ourselves. Foucault's insights notwithstanding, the collaborative efforts of science and technology scholars Woolgar and Neyland (2013:171), point to the fact that

Foucault's work operates at a somewhat general level of abstraction. It does not account for the ongoing, practical, unmotivated, and often idiosyncratic behavior of people, reducing people to cultural dopes (Garfinkel 1967), who act according to predefined subjectivities of self and selfhood. There seems to be little wiggle-room for resistance or reflexivity. An ethnomethodologically inspired reading of Foucault would, according to another science and technology scholar, Lynch (1991:55), conflict with the somewhat ominous insight that harmony exists between individual action and social order, which leaves no space for an autonomous subject. The ethnomethodologically inspired move, which also includes science and technology studies (STS), is to treat, for instance, the Panopticon as "[...] one example among many of an instrumental complex that can coexist with other such complexes in a discontinuous ecology that embodies heterogeneous, and perhaps even contradictory orderings of knowledge/power" (Lynch 1991:55).

Despite Foucault's emphasis on architecture playing an important mediating role, bringing about some specific effects, the precise role it may play in practice is left somewhat unclear (Woolgar and Neyland 2013:169). The question of what architecture *does* in particular settings is left unanswered in Foucault's work. This does not imply that his work, especially on the notion of order, cannot sensitize us to specific convictions related to a particular state of affairs, and it becomes valuable insofar as it invites examinations into the conditions of production prefiguring particular architectural forms. This is something I consider more explicitly in chapter two, where I develop a context for thinking about the contemporary spatial organization of psychiatric practice. While the history of psychiatric architecture is undoubtedly bleak, contemporary developments in psychiatric hospital design are reinvigorating ideas about the importance of the built environment for health, well-being, and recovery. Indeed, we might even be witnessing a complex rebirth of the clinic, as Curtis et. al. (2009) contend. Regardless, with the design concept of healing architecture, psychiatric inpatient spaces are being transformed as therapeutic environments, with spatial layouts and architectural elements thought to play an active role in patient recovery and psychiatric practice. As such, hospital

buildings are increasingly thought to be a component and active participant in the provision of psychiatric care.

## Research questions

This dissertation concerns the spatial organization of contemporary psychiatric practice, for the fact that it considers the problem of what ‘healing architecture’ *does* in a purpose-built psychiatric hospital in Denmark. As such, the inquiry moves us beyond any assumptions about what architecture might be designed to do, sidestepping the Foucauldian impetus to ascribe certain predefined effects to the spatial disposition of a setting, and instead aiming for a situated approach where investigating what ‘healing architecture’ does is an empirical endeavor, that, in turn, may offer us a more differentiated appreciation of the phenomena in question. In order to investigate this phenomenon and this problem, and thus provide direction for the dissertations overall inquiry, I pose the following research question:

**How are space and interaction ordered in and through psychiatric practice at the Slagelse Hospital?**

The subtitle of this dissertation is *a situated inquiry into ‘healing architecture’* because I consider the novel spatial circumstances of the Slagelse site by empirically investigating how the relationships between space and interaction are ordered in psychiatric practice. The research question, therefore, also functions as a particular proposition about how to study ‘healing architecture’ in practice and is my way of articulating the governing problem of the dissertation in the form of a question. As such, the question gives overall direction to the dissertation by turning the relationship between space and interaction into the central topic of investigation. The three papers of the dissertation are staged as inquiries into aspects of this relationship, offering different insights into the same overall problem. Each paper, therefore, inquires more narrowly into the problem of what ‘healing architecture’ does in practice by drawing on different conceptual sensibilities and by considering the following research questions:

**Paper I inquires:** How do nursing staff manage what they consider to be danger and disorder within contemporary inpatient settings?

**Paper II inquires:** How do nursing staff react to the ‘healing architecture’ of an inpatient ward? And what is the mediating role of the transparent nursing station for staff/patient interaction?

**Paper III inquires:** How is spatial order accomplished through psychiatric work? And how does this work shape the sense and significance of inpatient spaces?

In this dissertation, I have largely appropriated a mode of analytical inquiry inspired by social science scholars (Latour 2005; Lynch 2013; Yaneva 2013), where concepts can be thought of as sensibilities (Mol 2010; Neyland 2008), tools (Nicolini 2009), or even tricks (Becker 1998) – in other words as devices that can help solve problems of thinking about how space and interaction are ordered in practice. Before proceeding, some initial clarifications related to the key concepts mentioned in the research question are warranted. Space, interaction, and order are the main sensitizing concepts of the dissertation and I consider these more explicitly in chapter four, where my analytical approach is outlined and discussed. The notions of psychiatric practice and ‘healing architecture’ are central to the overall problem statement. In this dissertation, they refer to empirical phenomena, and are for this reason not used as analytical devices for thinking about the spatial organization of psychiatric practice.

## **Conceptual clarifications**

While the notion of ‘healing architecture’ designates an approach to hospital design, and a way of thinking about the relationships between spatial and material properties in the built environment and health outcomes, I take it to be an empirical phenomenon, and instead aim to investigate the implications of its manifest form. As a result, I entirely accept that the

psychiatric hospital in Slagelse represents a manifest form of ‘healing architecture’, making ‘healing architecture’ a particular spatial and material setting - an arrangement of physical architectural properties where doors, locks, glass walls, and the proximity between rooms, for instance, are part of said architecture. As a result, what ‘healing architecture’ does becomes a question of how different spatial and material properties and arrangements become implicated in everyday practical circumstances. For this reason, what ‘healing architecture’ is, or may become, cannot be separated from what psychiatric practice is, or may become. They must be studied and understood together. They are co-produced.

Following from this understanding of ‘healing architecture’, I understand space as both the medium and outcome of the interactions it recursively organizes - both a material arrangement and an achievement of material practice. Consequently, space is “intertwined with practice, rather than simply conditioning, carrying, or containing it” (Moser 2017:90). Studying space in this way calls for a situated perspective where the relationships between space and interaction are investigated in practice through the documentary tracking and ethnographic detailing of spatializations in action. This endeavor is modest insofar as there is no intent in devising any grand theories about the relationships between space and interaction, but rather, an empirical interest in detailing the ongoing work put into the continuous recasting of space and order in practice. Considering space and interaction by focusing on ongoing processes of ordering, shifts the analytical focus on what order is towards the processes out of which order emerges (see, Preda 1999:349). This takes us away from a Foucauldian mode of thinking about social order and architecture, moving us from an interest in its particular form to the various modes and modalities through which such form is achieved instead (Mol 2010:262). Order, even architectural order, is always in a somewhat uncertain state.

As this dissertation claims to consider the problem of the spatial organization of psychiatric practice, some comments on the notion of practice are arguably justified. While practice is a common-sense notion, it is, however, contestable and arguably overused (Mol 2010:260), quite

slippery and perhaps even imbued with magical qualities, as Gad and Jensen (2014) contend. It is the proverbial tent within which everyone and anything can potentially fit. The term practice can refer to a location or to action. It typically expresses something real as opposed to something abstract. You can be *in* a practice or be constituted *by* a practice. Practice may be a cause, an effect, and/or offer itself as an explanation. It may be an analytical object or a theoretical perspective, an input or an output. Regardless, the so-called practice turn in contemporary theory (Schatzki, Cetina, and Savigny 2001) has made practice undoubtedly *in vogue*<sup>2</sup>. While the notion of practice may be imbued with significant powers of explanation, the detrimental effect of such explanatory power is analytical paralysis (Gad and Jensen 2014:9). The notion of practice may, in other words, come to function as a placeholder or glossing device (Garfinkel 1967) rather than as a fitting tool for gaining empirical insight. For all of these reasons I am apprehensive about evoking the term here, especially because the notion of practice is intended to sensitize, not obfuscate, the analytical orientation. While practice theorists aim to develop particular practice-ontologies where sayings and doings are part of a broader plenum of practices (Schatzki 2016), the empirical approach described by Feldman and Orlikowski (2011) offers itself as a more agnostic proposition fit for my purposes. This approach, they argue, entails answering the ‘what question’ of practice by investigating “everyday activity in both its routine and improvised forms” (Feldman and Orlikowski 2011:1240). A key contribution of studies focusing on practice in this way is “[...] both the claim and the emerging grounded evidence that *practices matter*, and thus must be empirically engaged with in order to understand/improve organizational reality” (Orlikowski 2010:25 italics

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<sup>2</sup> It has been argued that the term practice has generated a bandwagon dynamic (Gherardi 2011:47), leading to the development of such approaches as strategy as practice (Whittington 1996), science as practice (Pickering 1992), knowing in practice (Gherardi 2000), and practice-oriented research (Orlikowski 2000). Practice-based-studies, then, serves as an umbrella term for a wide variety of studies across scholarly disciplines and theoretical positions, all sharing the assumption and problematic that knowing and acting are closely interlinked (Gherardi 2011). While the idea that social life is produced through ongoing and recurrent actions is central to the practice lens (Feldman and Orlikowski 2011:1240), practice theory should not be seen as a unified theoretical perspective (Nicolini 2012). This becomes evident with the emergent split between theories of practice foregrounding human agency (Schatzki 2002) and practice theories informed by a more symmetrical, post-humanist understanding (Schatzki et al. 2001). For a recent review see Gherardi (2016).

in original). This is, in all modesty, what I hope to do when I consider psychiatric practice a domain of activity within which I can empirically study how space and interaction are ordered and thus identify different aspects of what ‘healing architecture’ does in practice.

## **Sum and substance**

The dissertation is organized into three main parts. With the present chapter, Part I has been formally introduced. In the following chapter, chapter two, I create a context for considering the spatial organization of contemporary psychiatric practice by sketching out a trajectory of the spatial modulations found within the history of psychiatry. I continue to introduce and consider the design of the psychiatric hospital in Slagelse which, I argue, can be seen as a novel synthesis of ideas about mental health care, psychiatric treatment, and space found within this trajectory. I sketch out the most significant shifts related to the changing spatial forms of mental health care to make inferences about how some of these ideas have been re-invigorated in the design of the hospital in Slagelse.

Chapter three is a literature review. The aim of the review is to engage with interdisciplinary work found in health geography, the sociology of health and illness, and in STS, extending lines of inquiry related to questions of space, architecture, and the built environment in the interest of coming to terms with how to study what ‘healing architecture’ does in psychiatric practice. The review is organized into two main sections. The first section focuses primarily on literature within health geography and the second section focuses on interdisciplinary literature within the sociology of health and illness, and STS. While the former section concentrates on reviewing how and where mental health spaces have been studied, the latter focuses on studies that share a set of theoretical and methodological assumptions about how to study spatial and material circumstances. Both are important for the present dissertation. I argue that moving the analytical interest from the *lived experiences* users have of spaces - which is the prevalent approach to studying the impact and importance of mental health spaces in extant literature -

towards an interest in *practices* instead, is important insofar as we want to understand what ‘healing architecture’ actually does.

In chapter four I describe my analytical approach. An important point of departure for studying what ‘healing architecture’ does in practice is to direct analytical attention towards the relationships between space and interaction and, I argue, focusing on the ongoing processes of ordering in practice. As a result, I develop and detail four distinct approaches to understanding how space and interaction are ordered in practice: actor-network theory; ethnomethodology; symbolic interactionism (as found in Goffman); and Douglas’ social anthropological approach.

In chapter five, I consider my methodology by building on arguments introduced in the previous chapter. I argue that conducting a situated inquiry into ‘healing architecture’ entails drawing on a particular repository of concepts in conjunction with a methodological impetus found in both ethnomethodological and ethnographic traditions. Following from this, I introduce and reflect upon the specific methods I have applied, detailing how and where I conducted fieldwork, why I conducted qualitative interviews, the importance and use of documents, how I gained access to the field, and, finally, how I conducted the analysis.

This leads us to Part II, which contains the three papers of the dissertation. Paper I *The Spatial Organization of Psychiatric (Dis)Order* draws on the work of cultural anthropologist Mary Douglas (1966) when it asks: how do nursing staff manage what they consider to be danger and disorder within contemporary inpatient settings? Based on the claim that ‘healing architecture’ raises new questions about the demands on, and responses of, nursing staff working within such settings, the paper considers the relations between ward spaces, perceived dangers, and nursing work. The paper shows, firstly, how displacing patients, cleaning spaces, (re)moving objects and correcting patient behavior become salient tasks engendered by the spatial layout of a ward, and, secondly, how the invocation of the language of danger enables nursing staff to intervene when socio-spatial boundaries are transgressed by patients. In discussing the findings I suggest

that the spatial layout of the inpatient setting amplifies tensions between professional interests and designed intentions, creating what I call ‘sites of contention’ where the social order of a ward is openly negotiated.

Paper II *Unfulfilled promises? Staff reactions to the healing architecture of psychiatric inpatient wards* is an empirically driven paper that nonetheless draws on some of the fundamental theoretical impulses found in STS combined with Erving Goffman’s (1959) approach to studying the presentation of self in everyday life. Based on these conceptual sensibilities the paper inquires: how do nursing staff react to the ‘healing architecture’ of an inpatient ward? And what is the mediating role of the transparent nursing station for staff/patient interaction? The paper investigates the mediating role a nursing station plays within an inpatient setting and shows how the transparent glass walls of said nursing station shape the manner in which staff engage and encounter patients, as well as change the manner in which they conduct themselves when inside the office space. The paper shows how particular staging contingencies arise due to the transparent nature of the nursing station, rendering activities visible which were previously out of sight. An environment of uncertainty is produced due to these contingencies, which is the opposite of the intended design, which was to create a sense of safety and intelligibility.

Paper III *Healing architecture and psychiatric practice: (re)ordering work and space in an inpatient ward in Denmark*, draws on the work of ethnomethodologist and science study scholar Michael Lynch (1991) when it asks: how is spatial order accomplished through psychiatric work? And how does this work shape the sense and significance of inpatient spaces? Through the notion of spatial order(ing) the paper explores the key material and social effects of the hospital’s ‘healing architecture’ and the spaces and practices it contributes to enacting. By analyzing an instance of the administration of medication the paper shows that the ordering of spaces is central to the enactment of control over patients so often required in everyday psychiatric work, highlighting the tensions that arise between the spatial layout of the ward and the orderings preferred by staff. The paper suggests that ‘healing architecture’ might indeed have great impact on the

provision of psychiatric care, but that its instantiation as healing or therapeutic is better understood as a function of spatial orderings rather than as a strict material causation. As such, the spatial disposition of 'healing architecture' may have at least as great an impact on psychiatric work as on patient experiences of care and recovery.

Taken together, these papers contribute to our understanding of what 'healing architecture' does in practice by investigating different aspects of how space and interaction are ordered in practice. This enables me to answer the research question in the final and concluding chapter. In Part III, then, I summarize each of the three papers and discuss them in relation to the overall research question. I then consider how the dissertation has made it possible to offer a proposition to what 'healing architecture' does in practice, and I discuss the approach I have taken to enable such a proposition. Following from this, I (re)turn to the research reviewed in chapter three and discuss how the dissertation contributes to these bodies of literature. Based on the findings, as well as on my experiences with conducting the research for this dissertation, I conclude by considering what some of the practical implications for the professions of architecture and psychiatry might be, respectively.

## 2. Context(ing)

Contexting is, Asdal and Moser (2012) suggest, something scholars *do*. A context, then, is not something pre-given, passively lying out there, awaiting scholarly discovery, but is rather *made* by drawing objects, texts, and issues of interest together into a particular pattern. Acknowledging the potentially problematic practice of contexting (Asdal and Moser 2012), this chapter nonetheless aims to create a context for considering the spatial organization of contemporary psychiatric practice by sketching out a trajectory of the spatial modulations found within the history of psychiatry. Arguably, the design of the psychiatric hospital in Slagelse can be seen as a novel synthesis of ideas about mental health, psychiatric treatment, and space found within this trajectory, which is why I sketch out some of the most significant shifts related to the changing spatial forms of mental health care to make inferences about how some of these ideas have been re-invigorated in the design of the hospital in Slagelse. I consider the dominant ideas about psychiatric treatment and their spatial forms in the first section of this chapter. In the second section, I introduce the psychiatric hospital in Slagelse, focusing primarily on the development and design of the hospital building.

From the early modern period to the present, designing and constructing alternative spaces, whether conceived of as custodial or curative, has been a predominant social response in the West for managing those deemed deviant or mentally troubled (Topp, Moran, and Andrews 2007:1).<sup>3</sup> In this way, psychiatric spaces are linked to changing patterns of psychiatric discourse and treatment, intertwined in a single order of existence and, thus, inextricably bound to the forms of medical theorizing operant at the moment of construction (Prior 1988:110), creating

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<sup>3</sup> A note on the language used to describe those with mental illness is warranted here. In contemporary psychiatric practice, people with mental illness are, in the main, referred to as users of mental health services. In most inpatient hospital settings, however, patient is still used as the primary denominator. Throughout the history of psychiatry, a variety of epithets have been used to refer to people with serious mental illness, e.g., deviant, mad, and insane. While these labels are considered offensive today, I will use them when historically appropriate. In accordance with Davidson et. al. (2010), I think it is important to use the original language rather than to purge it from history.

an inseparable “[...] relationship between social and cultural forms on the one hand, and built and spatial forms on the other” (King 1980:3). From the eighteenth century and onward, each reform of psychiatric practice has shaped the development of new spaces for treatment, leaving previous spatial solutions mocked as crude or irrational (Topp et al. 2007:2). Perhaps a somewhat hyperbolic proposition, only time will, in fact, tell whether the current synthesis of ideas found in the spatial organization and design of the psychiatric hospital in Slagelse will receive such punitive judgment.

The literature on the history of the spatial transformations found in psychiatry is both vast and contested. Despite the historically suspect nature of Foucault’s accounts on the subject (for such critiques, see Scull 1987 and Shorter 1997), his excavation of the relationships between epistemology and materiality in psychiatry, together with his focus on the importance of spatial relations for the functioning of the mad business of the past (Philo 2004:33), has contributed much to the manner in which we are able to conceptually come to terms with the ordered relations between space and treatment in psychiatry. For this reason, his writing has been instrumental in developing the historical trajectory of the present chapter. Foucault traced important spatial shifts related to the management of those considered first as deviant, then as mad, and later as mentally ill, taking us from medieval imprisonment to classical confinement, and onto the late eighteenth century reforms of asylums. To continue this trajectory into the twentieth century, I direct my focus towards other pieces of literature, focusing on the development and importance of the recovery-oriented approach now widely considered the prevalent treatment paradigm in the West (Hummelvol, Karlsson, and Borg 2015). After summing up the most important aspects of this historical trajectory, I detail the key ideas and intentions built into the spatial form of the Slagelse site, offering insight into the design and development of the hospital building.

## The great confinement

According to Foucault (1961:39), from the middle of the seventeenth century, the mad were confined in large institutions together with the unemployed, beggars, vagabonds, and other marginalized groups, evoking what he called an era of great confinement. Prior to this era, social deviants were shipped out to sea, where the madman was at once absolutely free and simultaneously totally confined; the space of the ship was an enclosure that moved the mad far away from civility and society (Fogh Jensen 2013:143). This *Stultifera Navis*, or Ship of Fools, portrayed so poignantly by Hieronymus Bosch in 1549, was a point of departure for Foucault's archeology, guiding his description of the particular physical transference or moving around of the mad, from embarkation and passage to confinement and enclosure. While the establishment of the asylum system developed at an uneven rate across Europe, Louis XIV's state-initiated incarceration of social outliers in the 1660s made it clear how madness had not yet become differentiated from other deviances, with the Hôpital Général in Paris, a landmark institution of the time, functioning as "[...] a sort of semi-judicial structure, an administrative entity which, along with the already constituted powers, and outside of the courts, decides, judges, and executes" (Foucault 1961:40).

During this time, mental illness was considered a self-imposed moral deviance, with treatment often effected through physical constraint and punishment. The asylums of the time functioned as allocated spaces where order and reason would supposedly be restored, or at least be a place containing those who failed (Mcgrath and Reavey 2019:2). The internal organization of spaces reflected and functioned as a commentary on the social order of the time. At Salpêtrière, for instance, a late eighteenth-century French institution, the architectural layout segregated patients into a binary classification scheme of curable and incurable, with enclosures reserved specially for idiots (Livingstone 2003:69). As a building complex, these types of institutions became micro-societies in which the deviant was disciplined to become part of so-called normal society again. By containing the disorderly, orderly society was retained. The social exclusion and geographical isolation of people without reason simultaneously played a constitutive role in

the development of the Age of Reason. As such, enlightened thinking created unenlightened spaces (Livingstone 2003:71). The discovery that confinement in such institutions could have a therapeutic function, however, changed, in part, the discourse on madness, an insight that ostensibly emerged upon the Enlightenment in an almost revolutionary way (Shorter 1997:8).

## The asylum era

Towards the beginning of the nineteenth century, at the end of the French Revolution, reformists such as the British medical officer William Battie (1703-1776), the Italian psychiatrist Vincenzo Chiarugi (1759-1820) and the Parisian psychiatrist Philippe Pinel (1745-1826), separated patients considered mentally ill from other inmates, placing them in institutions devoted to moral management and medical treatment. Pinel, especially, is renowned for unchaining and liberating the insane at Bicêtre Hospital in Paris, where he was appointed head manager in 1795. Pinel considered mental illness as belonged under the purview of medicine, while at the same time arguing that recovery was indeed possible. He introduced *traitement morale* as a therapeutic practice focused on psychological rather than physical treatment, arguing that psychiatric treatment should be based on the decision “to govern by wisdom rather than to subdue by terror” (Pinel 1806 in Davidson, Rakfeldt, and Strauss 2010:41). *Traitement morale* would later be translated into English as moral treatment, despite the fact that *morale* referred to mental in the French context and not moral (Shorter 1997:20). The moralistic connotations in the English translation have caused some scholars to suggest that *traitement morale* and moral treatment should not be equated (Davidson et al. 2010:42). Whatever might have been lost (or gained) in the translation, the ideas about treatment, curability, recovery, and the importance of the built environment therein had a massive impact on the development of architectures for treatment practices and asylums. During the nineteenth century, asylums changed in both meaning and function. While no clear transformational shift can be marked, asylums during this era were considered spaces of retreat and recovery by some and as spaces of medicine and coercion by others.

## **The asylum as a medical space**

Psychiatric treatment gradually became medical treatment and disciplinary order appears as the condition for both exact observation and permanent cure. Foucault (1973a:101), however, rhetorically inquired about what it is that cures. During Pinel's time, the therapeutic process was distributed within the regulatory power of the asylum, and as Foucault (1973a:3) notes, "[...] this kind of immanent order, which covers the entire space of the asylum, is in reality thoroughly permeated and entirely sustained by a dissymmetry that attached it imperiously to a single authority [...]". The medical authority of the doctor, that is. Even the doctor's moral impetus was emphasized architecturally by the fact that his residence was usually placed at the center of the facility's axis. From there, he could literally and figuratively monitor everyday life *through* the architecture (Bruun Petersen, Poulsen, and Svarrer 2013:40). As such, the psychiatrist's body was considered part of the asylum itself, "[...] the space is covered with his eyes, ears, and actions [...] the asylum machinery and the psychiatrist's organism must form one and the same thing" (Foucault 1973a:182).

These descriptions emphasize some of the carceral aspects of the institutional setting of the time, with Foucault's work highlighting how a particular kind of social control followed in the wake of what was considered civilized and enlightened thinking. While patients were given more space to tackle their individual psychiatric problems, it was more often than not at the expense of their liberty, future aspirations, and identity (Brown and Reavey 2016:8). Psychiatry emerges as a distinct discipline in confluence with the construction of these institutional spaces, with asylums organized as an instrument of medical action due to the psychiatrist's increasing presence within them. The asylum of this time was, as Foucault contends, in its very materiality, a therapeutic operator:

"[...] the architectural arrangement itself, the organization of space, the way individuals are distributed in this space, the way they move around it, the way one looks or is

looked at within it, all has therapeutic value in itself. In the psychiatry of this period, the hospital is the curing machine” (Foucault 1973a:101).

Unlike the general hospital, where germ theory and ideas of miasma influenced the architectural layout,<sup>4</sup> psychiatric institutions were partitioned spaces, often containing single rooms for containment, organized to maximize scrutiny of its occupants. According to Foucault (1977), institutions functioned as spatialized technologies of disciplinary power, turning subjects into objects of knowledge, and asylums into analytical spaces working on its occupant’s conduct and behavior. The seventeenth century schema of confinement and closed spaces was replaced by open, observable, and transparent spaces during the late nineteenth century, a type of architectural organization that has been immortalized by Foucault’s (1973a, 1977) descriptions of Bentham’s (1995) Panopticon, from which the principle of permanent visibility and surveillance arose. The panoptic architecture is, first and foremost, a system of observation: a centralized, disciplinary point of view made possible by the collective impetus of architecture, a spatial formation, delimitation and rationality, a goal-oriented localization of distinct functions and people within a particular space (Foucault 1973a:75). The fundamental principle of the panopticon was to simultaneously enable the unilateral surveillance of inmates while securing lateral invisibility between them, ensuring comprehensive power over separate individuals through a subjectless gaze. Invisibility between those incarcerated was simultaneously a guarantee of order. This mechanism amplified techniques of power while dissolving the need for any physical violence. Visibility, however, was a trap (Foucault 1977:200). Individuals, instead, turned the observational gaze upon themselves, monitoring and regulating their self-conduct in reference to the norms of the institution, internalizing its practices and procedures.

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<sup>4</sup> Florence Nightingales ‘Notes on Hospitals’ (1859) offers a good example of how miasmatic convictions were translated into particular spatial arrangements. Nightingale wards – oblong structures with windows on both sides – were designed to ensure better sanitary conditions, with air circulation and light being of primary importance.

## **The asylum as a therapeutic space**

While the development of the somatic hospital was intimately linked with architectural modernism, the basic plan type of the asylum was not designed by architects, but rather by doctors and asylum managers (Theodore 2017:192). Doctors at that time were the specialists of space, as Foucault (1980:150) notes, and the notion that built environments shaped individual behavior became a strong proposition of the time (Yanni 2007). While the impasse of medical knowledge fundamentally changed the discourse of psychiatry, notions of salvation, care, and moral order had not disappeared. The psychiatric practice of the time was based on a double impetus containing two competing discourses: a moral discourse hinged on the belief of recovery, and a medical discourse anchored to the functions of natural science. One of the most salient expressions of this mode of treatment is perhaps to be found in the Parisian psychiatrist Jean-Étienne Dominique Esquirol's (1772-1840) plans to put the reforms of Pinel into practice.

Esquirol emphasized the importance of the link between administrative and medical power. Advancing the notion of the asylum as a therapeutic community within which patients should engage in a daily regimen of activities, reflecting what was considered an orderly life, Esquirol began to implement the ideas of moral therapy and individual responsibilities that would later reverberate, first into the experiments of dissident psychiatrists such as R.D. Laing and David Cooper in the 1960s, and later into the practices of social and community psychiatry in the 1990s (Shorter 1997:13). For Esquirol, having a therapeutic community meant that patients and physicians lived together in a psychiatric setting, where the goal was (re)instilling a sense of orderliness in the disorderly, of teaching patient's moral sentiment and moderation. It was this synthesis of medical treatment and moral management that gave way to the idea that extensive grounds and gracious gardens were a means of removing patients from problematic and disturbing sensory input while retaining the head doctor or psychiatrist as the key instigator for treating what was now considered the patient.

In the United States, an asylum superintendent named Thomas Story Kirkbride (1809-1883) created what became an influential spatial layout for asylum architecture based on the idea that access to nature was essential to healing the disturbed mind (Kirkbride 1880). But it was the York Retreat, developed and designed by the British Quaker William Tuke (1732-1822) in 1796 that was the first purpose-built asylum facility designed to support the practice of moral therapy. As such, the Retreat both embodied and instigated asylum reform, with Tuke moving for more humane treatment emphasizing optimism and kindness while maintaining a firm ordering of patients' lives (Edginton 2007:90). The spaces of the Retreat were designed to reflect the calm of nature, with the external pressures of a troublesome and stressful environment sought to be removed. In practice, this often meant geographically situating facilities in locations at a distance to the city, often in tranquil, picturesque surroundings.<sup>5</sup> Built *and* natural environments were considered important in facilitating the correct conditions for psychiatric treatment, and as Livingstone (2003:72) points out: "Here again medical knowledge was located within a wider moral order in which connections between interior psychology and external geography were assumed. Moral judgement, mental state, and medical treatment were intricately interwoven."

Decorated with flowers and plants, the York Retreat had porches, great verandas, and skylights, all in the interest of creating the circumstances for a simpler life. As such, the design of the Retreat reflects a fundamental belief in the importance of the built environment, that it creates a healing space that supports individual recovery. In relation to treatment practices, this made it important to investigate how the mentally ill encountered and made sense of the environment, which, in turn, established the notion that body and mind were inseparable, a connection that "enabled moral treatment to open up an avenue to the treatment of the mind through the creation of an environment that signified sanity" (Edginton 2007:91). The descriptions of these asylums are familiar, "[w]e know the images," as Foucault (1961:241) contends, but, as he goes

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<sup>5</sup> In Denmark, six asylums were constructed between 1852 and 1915. The most renowned asylums are Sct. Hans Hospital situated in Roskilde and Jydske Asyl near Aarhus (1852). But other asylums were also erected during this time near Vordingborg (1858), Viborg (1877), Middelfart (1888) and Nykøbing Zealand (1915).

on to argue, beneath the recognition of the mentally ill as people in need of treatment was a set of operations which organized the asylum and its methods of cure, substituting the “[...] free terror of madness [with] the stifling anguish of responsibility” (1961:247). As such, the asylums and psychiatric hospitals of the late Victorian period can be represented as both spaces of power and as therapeutic spaces. In both representations, however, the relationships between the material environment of the treatment facilities and the social relations within them are key to understanding the psychiatric practices operant at the time (Curtis 2010:191).

## **Deinstitutionalization**

In the nineteenth and early twentieth century, asylums functioned as the main spaces for psychiatric care. By the turn of the century and with the rise of the neurosciences (e.g. Rose 2007), the therapeutic environments of the asylums were increasingly considered superfluous, leading towards processes of deinstitutionalization, shifting the focus and practice of psychiatry in many Western countries. The language used to describe these environments varies throughout the literature, with psychiatric settings called a therapeutic environment, ward atmosphere, and psychiatric or therapeutic milieu (Liggins 2016:33). Regardless, the tangible psychiatric spaces from earlier were being replaced by diverse settings, locations, and administrations (Högström 2018), resulting in a decline in psychiatric hospitals, “a wane that has been heralded to mark the twilight of asylumdom” (du Plessis 2013:428). While policies of deinstitutionalizing mental health care have played out differently across contexts, resulting in more or less successful community-based alternatives to treatment in asylums (Nord and Högström 2017b:9), the important point here is that the shifts from treatment in asylums to care in the community, from institutionalization to deinstitutionalization, mark key shifts in the changing spatializations of psychiatric practice and how mental illness is delineated, defined, and managed. Although criticisms of asylum spaces can be traced back to as early as 1866 (see Davidson et al. 2010:145), the sociopolitical critiques and cultural climate of the 1960s undoubtedly played an important role in their overall demise in the West.

McGrath and Reavey (2019:3) point out how the closure of asylums attracted an unlikely coalition of left and right-wing politics, with the former driven by nascent service user movements and the latter by its opposition to large state solutions. Multiple reasons for asylum closures can be given and explored, such as the burgeoning individualism and consumerism of the mid-twentieth century (McGrath and Reavey 2019), public concerns about the conditions in state hospitals (Spaulding 2016), or the impact of advances in antipsychotic drugs and the high cost of delivering and managing inpatient care (Priebe and Chow 2013:2), but the fundamental critiques put forward by service user movements and dissident psychiatrists in the 1960s about psychiatry as a scientific discipline, the role it played in society, and the manner in which psychiatric treatment was organized and provided were instrumental in developing new ideas about the importance of therapeutic spaces and for the development of a recovery-oriented approach (Rosenberg 2016:86).

### **Anti-psychiatry and therapeutic spaces**

The ideas and notions of therapeutic spaces and psychiatric treatment found in the work of Szasz, Laing, and Cooper function as an important contributing factor for catalyzing the deinstitutionalization process. With the contemporaneous publications of Goffman's *Asylums* (1961), Foucault's *Madness and Civilization* (1961), Laing's *The Divided Self* (1960), and, finally, Szasz's *The Myth of Mental Illness* (1961), the "four-sided platform upon which anti-psychiatry marched into the world" (Hacking 2004:292) was created. These four books had an immense impact on the developments occurring in mental health provision in the 1960s, marking a dramatic shift in how mental illness and treatment were to be viewed by society and managed by professionals. Yet, the book that arguably had the most significant cultural impact was Kesey's 1962 novel *One Flew over the Cuckoo's Nest* because it formed the image of psychiatry for an entire generation (Shorter 1997:275). But, as Hacking (2004:292) contends, the power vested in these books can likely be derived from a case of in the right place at the right time as local authorities after the post-war boom were experiencing a lack of funds to maintain institutional

care, now finding the right impetus to release “innumerable troubled men and women into the streets.”

While Foucault and Goffman’s work was indeed influential in changing intellectual perceptions and sociopolitical understandings of the discursive and sociological workings of psychiatric hospitals as places for treatment, making visible the disciplinary and totalizing aspects of such institutional settings, it was perhaps the Italian psychiatrist Franco Basaglia that went the furthest in envisioning the possibilities of a therapeutic community as an alternative space to the institutional and disciplinary spaces of the asylums at that time. Basaglia is renowned as the man who closed the asylums in Italy (see Foot 2015). His practice and work were based on ideas of anti-institutionalism and participatory governance, social analysis, and a critique of the medical establishment, ideas that took form while he was the director of a large asylum in Gorizia. His first encounter with this asylum in 1961 was the incentive for initiating his efforts to close the asylums from *within* by radically reimagining the asylum space as a therapeutic community, ostensibly bringing freedom and democracy to both patients and staff (Foot 2015). Basaglia’s efforts to develop therapeutic spaces within the institutional setting ran in parallel with theoretical developments and institutional changes happening outside Italy, especially in the UK, where the Villa 21 and Kingsley Hall experiments conducted by Cooper and Laing were challenging previous notions about, and the relationships between, mental illness, society, and treatment.

In 1955, Laing published a paper together with two colleagues about a rehabilitative unit in the Gartnavel Hospital in Glasgow, commonly known as the Rumpus Room (Cameron, Laing, and Mcghie 1955). Laing was given permission to establish an alternative milieu to the otherwise overcrowded spaces of the hospital. He created an ostensibly therapeutic space with the aim to determine the impact of placing chronic patients in less distressing surroundings, re-envisioning psychiatric practice and the spaces of mental health care in doing so (McGeachan 2017). The Rumpus Room was a comfortably furnished space with access to magazines and materials for

knitting, it was located adjacent to a kitchen, a billiard room used by staff, and the doctor's bedroom. Laing reported that patients' conduct, as well as interpersonal relationships among patients and nurses, improved, in part, due to the altered spatial circumstances. Cooper (1967) later developed a similar experiment in 1962 when setting up a special unit within a large mental hospital outside London, commonly referred to as Villa 21. This experiment included the explicit intent to blur the roles between nurses, doctors, and patients to study patterns of communication and develop a form of therapy that did not solely focus on the individual patient. Although Cooper concluded that Villa 21 remained an institutional space containing subtle forms of violence, the insights gained from this experiment in anti-psychiatry functioned as a blueprint for developing Laing and Cooper's next experiment, a community house founded in Kingsley Hall under the psychotherapeutic Philadelphia Association in 1965.

Kingsley Hall was a large community space governed, in theory, by a complete open-door and free-for-all policy, blurring the boundaries between inside and outside, between material and social environments, and for this reason encouraging encounters and interactions among caregivers and care receivers. The notion and development of a therapeutic milieu was especially salient, carrying with it a shift in the manner in which the built environment is thought to have an impact on recovery, moving away from the disciplinary and analytical spaces of previous asylum architectures towards more experimental engagements and uses of the surroundings, in many ways echoing the ideas put forward by the reformists during the impasse of moral therapy in the early nineteenth century. The impact and importance of the material arrangements in these spaces was considered flexible, *re-arrangeable*, as potentialities (D'Hoop 2018:7), where encounters between patients and practitioners were encouraged. These experiments remain important in changing the landscape of psychiatric treatment throughout the second half of the twentieth century and have been credited with initiating various humanizing reforms in psychiatric treatment in the West, where the importance of the spatial circumstances for providing and managing mental health care are highlighted. In parallel with these experiments in psychiatry, the civil rights movements were advocating basic citizenship

rights and, as Davidson and colleagues (2010:14) noted, “[...] the recovery movement is first and foremost a civil rights movement initiated and led by, and for the direct benefit of, individuals with serious mental illnesses”. This movement has had an immense influence on current ideas about the provision of mental health.

### **Recovery: a focus, not a locus**

Processes of deinstitutionalization set the stage for the recovery movement (Spaulding 2016:13), making the concept of recovery part and parcel to the history of anti-psychiatry as woven into the developments that led to the fundamental proposition that mental illness is something that people have, not something they are. Mental illness came to be considered episodic rather than chronic, with treatment directed towards developing personal and social capabilities to enable individuals to take care of themselves in society (Rosenberg 2016:381), turning the focus away from medicalization and simple symptom relief towards well-being, empowerment, hope, community inclusion, and personal goals instead (Anthony 1993, 2000). Anthony (1993), a psychologist with a background in the rehabilitation of physical disabilities, introduced the concept of recovery as the guiding vision for U.S. mental health services as a response to the failed implementation of deinstitutionalization policies in a paper with now almost iconic status in the mental health field (see Korsbek 2017). In the paper, Anthony (1993:521) argues that the “seeds of the recovery vision were sown in the aftermath of the era of deinstitutionalization”. By and large, the push for a recovery-oriented approach entailed that mental health services in the West increasingly focused on moving psychiatric care into community spaces, ushering patients out of hospitals and into society, with the intended goal to empower, enable, and support people to be able to carry on with their own lives without constant interference (Mcgrath and Reavey 2019).

According to Davidson et. al. (2010:14), the primary challenge for a recovery-oriented approach is how to encourage and support people with severe mental illness in their everyday lives, including life outside institutions, making a key aim of recovery-oriented care “[...] to enable

people who had been thrust to the margins of society to reclaim their basic citizenship as free and autonomous actors”. Recovery is considered a political reaction against suppression and stigma (Hummelvol et al. 2015:3), an outcome of civil rights movements, a battle of values and principles, a war that needed to be won. While this war may have arguably been won, the notion of recovery remains a contested and ambiguous term, with scholars prompting research communities to engage in empirical investigations since recovery has come of age (Slade et al. 2012). Since the 1990s, however, implementing or appropriating a recovery-oriented approach in psychiatric practice has gained considerable momentum (see Williams et al. 2012), with policies increasingly focusing more explicitly on facilitating recovery-oriented mental health care in inpatient and outpatient settings.

In the 2000s, recovery-oriented mental health care has become an accepted term, figuring in national standards, guidelines, and policies, although it expresses a variety of conceptual understandings and modes of practice (Hummelvol et al. 2015:3). Recovery can be conceptualized, for example, as *clinical recovery*, which refers to when people recover from mental illness due to a particular clinical treatment, or as *personal recovery*, which refers to when people recover from the social consequences of mental illness while building a meaningful life (Davidson et al. 2016). As a result, personal recovery is often conceptualized as a journey, a non-linear process unique to the individual (Leamy et al. 2011). Initially, a critique of the therapeutic nihilism that characterized the psychiatric institutions of yesteryear (Rosenberg 2016:381), the notion of recovery has gradually become an accepted and general ideology for contemporary mental health care (Hummelvol et al. 2015). Developed to move psychiatric treatment and people in need of such treatment *out* of institutional spaces, the recovery-oriented approach is currently being applied *in* institutional inpatient settings as well, albeit with much struggle (e.g., Cleary et al. 2013; Spaulding 2016; Waldemar et al. 2018). But, as Anthony ostensibly mentioned during debates on where the recovery-oriented approach might be appropriate, “It’s the focus, not the locus” that is important (Spaulding 2016:14).

Overall, there is a strengthened focus on rehabilitation and recovery in the provision of mental health care in Denmark and internationally, with attention directed towards including the user rather than simply treating the patient (The Danish Government 2013). The vision for the future of psychiatric treatment in Denmark (Danske Regioner 2009) is based on this fundamental tenet, with recent policy documents explicating the importance of taking a recovery-oriented approach in inpatient and outpatient treatment (Region Zealand 2008). The recovery-oriented model, as Bruun Petersen and colleagues (2013:45) contend, poses new demands on the capabilities and capacities of contemporary psychiatric facilities, once again making it relevant to think about how to develop buildings that support the biological, psychological, and social aspects of individual recovery processes.

## **In sum**

From the great confinement to the era of the asylum; from incarceration to moral therapy; from anti-psychiatry to subsequent deinstitutionalization and community care, spatializations changed, marking key shifts in the relationships between ideas about psychiatric treatment and psychiatric spaces. They are key shifts in architectural technologies of knowing order. The movement from the architecture of madness (Yanni 2007) to the development of contemporary ‘recovery-oriented spaces’ and ‘healing architecture’ reflects a particular trajectory of the changing spatializations and epistemological transformations found in the practice, provision, and places of psychiatry and mental health care. The ideas about how to create therapeutic settings and treatment in support of recovery put forward in the nineteenth century, and later in reinvigorated forms in the mid-twentieth century, are still pertinent to contemporary developments in psychiatric care (Curtis 2010:194), with the recovery-oriented approach being a contemporary conceptualization of ideas that can be traced back to the moral treatment of the asylum era (McCranie 2011) and the therapeutic communities that developed during the anti-psychiatric experiments of the 1960s<sup>6</sup>.

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<sup>6</sup> The double impetus found in many of these developments, between a recovery-oriented approach and medically informed treatment, can, as Curtis (2010:188) argues, be considered early articulations of what

<i>Period</i>	<b>Treatment</b>	<b>Site</b>	<b>Space</b>
<i>The great confinement</i>	Punishment	Large institutions	Carceral and penal
<i>The asylum era</i>	Moral and medical	Asylums	Moral and medical
<i>Deinstitutionalization</i>	Recovery oriented	Community	Social

Table 1. Changing spatializations of psychiatric treatment

Asylums, sanatoriums, and other opaque spaces used to confine the mentally ill are currently being replaced by light, modern institutional spaces, designed with healing, recovery, and stabilization in mind (Mcgrath and Reavey 2019). The psychiatric hospital in Slagelse can be considered a paradigmatic case of a contemporary building mirroring ideas about psychiatric treatment. Current developments in hospital design are incorporating ideas about recovery and patient-centeredness (Bromley 2012; Vaughan, Sumartojo, and Pink 2018) that can be linked to the changing spatializations represented in Table 1, especially the synthesis of medical treatment, rehabilitation, and therapeutic environments is arguably linked to contemporary ideas about inpatient treatment and design. In the following, I investigate the design of the Slagelse site, considering what may be seen as one of the most recent developments within the changing spatial modulations of psychiatric treatment.

## Designing a recovery-oriented building

The psychiatric hospital in Slagelse is the first psychiatric hospital to be designed and erected in Denmark since the hospital in Nykøbing Zealand was taken into use in 1915. In contrast to the architecture of the late Victorian asylums, contemporary developments do not reflect any one dominant building type (Bruun Petersen et al. 2013:45), enabling architects and other relevant stakeholders the space to interpret, develop, and design what they consider the best spatial

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constitutes a therapeutic landscape for mental health care, incorporating physical, symbolic, and social elements in the provision of care to facilitate and support healing and recovery. The therapeutic landscapes framework is something I return to in the following chapter.

organization of contemporary and future psychiatric practices. The assumption that architecture and space are important to the provision of mental health care and the enablement of individual recovery remain central to contemporary developments and are clearly explicated in the vision statement put forward by Region Zealand in the competition program for the construction of the psychiatric hospital in Slagelse: “The physical surroundings have a large impact on our psyche and well-being. The architectural vision for the establishment of New Slagelse Psychiatric Hospital is therefore to create a physical frame that offers the best opportunity for treatment and subsequent recovery” (Region Zealand 2010b).

In answering this call, Karlsson Architects and Vilhelm Lauritzen Architects collaborated in proposing that the aim of the new hospital building should be to create unity between culture, structure, behavior, and bricks (Karlsson Arkitekter/Vilhelm Lauritzen AS 2010:43). Here, we find an intended synergy between design, material form, and activities. Karlsson Architects and Vilhelm Lauritzen Architects won the architectural competition for the Slagelse site with their project proposal that, according to Project Director Henrik Bendix Olsen, had the “innovative approach they were looking for”.



Image 1. Representation of the Slagelse Hospital

With the motto, the house in the park, the park in the house, Karlsson Architects spearheaded the project under the title A lighthouse for the future of psychiatric building. During initial phases of development, the design office went looking for inspiration at other sites, nationally and internationally, but, as the lead architect Kristian Karlsson explained, they returned disappointed:

“It was a disappointment. We expected to find the state of the art in Germany or in the US in terms of healing architecture, but we didn’t and neither did the hospital management. We didn’t find anything in Norway or Sweden, and what we encountered in Holland and in the UK was completely discouraging [...] We were forced to admit that we had to develop something ourselves” (Region Denmark n.d.).

As a result, the design office developed its own interpretation of what recovery-oriented healing architecture in the future of psychiatry might look like and which treatment ideals and notions it should mirror:

“We started with the thesis that, what is good for all of us – is also good for those of us who are sick. It just needs to be scaled. And then suddenly it became quite simple to define healing architecture. When the weather’s good, we want to get outside. Visit our summer cottage, be in the yard, relax on the porch for a cookout. Getting out – in nature – is the best of all. So that became our starting point, culminating in the theme the house in the park, the park in the house.” (Region Denmark n.d.).

While the concept of healing architecture is becoming an established notion within health care design, it is clear from the quotation above that Karlsson renders it open to interpretation, plainly drawing on notions about the healing qualities of nature seen in the asylum designs from the nineteenth century, but now, as Karlsson explains, nature is moved inside, made accessible, observable, and ostensibly less terrifying (Region Denmark n.d.). Apparently, the architects

perform the role of experts in developing the spatial circumstances for contemporary psychiatric treatment. It was important to the hospital management to create something that was different from Victorian asylums;

“[...] something that can be a counterpart to the role psychiatry has had in society. Sct. Hans was built 150 years ago; it was placed outside the city, far away, and wasn't something people really knew about. Psychiatry was something that was hidden. Now we are placing it in the city, close by, and making it into something open, transparent” (The Vice-Director of Psychiatry, Region Zealand, Karlsson Arkitekter/Vilhelm Lauritzen AS 2015:42).

The history of psychiatric architecture is evoked as something to avoid, with asylums of the past representing a crude spatial organization that the new development should stand in contrast to. Symbolizing openness towards the surrounding community was an explicit design goal from the outset of the building project, signaling a new direction for psychiatric practice in Denmark. In the words of the Director of Psychiatry in Region Zealand, Michael Werchmeister:

“Here we get something [psychiatric hospital in Slagelse] open which is normally closed. It is transparent; it has glass that you can see through; you can see what's going on. That's openness, instead of the black box that characterizes psychiatry in many other places, and that we're struggling to combat and open up [...] The physical environment treatment takes place in is given a completely different expression, showing openness, transparency, and that supports the changed attitude towards psychiatry we are trying to communicate to a society still living with a point of view dating back 30 years” (Werchmeister in Karlsson Arkitekter/Vilhelm Lauritzen AS 2015:43).

Placing the hospital in close proximity to the surrounding community and directly across from the general hospital was an important expression of the overall narrative of challenging existing ideas about psychiatric care as something dangerous or deviant. As the director clearly indicates in the above quote, the notion of transparency follows both functional and symbolic lines, aiming to make psychiatry tangible and accessible to people outside the facility, as well as enabling intelligibility through visibility for people inside the facility. The vice director of psychiatry in Region Zealand furthered this point by saying, “By placing it [the psychiatric hospital] close within the city, close to the somatic hospital, and opening it up to the outside world, that was important in order to say ‘well, this isn’t dangerous; it’s okay to come along inside’” (Bredkjær in Karlsson Arkitekter/Vilhelm Lauritzen AS 2015:43). A fundamental tenet of the overall design scheme was creating porous boundaries between the hospital and its surroundings, making visible what was once hidden, closely juxtaposing publicly accessible areas and roads with inaccessible psychiatric spaces. The project director for the Slagelse development further described the placement of the facility, stating, “this isn’t a closed universe, where something hidden is going on, people [are not] tortured or restrained [here], or whatever people might think” (Interview, Bendix Olsen, 2017). The building and its location thus aim to mark a shift in a particular discourse still shaping contemporary understandings of psychiatry, pushing a new narrative about an inclusive and transparent psychiatric practice enabled by an open and transparent architecture, in opposition to a narrative about the repressive, secluded, and opaque architecture common in earlier asylum designs.

## **Four design principles**

Karlsson Architects and Vilhelm Lauritzen Architects developed four key principles during the initial phases of design: 1) healing architecture and the principle of recovery; 2) transparency and proximity between people and functions; 3) generality and flexibility in rooms and sites; and 4) hierarchy of spaces and stimuli (Karlsson Arkitekter n.d.). These principles were partially based on input from different user involvement workshops whose primary goals was to develop new psychiatric products for a novel recovery architecture (Karlsson

Arkitekter/Vilhelm Lauritzen AS 2010:42). Juxtaposing quality of life for the end user with a good working environment, the workshops sought to combine a focus on needs, spaces, behavior, and relations in developing the design, emphasizing the importance of the built environment for patients and staff alike. With the first principle functioning as a general umbrella term for the entire project, and the third principle being a technical promise to the possible expansion of the facility, the second and fourth principles most closely informed the specific development of physical, material, and atmospheric features in the built environment.

Facilitating porous boundaries between psychiatry and society through the specific localization of the building was one way of symbolizing transparency and proximity between people and functions. On a more functional level, creating porous boundaries between patients and staff was seen as crucial to the design by the architects as well as the hospital management, and enabling encounters between staff and patients ended up permeating the entire design based on the assumption that the architecture should facilitate meetings between people, with the hospital manifesting a meeting place in itself, “that is, a meeting place between people who need help and people who have the opportunity to help” (Interview, Karlsson, 2017). Helping people who need help is, one might argue, simply the organizational purpose, but the notion of meeting or encounter is extended well beyond this purpose, making it a key component in the hospital’s spatial organization. Enabling encounters through architectural arrangements was closely tied to ideas of visibility; “that is, that you can find each other; see each other; that you are constantly present, but also that each individual can bring themselves best into play”, as the lead architect explains (Interview, Karlsson, 2017). Designing meeting places entailed enabling visibility, as seeing each other and ensuring that you are constantly present were considered important to psychiatric practice. This visibility was, furthermore, intended to facilitate predictability and intelligibility for patients during hospitalization. Accordingly, the architects offered the following definition of transparency:

“[...] a precondition for understanding what is going on, overview and contact. Throughout the site, walls between common areas, living room spaces, conference rooms and work areas [are] made of glass from floor to ceiling. If necessary, a nimble curtain can change the transparency and character of the room. A sense of safety, for both patients and staff, is attained by being able to see and know that one isn’t alone” (Karlsson Arkitekter/Vilhelm Lauritzen AS 2015:26).

According to the architects, being able to see what is going on and having an overview of spaces is deemed important for patients *and* staff. One of the key architectural expressions of this commitment to transparency was described in a report requisitioned by Region Zealand and authored by the National Institute for Municipal and Regional Analysis and Research prior to moving into the hospital (Jakobsen et al. 2014) as the attempt to reduce the physical separation of staff and patients, to make staff more available to patients by enabling better interaction between them, and to reduce the distance and distinctions between them and us (Jakobsen et al. 2014:76). In an interview published by Region Denmark, the lead architect explained this sense of constant presence as being important for patients:

“Patients can see them [staff], sitting and working, having meetings, etc. They can see that when someone laughs, it’s because someone said something funny [...] It’s not because someone’s laughing at me. That provides a sense of safety. And staff, on the other hand, can observe and see what’s going on unhindered. They can quickly intervene if necessary” (Region Denmark n.d.:5).

The intention was to create natural interaction (Jakobsen et al. 2014:76) between staff and patients through a series of deliberate design interventions, including the widespread use of glass to promote visibility, and the abundance of formal and informal common areas, establishing what the architects termed a hierarchy of spaces and stimuli (design principle 2). By changing the physical layout of inpatient settings, the hope was also that changes would occur

in the work practices that maintain any distinctions between them and us. Perhaps the most salient of these interventions is the nursing station. The inspiration for this aesthetic and spatial organization was derived from modern offices, not psychiatric facilities. As the lead architect explains:

“[...] the whole thing about being able to see and understand what is happening. After all, that’s something from our own world, our working life. Even if you’re not immersed in it [the activity], you get a sense of what’s going on, and who’s who, and where you can go [to reach staff]. That concept of transparency was actually taken from office building conference rooms, you might say, and moved down. [...] It [transparency] might be even more important when in doubt about what’s real, and who’s who, and [wondering about] how close can we get to each other and stuff like that. We get an environment with people, where you can see people, and you can, to the best of your abilities, understand what’s going on” (Interview, Karlsson, 2017).

Enabling the opportunity to see people is articulated as a precondition for comprehending what is going on with the hospital spaces thought to mirror the road to recovery. As such, the entire facility is designed to support a particular progression from removal of stimuli to their gradual reintroduction, with design interventions selected down to the choice of furniture based on the philosophy that staff and patients are considered equals. While inspired by the notion of recovery, the building also reflects contemporary technological developments, with LED lighting playing an especially important role in the design due to its ability, not only to reflect the circadian rhythm but also to create spatial conditions by providing variation in lighting. According to one architectural review of the Slagelse site, “the result of all this is a deceptively complex matrix of levels of engagement in which the architecture plays the role of a subtle facilitator and mediator” (Astbury 2016).

## In sum

By explicitly drawing together the notion of recovery with the concept of healing architecture, the design of the psychiatric hospital in Slagelse arguably represents a new synthesis of ideas. It draws on the ideas about the healing effects of nature and green surroundings found in the early asylum architectures; the therapeutic gains of social interaction found in the practices of moral therapy; and notions on evidence-based design developed at the turn of the century in relation to the concept of healing architecture, but also on some of the more radical ideas that grew out of the civil rights and anti-psychiatry movements of the 1960s, where patients became users and treatment became care. As such, the psychiatric hospital in Slagelse may indeed mark a change in the manner in which psychiatric facilities are conceptualized and built, with the role of the architect once again becoming prominent in the design and development of spaces for mental health care. The historical trajectory and the explication of the intentions built into the psychiatric building in Slagelse perhaps position the architect as a mastermind with certain politically and morally charged ideas about buildings functioning as technologies for treatment and for organizational and societal change.

Explicating the intentions of the architect are relevant insofar as they enable discussions on the spatial organization of contemporary psychiatric practice. The process of designing the psychiatric hospital in Slagelse, of how ideas from psychiatry were translated and given architectural form, prefigures this study. Knowing about the design is important for the current investigation insofar as the interests, hopes, and intentions can be understood as a proposition for how the ‘healing architecture’ and ‘recovery-oriented spaces’ of the Slagelse site are expected to *work* (Yaneva 2017), i.e., what they are designed to *do* (Gieryn 2002). What the three papers that constitute the main body of this dissertation consequently seek to investigate is not the design of the hospital building as such, but the implications of its manifest form. What I hope to gain from this effort to provide context is a sense of historical lineage, but also, and more importantly perhaps, of the particular intentions undergirding the changing spatial modulations of mental health care. In the following chapter, I first consider and review

research on the spaces and places of psychiatric practice, focusing particularly on scholarship within health geography and, second, I engage with work related to science and technology studies to come to terms with how the relationships between spaces and practices have been considered and studied.

### 3. Literature review

The present epoch will perhaps be above all the epoch of space. We are in the epoch of simultaneity: we are in the epoch of juxtaposition, the epoch of the near and far, of the side-by-side, of the dispersed. We are at a moment, I believe, when our experience of the world is less that of a long life developing through time than that of a network that connects points and intersects with its own skein.

- Foucault 1984a:1

In the previous chapter, I developed a context for considering the spatial organization of contemporary psychiatric practice by elaborating on some of the changing spatial modulations found within the history of psychiatry. In the design of the psychiatric hospital in Slagelse, many of the ideas about the impact and importance of space, the built environment, and material surroundings for supporting individual processes of recovery and psychiatric practices seem to have been reinvigorated, synthesized, and given manifest form. Space, architecture, and material surroundings have arguably always been important to the provision of mental health care, and the recent proliferation of theoretical tools and conceptual means for studying their impact and importance offers intriguing new avenues for research. For this reason, I have been inspired by different streams of literature, with work in health geography, the sociology of health and illness, and STS being particularly relevant for my research as each discipline offers unique insights into how we might approach studying the issue of the contemporary spatial organization of psychiatric practice. The aim of the following review is to engage with interdisciplinary conversations and cross-fertilizations already taking place, extending lines of inquiry related to questions of space, architecture, and the built environment.

While the purpose of writing a literature review is typically meant to enable the opportunity to add something to that literature by identifying research gaps (Sandberg and Alvesson 2011), this task becomes close to impossible when the domain of study intersects so many disciplinary boundaries. Gieryn (2000:482) articulates this challenge nicely in relation to his review of the sociological literature on place:

“It is difficult to spot the most vitally overlooked gaps when the domain of study is as unbounded as the one discussed here – place matters for politics and identity, history and futures, inequality and community. Is there anything sociological not touched by place? Probably not.”

Building on this proposition, I do not claim to address a major gap in the literature, nor do I aim to offer an exhaustive review. Instead, I follow Justesen’s (2008:22, my translation) suggestion that the “demarcation of a research domain is not naturally given, but a construction that partly depends on the projects problem and strategy for analysis”. The literature review is organized into two main sections. The first section focuses on literature primarily within health geography and the second section focuses on interdisciplinary literature within the sociology of health and illness and STS. While the former section concentrates on reviewing how and where mental health spaces have been studied, the latter focuses on studies that share a set of theoretical and methodological assumptions about how to study space. Both are important for the present dissertation.

## **The epoch of space?**

Whether we are indeed in the epoch of space, as Foucault (1984a) contends, is secondary to the fact that space has become a key point of analytical orientation and a substantive research topic in various social science disciplines, especially since the so-called spatial turn in social theory (Soja 1989). It is surprising, however, as Martin et. al. (2015:1008) point out, that the spatial turn has not led to the sustained analysis of the materiality of buildings in health care settings.

While the literature on space is considered highly fragmented (Weinfurtnner and Seidl 2018), earlier theoretical interests related to space found in the work of French thinkers such as Bachelard (1958), Foucault (1977, 1984a), and especially Lefebvre (1991), are particularly noticeable. Scholars within social sciences, such as organization studies (e.g., Baldry 1999; Beyes and Steyaert 2012; Dale and Burrell 2008; Halford 2005; Kornberger and Clegg 2004; Taylor and Spicer 2007), the sociology of health and illness (e.g., Buse, Martin, and Nettleton 2018; Fox 1997; Martin et al. 2015; Mesman 2009), nursing studies (e.g., Andes and Shattell 2006; Andrews, Chen, and Myers 2014; Andrews and Moon 2005; Halford and Leonard 2003), and STS (e.g., Henke and Gieryn 2007; Law 2002; Livingstone 2003; Mol and Law 1994; Yaneva 2017), have increasingly examined, conceptualized, and analyzed the importance of space directly, in many cases referring to the early theoretical work just mentioned. While approaching the notion and study of space in different ways, regular cross-fertilizations between these approaches have led to a host of empirical and theoretical innovations within and across them (de Vaujany and Mitev 2013).

Nowhere is this more salient than within human geography, where scholars have taken a critical view of any static understandings of space (e.g., Soja 1989; Thrift 1996), heavily influencing the later shift from medical to health geography (Kearns 1993; Kearns and Moon 2002), which has since become a “vibrant, engaged and methodologically diverse sub-discipline of human geography that explores all aspects of the relationship(s) between health and place” (Crooks, Andrews, and Pearce 2018:1). While work within these fields has pioneered methods for studying the spatialities of psychiatry and mental health care, they have often done so by investigating the mediating role of space for health outcomes, well-being, and recovery (Curtis 2010:187). For all the important insights this work offers, the primary analytical focus has been the lived *experiences* of people occupying, moving through, or entangled in the spaces and places where mental health care is provided. As a result, notions like therapeutic landscapes and enabling places have emerged to analytically account for the significance of such spaces in terms of particular questions or problems of health and illness. Consequently, less attention has

been directed towards how such spaces shape and are shaped by the *practices* taking place within them (for some exceptions, see Andrews 2016; Andrews and Shaw 2008; Water et al. 2018). Focusing on practice is important, I contend, insofar as the ordering of space and interaction in practice shapes the sense and significance of the spatial circumstances within which patients and professionals find themselves. In other words, the significance of ‘healing architecture’ cannot be understood *outside* of practice. They are co-constituted.

To come to terms with the importance of practice in studying ‘healing architecture’, I engaged with work in STS. Despite the interdisciplinary scholarship of this field (see Biagioli 1999), a shared impetus to study how practices are ordered and shaped in various locations with a variety of actors in different material and institutional framing conditions can be emphasized. What might be missing, however, are investigations of the conditions and implications of spatial and architectural arrangements for health care practices, as Moser (2017:87) contends: “Based on this interest in the material dimensions and ordering of care in STS, one might expect a thriving discussion and body of work engaging with spatial and architectural conditions of care. But so far, this has not been the case.” Juxtaposing the interests in the relationships between space and health care from health geography with the analytical tools and methods from STS offers a novel way to approach the study of what ‘healing architecture’ does in practice, I contend. To pave the way for such a juxtaposition, and to contribute to interdisciplinary engagements already taking place within and across these kinds of literature (e.g., Jacobs and Merriman 2011; Martin et al. 2015; Moser 2017; Nord and Högström 2017), a better sense of where to look is required.

To substantiate the claims about the importance of practice for the study of what ‘healing architecture’ does, this review examines two overall bodies of literature, organizing the chapter into two main sections. First, I review a body of work within health geography focused primarily on the geographies of space and mental health care. Second, I consider an interdisciplinary body of work found in the sociology of health and illness, and especially in

STS that more explicitly, albeit in different ways, consider the relationships between (material) spaces, practices, and interaction. Finally, I consider recent work on caring architectures that is situated at the intersection of health geography and STS. This body of work directly engages with questions similar to those posed in this dissertation.

## **Geographies of space and mental health care**

This first part of the review is divided into four subsections. As such, I begin by considering the scholarly work on different institutional and post-asylum spaces. Second, I review two salient theoretical developments within the field of health geography, focusing on the therapeutic landscapes framework and the notion of enabling places. Finally, I consider recent empirical studies of psychiatric inpatient settings, detailing how these studies build on, extend, and contribute to the theoretical developments just mentioned.

### **Institutional and post-asylum spaces**

As institutions, psychiatric hospitals are often considered coercive architectures (Dovey 1999; Markus 1993; Nord and Höglström 2017b), or spaces of confinement that restrict occupants in particular ways, privileging the options and actions of some over others (Foucault 1977; Goffman 1961). Drawing on Foucault and Goffman's seminal accounts, institutional geographers (Park and Radford 1997; Philo 1989, 1997, 2004; Philo and Parr 2000; Topp 2007) focus on both the geographies *of* and the geographies *in* psychiatric institutions, often treating them as places that seek to "[...] restrain, control, treat, 'design' and 'produce' particular and supposedly improved versions of human minds and bodies" (Philo and Parr 2000:513). Such suppositions surely evoke Foucault's (1977) analysis of Bentham's architectural figure, the Panopticon, where the institutional space is turned into a causal factor in the purposefully orchestrated transformation of individual subjects, enabling surveillance and control through the spatial organization of visibilities. Foucault's descriptions of the panoptic mechanism have been highly influential in studies examining the relationships between institutional spaces, practices of surveillance, and social control in psychiatric settings (Curtis et al. 2013:202), and

especially in mental health nursing (Buchanan-Barker and Barker 2005; Holmes 2001; Morrall and Hazelton 2000; Salzmänn-Erikson and Eriksson 2011, 2012; Stevenson and Cutcliffe 2006).

Indeed, Foucault continues to be the key point of reference for understanding the ordering of social relations in hospital settings, as Kanyeredzi and colleagues (2019:446) point out, highlighting how power and social control are enabled by architecture and distributed through particular spatial circumstances. This perspective is also present in the edited volume *Madness, Architecture and the Built Environment* (Topp et al. 2007), which investigates psychiatric spaces in historical context, ranging from the most intimate spaces, i.e., a corner that's for myself (Davies 2007), to the most systemic spaces, i.e., managing an entire asylum system (Ernst 2007). Studies in this volume investigate the interplay between all manner of spaces, configured as physical, social, technical, and ideological, and the ways in which psychiatry has been shaped and experienced, with Foucault, again being cited as an ongoing influence, as Philo and Pickstone (2009:653) note in their account of local historical geographies of psychiatry. Despite the extensive research on the spaces and places of mental health care (Högström 2012, 2018; Parr 2000, 2008; Philo 1992, 1995, 1997; Philo and Parr 2000; Pinfold 2000) and so-called post-asylum geographies (Kearns and Joseph 2000; Park and Radford 1997; Philo 2000; Wolch and Philo 2000), research on more contemporary and innovative hospital buildings, like the psychiatric hospital in Slagelse, are still rather limited (for an exception, see Högström 2019). Rather than focus on the materiality of buildings or inpatient spaces, existing studies show more interest in mapping and investigating the different locations and care settings occupied by people with mental health issues, as well as on user experiences and perceptions thereof.

Processes of deinstitutionalization in psychiatry (Högström 2018; Novella 2010; Turner 2004) have changed *where* the provision of mental health is located, thus fashioning the opportunity to study the role of space and place in a variety of community settings (McGrath and Reavey 2015; Milligan 2000; Parr 2000, 2008; Parr, Philo, and Burns 2004; Pinfold 2000; Tucker 2010).

As a result, concrete institutional sites have largely been ignored (McGrath and Reavey 2013) due to the discourses of placeless community care (Symonds 1998). Although some have noted a recent shift towards institutional care again, suggesting a potential move towards re-institutionalization (Priebe et al. 2005; Turner 2004), most institutional spaces are considered to be a failure of the system (Quirk, Lelliott, and Seale 2006), seen as something to be avoided (McGrath and Reavey 2015). Community care and the contemporary discourses of recovery have, furthermore, changed the nature and role of inpatient settings (Curtis et al. 2009; Wood et al. 2013a), making them more permeable (Quirk et al. 2006), for instance. For this reason, some scholars focus on researching the connections between the inside spaces of institutions and the outside spaces pending discharge (Tucker et al. 2018). McGrath and Reavey (2013) for example, have shown how service user subjectivities are shaped by moving between community spaces and inpatient settings, drawing on Foucault's (1984a) notion of heterotopia to capture the element of control embedded in the spatial and material layouts of service user sites. Examinations of the multiplicity of these various psychiatric sites are a testament to the wide-ranging empirical points of orientation taken by health geographers and scholars engaged with this field of research, informing us about the lasting importance of different spatial circumstances for the provision and experience of mental health care.

## **Therapeutic landscapes**

Although Jacobs and Merriman (2011:219) contend that geography is “an analytical discipline oriented towards description and diagnosis of already-existing spatial circumstances,” as the previous review section also shows, many theoretical and conceptual developments can be identified, with the therapeutic landscapes framework being one of the most influential in the field. Health geographers have significantly expanded the number of potential variables that may play a role in the promotion of well-being and recovery by applying the interpretive framework of therapeutic landscapes (Gesler et al. 2004; Papoulias et al. 2014). Health geographer Wilbert Gesler (1992) initially introduced the concept of therapeutic landscapes to capture the physical, social, and symbolic dimensions of place and the ways these dimensions

may impact experiences of health and well-being. As such, the notion of therapeutic landscapes functions as a geographic metaphor that draws on theoretical impulses from humanism, structuralism, and cultural ecology to better understand a broader set of variables of potential importance to processes of healing and well-being. As Gesler (1992:743) explained in an early account:

“Thus therapeutic landscape becomes a geographic metaphor for aiding in the understanding of how the healing process works itself out in places (or in situations, locales, settings, milieus). For example, a confrontation between a patient and a physician in a treatment room is affected by the physical attributes of the room (e.g. temperature, size, color of the walls, arrangement of the furniture), the ideas and intentions of the actors (e.g. illness and treatment beliefs, symptom description and interpretation, concealment of certain facts), and the structural forces underlying the physician-patient relationship (e.g. dominance-resistance, type of medical system, territoriality).”

The concept of therapeutic landscapes aims to capture the physical, social, and symbolic aspects of a particular place in the interest of exploring how and why certain environments seem to contribute to healing and recovery and, since its inception, has become a dominant approach within health geography. Early applications tended to focus on the healing properties of extraordinary places such as pilgrimage sites (Gesler 1996) or groves and hot springs (Gesler 1998), with later studies extending into more mundane spaces to explore the healing qualities of everyday spaces of interaction (e.g., Smyth 2005). The notion has since been applied in a variety of contexts (Bell et al. 2018; Gesler 2005; Williams 2007), with studies focusing on the implications of blue spaces (Foley and Kistemann 2015), green spaces (Marcus and Sachs 2013), and hospital spaces (Curtis et al. 2007; Gesler et al. 2004; Wood et al. 2013a, 2015), for instance.

While the therapeutic landscapes framework remains highly influential, only few studies have drawn directly from this approach in research on psychiatric hospitals, evaluating, for example, the design of inpatient settings in a mental health unit in London (Curtis et al. 2007, 2009; Gesler et al. 2004). Gesler et al.'s (2004) study found that hospital design is important for patient well-being, with social and symbolic elements of the built environment being highlighted as more important than physical elements. The framework has also been used to shape and buttress particular design developments (Wood et al. 2013a, 2015), and Curtis and colleagues (2007), for example, assessed the hospital design of a mental health unit by talking to staff and patients about which aspects of the built environment they found beneficial or detrimental to experiences of health and well-being. Recent developments in the therapeutic landscapes framework can be found in another one of Curtis and colleagues' (2013) studies, where they examine the relationships between symbolic and material dimensions of risk and surveillance within an inpatient setting, extending the framework to include aspects relating to social control. They show how the social construction of risk is related to certain spaces within the ward, which, in turn, influences the therapeutic aspects of said spaces, with new spatial practices consequently being enacted.

Despite, or perhaps because of, these many applications, the concept of therapeutic landscapes remains somewhat ambiguous (Bell et al. 2018:128). How we are to understand the notion of therapy, for instance, remains unclear, leaving unresolved what people are seeking to analyze or heal through therapeutic encounters in a place. Echoing this concern, Bell and colleagues (2018:128) ask, "To what extent are such encounters a temporary source of respite [...] or a deeper source of transformation?". Kearns and Moon (2002) also argue that the positive aspects of therapeutic landscapes tend to be over-valorized, hindering potential insights into any detrimental effects they might also have. Resonating with this critique, Conradson (2005) argues that such frameworks also have a tendency to attribute the built environment with intrinsic therapeutic properties, giving relatively little consideration to the relational dynamics through which therapeutic effects might emerge (see also Cummins et al. 2007; Reavey et al.

2019). The application of the framework has furthermore been criticized for functioning as an explanatory device, a bumper sticker, with researchers doing little more than claiming certain phenomena to have therapeutic qualities (Andrews 2004:308). In many of these studies, space is treated as a static material fact rather than a dynamic process that emerges in myriad interactions and practices (Water et al. 2018). This has led scholars to develop more relational approaches. I turn to some of these in the following.

## **Enabling place**

The critiques of the therapeutic landscapes framework have prompted scholars to develop more relational approaches to the conceptualization and empirical analysis of place, and place effects in health more directly that capture the dynamic interplay between spatial circumstances and health outcomes, recovery, and well-being (e.g., Conradson 2005; Cummins et al. 2007). A variety of novel theoretical orientations have emerged including, but not limited to, enabling places (Duff 2012), therapeutic assemblages (Foley 2011), therapeutic mobilities (Gatrell 2013), and landscapes of care (Milligan and Wiles 2010; Pinfold 2000). These conceptualizations have a heightened and situated sensitivity towards the therapeutic properties and/or emergent effects of particular spaces and places, moving beyond linear notions of therapeutic/non-therapeutic causation towards ideas of networks of assemblages of health instead (e.g., Duff 2010, 2015; Price-Robertson, Manderson, and Duff 2017). This research has contributed much to the innovation of qualitative studies on health and illness by treating health and illness as dynamic and emergent expressions of specific socio-material assemblages (Andrews and Duff 2019:125).

Such studies have been labeled as posthuman geographies (Duff 2018) because they move the analytical focus beyond the reified subject to include a multiplicity of forces, human and non-human encounters, and actor-networks instead (Duff 2011, 2014). Such developments owe much to post-structuralist approaches and so-called nonrepresentational theories (for recent reviews, see Andrews et al. 2014; Andrews and Duff 2019). According to Duff (2018:138), STS

have arguably “made the most significant theoretical contributions to discussions of posthumanism within health geography”. The influence of STS is especially clear in the argument that subjects cannot be thought of as passive end-users of technological innovations, nor as users of technological artifacts that remain under their authority, instead, users ought to be regarded as co-constituted effects of networks and assemblages of heterogeneous actors. Human experience no longer functions as the self-evident center of all occurrences, which ascribes agentic capacity to a much broader spectrum of actors, include architecture. I will return to STS research that considers these issues in the second section of this chapter.

The notion of landscapes of care builds on earlier geographical work on deinstitutionalization and the landscapes of despair (Gleeson and Kearns 2001) created as a consequence thereof, to emphasize the importance of macro-level processes of governance and interpersonal encounters. For this reason, landscapes of care are considered “[...] spatial manifestations of the interplay between the socio-structural processes and structures that shape experiences and practices of care” (Milligan and Wiles 2010:739). Such theoretical developments call attention to the social and spatial aspects of health, illness, and recovery, detailing the importance of having a relational understanding and account of space and place. Duff’s (2012) notion of enabling places has, in this regard, gained significant purchase among cultural and health geographers, providing a useful development of the therapeutic landscapes framework for examining the role of place in relation to recovery from mental illness. Identifying the importance of social, material, and affective resources in promoting recovery, Duff (2012:1388) details how participants draw on these resources in support of activities considered vital to the everyday work of recovery. While much of this work does not consider inpatient hospital spaces, a group of scholars collaboratively working at the intersection of social psychology and health geography have conducted a series of empirical studies analyzing the relationships between space and user experiences of recovery, all the while developing and extending the therapeutic landscapes framework. I turn to these studies in the following.

## Inpatient psychiatric settings

Empirical research examining the nature of psychiatric inpatient wards (Bowers et al. 2005; Curtis et al. 2009; Jones et al. 2010; Quirk and Lelliott 2001; Quirk, Lelliott, and Seale 2004; Quirk et al. 2006; Thomas, Shattell, and Martin 2002) directs attention towards the importance of inpatient spaces for experiences of mental distress and recovery. As previously noted, health geography scholars have typically studied these kinds of hospital settings through the interpretative framework of therapeutic landscapes (Curtis et al. 2009; Gesler et al. 2004), expanding the aspects considered important to health outcomes and recovery. Recent contributions, however, expand this framework significantly by drawing on poststructuralist thinkers, assemblage theory, and work within STS, to better understand and capture the social and material aspects (Brown and Reavey 2019), different topologies (Brown and Reavey 2016), atmospheric constituents (Kanyeredzi et al. 2019), and sensory components (Brown et al. 2019) related to experiences of mental distress and recovery in inpatient settings. In a key contribution, Reavey et al. (2019) extend the therapeutic landscapes framework by drawing on Lewin's notion of life space to show how the psychological space within the inpatient setting does not reside *in* the person nor *in* the environment, but is "constituted through the *relations* that are afforded within the ward" (Reavey et al. 2019:280, italics in original). This work builds on theoretical developments in recent posthuman geographies by closely studying the lived experiences of patients in psychiatric wards in hospitals, focusing both on the physical spaces of the setting and the more transient and affective spaces conjured through the relations and atmospheres of those spaces (McGrath and Reavey 2019:16), significantly contributing to health geographies of inpatient spaces.

## In sum

Although much could be gained from considering the Slagelse site as one location embedded within a broader landscape of spaces for mental health care, as the literature on post-asylum spaces indeed invites one to do, I have chosen to remain inside the institutional setting of the hospital in Slagelse. While institutional geographers have considered such settings, they have

often done so with an interest in explicating power relations and detailing the constraining effects of institutional and spatial circumstances, often drawing on the work of Foucault, as Philo and Parr (2000) also point out. Whilst acknowledging the importance of this literature and sharing an interest in the institutional settings they study, I am not here concerned with tracing power relations or with detailing the determining effects of a particular architectural order. Rather, I take a different perspective where order is considered an uncertain effect of ongoing processes of ordering, expanding the number of variables of potential significance when taking an interest in studying how the spatial, material, and institutional settings make a difference.

A similar move can be identified in the literature drawing on the therapeutic landscapes framework. Here, symbolic, social, and material aspects of the environment, both natural and built, are considered. This literature expands our understanding of what the importance of the environment for health, well-being, and recovery is, significantly, but, and in concurring with the critiques put forward in the review, I think that this perspective tends to over-valorize the therapeutic properties of the environment, looking to confirm when *something* is therapeutic, rather than analyzing the relational aspects of health and health care. This is, on the other hand, what the conceptual developments considered in the subsequent section aim to do. The focus on enabling places, for example, directs the attention towards the emergent aspects of health and recovery, moving us beyond any simple therapeutic/non-therapeutic causation. While these ideas are central to the present study, I am not in the first instance concerned with health outcomes. This is, however, something that the recent studies on inpatient settings are when they focus on a variety of social, spatial, and material aspects related to mental health care and recovery.

Despite these developments, which arguably prioritize closer consideration of an individual's subjective experience of space (Liggins 2016), these studies remain attentive to the *experiences* of users in relation to recovery, well-being, and healing, with less attention directed to the *practices*

within which users might find themselves. Focusing on the practices of mental health care in spaces considered to support recovery is of fundamental importance, I argue, insofar as such spaces are considered both a resource for and an effect of ongoing activities and interactions. The conditions for experiencing the spatial circumstances of various mental health care settings are, in other words, not stable, and research focusing on the dynamics between space and interaction in health care settings is, based on this claim, missing. For this reason, I now turn towards work at the intersection between health geography, the sociology of health and illness, and STS that more explicitly takes a practice-based point of orientation, sidestepping the focus on individual user experiences of particular spaces.

## **The enduring importance of place**

This second part of the review is divided into five sub-sections. Across these, I consider interdisciplinary work that engages with the role and importance of space, architecture, and materiality in and for different practices. While the previous section primarily considered different studies of the geographies of space and mental health care, this section considers and engages with studies that share a set of theoretical and methodological assumptions about how to study space and place, rather than an empirical point of convergence. This interdisciplinary work is important for this dissertation insofar as it offers the conceptual and analytical means by which to consider what ‘healing architecture’ does in practice, rather than how its users might experience it.

## **Architecture in action**

Situated within STS, a small, but growing, strand of literature has directed its primary ethnographic attention towards architecture by detailing the process of designing, developing, and, finally, constructing particular buildings (Fallan 2008; Yaneva 2008, 2009, 2012; Yaneva and Simon 2008). These scholars aim to reveal the complexity of design practices by detailing how architects work in and across a variety of settings, with a great variety of objects and materials. In their work, a building is not just a building, but rather, a complex socio-material

arrangement made manifest through a variety of entanglements, where multiple stakeholders (architects, users, professionals) may have had a stake in its development. The role of the architects, one of the key practitioners of architecture, the other being its users (Jacobs and Merriman 2011), immediately becomes complicated when thinking about architecture as practice. This is especially significant in Yaneva and Guy's (2008) special issue of *Science Studies* on architecture, where a conceptual vocabulary from STS is used across various studies to consider how social relations are built into architecture through the heterogeneous practices involved in its development. Yaneva (2008) considered these practices in terms of architecture in the making, extending earlier STS work focusing on the relations between design, technologies, and users (e.g. Akrich 1992; Latour 1992).

The insights that such work offers has implications for the way the relations between architecture and health care can be considered. Hospital designs mirror the sociocultural, economic, professional, and aesthetic priorities prevalent at any given time (Bromley 2012), with contemporary health care buildings reflecting neoliberal forms of subjectivity in which patients are constituted as consumers rather than users of health care, as Martin et. al. (2015:1007), for instance, contend. Akrich's (1992) seminal text enables us to understand architectural design as practices of inscription, where particular intentions are written into the material environment of a building, offering its inhabitants particular programs of action (Latour 1992) to follow. Through an empirical study of the construction of the biotechnology building at Cornell University, Gieryn (2002:53), for example, shows how architectural design can be seen as, "a social theory of a future science, rendered architecturally", or as Yaneva (2017:65) would put it, as a particular vision of the world inscribed in the spatial layout of a facility. Design, we learn from these studies, is not a value-neutral activity simply responding to functional requirements but is instead imbued with politics (for a classic study, see Winner 1980) that, in their materializations, mediate social orderings in practice (Söderström 2017:57). This latter point is a proposition that the present dissertation engages with directly, and I develop a way to come to terms with it, in the following chapter.

## **Buildings as technologies**

Buildings, then, can be understood as an intentionally constructed materiality (Reichmann and Müller 2015:17) and, for this reason, a building is not simply an inert object but, as Gieryn (2002:41) asserts, a technological artifact that is “[...] simultaneously the consequence and structural cause of social practices.” Gieryn (2002:41) argues that sociological analysis of buildings should account for how buildings are structures that structure social action, but structures that remain open to restructuring by human agents. In this sense, buildings are agential, generative of actions and reactions, and should not be considered as static objects, but rather as projects that may change over time, as Latour and Yaneva (2008:82) contend, while they continue to consider the implications for our understanding of space: “You need only to think for one minute, before confessing that Euclidian space is the space in which buildings are drawn on paper but not the environment in which buildings are built—and even less the world in which they are lived.”

While Gieryn (2002:36) develops a way to analytically engage with this double reality through a tripartite conceptual scheme considering heterogeneous design, black boxing, and interpretive flexibility, Guggenheim (2010:165) focuses on buildings as a quasi-technology connected with action, such that buildings ought not to be regarded as “objects that prefigure actions, but objects that are sometimes technologies and sometimes not, depending on who is using them and how.” Buildings and architecture are conceptualized as mutable immobles (Guggenheim 2010), fixed in space, but always exposed to change and, as such, acting in concert with users and stakeholders. While these studies take buildings as the substantive analytical focus, they pay less empirical attention to the way buildings and the material arrangements such buildings make possible, make a difference for the activities that take place within them. This is, however, the central interest of this dissertation and something STS scholars have accounted for in studying scientific practices at particular scientific sites, such as the laboratory.

## Sites of the scientific

The specificities of the locales research is conducted in, the interactions among occupants and their engagements with material surroundings have all become key points of analytical interest for scholars in diverse fields, following the lead of innovations in STS (Amsterdamska 2007; Henke and Gieryn 2007; Latour 1987, 1993; Livingstone 1995, 2003; Ophir and Shapin 1991). According to this approach, buildings and settings give material form to a kind of institutional reality, to particular scientific practices, making the “transcendent and timeless enter the forms of the mundane and the contingent” (Ophir and Shapin 1991:3). As Galison (1997:785), for instance, contends in his study of the material culture of experimental microphysics, “we are witnessing a physicalized architecture of knowledge.” Livingstone’s (2003) book, *Putting Science in Its Place*, makes the interest in *where* science is conducted the key question and point of convergence, explicitly bridging modes of geographic inquiry with the fundamental interests of STS.

In early laboratory studies (Galison 1997; Knorr-Cetina 1981; Latour and Woolgar 1979; Lynch 1985, 1993), analytical attention was directed towards the mediating role physical spaces can play in ordering scientific practices. Latour and Woolgar (1979:45), for example, demonstrate how the partitioning of laboratory spaces is also a partitioning of activities, where sub-divisions create distinct areas within which paper, dictionaries, and books may be managed in one space and “cutting, sewing, mixing, shaking, screwing, marking” may be done in another. Laboratory work, they show, is bound up with a variety of objects, ranging from the scientific to the mundane, and none of them can be determined by intrinsic material properties, though neither are they determined by any direct, unmediated relationships with those who interact with them. These studies direct analytical interest towards the physical objects, spatial layouts, and material arrangements of laboratory settings, and then investigate how these shape, work, and evoke particular scientific practices. The same analytical tools that were brought to bear on the studies of laboratories have later been moved out and into a variety of other fields, including health care (Driessen 2019; Mol, Moser, and Pols 2010; Nord 2011), psychiatry (Ootes 2012; Pols

2004, 2016), disability studies (Moser 2005, 2006), and, most recently, also architecture (Moser 2017; Yaneva 2017).

Transferring the insights from the laboratory studies to the study of architecture is, as Müller and Reichmann (2015:218) contend, a logical step because the architecture and material arrangement of any setting possesses a physical presence that influences, shapes, and thus participates in constituting practices. Architecture is taken to be a particular material arrangement or phenomenal field, which, according to Lynch (1993:132), turns the laboratory setting into “matrices for human conduct that do not simply provide places where human beings work but instead provide distinctive phenomenal fields in which organizations of work are established and exhibited.” If the possibilities for action are linked to the phenomenal fields in which they take place, then the production of social order is coextensive with the production of knowledge (Preda 1999:351). The consequence of drawing on STS is that space and architecture may be understood as the effect of a wider set of heterogeneous relations they constitute. The foundation of this material-semiotic approach is that objects and subjects, people and places, are equally made and sustained in and by ongoing relations (Law 2004). Moser (2017:89) explains this contention in her recent consideration of an STS approach to space and materiality:

“An architectural process aiming to literally making space for care, necessarily envisages care relations and devices care practice. The spatial and material on the one hand and the social on the other emerge, and are attributed and ascribed characteristics and qualities, from their network of relations. They are ‘co-produced’.”

These insights are absolutely key to the present dissertation, some of which will be further elaborated in the following chapter. The laboratory studies presented have arguably been influential for studies considering the material culture of a variety of settings, investigating their importance by studying different work and/or care practices, for instance. I turn to some of

these studies within the sociology of health and illness, as they, similar to the approach I am developing, advocate the importance of considering the influence of the built environment by taking a practice-based perspective.

### **Situated materialities and spatial arrangements**

Sidestepping discussions on the differences between space and place (for a discussion on this, see Gieryn 2000), scholars have recently started to address the material stuff of different care spaces more closely, examining, for instance, the meaning of clothing and linen in dementia care (Buse, Twigg, et al. 2018; Buse and Twigg 2014), the importance of interior design in cancer units (Martin 2017), and the significance of architecture in health care contexts (Bell 2018; Martin et al. 2015; Nettleton, Buse, and Martin 2018). This work offers important insights into the mundane, but nonetheless fundamental, aspects of material culture for care practices, emphasizing the importance of *practice*, where relations between materiality and care are seen as ongoing, emergent, and processual (Buse, Martin, et al. 2018). Training analytical focus on the accomplishment of care by incorporating a broader spectrum of actors is central to the analytical and methodological innovations introduced in this research. These insights are central to this dissertation insofar as they emphasize the importance of how space becomes implicated in and significant for situated actions and interactions.

In this spirit, studies have analyzed the salience of material and spatial arrangements in clinical spaces, focusing on the geography of patient safety (Mesman 2009, 2012), the intensive care unit (Lusardi 2016), and the operating theater (Fox 1997; Schubert 2007). Fox (1997) highlights the importance of the spatial layout of the theater for the enactment of three circuits of hygiene that surgical staff move through to ensure sterility. The architecture of the setting functions as a resource, as a contributing factor for reminding staff to undertake the necessary procedures prior to conducting operations. In a similar vein, Driesen (2019) shows how user-building interactions shape dementia care in institutional settings. Suggesting the notion of socio-material awareness, she details how the building actively shapes care interactions. Other

scholars in dementia studies have also shown the salience of space for the enactment of care, detailing how the maintenance of access to private spaces for nursing home residents is crucial, for example (Nord 2011). How particular spaces intersect with patterns of ordering is salient in this work, drawing attention to the dynamics of and relationships between space and practice. This interest is central to Bell's (2018) hospital ethnography, through which she details the way the arrangement of furniture in examination rooms shapes the sense and significance of the space, adding to our understanding of how architectural features and material assemblages participate in the enactment of hospital care. While this body of literature highlights the importance of the materiality of space in considering how care is enacted and experienced, and how paying attention to the physical landscapes of health care settings can offer new insights concerning health care practices, many of the studies mentioned here remain primarily focused on the 'micro-materialities of space' (Heath et al. 2018) and care, with less attention directed towards the constitutive effects of practices on space. The reciprocal relationships between care, architecture, and order are, however, central to the body of work considered in the final section of this review, and to the interests of this dissertation.

### **Caring architectures and social ordering**

In a 2011 editorial for a special issue in *Social and Cultural Geography*, Jacobs and Merriman (2011:211) propose the notion of practicing architectures to move beyond, "an emphasis on symbolic meaning (representationalism) and towards a consideration of the practical and effective or 'non- representational' import of architecture". In this way, they situate architecture *in* practice, moving their understanding of architecture from being a fixed, immutable object towards architecture as an effect of a broader spectrum of doings, shifting the analytical attention from architecture as a noun to architecture as a verb. Highlighting two particularly important architectural practitioners (designers and users), they go on to argue that scholars and practitioners ought to focus on material matter and on humans mattering. This resonates with conceptual development in STS (Hetherington 1997; Law 1994; Mol 2010; Moser 2017), where architectural order is seen as an ongoing accomplishment, something that takes work.

Social order, therefore, becomes “an outcome not of impervious, omnipotent, *out there* structures or systems, but *right here* coordinated (although not always rational) agreements and arrangements based in contingently formed skills and interpretations” (Jacobs and Merriman 2011:212, italics in original). These theoretical impulses can be seen as part of a broader interest in widening the spectrum of potentially relevant actors who play a mediating role for health, well-being, and recovery, building on the work previously considered under the term posthuman geographies.

A recent publication on caring architectures explicitly follows this kind of approach, with the editors aiming to look “beyond architecture and buildings as mere objects, and instead apply a relational spatial perspective, which positions architectural space as an actor and co-producer” (Nord and Högström 2017b:11). They continue, arguing that buildings “have agentic properties in that they do things to and with people” (Nord and Högström 2017b:11). Engaging with different sites located geographically in Sweden and Scotland, each chapter in their book, apart from the four conceptual commentaries, examines a particular institutional environment through the lens of what might collectively be considered as non-representational theory. In presenting the studies in the book, Nord and Högström highlight that they all consider architecture as embedded in space, thus echoing Jacobs and Merriman’s proposition to study practicing architectures. The point, they argue, is to consider care practices as made manifest in and through architectural spaces, studying the nonrepresentational aspects of health and illness and, thus, including a broader spectrum of inanimate materials, objects, and space into the analysis.

This is also where STS and non-representational approaches arguably meet as both seek to move beyond simply assuming the natural order of things. Instead, the focus is directed towards how matter and meaning are co-produced in institutional architecture through everyday practices of care. While my concerns are more general insofar as I am interested in considering what ‘healing architecture’ does in practice, not considering, in the first instance,

the therapeutic or healing effects thereof, the body of work related to caring and practicing architectures is important for this dissertation as it experiments with various approaches to the relationality between architecture and practice and illuminates potential “pathways for considering the myriad ways in which power and resistance become entangled through such architectural spacings” (Evans 2017). While non-representational approaches are salient for developing our conceptual vocabulary and analytical resources, further empirical engagements are arguably called for in the interest of coming to terms with how something like ‘healing architecture’ makes a difference in and for psychiatric practice and how we may begin to study it.

## **In sum**

While it is apparent that space, place, and materiality matter in the experience and management of mental illness, it is also apparent, however, that space is a somewhat nebulous term that can be used to describe material, psychological, symbolic, and social environments, ranging from the arrangements of particular buildings to the individual makeup of people in community settings (McGrath and Reavey 2019:20). As this review evidences, a wide range of approaches to studying these aspects and their interrelations can be considered and appropriated. While I share the fundamental interest in studying the impact and importance of mental health spaces with much of the scholarly work reviewed in the first section of this review, I do not direct my analytical attention towards how such spaces mediate or support health outcomes, well-being, or recovery. Instead, I aim to come to terms with what ‘healing architecture’ does *in practice* by considering the relationships between space and interaction. This analytical shift situates the interests of this dissertation within ongoing discussions related to a body of work loosely clustered under the conception of non-representational studies (Nord and Högström 2017b), more specifically, perhaps, to studies engaged with examining how spaces become implicated in practices (Martin et al. 2015; Moser 2017), how material surroundings matter for interaction (Buse, Martin, et al. 2018; Mesman 2009), and studying what architectures do (Gieryn 2002;

Jacobs and Merriman 2011; Yaneva 2017). For this reason, I turned to interdisciplinary work, especially within the sociology of health and illness and STS.

First I considered the work on architecture in the making. This work is significant for coming to terms with the heterogeneity of the practices of architecture, but subsequently, and more importantly for my purposes here, of understanding how architecture is imbued with politics and inscribed with intentions. Buildings, therefore, are not value-neutral containers. I then considered work in STS concerned with studying buildings as technologies, making buildings the substantive analytical focus. The latter point is important insofar as studies in the social sciences have tended to overlook the importance of health care buildings (Martin et al. 2015). While I share the interest in what buildings *do*, I direct my analytical attention towards the spatial and material arrangements that buildings contain rather than towards the processes of transformation that buildings themselves might undergo. Understanding architecture in this way directs the inquiry towards how people engage and interact with, move through, and orient towards particular material arrangements in situ. By placing the building inside practice, and more narrowly even, within interaction, the physical, spatial, and architectural properties that constitute ‘it’ are made visible and analytically accessible. How a building makes a difference, then, becomes a question of how it becomes implicated in different practical circumstances. This led me to a body of work in the sociology of health and illness interested in the situated materialities and spatial arrangements of care, where Buse and colleagues’ (2018:246), for instance, call for considering the ‘spatialities of care’ and “how the dynamics of space intersect with patterns of social ordering” is particularly relevant in relation to the research interests of this dissertation.

Privileging human agency over the built environment in accounts of social order evaporates, Gieryn (2002:37) contends, once we acknowledge that both agency and building are mutually constituted. This is apparent in the growing body of work on caring architectures, where an impetus to study architecture as a “process of spacing rather than an immobile object” (Nord

and Högstöm 2017b:14) is widely shared. While the efforts developed in this work to understand how the dynamics of space intersect with patterns of social ordering in practice contributes much to our conceptual repertoire, with studies drawing on the work of such distinguished scholars as Barad, Deleuze, Lefebvre, and Latour, further empirical engagements and discussions of the methodological means for analyzing the relationships between architecture, space, and practice remain warranted, I think.

To perform and substantiate an analysis that takes different aspects of the relationships between space and interaction into account in the interest of analyzing what ‘healing architecture’ does in practice, I draw on four distinct approaches that are considered and described in the next chapter. This approach contributes to work within health geography, I argue, by enabling critical reflections on the design of contemporary hospital spaces, which, in turn, may enable discussions on what constitutes more feasible expectations of what ‘healing architecture’ may realistically do in psychiatric practices. As such, I hope to offer insights into the impact and importance of ‘healing architecture’, by focusing, not on user experiences or health outcomes, but on how interacting parties draw upon, inhabit, orient towards, react to and, as such, constitute space. To reiterate, this focus moves the analytical interest and attention away from individual *experiences* of spaces towards the production of spaces in *practice*.

## 4. Analytical approach

A theoretical term is worth little unless it fits into the circumstances of the world, casting light on the corners that need illumination.

- Jasanoff 2015:24

An important point of departure for studying what ‘healing architecture’ does in psychiatric practice is to direct analytical attention towards the relationships between space and interaction, focusing on the ongoing, iterative, and sometimes precarious processes of *ordering* in practice. Arriving at this conceptual disposition happened somewhat incrementally for me, in dynamic tension with the empirical material (Nicolini in Pedersen and Humle 2016:112), making it possible to come to terms with the notions of space, interaction, and ordering. These notions have been instrumental in shaping my analytical orientation, functioning as sensitive terms (Mol 2010), a repository of tools chosen to help me consider the consequences of the spatial organization of contemporary psychiatric practice. The point of such an approach is, as Mol (2010:257) argues, “not to purify the repertoire, but to enrich it. To add layers and possibilities. [T]erms are not stripped clean until clarity is maximized. Rather than consistency, sensitivity is appreciated as a strength.” Coming to terms with the relationships between space and interaction in relation to the accomplishment of order in psychiatric practice has been important for analytically approaching the question of what ‘healing architecture’ does in practice.

The notion of ordering is often ascribed to the work of John Law (1994), particularly to his idea of modes of ordering<sup>7</sup>. Shifting from the noun (order) to the verb (ordering) stresses that

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<sup>7</sup> Law’s notion of modes of ordering draws together insights from symbolic interactionism, actor-network theory and Foucault’s notion of discourse (Law 1994:21–25), enabling quite some flexibility in terms of analytical appropriation, which suits my purpose here. According to Law, modes of ordering are: “[...] recurring patterns embodied within, witnessed by, generated in and reproduced as part of the ordering of human and non-human relations” (Law 1994:83).

ordering involves work, that it is open-ended, which is why order becomes a precarious achievement (Mol 2010:264). In this sense, not even architectural order is a given or unambiguous (Moser 2017:89). Law's work has much to offer in itself and I borrow the notion of ordering to create a point of convergence through which the relationships between space and interaction can be understood and conceptualized. As such, ordering functions as an umbrella term, lending itself well to this purpose because it directs the analytical attention towards how space and interaction are intricately interwoven, how they become folded into each other in practice. How space and interaction actively become folded into each other in practice, how they become mutually constitutive, can be considered and understood in different ways.

For this reason, I apply the following four distinct, albeit not fundamentally dissimilar, approaches for coming to terms with how space and interaction are ordered in practice: actor-network theory; ethnomethodology; symbolic interactionism (as found in Goffman); and Douglas' social anthropological approach. Although driven by different analytical vocabulary, these approaches arguably unite around the idea that space can be understood as both the medium and the outcome of action, i.e., as a resource for and an achievement of ordering in practice. Space and interaction, then, are fundamentally intertwined in the production and accomplishment of order. I am well aware that the epistemological and ontological assumptions undergirding each of these approaches might not be congenial towards one another, but I do not consider them incommensurable in the approach I am advocating here. Rather than opting for an integrated theoretical framework, I use these different approaches to sensitize my research approach towards various aspects of ordering taking place, in situ, within the inpatient wards of the Slagelse site. In the following, I clarify which aspects have been instrumental in sensitizing my analytical approach.

## Materiality mediates

Studying what ‘healing architecture’ does in practice entails considering how to come to terms with its manifest form, thinking about what a building does and, thus, analytically clarifying how *things* do things. For this purpose, some of the key insights from actor-network theory have been instrumental. One of the fundamental assumptions of actor-network theory can be found in Latour’s (1993, 2005) principle of generalized symmetry, according to which humans and non-humans are active entities in the creation of actor-networks and, as such, equal ontological constituents of the social world. This changes the foundation for classical sociological reasoning by reversing the direction of explanatory power, making pure entities like Nature and Society the effects of connections made between things and people in practice; they arise as socio-materially mediated. What presents as an established order is simply the stabilized result of a variety of ordering processes in practice. Nature and Society explain nothing, Latour contends; they are instead “[...] immanent in the work of mediation and transcendent after the work of purification” (Latour 1993:95). The purified object is often taken for granted and its socio-material constitution black-boxed, i.e., concealed or forgotten. Latour’s suggestion is to open the black box and study the associations between humans and non-humans inside. This does not mean that people and things are equal, that objects are ascribed human faculties, but it means “*not* to impose a priori some spurious *asymmetry* among human intentional action and a material world of causal relations” (Latour 2005:76, *italics in original*). This assumption may, in the first instance, be taken as methodological, insofar as the epistemic position of the researcher is laid out in relation to the object of inquiry (see Preda 1999, 2000). In other words, an analytical framework for studying *both people and things in practice* is provided, making the potential answers to the question, ‘Who does the doing?’, slightly more multifaceted as “[e]vents are made to happen by several people and lots of things. Words participate, too. Paperwork. Rooms, buildings” (Mol 2002:25). Yes, even buildings *do* things (Gieryn 2002).

Latour (1993, 2005) offers the distinction between intermediaries and mediators to come to grips with how and with what, social order is held together. In his vocabulary, an intermediary

is *something* that can transport meaning without transformation; defining the input of something would then be the same as defining its output. Defining the input of a mediator, on the other hand, is never a good predictor of its output, which is why its effects must be empirically and not analytically determined.

“Mediators transform, translate, distort, and modify the meaning or the elements they are supposed to carry. [...] No matter how apparently simple a mediator may look, it may become *complex*; it may lead in multiple directions which will modify all the contradictory accounts attributed to its role” (Latour 2005:39, italics in original).

While an intermediary may be defined prior to the process of actions, a mediator can only be defined *in* this process (Yaneva 2017:169). While mediators can be many things, Yaneva, in many ways a protégé of Latour, proposes thinking about buildings as mediators, as active forms, “[...] which do not simply host, accommodate or contain, but rather transform and fabricate new capacities in those who pass through them.” (Yaneva 2017:32). This proposition leads her to speculate about the politics of buildings, probing her to ask, “What does a setting (practice, form, site, material arrangement, built form) *do* to those who are engaged in it?” Architecture, therefore, plays an active role in doing politics, she argues. For this reason, she directs analytical attention towards how encounters, i.e., doings, and interactions are embedded in particular spatial and material circumstances. Practices, therefore, are comprised of a variety of heterogeneous elements; both subjects and objects, people and places, humans and non-humans, making an actor that which is made to act (Latour 2005:43–62). In this approach, a building is constituted by material arrangements that *frame* interactions, not in the metaphorical sense suggested by Goffman (1974), but in a more literal sense, where objects, walls, and spatial layouts, for example, all play a significant role in establishing social order (Latour 1996). While the former may be true of Simian Societies, where any action by any member is oriented to co-present others, it is not so in human societies (Latour 1996:229):

“We say, without giving the matter too much thought, that we engage in ‘face-to-face’ interactions. Indeed we do, but the clothing that we are wearing comes from elsewhere and was manufactured a long time ago; the words we use were not formed for this occasion; the walls we have been leaning on were designed by an architect for a client, and constructed by workers – people who are absent today, although their action continues to make itself felt” (Latour 1996:231).

Interaction, then, is not simply a question of intersubjectivity, where what one person does is contingent upon what all the others are doing, but of interobjectivity, which moves us beyond the paradigmatic contention that sociality is merely social, only constituted by face-to-face-interaction between human agents. What we are left with is a flat level of social practice, where material things are routinely drawn upon, relied upon, and applied in different situations, changing and transforming the manner in which we relate, interact, and encounter one another.

In Latour’s (1992) analysis of a few mundane artifacts (a door closer, a speedbump, child car restraints, and hotel keys), we find germane examples of the basic dynamics of everyday interaction between humans and non-humans. Take the wall-hole dilemma, for instance: without the invention of doors, the effort of entering a room would be immense. Add hinges and the work of enabling passage while securing subsequent closure of the hole in the wall is displaced, turning the effort into a minor one (Latour 1992:228). The work of reversibly solving the wall-hole dilemma is, in other words, *delegated* to the hinge. Problems with this delegation may arise as people tend to leave doors open. Employing a porter can solve this issue but, then again, people remain unreliable, Latour contends, and the porter’s work (closing the door when others forget) can be effectively delegated to another non-human artifact, an automatic door closer whose function is to open and close the door.

This example shows that materials and objects are not simply a repository or standing reserve (Yaneva 2017:161) for preconceived actions. We can actively engage with materiality in such a way, yes, but materiality also engages with us. Hendriks (1997), for instance, demonstrated this in his ethnographic account of how simple objects of everyday life, like benches, rugs, and egg timers coordinate and order the actions of autistic teenagers, thus sustaining social order on a ward. Such artifacts do not simply reflect social order but may displace the contradictory interests of people and things, changing what may have been a major effort into a minor one by way of delegation (Latour 1992:229). As Hendriks' study clearly shows, delegation does not simply happen in one direction; artifacts can impose certain behavior back on to people (Latour 1992:232).

## **Interactional repertoires and staging problems**

Goffman's work offers a great panoply of terms and phrases (Scheff 2003:53) for considering any domain of activity, any interaction order (Goffman 1982) that is, which also implies considering the importance of the physical surroundings and any present objects or materials. As Lynch (1996:248) asserts, for instance, Goffman has had an "[...] explicit and repeated emphasis on how material stalls, partitions, passageways, windows, articles of clothing, and vehicular units constitute the circumstances, props, backdrops, strategic resources, and modalities of social interaction." Most notably perhaps, Goffman's work on the presentation of self in everyday life (1959) directs extensive attention towards the material environment of working lives. His work directs our attention to the internal differentiation of the spatial organization of work, with different practices of impression management being exhibited due to particular spatial circumstances. Regions, for example, may function as particular barriers to perception, bounded places which, in turn, establish the circumstances for performances appropriate to particular places. Goffman (1959:120) offers the example of maids and managers in conflict over the boundary between the kitchen and the dining room:

“The maids wanted to keep the doors open to make it easier to carry food trays back and forth, to gather information about whether the guests were ready or not for the service which was to be performed for them, and to retain as much contact as possible with the persons they had come to work to learn about. Since the maids played a servant role before the guests, they felt they did not have too much to lose by being observed in their own milieu by guests who glanced into the kitchen when passing the open doors. The managers, on the other hand, wanted to keep the doors closed so that the middle-class role imputed to them by the guests would not be discredited by a disclosure of their kitchen habits. Hardly a day passed when these doors were not angrily banged shut and angrily pushed open.”

As a symbolic interactionist, Goffman focuses on people's engagements with the world, with how they interact, encounter, and negotiate particular interpretations of reality. Symbolic interactionism is the study of how self and selfhood are (re)created in social interaction. For this reason, analytical attention is directed towards how people use and interpret particular symbols in an effort to maintain and manage impressions of self. As the example above shows, the maids and managers interpret the reality of the kitchen and dining spaces differently, creating certain staging problems, with the doors between spaces becoming somewhat controversial and a “[...] sore spot in the organization of work.”(Goffman 1959:120). As such, spaces are not merely out there, but indeed means that may be used in any here-and-now situations. Goffman offers the notions of front and back regions to come to terms with the implications of the physical setting for social interaction. Performance in the front region can be taken as an individual's effort to give the appearance that their activities in that region hold certain standards. A back region or backstage, on the other hand, can be taken as a place where such standards are dismissed, “[...] a place relative to a given performance, where the impression fostered by the performance is knowingly contradicted as a matter of course” (Goffman 1959:114). Here, performers can relax, drop their front, as it were, and step out of

character. The relationships between regions are open for negotiation, making them vulnerable to various staging problems (Goffman 1959:121), as shown.

The relationship between spaces and social performances, therefore, becomes the focus of analytical interest. For this reason, Goffman (1967:2) advocates focusing on situations and the “[...] syntactical relations among the acts of different persons mutually present to one another.” Meaning, therefore, is derived from within social interaction, and self and selfhood are created in successions of negotiations between interacting parties. Goffman redefines the nature of organization around dramaturgically defined spaces, making us aware of the relative nature of spaces, as the example with the maids and managers also demonstrates. The vocabulary found in his work sensitizes us to the subtle characteristics of social interaction, how people perform, and how such performances include roles for interacting parties to assume. This prompts us to pay close attention to moments and their people rather than people and their moments (Goffman 1967:3). These moments are often quite transient, subtle in regard to levels of involvement and focus of attention, but not any less important for studying processes of ordering. The visual regard (Goffman 1982:3) of participants, for example, is especially salient in relation to achieving or dismissing the focus of attention. In Goffman’s book, *Frame Analysis*, he calls his approach situational, meaning, as he explains, that he is concerned with:

“[...] what one individual can be alive to at a particular moment, this often involving a few other particular individuals and not necessarily restricted to the mutually monitored arena of a face-to-face gathering. I assume that when individuals attend to any current situation, they face the question: ‘What is it that’s going on here?’” (Goffman 1974:8).

This directs my analytical attention towards the manner in which people conduct themselves within particular spaces *relative to* other spaces and *relative to* other people, as well as to how these people negotiate and come to understand the circumstances within which they find

themselves, prompting us to pay close attention to people's performances, their demeanor, and to the way they react in particular situations to certain spatial arrangements.

## **Practical action and the production of order**

According to Lynch (2001:131), ethnomethodology can be defined as the study of practical action and practical reasoning. Across ethnomethodological studies, there is an interest in the local and reflexive constitution of social order. Garfinkel, the founding father of ethnomethodology, coined the term ethnomethodology in the mid-1950s to elicit a focus on culturally specific taxonomies like those found in other ethnosciences like ethnobotany and ethnomedicine. By analogy, ethnomethodology is the study of ordinary methods through which people conduct their practical affairs (Lynch 1993:5). Garfinkel reasserts the problem of social order in empirical terms by holding that order must be witnessable. For this reason, sociological concepts are seen to divert attention away from the lived order, constructing it as an epiphenomenon onto which concepts are then imposed as explanatory devices, which at best render a highly abstracted version of the processes through which order is created. In Garfinkel's (1967:1) words, the aim is to:

“[...] treat practical activities, practical circumstances, and practical sociological reasoning as topics of empirical study, and by paying to the most commonplace activities of daily life the attention usually accorded extraordinary events, seek to learn about them as phenomena in their own right.”

Focusing on what practitioners *do* in practice reveals adaptive and pragmatic intelligibility that is not easily captured by theoretical propositions. Contrary to the notion that the task of social science is to reveal, or uncover the order of things, ethnomethodologists insist that the immediate, observable, and singular details of social action are orderly at their surface (Lynch and Peyrot 1992:117), that facts are treated as accomplishments (Pollner 1974), and that order and orderliness are indigenously produced, experienced, constructed, drawn upon, and

appreciated features of social life. Order, in other words, is composed of *just* these people, at *just* this time, at *just* this place, doing *just* this, lending any situation its specific just thisness, or haecceity (Lynch 1993:283). Ethnomethodologists, therefore, attempt to investigate a patchwork of orderlinesses without assuming that any singular orderly arrangement reflects a wider set of norms (Lynch 1993:125). As Pollner and Emerson (2001:120) explain: “The orderliness of social life ceases to be a problem raised and resolved by social theorists but a practically achieved phenomenon ‘incarnate’ in the interaction and activities of social actors in actual particular circumstances.”

Order becomes visible, observable, and thus analyzable, through the ways in which participants in particular situations orient towards specific features of the circumstances within which they find themselves; how they, in other words, make them accountable (Pollner and Emerson 2001:120). The concern with accountability and social legitimacy is an everyday, pervasive organizing orientation for action (Woolgar and Neyland 2013:32). What is at stake, then, “[...] is not the theoretical problem of order, but the substantive *production* of order on singular occasions” (Lynch 2001:131, italics in original). In this ethnomethodological line of reasoning, spaces do not simply contain activities but are irredeemably implicated in the organization and accomplishment of activities. This directs my analytical orientation towards how participants ordinarily orient to spaces in the course of conducting practical activities. Our ordinary everyday sense of space should consequently be taken as the topic of inquiry, not as a resource for analysis, moving us beyond any vernacular constructions of what space might be. Crabtree (2000:8) offers useful methodological advice in terms of studying space from an ethnomethodological perspective:

“This shift in focus requires us to examine in detail the ways in which we ‘go about’ performing and accomplishing situated activities. As activities are, without exception, always embedded ‘within’ space, are always spatially situated, explication of the ways in which situated activities observably ‘get done’ promises to tell us much about the social

organisation of space and place. The effort need not be an undirected one either but in concentrating on the real-world, real-time performance of activities, focus expressly on 1) the embodied practices for the accomplishment of situated activities and 2) the interactional competences employed in the use of spatial arrangements and technological instruments (i.e. material arrangements of equipment).”

As such, we should closely follow, describe, and detail the concrete, situated activities taking place within and across physical spaces. According to Woolgar and Neyland (2013:171), one could say that space is a mutual accomplishment that places an emphasis on matters of practical, ongoing constitution work that “space is an ordered outcome of work done to make sense of and account for spaces in ordinary, pervasive, and ongoing interactions.” Practices may then recursively build upon and make use of the ordered outcomes of interactions that the enacted spaces provide. Enacted spaces, then, are no less real than physical spaces. On the contrary, as Lynch (1991:73) holds:

“Although walls, entrances, hallways, and the like have the advantage that they are readily described in diagrams and they do not disappear when the persons inhabiting them go away, this does not necessarily give them a more fundamental or ‘objective’ role in activities than those less obvious contextures of space, technique, and language that disappear when relevant activities come to a close.”

Spaces are not so much a *locale* within which activities simply take place, but, following Lynch (1991), a complex habitual field of space and interaction. Places of work are therefore better understood by what Lynch characterizes as locally organized topical contextures (Lynch 1991:53). As such, spaces are organized in contextures of activities involving different forms of participation, which demands that analysis concern itself with a broader range of objects, people, talk, and material arrangements. The ethnomethodological impetus, then, is to study the local rationality of member’s own (ethno)methods, i.e., why something makes sense to do for

participants, in situ, in their practical contexts, even if this is at odds with how they are supposed to conduct themselves, with how things are supposed to work in theory or according to design. The entry point for studying the accomplishment of social order, then, is to follow the practical doings of the people working, interacting, and engaging in activities in that setting, moving the analytical focus from distinct spaces and people to the interactions between them.

## **Systems of classification shape practices of ordering**

People have always navigated a variety of classification spaces. Douglas (1966, 1968) has drawn attention to this fundamental feature of all societies by investigating how culture is embedded in the concrete, mundane, and collective ordering of social life through particular systems of classification. According to Douglas, classification systems of all types are inherently social institutions that reflect the way things are in the social world. Classification systems, then, grow out of and are sustained by social institutions (Bowker and Star 1999:61). Any such system of classification inevitably gives rise to anomalies, and any given culture must consequently confront such deviant events. For this reason, Douglas (1966:48) suggests that attention should be directed towards the manner in which a culture deals with the experience of such events. In her book 1966 *Purity and Danger*, Douglas argues that ideas about pollution and danger are inherent in the establishment of social order. Her interest in the relationship between purity and danger are closely linked to her contention that the cultural orders that give symbols their meaning are hinged on particular systems of classification.

For this reason, she attempts to go beyond piecemeal explanations of ritual pollution, opting instead for a systemic approach, through which acts of classification are situated within “[...] the total structure of classifications in the culture in question” (Douglas 1966:vii). It follows, then, that people’s ideas about purity, cleanliness, dirt, and danger are part of a larger whole. This applies to primitive religions as well as to our own contemporary culture, and the notion of dirt bridges the two. While we denounce it, they taboo it. In both instances, labeling something as dirt is an act of classification, “[...] a spontaneous coding practice which sets up a

vocabulary of spatial limits and physical and verbal signals to hedge around vulnerable relations” (Douglas 1966:xiii). This contention evokes a dynamic between two connected conditions: a set of ordered relations and a contravention of that order. But it also connects the ambition to establish social order with the activity of (re-)arranging material order, making the latter conform to an idea inherent in the former.<sup>8</sup>

Douglas discusses and exemplifies the relationships between social and material order through contemporary ideas about household cleanliness. The Western household, she contends, symbolizes a set of beliefs about where certain objects and activities can occur, and what kinds of objects are appropriate to certain areas of the home. This creates a particular household geography in which each space evokes a certain set of rules of conduct. Kitchen, living room, and bedroom all prescribe an expected behavior, as well as function as the appropriate place for objects such as knives, sofas, and linens. The physical boundaries between these different rooms also function as symbolic boundaries, in turn creating the grounds for what Douglas labels as dirt. Dirt occurs when boundaries have been transgressed, mapping out the household in a particular normative grid. As such, dirt can be seen as the contradiction of a system of classification:

“Shoes are not dirty in themselves, but it is dirty to place them on the dining-table; food is not dirty in itself, but it is dirty to leave cooking utensils in the bedroom, or food bespattered on clothing; similarly, bathroom equipment in the drawing room; clothing lying on chairs; outdoor things in-doors; upstairs things downstairs; under-clothing appearing where over-clothing should be, and so on” (Douglas 1966:45).

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<sup>8</sup> In STS, Douglas’ work on dirt and disorder has been used to analyze the impact of safety issues on high-energy physics (Galison 1997); the importance of contamination in a materials science laboratory (Mody 2001), and in relation to safety work in the Los Alamos National Laboratory (Sims 2005). In the last-mentioned, Sims draws attention to two key aspects of Douglas’ work that are particularly relevant to studying practices of ordering. Firstly, that pollution beliefs are bound to ideas about the proper order of the material world and, secondly, that these beliefs are used to sanction certain forms of social order (Sims 2005:336). These studies have been informative for my own appropriation of Douglas’ work.

Dirt, as Douglas (1966:44) argues, is “the by-product of a systematic ordering and classification of matter, in so far as ordering involves rejecting inappropriate elements.” This means that objects, as well as people, can be considered out of place. Although situated within structuralist social anthropology, Douglas’ tendency to allow for a plurality of meanings hinged upon particular systems of classifications in relation to accounting for the accomplishment of social order in any cultural setting means that Douglas’ work “[...] does not fit comfortably within the canon of structuralist anthropology” (Campkin 2013:50). When she refers to the notion dirt to point to spaces where a specific order has been transgressed or violated, she does not, as she explains, refer to a systematic metaphysics; rather, metaphysics are the “by-product, as it were, of urgent practical concerns” (Douglas 1966:113). This is important insofar as it allows analytical flexibility in the manner in which ordering practices are understood and accounted for. Building on these insights, my analytical attention is directed towards the work that classification does in ordering space and interaction.

## **In sum**

Having described four different ways of understanding the ordering of space and interaction in practice, I will now briefly highlight and discuss their respective sensitizing qualities and how they might analytically supplement one another. Such modes of ordering might be taken as enabling imputational sensitivity (Law 1994:110) towards studying different aspects of the relationships between space and interaction in ordering processes. I have attempted to capture and summarize these sensitivities in Table 2.

<i>Approach</i>	<b>Primary source</b>	<b>Sensitizing quality</b>	<b>Analytical concepts</b>
<i>Actor-network theory</i>	Latour (1992, 2005)	Human and nonhuman actors	Mediation
<i>Symbolic interactionism</i>	Goffman (1959, 1974)	Modalities of social interaction	Front/backstage
<i>Ethnomethodology</i>	Lynch (1991, 2001)	Practical action and reasoning	Order as accomplished
<i>Social anthropology</i>	Douglas (1966, 2007)	Culture as a system of classification	Dirt/disorder, full range of dangers

Table 2. Concepts and sensibilities

The first sensibility comes from actor-network theory. Drawing on the insights offered by an actor-network-theory approach sensitized me to how *things* become part and parcel to processes of ordering in practice and how things can be considered as mediators. Things cannot be determined by any intrinsic material properties, neither can they be taken as mere social symbols; they must, instead, be understood through the mediated relationships with those who interact with them. A broader spectrum of actors is thus included in the analytical scope, prompting me to consider how glass walls, closed doors, and wide hallways, for instance, become active constituents in processes of ordering. The notion of mediator enables me to understand and come to terms with the implications of what such things *do* in everyday practices.

The second sensibility comes from engaging with Goffman's work, which is particularly relevant for coming to terms with the relational aspects of spaces. As a symbolic interactionist, the timing and spacing of social interaction are of key concern and the architecture of particular places is relevant to this concern insofar as settings enable specific types of available co-presence. Movement in and through specific regions furthermore carries with it particular expectations to honor certain boundaries. Goffman's notions of front and back region enable sensitivity towards the manner in which interacting parties perform certain roles in particular

settings, and how these roles become the product of negotiations which, in turn, define and establish social order. In the accomplishment of social order, then, there are no conceptual grounds for claiming that things, objects or spaces act in the same way as humans do. Situating the mediating role they may play 'in' interaction affords analytical access to better understand how they may come to make a difference in practical circumstances. This allows for analytical engagement with important theoretical impulses from actor-network theory while retaining the interactionist contentions that social facts are accomplished by human actors (Garfinkel 1967) and that participant experiences produce real consequences (Goffman 1974). These first two sensibilities have been particularly salient for developing paper II, where the mediating role of the nursing station is considered in conjunction with how staff react to the transparent nature of this office space.

The third sensibility comes from ethnomethodology, or, more accurately perhaps, from an ethnomethodologically inclined science and technology studies approach. For my purposes, the ethnomethodological move to abstain from entertaining what Lynch (2001:147) calls "the grand theoretical delusion that 'the logic of practice' is a unitary subject of social analysis" functions well as a heuristic for directing analytical attention to the nooks and crannies (Hirschauer 2005) of how psychiatric practice may be ordered in and through situated actions. As such, my aim is to exploit the heuristics of ethnomethodology for directing my analytical attention towards everyday practical action, to selectively heighten sensitivity (Pollner and Emerson 2001:118) towards what may otherwise be taken-for-granted practices that comprise the social order. How 'healing architecture' makes a difference, then, becomes a question of how it becomes implicated in different practical circumstances, how it *does* something *in* practice. What this something is or how this something becomes a something (Lynch 2001:135) in practice is left empirically open. The upshot of such an ethnomethodological approach is the appreciation of members' own methods of making sense of the spaces through which they move, and by detailing this movement, these understandings, we can arrive at a better understanding of how space and interaction are ordered in practice. This sensitivity has been

especially important for the analytical thrust of paper III, where the sense and significance of inpatient spaces are detailed by analyzing the work of administering psychiatric medications.

The fourth and final sensibility is drawn from Douglas, whose contention that spatial arrangements are connected to social order provides a set of analytical resources for understanding the connections between different ordering practices and the material arrangements within which they unfold. This sensitizes me to the patterns of actions that continuously seek to re-establish social order, towards processes of ordering directed towards the elimination of the sensation of disorder in the interest of attaining what Douglas calls unity in experience. Mapping out the full range of these actions enables me to collect evidence of a particular system of classification *at work*. This sensitivity was instrumental for developing paper I. In the following chapter, I describe how these sensibilities were put to work, how they guided my approach, and how they informed my choice and use of methods.

## 5. Methodology

We are not proposing an inquiry free of presuppositions, we are disclaiming that our inquiry is theory-laden in the sense of being framed by a professionally fashioned nexus of definitions, propositions, and a priori expectancies. The promise of such an approach is to gain a more differentiated appreciation of the phenomena in question (and of their situated uses and fates) than we would gain if we were to address them as ‘concepts on holiday’.

- Lynch, Barnouw, and Bogen 1996:273

For me, conducting a situated inquiry into ‘healing architecture’ has entailed drawing on a particular repository of concepts in conjunction with a methodological impetus found in both ethnomethodological and ethnographic traditions that, in accordance with Moser (2017:85), seek to “learn about the ordering of reality from within the practices and actors’ own methods”. Resonant with what Lynch and colleagues propose in the above opening quotation, this situated inquiry is not free of presuppositions. It is framed by my interest in the relationships between space and interaction, sensitized by the approaches detailed in the previous chapter to gain a more differentiated appreciation of the phenomena in question, of coming to terms with what ‘healing architecture’ does in psychiatric practice. The inquiry, then, is not undirected but focused on describing just what it is that patients and staff do in particular spaces, presenting actions and interactions as rational on their own terms (Moser 2017:83). Arguably, this type of inquiry has been missing in social science research on space, where vernacular understandings of space have failed to convey an adequate sense of the ways in which spaces are implicated in ordinary practical actions (Crabtree 2000). In this chapter, I consider and reflect on my methodology as well as detail the methods I applied to collect data.

To enable the possibility of becoming sensitive to processes of ordering in practice, I aimed for what Pedersen and Humle (2016:3) called constructive obstruction throughout the process of conducting my inquiry. Actively and reflexively juxtaposing empirical insights with concepts and methods enhances, they argue, “[...] a dialogical way of thinking, which makes it possible to revise and remake theoretical assumptions as well as methodological reflections”. Following this, my ethnography developed in tandem with and was made relevant to the situations being studied (Neyland 2008:12), slowly, but surely, affording me to come to terms with how spaces make a difference in practice. While the term ethnography might be overused and has become a modish substitute for qualitative research (see Ingold 2014 for this critique), the type of organizational ethnography Pedersen and Humle advocate offers a way to constructively engage with concepts and observations in a generative relay, where insights taken from the field may challenge the concepts informing the inquiry. According to Kärreman (2016:76), working with such a relay between observation and conceptualization may indeed be what organizational scholars need to engage with to avoid devising clear-cut scholarly contributions by way of constructing more or less abstract concepts. Instead, he argues, “we need concepts that are attached to findings,” something we might cultivate and enable by simply asking: what is going on here? (Alvesson and Kärreman 2007:1270).

Applying what might be a rather crude reading of Goffman’s (1974) famous question – What is it that is going on here? – caused me to direct attention towards the localization and physical place of particular events and the situations, encounters, and types of interactions occurring within them. This functioned well as a heuristic for drawing my attention to *where* people were doing *what* and *why* they were doing it *here*. Goffman (1974:8) takes issues with this proposition, however, calling it considerably suspect because any situation or event can be described with a variety of concepts that allow different perspectives, narrow or broad, close up or distant. Goffman preempts this critique by bluntly stating that he will choose arbitrarily and without justifying his choices. In this sense, choices are made, circumstances defined, and the question

biases matter in the direction of unitary exposition and simplicity, as Goffman (1974:9) explicates:

“So, too, to speak of the ‘current’ situation (just as to speak of something going on ‘here’) is to allow reader and writer to continue along easily in their impression that they clearly know and agree on what they are thinking about. The amount of time covered by ‘current’ (just as the amount of space covered by ‘here’) obviously can vary greatly from one occasion to the next and from one participant to another.”

Using Goffman’s famous question as a device for thinking about the relationships between space and interaction transforms his question from one inherent in social interaction to a methodological sensibility, a tool for doing fieldwork. Combined with Latour’s (2005:12) maxim to follow the actors themselves, I tried to focus on spaces as both containers *for* action but also as participants *in* action. While Goffman’s question, together with the conceptual sensibilities presented in the previous chapter, directs the analytical attention in certain directions, combined, they do not offer the tools to capture, collect, and produce relevant data on the phenomena in question. For this, we need a particular set of methods. In the following, I detail how and where I conducted fieldwork, why I conducted qualitative interviews, the importance and use of documents for the dissertation, how I gained access to the field, and, finally, how I conducted the analysis.

## **Doing fieldwork**

Fieldwork took place at the psychiatric hospital in Slagelse between June 2016 and August 2017. The methods I applied to produce data during this time were primarily participant observations (Delamont 2011; Ingold 2014) and the shadowing (Czarniawska 2007; McDonald 2005) of nursing staff, training my focus all the while on Goffman’s proposition to inquire what is it that is going on here?. Interviews were subsequently conducted to gain insight into how staff experienced working in the new spatial circumstances of the hospital setting. Prior to the

more systematic and coherent intervals of fieldwork, I conducted two short pilot studies, one in the community mental health care unit and one in an inpatient ward. With the conjunction of hospitalized patients, professional staff, and spaces specifically designed to promote recovery and support mental health work, the inpatient wards appeared to be a microcosm for studying what ‘healing architecture’ does in practice. For this reason, I went on to conduct approximately 180 hours of fieldwork in two inpatient wards, both organized in an integrated manner to support patients admitted voluntarily, as well as patients compulsorily detained under mental health legislation.<sup>9</sup>

Day	Evening	Hours	Shadowing	Observations	Interviews
<b>Community Mental Health Care Unit</b>					
2	-	13	-	2	3
<b>Ward A</b>					
11	2	67	9	4	4
<b>Ward B</b>					
16	2	90	6	12	5

Table 3. Distribution of time and methods applied during fieldwork

Table 3 provides a rough overview of the distribution of the time I spent in the respective wards and the methods I applied. Distinguishing between shadowing and observations was far less clear cut in practice, but the table is nonetheless indicative of the distribution and use of these two methods. Also, the table does not account for *all* of the time I spent in the wards or the total amount of time I spent at the hospital. I had great freedom to choose when and how long I would be present, occasionally working out of the research department at the hospital, affording me the freedom to drop by the inpatient wards. While this freedom was certainly

<sup>9</sup> This organizational structure has since been changed and, in January 2019, as far as I am aware, inpatient wards are now either open or closed.

nice, I quickly realized that arriving before morning meetings when intentionally conducting fieldwork was preferable and allowed me to adapt my presence to the wards' daily rhythms. I conducted fieldwork during day and evening shifts, but dayshifts (07:30 am to 3:00 pm) were given priority because almost all planned activities, coordinating, and formal tasks were conducted during those hours. Evenings were usually quieter, with fewer staff, and no scheduled activities besides dinner. For these reasons, evening shifts would often replete with a sense of boredom, leading to the decision to focus on dayshifts, which most often bustled with activity.

### **Shadowing staff**

Shadowing (Czarniawska 2007; McDonald 2005), a form of participant observation where the researcher follows a member of the organization under study over a period of time, with a running commentary often elicited from the person being shadowed by posing questions, is an important aspect of learning about what it is that is going on. I primarily shadowed nursing staff, observing encounters between patients and staff in and through particular spaces, and focused on *where* tasks were being performed. Shadowing was a good method for encountering professionals and patients in different spaces and in different situations related to different tasks. I learned about everyday organizational routines by directing my attention to the practical actions of staff and their interactions with each other and with patients. Shadowing as a method is especially good for gaining direct insight into practices without having to worry (too much) about people performing or pretending to act differently than they usually would. As Czarniawska (2014:48) reflects, “[...] it is unlikely that the shadowed people and the encountered others collude in staging and maintaining a special performance merely for the sake of the researcher”. People who are being shadowed cannot risk a special performance without the danger of being exposed by co-workers or others who are present.

I shadowed nursing staff with various professional backgrounds, i.e., nurses, care workers, auxiliary nurses, and a physician, by attending their appointments with patients, conferences,

watching routine collaborative work in relation to the enrollment of new patients, observing – what I experienced as – critical situations with alarms going off, in addition to participating in mundane conversations over lunch and dinner. The pattern of data collection was thus adapted to the organizational rhythm of the hospital (Hammersley and Atkinson 2007:178). Shadowing provided access and insight into unique aspects of the everyday ordering practices taking place within the inpatient settings because of its emphasis on the direct study of contextualized actions (McDonald 2005:470). As such, it can be regarded as a more targeted approach to fieldwork, enabling the researcher to capture the transient, verbal, and embodied aspects of any practice. This also provided me with the opportunity to gain insights into the potential differences between frontstage and backstage presentations by actors (Van der Waal 2009), especially because staff often moved in and out of the staff office and into the wider ward environment, changing their demeanor, adapting their performances to the spaces.

Shadowing staff through the different inpatient spaces also gave insight into the manner in which these spaces were utilized as resources in everyday work practices and in encounters with patients. Rooms, spaces, and offices can all, as Preda (1999:351), for example asserts, be thought to function as “[...] artefactual epistemic resources [that] define the local setting through their spatial arrangements that constrain the actions of human actors”. In line with this reasoning, I tried to consider the physical spaces of wards as material features that might be drawn upon as interactional repertoires that orient activities in particular ways, offer points of reference for boundary making, and function as epistemic resources for defining the appropriate places for certain conduct and activities. In translating this proposition into a methodological sensibility (Neyland 2008), I was inspired by the early laboratory studies (Galison 1997; Latour and Woolgar 1979; Lynch 1985, 1993) as they direct attention towards the mediating role physical spaces can play in ordering certain (scientific) activities. This was informative for directing my own attention to the relationships between practical action and spatial circumstances.

## Participant observation

Participant observation is often used as a term to cover a variety of methods of observation (Delamont 2011), with the degree of participation also varying significantly. Ingold (2014:386), for example, contends that observation should be done by recognizing one's participation *in* the practices of interest, abstaining from any attempt to place oneself *outside* of it: "To observe means to watch what is going on around and about, and of course to listen and feel as well. To participate means to do so from within the current of activity in which you carry on a life alongside and together with the persons and things that capture your attention". Shifting between shadowing staff and conducting observations throughout the duration of my fieldwork also meant shifting between forms of participation and currents of activity. Shadowing automatically placed me inside the current of one person's particular work routines and ordering practices, drawing me along the way, as it were, while conducting observations by hanging out in different spaces placed me somewhat outside of such currents, plunging me into the thick of it. I experienced a somewhat dramatic change in the sense of urgency and temporality, for example, when moving from the office space to the wider ward environment, with staff typically occupied or in a hurry, and patients seated, waiting, passing the time.

Participant observation becomes an act of correspondence, a mode of engagement where the participant observer intervenes, questions, and responds to the situations they find themselves in. Acknowledging that the ethnographer's mode of involvement in the field creates different types of accounts (Emerson, Fretz, and Shaw 1995:12), I tried to shift my position within the inpatient wards in an attempt to generate subtle shifts in foci, participation, and perspective to sensitize myself to the differences in, and negotiations about, what counts in just these circumstances (Lynch 2013) and gained a sense of the different current of the inpatient setting. The entry point for studying what 'healing architecture' does in psychiatric practice was to recognize the fact that everything takes place somewhere:

“Not in the world in general, or in ‘a social setting’, but in this place, right here, and whatever is true of this place is going to affect it. So take a close look, and keep looking, at the features of that place: the physical features (where it is and what kind of place that is to live, work and be) and the social features (who is there, how long they’ve been there, and all the other things demographers, sociologists, anthropologists, and historians tell you to attend to). It helps to repeat ‘Everything has to be somewhere’ to yourself frequently” (Becker 1998:56).

Everything has to be somewhere! The problem I was interested in researching was capturing how this somewhere comes to matter and for whom. Early on, I conducted a few methodological experiments in the attempt to capture space in action, trying to understand how spaces made a difference for everyday actions, encounters, and work. For this reason, and inspired by the method of snaplogging (Bramming et al. 2012), I asked a member of the nursing staff to photograph three spaces she experienced as important in her everyday work. She photographed a colleague, her preferred workstation inside the office, and her calendar, rather than three specific spaces. Although offering insight into what she considered important, I decided not to pursue this method of inquiry further, as it moved the analytical focus away from ‘healing architecture’ as the substantive point of orientation, which I was adamant to retain. This led me to conduct a second experiment in which I attempted to note *where* people were, how they *moved*, and what activity they were engaged in by marking these actions on a diagram of ward spaces.

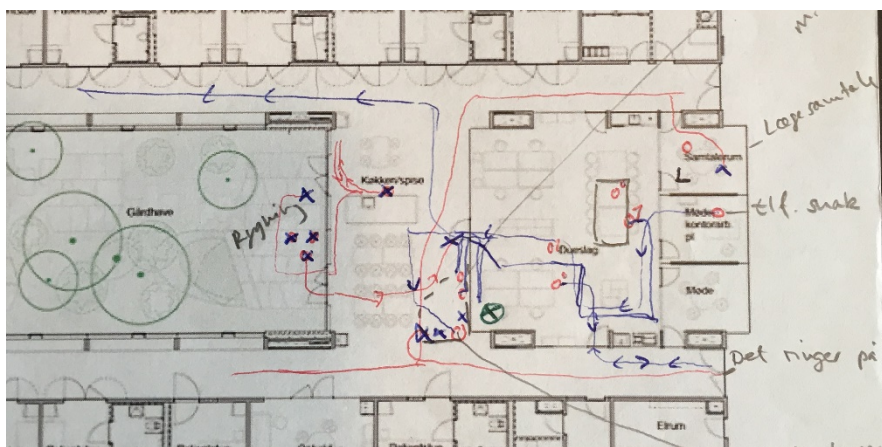


Image 2. Marking localization, movement, and activity of actors

The image shows a snapshot of about four minutes of activity. Blue Xs represent patients, red circles staff, the green X me, and the long lines with arrows, trace movements. I repeated this experiment a couple of times but quickly recognized the difficulty in gaining good representations as capturing the movements of seventeen patients and up to ten members of staff, while simultaneously trying to ascertain the purpose of such movements, was too difficult. Also, it did not offer any substantial answers to the questions I was posing, such as, how does space make a difference and for whom? What the experiment does make visible, however, is a domain of activity relegated to a rather small area of the ward, the placement of the office space playing a significant role in establishing it as an important zone of interaction, an almost unavoidable point of convergence, and thus an important space to observe. I subsequently spend most of my time during observations in the staff office or the adjacent common area, moving freely between the two.

Being able to change location in this way sensitized me towards how spaces can change sense and significance in relation to the actions taking place within them. This brings up the issue of the relationships between particular practices and the spaces they inhabit, “[...] animate, provide for the significance of, and rely upon” (Suchman 1996:35); that is, how people shape and are shaped by the spaces they occupy. Observing how spaces make a difference, I was

learning how observing entailed observing practical actions from different positions and vantage points, which furthered my commitment to detailing what practitioners *do* in practice (Orlikowski 2010:24). Doctors, nurses, and patients are all, in this sense, practitioners whose conduct is interesting to detail. The importance of any one specific individual is thus sidestepped in favor of focusing on the practical activities and direct experiences of a wider group of people, which, according to Orlikowski (2010:24), reveals adaptive and pragmatic intelligibility that is not easily captured by theoretical propositions.

## **Taking notes**

I initially tried to take nothing for granted, following Becker's (1998:76) proposition to note down everything, that is, aiming to report the "universe of relevant occurrences," rather than merely sampling it. Description is, in many respects, considered the main feature of ethnographic work, but drawing inspiration from an ethnomethodological approach entailed focusing more specifically on members' own descriptions, as it is through their descriptions that "members produce the order and orderliness of their daily lives and activities" (Pollner and Emerson 2001:128). Pollner and Emerson (2001:129) suggest that this line of inquiry orients the ethnographer towards the ongoing way in which members make sense and towards their descriptions, categorizations, classifications, and conceptualizations in situated actions. For this reason, I tried to capture conversations by jotting down quotes in situ. Talk would often be a natural source of data as staff spent much time inside the office space conversing with colleagues. Consequently, fieldnotes often consisted of passages of speech since this kind of action was prevalent.

I always tried to note who was present in a situation, where they were, at what time and under what circumstances (Hammersley and Atkinson 2007:185) to contextualize my notes. Justesen and Mik-Meyer (2012) distinguish between four different, but commonly used, types of notes that help structure observations for future analysis. Brief notes are taken in a notebook during fieldwork to help jog one's memory and to remind about specific events, which are then

reproduced in as much detail as possible when writing descriptive notes, the second kind of notes. Next, analytical notes are written to suggest initial relationships between various events. Lastly, reflective notes document feelings, thoughts, and interests towards the field, e.g., problems, issues, and themes (Justesen and Mik-meyer 2012). Initially, I tried to follow this categorization scheme but quickly struggled with separating one category from another during notetaking. A more simple coding procedure was therefore used to organize fieldnotes, which were jotted down in small notebooks and written up as quickly as possible after each phase of data collection (Emerson et al. 1995).

A difference in style and form is noticeable in my notes in relation to whether I was hanging out or following staff. During observations, my notes would typically account for the presence of people in and through spaces, or be snapshots of particular situations. These shorter descriptions, which are closer to mere jottings, seem to share a common feature, which points to the fact that not much is always going on. During shadowing, I would usually have longer descriptive notes due to the actions I followed because I observed more coherent passages of activities and encounters. Descriptive fieldnotes inevitably reduce the messiness of social reality, transforming witnessed events, people, and places into words and jottings in a notebook (Emerson et al. 1995:12). This transformation inevitably involves a process of selection when choosing what to write about and document, with certain things inevitably being left out.

## Doing interviews

While the key point of analytical orientation is to focus on processes of ordering in practice, making participant observations, shadowing the main mode of field involvement, and gaining accounts of how staff understood, experienced and reflected upon working within and across inpatient spaces was important insofar as these accounts revealed something interesting as to why they do what they do, why they solve *this* task *here*, conduct *that* activity *there*, or move *these* patients to *those* locations. Interviews were directed towards gaining knowledge on how psychiatric work was done, as accounted for by staff. We might, in light of such an interest, as

Mol (2002) contends, listen to informants as ethnographers, not as an ethnographer of feelings, meanings, or perspectives, but as someone who talks about and accounts for how psychiatric work is done in practice. What people say in an interview, as Mol (2002:15) further explains, “doesn’t only reveal their perspective, but also tells about events they have lived through.”

For this reason, interviews were primarily conducted to elicit accounts on the relationships between space and work practices by inviting staff to talk about where they did what activities and why. As a result, I would pose questions about what they specifically did and have respondents walk me through a workday, enquiring about their tasks and what they saw as important to solve them. Once again, the question – What is it that’s going on here? – drew my attention, as well as of informants, to *where* they were doing *what* and *why* they were doing it *there*. Even though posing why questions might be experienced as a cross-examination of a particular state of affairs and, thus, as the interviewer passing judgment on accounts given by the informant, I still found it important to invite reflections on why staff were doing things or solving tasks in *this* space as opposed to *that* space. I would try to invite comparative reflections on why *here* and not *there*, often gaining insights into how spaces were ascribed particular meanings by asking, for instance, what the spatial layout meant to their everyday work. Why answers were then subsequently followed by how questions.

Asking how rather than why during interviews can be employed as a tactic to invite informants to give more descriptive accounts of what is going on, letting them tell stories with contextual detail focused on actions rather than reflections (Becker 1998:59). As such, posing how questions also gave insight into *where* things took place because informants descriptions would take me into and across a variety of locations within the wards, giving insight into how a variety of spaces were experienced. Introducing informants to a diagram of ward spaces during interviews was a way to enable space-focused accounts, prompting informants to tell as well as reflect upon different localized activities, tasks, and situations. As such, the diagram functioned as a narrative prompt (Gaztambide-Fernandez 2009:246), directing attention to different spaces

and the activities occurring therein. The diagram offered a representation of the physical layout of the ward, its spatial disposition, and the proximity between various rooms, but informants' descriptions of what took place in those spaces and rooms, however, afforded accounts explicating the sociality of those spaces as well, making the interplay between physical and social spaces available for interrogation and analysis. As interviews with staff were conducted during or shortly after fieldwork, I was also able to evoke certain situations observed during fieldwork and inquire specifically about why a patient was moved, for instance, or how the informant experienced working within the transparent walls in the nursing station.

I conducted thirteen semi-structured qualitative interviews after the initial three pilot interviews (see Table 4). Two overall sets of actors were interviewed, those (nurses, auxiliary nurses, pedagogues, and physicians) with knowledge of and engagement in the everyday work taking place in the inpatient wards where I conducted fieldwork and those (architect, project director, and hospital management) who were knowledgeable about the design, development, and visions undergirding the design and development of the hospital.

Professional position	Number of informants
Henrik Bendix Olsen, project director	1
Kristian Karlsson, lead architect	1
Hospital management	2
Head physician	1
Head nurse	3
Nurse	5
Auxiliary nurse	2
Care worker	1

Table 4. Overview of interviews

After identifying key stakeholders with knowledge about the design of the psychiatric hospital, I contacted them directly and interviewed the lead architect, Kristian Karlsson, and the director of the building project, Henrik Bendix Olsen, as well as two members of the hospital management. Most of the informants from the psychiatric wards were recruited during fieldwork. This type of recruitment can be characterized as purposeful sampling, where the researcher identifies information-rich cases to acquire deeper insights into particular issues (Patton 1990). In these instances, I recruited people I had become acquainted with during fieldwork. Sampling was based on gaining an occupational spectrum that included nurses (5), care workers (1), physicians (1), auxiliary nurses (2) and head-nurses (3) to find out if the manner in which they navigated work and spaces made a difference. As it turned out, it did not matter a great deal as they all collectively worked together in the same spaces. This was especially true of everyone except the head physician, who had an office outside the ward. Informants were approached after I obtained approval from the head nurse but were always given the opportunity to decline participation. Interviews with staff were conducted at the hospital during work hours.

In preparation, and to guide the course of the interviews, I created particular topics of interest, drew up a research question on this topic, and asked questions that would hopefully enable dynamic, productive interaction during the interview (Kvale 1997:134). All the interviews were semi-structured, converging around a set of predefined topics pertaining especially to space, work, and the relationships between them, while always allowing informants to elaborate and expand on these topics (Neyland 2008), thus making room for detours to explore the routes and movements of work practices taking place in and across hospital spaces more broadly. Asking staff to take me through their workday was an attempt at inviting narratives about their daily activities, enabling the confluence of interpretation, explanation, causes, and reasons in order to get rich descriptions of everyday work (Czarniawska 2014:31). At the end of the interviews, I would present nursing staff with the four design principles developed by the architects and then elicit reflections on the concepts of recovery and healing architecture. My

rationale for doing this was to see how they would react, think about, contest, or elaborate on these design principles. In most cases, the design principles came across as too abstract to relate to, with most nursing staff commenting on them in very generic terms. Interviews lasted between 60 and 90 minutes, were digitally recorded and then transcribed verbatim by me or by student assistants employed at the Department of Organization, CBS.

## Documents and other materials

A variety of written materials were obtained, read, and stored during this research project. Documents relating to the design and development of the psychiatric hospital were particularly salient for understanding the ideas and intentions now manifest in the hospital in Slagelse. Reference to the ideas and underlying visions incorporated into the hospital building is present in all three papers in this dissertation because they function as an important backdrop for understanding how ‘healing architecture’ is thought to play an active role in the promotion of patient recovery and support psychiatric work. The documents include the competition program written by Region Zealand, the architectural proposition for the psychiatric hospital by Karlsson Architects and Vilhelm Lauritzen Architects, and an assortment of appendices with diagrams, pictures, and visualizations of the site. Kristian Karlsson, the lead architect at Karlsson Architects, was generous in providing all this material, his colleagues also providing me with additional pictures of the site. Written approval was obtained to use pictures in all three papers and in this dissertation (see Appendix).

While these documents are central in relation to explicating the intentions behind the building, a host of other written materials were obtained and used as secondary sources to this same end, including *Karlssons lille bog om Psykiatrisygehuset*, a small booklet about the hospital available on Karlsson Architects’ website,<sup>10</sup> architectural reviews (e.g., Astbury 2016), and municipal and regional reports (Region Zealand 2010a, 2012a). Because of the novelty of the site, a range of materials, including referendums, PowerPoint presentations, and websites describing, reflecting

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<sup>10</sup> <https://www.karlssonark.com/>

upon, or presenting the design and the hospital facility was available, accessible, and thus obtained. Most importantly perhaps, this included a document on the design principles developed for the construction of the building. Other documents of importance are governmental and regional policies related to the descriptions (Region Zealand 2008, 2014), vision statements (Region Zealand 2012b, 2012a, 2018; The Danish Government 2013), and action plans (Region Zealand 2018) developed for current and future directions for psychiatric treatment.

Finally, an astounding amount of local and national newspaper articles architectural reviews (Astbury 2016), and critical commentary in magazines (e.g., Due 2016, 2017; Winding 2017) were published on a continuing basis during the time of this project. Much of this has served as background material, keeping me up to date on public, professional, and personal opinions regarding the merits and foibles of the hospital facility, while also providing insight into what I experienced as being the disconnected worlds of architectural and medical practice. The building was awarded a variety of prizes, such as the 2017 MIPIM award for Best Healthcare Development, and praised in architectural reviews, but medical professionals publicly criticized fundamental aspects of the facility's architectural and spatial features. The hospital was considered controversial for various reasons, for instance, in relation to patient safety, transparency, and the lack of staff resources, a topic I will revisit in the section on implications for practice.

## **Access, positioning, and ethics**

Ethnographic research can take place within a single or across multiple sites. The selection of a site subsequently creates a locus for the ethnographer and a location within which to conduct research. In the following, I detail the manner in which I initially gained access to the field, how I positioned myself, and how I was positioned by others while in the field. Finally, I offer some ethical considerations in relation to conducting fieldwork within the psychiatric hospital in Slagelse.

## Negotiating access

While descriptions of accessing the field may be underrepresented in the literature on organizational ethnography, it remains, as Bruni (2006) observes, a significant aspect of any research endeavor that is often taken for granted. Identifying an initial access point, an opening, a specific door, is arguably the first step in such an endeavor. It is important to understand the process of gaining access to a particular site because finding the correct door suggests that *a* door actually exists, that it is always in the same location, and that the researcher is actually able to find it (Feldman, Bell, and Berger 2003:ix). This further entails attracting enough interest or attention from someone on the inside, from someone behind the door, and subsequently convincing someone to open the door just wide enough for you to be able to explain what you want (Feldman et al. 2003:x). Staying with this metaphor just a while longer, the first door I located, knocked on, and gained passage through was the door of the Vice Director of Psychiatry in Region Zealand.

A short digression is warranted to contextualize the circumstances under which this initial meeting took place. I had applied for a Ph.D. position at the Department of Organization at Copenhagen Business School in the spring of 2015 on the topic of health innovation, during which time I was employed at a small company working with vocational training for people with mental illness. Although I was called for an interview, I did not get the position, alas. From this process, I learned the importance of having a strong research case. When the Department of Organization posted a new PhD position six months later, I decided to try and find a case for my application. Due to my work with vocational training for people with mental illness, I was interested in current municipal developments within psychiatry in Denmark, which is why I knew about the developments with the psychiatric hospital in Slagelse, which brings me back to Vice Director's door.

This initial meeting was important insofar as it was my first encounter with a relevant stakeholder that enabled me further access to the field. Despite initially having knocked on the

correct door, the reality of gaining access, keeping that access, and perhaps expanding it is better understood as a never-ending process of engaging with multiple actors. Although initial access to the hospital setting was gained and later formalized by establishing a relationship to the research department at the hospital, I also had to negotiate access to the inpatient settings, where I later ended up conducting my fieldwork. Although instrumental for gaining further access, my connection to the research department was not unconditionally unproblematic as I was initially considered part of a department closely connected to hospital management, making staff in the inpatient settings somewhat skeptical towards my intentions. This became clear upon my first meeting with a head physician who inquired without hesitation, “Who sent you, management?” (Fieldnotes 17.01.2017). Access, then, is better understood as a trajectory (Bruni 2006), a relational and dynamic process of building relationships (Feldman et al. 2003:vii) that continues throughout the duration of fieldwork.

The research narrative that developed during the initial phases of the research project converged around my interests in the new spatial and organizational circumstances found within and throughout the hospital. Although not cognizant of the instrumental role this narrative might play, it worked as a telling practice (Goffman 1989:126), which, in many ways, afforded me further access to different areas of the hospital, legitimizing my presence, especially, I think, because it made clear that I was not studying the relationships between psychiatric work and clinical outcomes, nor assessing causality between what staff were doing and how patients were feeling. This made my presence non-threatening, I thought. The narrative, however, as modulated through various encounters, but somewhat solidified when I was asked to produce a series of documents that were distributed to relevant stakeholders about who I was, what I was doing (or intended to do), and what it might entail for the people I encountered.

## Role interpretations

Goffman (1959, 1967) taught us the importance of the art of impression management and that correct role interpretation is important in social interaction. Our appearance matters, in other words. Initially, I was hesitant about how to conduct myself, how to present myself, and to whom, while also being uncertain about my role, my purpose, and the degree to which I was allowed to participate, follow, or otherwise engage patients when inside the inpatient wards. I quickly became aware of the importance of the staff office for everyday work and interactions, oftentimes finding myself either within or in close proximity of it. Staff would always begin their shifts inside the office, a routine I also picked up, which meant that I developed a sense of assurance and safety when inside this space, always returning to it if unsure or uncertain about *what* or *who* to observe or follow, seemingly similar to the manner in which nursing staff conducted themselves when on duty. Over time I became more and more familiar with how to conduct myself, penetrating (Goffman 1989:129) the group, as it were. This also meant that patients, more often than not, would think I was a member of staff, usually a doctor despite my credentials stating I was a Ph.D. student.

During fieldwork, I would greet patients and staff and talk to both groups in an effort to extract myself from being identified as a staff member, trying to create an image of myself that was independent of the staff. Patients were informed about who I was and why I was there by way of introduction, and they were always asked for permission to document statements they made in my notebooks. Patients, in the main, were very welcoming and interested in my work, and I did not experience any animosity towards my person or presence. I gained patients' trust by lending an ear, participating in leisurely activities in the common area, such as reading magazines or drinking coffee, but mostly by simply hanging out. On multiple occasions, patients would even encourage me to write something down. A few patients eventually considered me as someone they could trust, and they encouraged others to speak to me if they had critique to voice. Even though I informed them about my research interests, they seemed to project an image of someone who might be able to solve their problems or improve the

circumstances they were hospitalized under. This also applied to staff, some suggesting that I develop suggestions for organizational and cultural changes, for instance.

Both patients and staff were highly accustomed to the presence of multiple people who they did not necessarily know. This made it somewhat uncomplicated for me to be present in a variety of different settings, as co-present others would usually assume that I was a student. When relevant and appropriate, I would either be presented by the person I was shadowing, for instance, when participating in conference meetings across units, or I would introduce myself during initial encounters. As such, I have been presented as the researcher, the fly on the wall, and a guy studying our work, and, among staff, I became known as the guy with the notebook. Although actively positioned as someone who was just tagging along, I was often drafted to help out, so to speak. Pollner and Emerson (2001) have shown how being just an observer during fieldwork is somewhat of an illusion, as the observer continuously has to achieve and sustain the role as an observer to avoid getting dragged into certain activities, or participate more fully in the action observed. I experienced this on multiple occasions when asked, for example, to collect certain items, jot down information, relay information about the whereabouts of people, move furniture to make room for staff in heated situations, or run for help outside the wards. This practice of participation can, as Ingold (2014:389) also explains, be rather “unnerving, and entail considerable existential risk”, and indeed on occasion, it was.

## **Moments of disconcertment**

Disconcertment, Verran (2001) argues, can be used as a tool by analysts, something to be harnessed and strategically deployed in the process of research. Verran discusses the notion of disconcertment in relation to her experiences of conducting fieldwork in Africa, where she studied how the Yoruba teach mathematics. According to Verran, moments of disconcertment are interruptions that we should learn to value and use, despite being “fleeting experiences, ephemeral and embodied [...] easy to ignore and pass by”. They must, she argues, be “privileged and nurtured, valued and expanded upon” (Verran 2001). Moments of

disconcertment are occurrences where something seems to be out of order, where there might be a sense of dissonance between something familiar and something 'other'. Verran experienced disconcertment when observing the manner in which the Yoruba were teaching measuring length by using a little card and some string. Length and number were realized in a different way from what she was used to and two logics about mathematics collided - an African and a Western logic. Disconcertment, then, occurs as a comparative moment, where one experiences both sameness and difference.

Unfortunately, I first encountered Verran's work after having conducted both fieldwork and data analysis. While Verran encourages sustained exploration and analysis of moments of disconcertment, taking the experience of discomfort seriously in the process of research, I did not think to systematically utilize the embodied experience of fieldwork to investigate my data. However, much of the data analyzed for this dissertation was indeed selected based on an initial sense of disconcertment, a feeling that something was at stake or out of order. While sometimes this sense was my own, at other times it seemed to be tangibly present with those whom I was observing. Having conducted fieldwork in a psychiatric inpatient setting, this is perhaps not so surprising. Nonetheless, and in using Verran's vocabulary, different moments of disconcertment did lead to initial analytical insights, becoming, somewhat implicitly perhaps, an ordering device for my data selection. Repeatedly, I had the somewhat odd sense that what inpatient care was really concerned with was practically moving things around and displacing patients from here to there in efforts to maintain an orderly ward, rather than having therapeutic conversations with them. This experience turned into the analysis of Paper I of this dissertation, for instance. Other experiences of discomfort related to my encounters with certain patients, especially when approached directly, drawn to the side to talk, or when they confronted me about the circumstances of their hospitalization, asking me to help them.

While some of these encounters were indeed uncomfortable, disconcerting moments more often arose during staff/patient encounters, especially when staff attempted to manage, care

for, and control a distressed patient. One example serves as an illustration. ‘K’, a female patient, thought she was being followed, surveilled, and harassed by an assassin who was invisible to everyone but her. Her actions and conduct on the ward made it abundantly clear how real she experienced the situation. She ran around the ward, moving up and down the hallways, trying to hide behind furniture and bang on the glass façades of the nursing station, where I was situated. The following excerpt is from my fieldnotes:

I look at the digital clock on the wall. It is 07.25. I see K running around just outside the nursing station. “She is in so much pain” says U, one of the nurses on duty, concerned, and informs her colleagues that K is convinced that an assassin is after her and that he has already killed two people. K literally jumps up and down and around, ducks and looks nervously over her shoulder to see if anyone is after her. “She needs some medicine” says U as she gets up from her chair and walks towards her as she is standing in the door-opening of the nursing station. A little later there is sudden turbulence and a racket which grabs our attention. Staff are in the hallway just outside the nursing station. The head physician and a nurse leave the nursing station to go out to see what is going on. Suddenly I hear U saying with a tangible sense of urgency in her voice “she needs medication now!” In order to see what’s going on I leave the nursing station, enter the wider ward environment, and sit down on the sofa just around the corner from where staff have now gathered. The side doors of the nursing station are blocked by staff surrounding K and I exit through the center door instead. I can’t hear what’s going on. K is speaking gibberish as she suddenly comes over and sits down next to me. I flinch, but try to remain calm. She looks at me and says something I can’t quite comprehend. I feel very uncomfortable, somewhat exposed and unsafe and I slowly get up without saying anything to K and enter the nursing station again. I am now at a safe distance from the situation.

Following the above, nursing staff gathered inside the nursing station, planned and coordinated how to manage K, and ended up giving her medication in her room at the far end of the ward. To K, the ward is a dangerous place. She felt captured and wanted to exit. Simultaneously, staff were trying to convince K that this was the safest place she could be and that they would protect her. Taking care of K in this situation entailed administering medication, but also of convincing K that the ward afforded a safe environment. The latter was practically attempted by walking K around the ward in an effort to show her that no assassins could be hiding anywhere. I got the sense that K was in a different place than we were, in a dangerous location which she, in turn, tried to adapt to by interacting with the spatial and material circumstances in a particular way, hiding, running away, ordering her environment so as to regain a sense of safety. These ordering efforts were taken as disorderly by staff, an expression of her disorderly state of mind, which they needed to help bring back to an orderly state. I experienced these kinds of tensions between patient conduct, staff interests, and spatial circumstances to be rather disconcerting. Such experiences have been central to the analysis in all three papers, but are especially visible in Paper III. During such situations I would often feel uncomfortable, uncertain, and in doubt about whether or not it was appropriate for me to observe what was going on. I reasoned that such situations were a central part of everyday interactions and work practices and, as such, within the scope of interest. I would, however, attempt to avoid any excessive attention being drawn to my presence in such sensitive moments, situating myself at a distance to what was going on to avoid interfering with the proceedings.

## **Ethical considerations**

Applying for approval from the National Committee on Health Research Ethics in Denmark was not compulsory for this research to take place in that the project did not involve any formal clinical intervention, nor did it concern biological material. Before fieldwork commenced, information on the research project, its interests, and intents, as well as its use of methods, was circulated to the head nurses of wards, who then ensured that staff were informed. Information flyers and posters about the study were developed and distributed to

each ward. Posters, however, were not displayed, as this was against the architectural guidelines in place at the site. Consent to the researcher's presence in the inpatient settings was initially obtained by hospital management and concomitantly obtained verbally by nursing staff in each ward. In its initial phases, the research project was developed in close conversation with key stakeholders from the hospital management in Region Zealand. These conversations led to further conversations with the hospital's research department, which approved the research plan for conducting the study. This ensured access to relevant personnel and made informing relevant actors about the research project less complicated. Formal consent was initially given in the form of a written statement that the research could be conducted on site, just as a declaration of confidentiality was signed (see Appendix).

Although tensions over research ethics may arise when social scientists study health services in medical institutions, as Hoeyer et. al. (2005) have shown, the everyday practices of work, treatment, and education at the site made it somewhat uncomplicated to gain access to inpatient settings because multiple stakeholders constantly move in and out of wards and in and out meetings. In accordance with local hospital practice, written informed consent was not obtained; however, patients were always asked whether or not notetaking would be alright when in direct conversation. Verbal consent was thus obtained when possible. Anonymity was ensured for all participants, and names have been truncated to a single letter in the analysis. Interview informants were always informed about anonymization and the right to decline participation. The hospital was not anonymized as one of the fundamental points of orientation for this project is the novelty of its design. Data is stored in accordance with Copenhagen Business School's data protection rules and regulations.

## **Doing analysis, producing data**

Despite going into the field with preset conceptual ideas and presuppositions, I tried to stay open to emerging insights gained from doing fieldwork. The two main methods for producing data were shadowing and participant observation. Each method solicited different data types,

i.e., brief but many jottings and long descriptions of courses of action. While both have been conducive to attaining an overall sense of what was going on in the inpatient wards, neither seem to immediately offer any explanations as to what healing architecture *does* in practice. Both data sources were written up, organized using Nvivo software, and coded with initial open codes. These codes were, similar to the concepts I was tinkering with, developed to help me think about my data in a systematic and organized way (Coffey and Atkinson 1996:32). Three analytical approaches grew out of working with the data in this way. I started drawing things together across what I jotted down from observations, taking things apart in each long shadowing description I had produced, and by capturing mediations by focusing on how patients and staff reacted to the transparent nature of the office space, while aiming to juxtapose all three sources with my interview material, searching for any similarities and/or (in)consistencies.

### **Drawing things together**

Building on the insight that what staff were essentially doing was engaging in the processes of ordering, I started to map out all the activities that I thought related to such processes, primarily based on my fieldnotes from participant observations. I got the impression that the staff were highly engaged in moving things from here to there, displacing patients from one area to another, relocating activities to what were considered more appropriate places. Based in this inkling, I started (re)coding my fieldnotes. Simultaneously, I began reading Douglas' (1966) work, which offered a particular way of understanding these activities, namely as part of a systematic ordering of things and people in accordance with a particular, culturally moored, system of classification. Following from this, I made lists with activities and situations where staff (re)moved objects, cleaned spaces, and sanctioned behavior, giving me a sense that being out of place was certainly something that was continuously being negotiated within the inpatient setting and labored over by staff. Aggregating all the data into lists with these activities, mapping all these types of orderings, gave me the empirical and analytical basis to write Paper I in this dissertation.

## **Taking things apart**

As opposed to the previous analytical approach, when working with the longer, fuller descriptions of particular courses of action, I focused on conducting meticulous readings of each, taking them apart, as it were, to gain insights into the interactional aspects and practical doings of all participants – human and non-human – present in those courses of action. Taken together with the impetus from ethnomethodological studies of work and the early science and technology laboratory studies, I started considering the relationships between the physical spaces of the site and the enacted spaces constituted through the courses of actions I was following during shadowing. Across many instances, constitution work was significant to the efforts of managing patient behavior, and I found a strong vocabulary for making sense of this work in Lynch (1991). Going through the long fieldnote descriptions (1-3 pages) while focusing on movement through spaces, the reasons for these movements and the coordinated efforts to achieve certain goals while interacting with patients in spaces laid the empirical and analytical basis for what became Paper III in this dissertation.

## **Capturing mediations**

Throughout the entire process of fieldwork, the relationships between the office space and the wider ward environment were often considered in my fieldnotes, both in relation to the types of interactions and encounters that took place in and around these spaces and in relation to the manner in which staff and patients actively and continuously expressed their opinions about the glass walls separating the two spaces. Aggregating all the data describing encounters taking place in the door opening of the office and compiling quotes related to staff and patients' experiences of and reactions to the transparency of the inpatient ward prompted me to consider Goffman's (1959, 1963) work more closely. The interview material turned out to be significant for producing an analysis focusing on the consequences of the transparency of the nursing station, as staff spoke extensively about their experiences in this regard. Drawing on Goffman's ideas of front and back regions, together with Latour's notion of mediator, created the impetus for developing the analysis for Paper II in this dissertation.

## **In sum**

While the initial difficulties in identifying how ‘recovery-oriented spaces’ and ‘healing architecture’ made a difference afforded me some frustration, these difficulties also made room for gaining a more differentiated appreciation of the phenomena in question, thus enabling the development of a methodology sensitive to the various aspects of processes of ordering space and interaction in practice. Aiming to cultivate and engage with a process of constructive obstruction gave way, for example, to the notion of ordering as an entry point to study what ‘healing architecture’ does in practice. Training my focus on practical actions and doings within the inpatient settings made shadowing and participant observation particularly salient methods for capturing the relationships between space and interaction. These methods also made it possible to conduct a situated inquiry, offering the means for exploring the problem of what it is that is going on in practice, without forgetting the presuppositions I carried with me.

Working with different types of notes allowed various types of analysis. Drawing all the insights related to different types of orderings noted during participant observations together gave me the empirical and analytical basis to write Paper I in this dissertation. The longer fieldnote descriptions of movement through spaces, the reasons for these movements, and the coordinated efforts to achieve certain goals while interacting with patients in and across spaces made after shadowing laid the empirical and analytical basis for what became Paper III in this dissertation. And, finally, interviews were salient for coming to terms with how staff reacted to working within the new spatial circumstances afforded by the site and gave me a better understanding of the changes in their demeanor and performance when moving between spaces. All these insights are put to work in and across Papers I, II, III in the next section of this dissertation.

# **PART II**

THE THREE PAPERS OF THE DISSERTATION

## 6. Paper I

### The Spatial Organization of Psychiatric (Dis)Order

#### Abstract

Contemporary notions of healing architecture are significantly transforming the design of psychiatric inpatient facilities. While aspects of the interplay between ward spaces and nursing work have been addressed in recent research, the development of recovery-oriented architecture raises new questions concerning the demands on, and responses of, nursing staff working within such settings. Drawing on the work of anthropologist Mary Douglas, this paper considers the relations between the physical layout and nursing work within two inpatient wards in a new purpose-built psychiatric hospital. Based on ethnographic fieldwork, I analyse the relations between ward spaces, perceived dangers, and nursing, showing firstly how displacing patients, cleaning spaces, (re)moving objects and correcting patient behaviour become salient tasks engendered by the spatial layout of a ward, and secondly how the invocation of ‘the language of danger’ enables staff to intervene when socio-spatial boundaries are transgressed. In discussing the findings I suggest that the spatial layout of the inpatient setting amplifies tensions between professional interests and designed intentions, creating ‘sites of contention’ where the social order of a ward is openly negotiated. In so doing, the paper contributes to discussions on the interrelations of space, work, and social order.

**Keywords:** hospital ethnography; space; nursing work; culture; Mary Douglas; (dis)order

## Introduction

Psychiatric facilities are being designed to reflect contemporary models of care (Bromley 2012; Vaughan et al. 2018), significantly transforming the spatial dispositions of inpatient facilities (Curtis et al. 2009), and in many instances mirroring a shift in psychiatric treatment from containment to recovery (Jovanovic et al. 2019). Consequently, psychiatric hospitals are designed to promote patient recovery and support psychiatric practices through particular architectural properties and propositions, such as ambient features and spatial layouts, with attention directed towards facilitating social interaction through transparency and openness (e.g. Jovanovic et al. 2019; Lawson 2010). Following this trend, significant investments have recently been made in new hospital facilities in Denmark, drastically changing the spatial circumstances for psychiatric inpatient care. With the idea of recovery literally built into the bricks and mortar of the facility, the new psychiatric hospital in Slagelse, Denmark, built in 2015, is part of a broader effort to achieve ‘world-class psychiatry’ (Danske Regioner 2009) through the development of commissioned healing architectures. The design of such facilities, however, raises new questions concerning the demands on, and responses of, nursing staff working within them (Andrews 2016; Mikesell and Bromley 2012).

While an extensive body of literature concerning the importance of the built environment for mental health provision (e.g. Connellan et al. 2013; Reavey, Harding, et al. 2017) and the role of ward spaces on patients’ perceived well-being exists (Annemans et al. 2018), less research has concentrated on the impact of designed spaces on professional staff and work practices (Andrews 2016; Mikesell and Bromley 2012; VanHeuvelen 2019). The interplay between space and work in health care settings, however, has been studied in relation to patient safety (Mesman 2012), sterility (Fox 1997) and nursing (e.g. Andes and Shattell 2006; Halford and Leonard 2003), for instance. The latter being especially salient in the work of Gavin Andrews (e.g. Andrews 2006, 2016) who has argued extensively for a spatial focus on nursing work, investigating how nurses manage, mitigate and manipulate spaces in “everyday activities and

actions undertaken on a frequent basis” (Andrews and Shaw 2008:463). While this work sensitizes us to the spatiality of nursing, it remains pertinent how contemporary inpatient settings shape the ‘actual work’ of nursing (Deacon and Fairhurst 2008) and how relations between perceived risks, control, and ward-spaces might be affected (Curtis et al. 2013).

According to Bartlett, a key objective of psychiatric practice has always been the accomplishment of order through “structuring therapeutic settings, in both their architectural layout and the permissible use of space” (1994:192). In this paper I draw on the work of cultural anthropologist Mary Douglas, which makes this relationship come into focus as it draws our attention towards the spatiality of disorder and the subsequent ordering practices that strive to correct it, that is, to the relations between space and culture; between the architectural layout of a ward and the perceived dangers of nursing staff. In Douglas’ account, achieving social order includes removing or resituating something or someone from *here* to *there* in acts that can be said to involve spatial displacement within an existing social order. Working from material collected in an ethnographic study of two inpatient wards at the psychiatric hospital in Slagelse, this paper examines how nursing staff seek to manage and mitigate disorder. By asking; ‘how do nursing staff manage (what they consider to be) dirt, danger, and disorder?’ this paper analyses the interplay between ward spaces, perceived dangers, and nursing work. In so doing, the paper contributes to the understanding of how newly designed spaces shape the spatial dynamics of nursing work within contemporary inpatient settings.

## **Dirt and (dis)order**

Throughout her work, Mary Douglas (1921-2007) was concerned with systems of classification, that is, cultural orders that give symbols their concrete meaning. With an interest in comparative religion and writing within structuralist social anthropology, Douglas aimed to understand culture by studying social organization through the classification of symbols, and by making sense of these classifications by placing them in relation to the ‘total structure’ or ‘larger whole’ of classifications in that culture (Douglas 1966:vii). Douglas, therefore, looks to dirt,

disorder and rituals of cleanliness to provide evidence for shared cultural patterns, drawing out ‘the full range of dangers’, that is, the beliefs and behaviours related to practices of purification, in order to arrive at an understanding of how power and social order are established and maintained. In her 1966 book, *Purity and Danger*, Douglas (1966:48) argues that pollution and danger beliefs are inherent in the establishment of social order and that conceptions of dirt in generalised forms emerge out of a culture’s ideas about order and disorder, thus providing a particular system of classification. In pursuing dirt, in cleaning and tidying, and other such purifying practices, we are, Douglas argues, involved in a perpetual process of arranging and “[...] positively re-ordering our environment, making it conform to an idea” (1966:3). Demarcating boundaries and punishing transgressions have as their “main function to impose system on an inherently untidy experience.” (Douglas 1966:5). This way of understanding dirt invokes a substantial dynamic between two connected conditions: a set of ordered relations and a contravention of that order (Douglas 1966:44). In a later essay Douglas elaborates on the concept of dirt in the following way:

For us dirt is a kind of compendium category for all events which blur, smudge, contradict, or otherwise confuse accepted classifications. The underlying feeling is that a system of values which is habitually expressed in a given arrangement of things has been violated. (Douglas 1968:198).

Classifying something as dirt implies an underlying social order and identifying its elimination thus exposes power. Handling dirt, drawing boundaries, protecting borders, categorising and other forms of control invoked by things considered to be anomalous can, therefore, be seen as examples of certain efforts to manage what Douglas (1966:44) calls ‘matter out of place’. Dirt, then, is above all a spatial category. In her thinking, direct connections are drawn between physical states and social organization, between the material and the metaphorical, with beliefs about danger functioning as “a spontaneous coding practice which sets up a vocabulary of spatial limits and physical and verbal signals to hedge around vulnerable relations.” (Douglas

1966:xiii). Beliefs about dirt and danger reinforce social pressures, pressures which are spatially organised and spatially organizing.

## **Perceived dangers**

While danger-beliefs are embedded within a larger cultural pattern, danger does not exist in and of itself. Situations, patients and objects, for instance, might all *become* dangerous through certain events but are not a priori discernible as such. Some dangers are great and others small, but invoking danger can, for all practical purposes, become an important aspect of legitimising action towards (re)establishing order. Avoiding danger can, therefore, be seen as the attempt to relate form to function in the pursuit of unity in experience, which is why danger arises when form seems to have been attacked (Douglas 1966:3,43,130). Labelling a patient as dangerous, for instance, makes it possible to identify appropriate actions in *this* or *that* particular situation, while avoiding danger, as Douglas (1966:48) contends, (re)affirms and strengthens the definitions to which they do not conform. While danger might situationally arise, identifying the practices' of classifying something or someone *as* dangerous enables analytical recourse to the identification of an overall system of classification, a cultural social order that is.

Mapping what Douglas (1966:4,122) calls 'the full range of dangers' or the 'inventory of powers' thus becomes the analytical task when interested in examining the ordering of everyday life, of social organisation within a culture, that is, when interested in how systems of classification *work*. Classification is part of the fabric of human interchange and her work provides a suggestive lens for examining this fabric, especially in relation to how order is established and maintained by spatial means. Here the notion of dirt directs our attention towards the concrete instances in which boundaries are transgressed, where rules are violated, where order is contravened. Her work furthermore offers the conceptual tools for understanding how labelling something or someone as dangerous might warrant action and intervention. This reveals relations of control and power and, more specifically, underlying social and cultural expectations to maintain a certain state-of-affairs. For the purposes of this

paper, these insights will be brought to bear on the analysis of how nursing staff manage what they consider to be danger and disorder within two inpatient wards at the psychiatric hospital in Slagelse.

## **Context and site**

This study took place at the psychiatric hospital in Slagelse, Denmark, with approximately 200 hours of fieldwork conducted shortly after its inauguration. The hospital is designed with high degrees of transparency and openness, with flexibility in the spatial disposition of wards attributed particular significance; this is supposed to allow wards to adapt to different stages of a patient's state of wellbeing. Beginning hospitalization in the building's most secluded and private space – the patient room – patients are expected to initially encounter a sense of safety. When ready, patients are encouraged to move on to and into semi-public spaces (corridors, courtyards, and common areas) where the first encounters with others are thought to take place. Entering and engaging with the building's most public spaces (cantina, park area, and atrium) means approaching the end of hospitalization (Karlsson Arkitekter/Vilhelm Lauritzen AS 2011). Movement through these spaces is assumed to be important for promoting wellbeing, with an apparent linear trajectory towards recovery built into the very form and function of the building. The physical layout of a ward (see Image 4) is thought to encourage the progression towards active participation, engagement and finally recovery.

Karlsson Architects and Vilhelm Lauritzen Architects won the architectural competition for the hospital, spearheading the project under the title 'A lighthouse for the future of psychiatric building', drawing explicitly on the principle of recovery in the design process (Karlsson Arkitekter/Vilhelm Lauritzen AS 2015). As such, the building mirrors a model of care contemporary both in Denmark and internationally (Singh, Barber, and Van Sant 2016), with policies increasingly focusing on a recovery-oriented approach to the provision of mental health care (Region Zealand 2008, 2014). Psychiatric treatment at the Slagelse hospital is therefore expected to support recovery, that is, "the personal process that helps you move

forward in life and live a meaningful life”, which is in turn supported by ‘recovery-oriented treatment and rehabilitation’, that is, “a treatment that helps people move forward in life by focusing on self-determination, involvement, and hope” (Region Zealand 2014). In support of this, the spatial layout of the building aims to enable the active participation of patients in and through particular physical spaces, with the progression towards recovery ensuing by moving through the buildings ‘hierarchy of spaces’ (Karlsson Arkitekter/Vilhelm Lauritzen AS 2011).

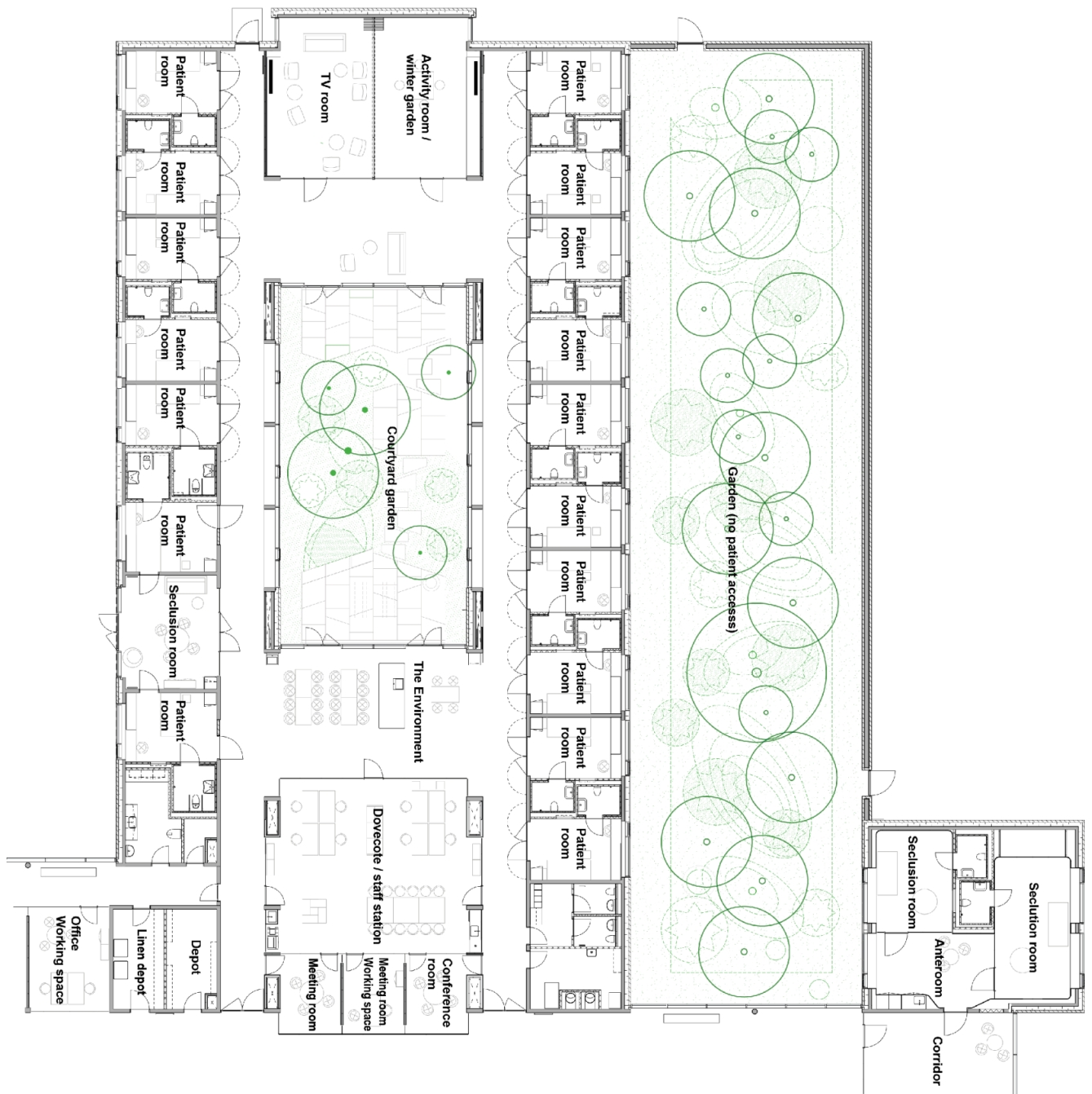


Image 3. Diagram of ward layout – © Karlsson Architects/VLA

## **Mapping the full range of ‘dangers’**

The architectural proposition of the Slagelse site is thought to play an important role in the provision of psychiatric care, with the spatial layout of inpatient wards designed to promote individual recovery as well as support psychiatric practice. Drawing on Douglas’ fundamental insight that spatial arrangements are connected to social order through systems of classification provides the analytical thrust for investigating the interplay between perceived dangers, nursing work, and space within the inpatient settings. The first part of the analysis shows how displacing patients, cleaning spaces, (re)moving objects and correcting patient behaviour become salient tasks partially engendered by the spatial layout of a ward. In the second part of the analysis, I track a particular chain of events where two patients violated ward rules and transgressed a variation of different socio-spatial boundaries and show how the invocation of ‘the language of danger’ enables nursing staff to take action in the attempt to re-establish social order. In both cases, spaces play an important role in relation to work-practices that are embedded in a broader cultural pattern, a system of classification which is put to work in the interest of avoiding risk, maintaining an orderly ward, and staying in control. In discussing these findings I suggest that the interplay between ward spaces and nursing work in many instances create ‘sites of contention’, that is, spaces of tension between professional interests, patient mobility, and designed intentions.

## **Keeping things ordered**

Each of the six psychiatric inpatient wards unfolds off main arterial corridors, placed in close proximity to fitness rooms, laundry rooms, and kitchens to facilitate easy access and use. In practice, however, use of these training spaces was very limited during the time of fieldwork as many patients were compulsorily detained and staff resources did not allow nurses to leave the ward, essentially turning the inpatient wards into closed units. This meant that the practical management of laundry was left for nursing staff to manage. I observed how they would spend significant amounts of time collecting misplaced clothes, washing laundry, and returning garments and linen to patients, despite such activities considered an important part of

promoting recovery and empowering patients' social skills. Sometimes nursing staff would be preoccupied with managing the distribution of dirty and clean clothing throughout an entire shift, walking from laundry room, to patient rooms, to the laundry shaft in the hallway, to the depot between wards, and back to patient rooms, simply because patients either weren't allowed to leave the ward or because staff didn't want to risk leaving them to their own devices outside the secure confines of the ward. In a very practical sense then, managing laundry is a matter of ensuring a 'pure' and hygienic setting, maintaining clean spaces in both the literal and symbolic sense, safeguarding against an untidy experience, with the spatial and practical circumstances of the setting making these efforts quite comprehensive.

A practical concern among nursing staff, then, is keeping a clean and orderly ward, ensuring that not only laundry is managed, but also that things are kept in their proper place; e.g. medicine in the medicine room; cutlery in drawers; lighters in locked cabinets; shaving equipment in the office. In the main, ensuring objects to their proper place was done in the interest of avoiding them being put to detrimental use. Removing hand sanitizer from common rooms, porcelain from kitchens, or personal items from patient rooms was done for safety reasons, for instance. In other instances, objects were left and spaces isolated instead. The two rooms at the far end of the wards were, for the most part, locked, because patients had attempted to strangle themselves with electrical cords or curtain strings. Locking the doors to these rooms prohibited entrance and thus alleviated perceived dangers. Staff no longer had to actively surveil the area, and as one nurse commented; "It quickly becomes the culture; well, now they're just locked" (Interview, auxiliary nurse, 2017). Keeping control over spaces in the interest of avoiding potential danger was central to everyday concerns, with the spatial layout of the ward engendering the intervention to limit the use of certain areas, due, for instance, to lack of visual oversight.

Other spaces were more frequently laboured over by staff in the attempt, not only to keep a clean ward but in continuously reconstituting the circumstances for practicing accepted social

interaction, that is, in establishing social norms mirroring the expected social order pending patients upon discharge, such as being able to interact with other patients and conduct oneself in common areas deemed appropriate to such spaces. The unbounded space of the Environment, a common area located between the nursing station, the courtyard, and the Seclusion room, designed to be a wards most social space, was observed to be particularly challenging in this regard. As a point of convergence, passage and (inter)action on the ward, and with no spatial boundaries to suggest appropriate use, this space was an area where the risk of disorder was always imminent, keeping staff occupied with regulating and correcting what was considered inappropriate social behaviour. Remarks such as; stop shouting; mind your own business; you can't come in here; you can't be in there; calm down; and don't do that, were frequently used by staff to correct patients putting their feet on the table, being too noisy or physical, using inappropriate language, or 'simply' talking about something in the 'wrong' place. As a case in point, the following observation shows how some topics were viewed as inappropriate for the Environment. While shadowing an auxiliary nurse, we made small talk with four patients, discussing personal issues and experiences but not their individual treatments or medication. When one of the patients began discussing her medication, the atmosphere changed from calm and sociable to confrontational and aggressive.

The patient starts to talk about how she experienced the effects of the drug, clearly unsatisfied. The auxiliary nurse and the patient begin to discuss its clinical effects and disagreement about it arises. The tone of the conversation changes dramatically and the other patients fall completely silent. The patient discussing with the nurse becomes aggravated when the nurse suddenly tells her: "It's stupid to talk about medication out here" (Fieldnote, 10.03.17).

*Here*, being the operative word: while the Environment invites social interaction, it is governed by a particular socio-spatial order enforced and regulated by staff. Patients can talk about mundane topics, like what they have been doing or whom they have been home to visit, but

when one patient starts talking about her discontent with her medication, the nurse immediately intervenes. But why is it 'stupid' to talk about medication in the Environment one might enquire? The nurse subsequently disclosed that discussions about medication should take place in more suitable spaces, in conference rooms and not in common areas because patients shouldn't learn about each others treatment as they might be receiving the same medication while potentially reacting quite differently to it. Having conversations about medication in clinical spaces is to protect patient confidentiality, but, arguably, also to avoid disruption and conflict across the ward. While medication is a fundamental aspect of contemporary psychiatric treatment, it arguably remains somewhat of a taboo; the nurse essentially does not know how the medication will affect the patient's recovery and thus tries to avoid discussion, talk, and any explicit conversation about its effects, or, in this case, the lack thereof, in order to maintain an orderly state-of-affairs. Utilizing the spatial layout as a reference-point to sanction the patient talking about medication, the nurse evokes her formal power to enforce a particular social order, categorizing the topic of conversation as 'out of place'.

While correcting behaviour is one way of managing ward orderliness, another frequent observation was removing the element of disorder by enforcing spatial boundaries, for instance by ensuring that patients stayed inside the Seclusion room and out of the Environment. Because ward doors cannot be locked, patients tend to leave the Seclusion room incessantly to enter the wider ward environment, prompting staff to take action to get them to return. For instance, during a severe manic phase, a female patient, H, continuously left the Seclusion room, shouting, singing and playing music, causing staff, in this case, nurse S, to continuously intervene:

S shouts in a friendly tone: "go back into the Seclusion room H". One minute later she comes out again and rambles something incomprehensible. She is very loud and all the other patients in the Environment turn towards her. Not long after, she's out once again, but this time she's brought her cell phone, blasting loud music. The music is

audible throughout the entire ward and she tries to sing along while dancing. Once again, S has to leave the Dovecote and bring H back to the Seclusion room (Fieldnotes, 01.02.17).

In this instance S tries to ensure that H stays inside the Seclusion room in an attempt to promote the protective isolation it offered, preventing H from receiving too many stimuli and to ensure that the wider ward environment was not disrupted, as this might ostensibly be inexpedient to the other patients' recovery. This was a recurring scene during fieldwork and nursing staff actively sought to (re)establish boundaries by narrowing the legitimate use of space, often using patients' individual rooms to do so. While patients are considered to have control over patient rooms and are allowed to domesticate it with personal items, nursing staff often use these spaces as spaces to control situations and patients deemed potentially dangerous or disorderly. On the main, if patients violated ward rules or unnecessarily disturbed ward orderliness staff would (re)move them from shared spaces and sequester them into their rooms. As a case in point, the following excerpt from fieldwork illustrates how 'J', a female patient, is perceived to be 'too angry' to reside in the wider ward environment:

J seems angry; she snaps at people and speaks in an aggravated tone of voice. Staff have assessed that she needs medication and five staff members escort her to her room at the far end of the ward. C, the nurse with the medication, positions herself next to J, with the others remaining in a semi-circle in the door opening. J gets up and gestures angrily with her arms all the while C tells her not to be so angry. She is asked to take a seat and relax, but J doesn't want to. Instead, she leaves the room and walks down the hallway. Two staff members exchange glances and subsequently apprehend J, grabbing her by the arms with what is obviously a rehearsed hold. They return her to the patient room, place her in the bed and maintain their hold. J is aggravated but doesn't resist. They try to explain to her that if she would just relax they could loosen their grip. The

psychologist present convinces J to lie down under a heavy blanket and staff subsequently let go and leave the room. J doesn't follow. (Fieldnotes, 18.08.17)

Apparently, J's behavior is considered disorderly, her displayed anger is assessed to be problematic and nursing staff gather to move her down to her room, away from shared ward spaces. They collectively gather to minimize the risk of assault and ensure strength in numbers as they administer the medication to alleviate J's present state. When J leaves the room, she walks away in a decisive albeit calm manner, leading to an intervention where staff physically apprehend her and return her to the room. They clearly consider her conduct inappropriate to the wider ward environment, seeking to contain the situation within the patient room, thus avoiding interference from other patients while preventing further disturbance of ward orderliness. While these actions might be for the good of J, the situation illustrates the spatial manner in which staff manage and control the situation: moving J to her room and thereby reasserting the Environment as an orderly space. Room for disorder is often limited to the patient room and as one nursing staff member put it, although in relation to another patient; "She can be as insane and scream as much as she wants, in her own room" (Interview, 2017).

## **Managing disorder**

### *Transgressing boundaries, taking action*

As a transgression of spatial and organisational boundaries, entering another patient's room violates ward rules. Safety issues and exchange of contraband were conveyed as key reasons for this rule, but it also related to nurses' overall interest in having a sense of control over ward spaces. Consequently, patients are not allowed in each other's rooms because "then we don't know what they're doing – they have to be visible", as one nurse explained (Fieldnotes, 02.08.17). The following chain of events shows how being out of place is perceived to be potentially dangerous, and how managing certain objects become an important way of avoiding risk and thus securing safety. The situation took place during fieldwork while I followed S, an auxiliary nurse, when two patients, M and T, were found together in the Seclusion room:

M and T are seated in the outdoor, cage-like extension of the living room inside the Seclusion room; their backs are resting against the transparent glass doors, making it impossible to open them. The auxiliary nurse discovers where the two patients are and initially tells them that they are not allowed to be together in each other's rooms. She knocks on the door, waves her hands and tries to speak to them through the glass, but they disregard her and pretend she is not there. (Fieldnotes, 24.08.17).

Two patients sitting next to each other in the Seclusion room is perceived as potentially dangerous, because of unpredictable patient behaviour, while also being a violation of ward rules. Earlier during her shift, S overheard T say that she wanted to strangle herself. Even though T and M were just 'sitting there', S decides to mobilise her colleagues to help get them out of the room due to the threat of suicide and the rule violation. She explains her concerns to them, arguing that they must intervene. The situation is categorised as potentially dangerous due to the patients' violation of spatial boundaries, their disregard of S's request and especially because T was potentially suicidal. The following excerpt is a direct continuation of the previous fieldnotes cited:

S leaves the room and asks all of her colleagues to help her deal with the situation. They assemble and collectively enter the Seclusion room, placing themselves in a semicircle around the closed glass doors, watching the two patients, who remain seated with their backs turned. "They are a bad influence on each other", says one. "Can we simply push them?" asks another, implying that they should try to force open the doors. The others discuss what to do to get them out of there. "They just want attention", a third contends, suggesting that they simply leave them alone.

Clearly, an agreement exists that ward order has been breached but, as the example indicates, how to manage the situation and return it to a state of orderliness is far from straightforward.

Various understandings of the situation are articulated, but tacit agreement exists that the patients are, as it were, out of place. It is somewhat unclear how staff are supposed to interpret what is going on; do the patients just want attention? Are they bad for each other? And can (or should) staff intervene by force? The staff discussed amongst themselves what to do and without reaching an agreement they, as a matter of routine, return to the Dovecote to plan a response because it allows continued surveillance of the situation and a secure place to coordinate. Standing inside the Dovecote, the nursing staff suddenly start discussing which objects to remove from T's room, instead of how to remove the patients from the Seclusion room. Breaching the rules is generally seen as a serious violation that often leads to further restrictions, like limiting the use of particular ward spaces. The next fieldnote presents some of the discussions nursing staff had to determine whether or not certain objects should be removed from T's room, shifting the focus of concern, and how a young physician becomes implicated when nursing staff formally need her approval to move forward:

The nursing staff suddenly address a young physician working on her computer. Until now she has not been involved with the spectacle occurring outside, but as a physician, she has the formal authority to decide whether or not nursing staff are allowed to inspect a patient's room. S makes it known that, earlier, she overheard T say that she wanted to strangle herself. She tells the young physician that she is responsible for writing down which objects can be removed from T's room in her file. Another auxiliary nurse follows suit, reminding the physician that it must explicitly state what they can and cannot remove. "That's difficult ...", exclaims the physician. "Yes, it is", acknowledges one of the nurses and observes that they are leaving her with all the responsibility.

Despite the fact that there is no acute threat of active self-harm, the potential risk of suicide prompts nursing staff to involve the physician to legitimise any subsequent intervention. This reveals the different professional and jurisdictional responsibilities between staff, with the group of nursing staff pressuring the young physician to concur with their assessment and thus

legitimize their intent to search T's room. But before the physician manages to write or say anything, the nursing staff take action. Their knowledge of patient behaviour, their ongoing interactions with patients and their sense that T might actually commit suicide, combined with the invocation of the language of danger, as Douglas would say, seemingly enable and legitimize action, warranting an apparent evasion of the formal authority of the physician. While the risk of something detrimental happening to T is the key focus of attention, the nursing staff's professionalism is also at stake as their judgement of the situation can be called into question by the physician.

### *Classifying objects*

The situation with the two patients is considered serious and the nursing staff are engaged in finding a resolution. Following the discussion in the Dovecote, S approaches T, who is still seated next to M, and says that they have decided to inspect her room: "If you want to be present, now's the time!", but neither patient appears to react.

Armed with plastic bags and blue sanitation gloves they walk over to T's room. They commence the inspection by removing various objects: shoelaces, bags, clothes, towels, and sandals. They also lock some seeds in a cupboard. Apparently, T knows a good deal about botany and they are worried that a certain amount of seeds might be poisonous. They also inspect the skirting boards, her beanbag, and the bed. The bags underneath the bed are also removed. S and her colleague focus on examining the room and only stop to ask each other to assess if an object is dangerous or not. All clothes are put into bags and placed within the Dovecote together with the other items collected. T's room is almost empty. Only drawing materials, pencils, paper, and slippers remain.

T's room is essentially empty, stripped of any and all objects considered potentially dangerous. Even though it is her private room during hospitalisation it remains an institutional space accessible to staff at all times. Due to the risk of suicide, nursing staff take pre-emptive measures and remove all objects in the room to mitigate the risk. Danger is invoked through

the classification of the patient as suicidal, and managing the situation becomes a matter of removing items that might be used to that end. The objects, then, are not intrinsically dangerous but might become dangerous if used inappropriately. Their properties do not change, but their classification does.

### *Territorialising space*

Approximately ten minutes after the inspection T and M come out of the Seclusion room and S tells them about the inspection. They pretend not to hear S and start to walk down the corridor:

S tries to tell them that they are not permitted to walk together, but T just smiles roguishly, while M insists that they can talk to each other if they want. They continue demonstratively down the hall – “damn it, then I’ll go with you”, says S bluntly, following them down the corridor.

Despite securing the room and alleviating the immediate threat of suicide, S seems reluctant to leave M and T to their own devices. The ward’s spatial layout affords movement from one end to the other, permitting patients to walk a full circle around the courtyard at its centre. In this situation, M and T use this spatial disposition to provoke S, territorialising the space, as it were. Patients walking down the corridors together is usually not a problem, but S’s reaction clearly shows that she does not approve in *this* particular instance, perhaps also because her authority is challenged by T and M. S wants them in her line of sight, within control, and follows them down the corridor. Because the corridor and the far end of the ward can become problematic spaces to occupy, and are seen by staff to be ‘risk zones’ due to lack of visibility and audibility, S tries to maintain control of the space by following them, aiming to enforce her own spatial order. While staff sometimes encourage movement around ward spaces and were observed to take walks with patients, in this instance the spatial layout enables T and M to create disorder in the eyes of S.

## Discussion

The spaces of the psychiatric wards at Slagelse are designed to ensure a particular allocation, distribution, and separation of people, creating a particular set of ordered relations, which staff may then actively utilize in the effort to achieve ward order. The spaces reflect key assumptions of the recovery-oriented approach, such as having room to engage and encounter staff and fellow patients, and freedom to move around. By acknowledging the importance of these spaces, this paper has sought to investigate the relations between ward spaces, perceived dangers, and nursing work, focusing specifically on how the physical spaces of the inpatient wards shaped the spatial organization of psychiatric order. Drawing on Douglas' fundamental insight that spatial arrangements are connected to social order through the continuous work of particular systems of classification, these relations were considered in terms of the spatiality of disorder and the subsequent ordering practices that strive to correct it. Drawing out the 'full range of dangers', the beliefs, behaviours, and actions related to practices of purification taking place within the inpatient wards, this paper has shown how staff engage in both very literal and more symbolic acts of ordering, revealing through the identification of these acts how power and social order are enforced and sustained.

At the most literal level, and partially engendered by the spaces of the wards, nursing staff were observed to be engaged in the ongoing tasks of cleaning spaces, (re)moving objects, displacing patients and correcting what was considered to be inappropriate or unacceptable social behaviour for the locations within which it took place, i.e. doing what Deacon (2008) essentially categorised as 'housekeeping'. This work might, in isolation, appear to be incidental to the more formal aspects of psychiatric practice, something which the literature categorises as custodial, routine and even as a barrier to the 'more important work' of enabling recovery and establishing therapeutic relationships (Deacon 2003). It was, however, observed to be an important part of the 'actual work' (Deacon and Fairhurst 2008), often involving forms of mundane governance (Woolgar and Neyland 2013), where particular spaces are made manageable through categorising something or someone as 'out of place', that is, through acts

of classification. While these acts cannot be said to inflict any sense of immediate danger, moving things from *here* to *there* is done in the interest of keeping things ordered, and hence, of reaffirming a particular social order.

While nursing staff have a clear sense of what an unsettled or disorderly ward entails, a precise definition of what disorder is could not be given. Labelling the ward as disorderly or patients as dangerous in most instances happened through situated and local assessments of some particular state of affairs. Despite the quiddity of disorder, what characterized order on the wards was the absence of disorder, making interventions towards avoiding it highly constitutive of the sense and significance of ward spaces. As the second part of the analysis showed, categorising patients and objects as potentially dangerous and evoking ‘the language of danger’ was salient in the attempt to re-establish ward order. It was employed for all practical purposes to take action in *that* situation relating to *those* problems. By referring to the transgression of particular spatial boundaries, the violation of ward rules, but most importantly perhaps, to the fact that imminent danger might manifest in the form of a suicide attempt, legitimised certain courses of actions, while challenging the professional boundaries between nursing staff and the physician. Determining which actions are appropriate to the situations at hand is, however, rarely straightforward, leaving space, as it were, for the negotiation of ward order.

Analysing the interplay between ward spaces, perceived dangers, and nursing work through the lens of Douglas’ work provided an interpretative framework for exploring the role spaces as an important element in the production and co-constitution of social and cultural ordering systems in place in the inpatient settings. While systems of classification can be more or less formal and abstracted from contextual detail; ordering practices, on the other hand, are always local, situated and saturated with contingencies. Seeing the interventions and actions, the work of nursing staff that is, as an inventory of powers evoked and enforced through the classification of things, people and spaces, enables and permits the empirical mapping of the full range of

these contingencies and to subsequently take them as evidence of a particular cultural pattern, of concerted efforts towards establishing social order.

One of the key findings of this paper is how inpatient spaces seem to amplify tensions between the professional interests of staff, the actions and behaviours of patients and the designed intentions of the site, creating what I suggest might be called ‘sites of contention’, that is, spaces where the social order of a ward is openly negotiated. The open and transparent layout of the wards, its formlessness if you will, enables movement and social interaction in accordance with the design, but simultaneously increases what nursing staff consider to be disorder, leaving them with the task to establish form out of formlessness, to create socio-spatial boundaries not physically in place, revealing a variety of spatially oriented ordering work directed towards maintaining ward orderliness and by implication, the social order of the wards.

The spatial layout of the psychiatric wards at Slagelse is, like more and more new psychiatric spaces for inpatient care (Bromley 2012; Connellan et al. 2013; Curtis et al. 2009; Jovanovic et al. 2019), designed to promote recovery, ostensibly strengthening clinical treatment and psychiatric practice through their bespoke healing architecture. Through such efforts, the role inpatient spaces is highlighted, *explicating* (Simonsen and Højlund 2018), as it were, the progression towards recovery by spatial and architectural means. This paper has contributed to current work advocating a focus on work-practices within contemporary hospital settings (Andrews 2016; Mikesell and Bromley 2012; VanHeuvelen 2019), by detailing the concrete and situated manner in which nursing staff engage with, are shaped by, and utilize ward spaces in the interest of achieving and maintaining social order on the wards. The nursing work tracked here was highly spatial in orientation, resonating with findings presented in the work of Gavin Andrews (2016; 2008), and future research might investigate more closely the interrelations between architectural design, the spatial aspects of professional work and social order in the interest of better understanding the implications of these named interrelations in light of the ultimate and accepted goals of patient recovery.

## 7. Paper II

### Unfulfilled promises?

#### Staff reactions to the healing architecture of psychiatric inpatient wards

##### **Abstract**

Psychiatric hospitals are increasingly designed to reflect contemporary models of care. As such, inpatient settings are changing based on the promise that the built environment will promote patient recovery and support psychiatric work. While extant literature examines how such novel designs mediate health outcomes and shape patient experiences, less attention has been directed towards staff experiences and the mediating role of the built environment for staff/patient interaction. By focusing on the nursing station at two inpatient wards of a new, purpose-built psychiatric hospital in Denmark, this study shows that the transparent properties of the built environment produce an environment of uncertainty and distance instead of intelligibility and closeness, which in turn shapes the nature of staff/patient interaction. This study indicates that greater attention must be directed towards analysing the impact of novel designs on the relational dynamics between spaces and people to appreciate how, and for whom, the built environment makes a difference in practice. This study thus contributes to the literature on the unique characteristics of psychiatric inpatient settings and how such settings impact the psychiatric staff.

**Keywords:** nursing staff; spatial organisation; built environment; hospital design; ethnography; Denmark

## Introduction

The architecture of psychiatric institutions has changed dramatically over the last 50 years (Nord and Högström 2017b), due especially to a shift in psychiatric treatment from containment to recovery (Jovanovic et al. 2019). In contrast to the disciplinary institutions depicted in Foucault (1961, 1977) and Goffman (1961), new inpatient facilities are becoming evermore permeable (Quirk et al. 2006), functioning as spaces of transition (Curtis et al. 2009; Wood et al. 2013a) and increasingly designed to reflect contemporary psychiatric care models (Bromley 2012; Vaughan et al. 2018). While solid evidence may not exist for any causal relationship between psychiatric ward design and treatment outcomes (Papoulias et al. 2014), it is well established that the quality of the built environment plays an important role in mental health provision and patients' perceived well-being (Connellan et al. 2013; Reavey, Harding, et al. 2017). Against this backdrop the notion of healing architecture (Frandsen et al. 2009; Nickl-Weller and Nickl 2013) has become a prominent feature of current hospital design, promising better patient outcomes and improved work conditions based on the contention that particular elements of the built environment, such as ambient features, spatial layout, interior design and access to outside spaces, have a positive impact on treatment outcomes (e.g. Frandsen et al. 2009; Lawson 2010; Ulrich et al. 2008).

In its instantiation in specific hospital settings, healing architecture is designed to work, to promote patient recovery and healing by imagining inpatient settings as therapeutic environments (Curtis et al. 2007; Gesler et al. 2004; Wood et al. 2013a) that foster social interaction between staff and patients (Jovanovic et al. 2019). Such imaginaries involve particular promises that are tied into organisational, behavioural and architectural scripts (Akrich 1992) that, as Timmermans (2013, pp. 3-4) points out, inevitably “underestimate the complexity of the social world”, with “spillover effects and collateral damage” as unintended consequences. The literature is extensive on health geography, environmental psychology and architecture on how the built environment affects patient outcomes, but less attention has been

directed towards how contemporary designs affect staff (Mikesell and Bromley 2012; Tyson, Lambert, and Beattie 2002; VanHeuvelen 2019), how hospital spaces influence healthcare professionals' work (Andrews 2006; Andrews and Evans 2008) and what the unintended consequences might be for staff/patient interaction. VanHeuvelen (2019), who recently called for further research into how healthcare facilities are used, experienced and interpreted by providers, points out that sociological enquiries on the importance of built environment designs can potentially serve to shape patient and staff interactions and behaviours (VanHeuvelen 2019:694).

Answering this call, this study draws on ethnographic fieldwork conducted between 2016 and 2017 in two inpatient wards at a new purpose-built psychiatric hospital in Denmark and describes some of the unintended effects of the site's bespoke healing architecture. By focusing specifically on the nursing station, a feature that plays a key role in staff/patient interaction (e.g. Andes and Shattell 2006; Jarrell and Shattell 2010; Jovanovic et al. 2019; Riggs, Due, and Connellan 2013; Shattell, Andes, and Thomas 2008; Southard et al. 2012), I show that the station's transparent properties mediate and produce an environment of uncertainty and distance instead of intelligibility and closeness, which in turn shapes the nature of staff/patient interaction. While therapeutic outcomes and patient experiences are of key importance, drawing inspiration from Goffman's work (1959, 1963), combined with recent work in science and technology studies (Latour 2005; Lynch 2013; Yaneva 2017), directs attention towards the dynamic interplay between people and spaces. The built environment is a means of mediation and negotiation between the expectations of designers and people's requirements (Yaneva 2017:73), enabling a simultaneous appreciation of the design and use of the built environment during the analysis (Martin et al. 2015). Understanding these relationships is important insofar as the relationships between nursing staff, patients and the spaces and places they interact are deemed fundamental to the provision of care (e.g. Malone 2003).

The remainder of this study is structured as follows. First, the hospital site is presented, focusing specifically on the design. The subsequent section describes the methodology, followed by a presentation of the findings. The paper then concludes with a discussion of the implications of the built environment for staff and staff/patient interaction.

## **Context and method**

### **The hospital site**

The road to recovery has literally been given architectural form at the psychiatric hospital in Slagelse, Denmark (Astbury 2016; Karlsson Arkitekter/Vilhelm Lauritzen AS 2010), making it a paradigmatic case (Flyvbjerg 2006) of contemporary psychiatric hospital architecture. The empirical material is limited to two psychiatric inpatient units, but the hospital is at the vanguard of contemporary international hospital design, reflecting state-of-the-art developments in the field in general and in relation to the development of healing architecture in particular, making it a particularly well-suited site for studying the impact of contemporary hospital design. Developing the hospital in Slagelse resulted in the restructuring of psychiatric care for the entire region, moving approximately 650 employees from five different facilities across Zealand to relocate them to a 194-bed hospital with an emergency reception, outpatient treatment functions, and research and education facilities. Structured to promote quick patient turnover, the hospital houses six inpatient wards, each accommodating seventeen patients and is organised in an integrated manner to support patients admitted voluntarily and patients compulsorily detained. In practice, this means that wards essentially function as closed spaces. Ward staff include physicians, nurses, educators, social workers and auxiliary nurses managed by a chief physician and a head nurse. Ward management is locally organised, and wards are staffed twenty-four hours a day, divided into eight-hour day, evening and night shifts.

The assumption that the built environment is important to the provision of mental healthcare and the enablement of individual recovery is a key aspect of the hospital's design scheme.

Karlsson Architects and Vilhelm Lauritzen Architects won the architectural competition because, according to project director Henrik Bendix Olsen, their project proposal had the “innovative approach they were looking for” (Interview 2017). The Danish design office spearheaded the project, called “A beacon for the future of psychiatric Construction”, based explicitly on the principle of recovery. The winning architects’ competition proposal aimed to: “[...] create unity between culture, structure, behaviour and bricks. [Because i]t is our belief that the value of the physical framework is expressed through the activities that a building supports” (Karlsson Arkitekter/Vilhelm Lauritzen AS 2010:43). Measuring the value of the material environment by the activities a building supports establishes a relationship between the organisation of space, and of work in space, with positive synergies between them as an intended outcome. To architecturally support this, the winning architects developed four key principles during the initial design phases: 1) healing architecture and the principle of recovery; 2) transparency and proximity between people and functions; 3) generality and flexibility in rooms and sites; and 4) hierarchy of spaces and stimuli (Karlsson Arkitekter n.d.). Architecturally, deliberate design interventions manifested these principles, for example, through the widespread use of glass partitions. Perhaps the most salient intervention was the nursing station, which was designed to promote staff-patient encounters, to combat them-and-us hierarchies between staff and patients, and to promote openness and transparency, particularly in terms of staff practices, helping to demystify the work of everyday psychiatric care (Karlsson Arkitekter/Vilhelm Lauritzen AS 2010). Visibility is crucial to the overall design, ostensibly enabling a sense of comprehension, offering the possibility to see what is happening while rendering actions intelligible to inhabitants.



Image 4. Nursing station – © Karlsson Architects/VLA, Photograph by Jens Linde

The nursing station, a large office space in the inpatient wards, is physically off limits to patients, drawing a line between staff space and patient spaces. The room's transparent glass walls allow staff to quickly intervene to defuse and react to unwanted, disruptive or violent behaviour. Access to the nursing station, basically a glass box, is limited to three solid doors. Notably, the architectural solution represents an attempt to align the sometimes incompatible clinical goals of promoting interaction between staff and patients in an effort to improve rapport and reduce perceived staff/patient hierarchies, while simultaneously promoting a high degree of patient visibility to facilitate monitoring and order. The setup affords a direct line of sight in almost every direction not only from, but also outside of, the station.

## Fieldwork and data

The qualitative material this study uses was collected as part of a broader research project on healing architecture, spatial organisation and psychiatric practice. Before fieldwork commenced, information on the research project was given to the wards' head nurses, who then informed

the other staff. Information flyers and posters about the study were developed and distributed to each ward, just as the hospital management consented to the fieldwork and the head-nurse on each ward gave verbal consent, with a declaration of confidentiality also signed. The hospital provided me with an official ID, a keycard and a key, giving me access to the hospital and the inpatient settings. The hospital did not require informed written consent from patients. Even though patients were not the focus of attention, they were informed about the research when appropriate and I always asked for permission to take notes when speaking directly with them. The data for this paper are stored in accordance with local data protection guidelines.

This study focuses specifically on the nursing station for two reasons: its importance to everyday work practices and its specific design features. Conellan et. al. (2013:153) found that nursing stations emerge “as the single most significant factor in mental health facility design”, which approximately 200 hours of fieldwork confirm. Focusing on relationships between the material properties of the nursing station, its location and proximity to other ward spaces, and its mediating role for staff/patient interaction, this paper draws especially on data from participant observations (Delamont 2011) of work taking place in and around the nursing station. Drawing inspiration from Goffman (1963) I worked ethnographically to capture how the spatial organisation and internal differentiation of spaces made a difference for the work and social interaction taking place.

To support observations, seventeen semi-structured qualitative interviews (Kvale 1997) were conducted to obtain accounts of how staff experienced working in the nursing station, as well as how they experienced the station’s placement in relation to adjacent ward spaces. Exploratory, the interviews were structured around various themes but included open questions on the impact of the built environment, such as “How do you experience working in these new settings compared to your previous place of work?” During interviews, respondents were asked to describe the ward’s various spaces in relation to their tasks and were given a diagram to help focus attention on the spaces. Digitally recorded and transcribed verbatim,

interviews lasted 60 to 90 minutes and were conducted during or after fieldwork. This made it possible to elicit comments on particular situations observed during fieldwork, for instance concerning the multiple patient enquiries taking place in the nursing station doorways.

NVivo software was used to organise the data. Initial open codes were continually revised and revisited during the analysis, especially when interest in the intention of the design grew due to staff accounts and observations. Simple codes jotted down in small notebooks were used to organise and categorise fieldnotes before being written up as quickly as possible after each data collection phase (Emerson et al. 1995). To support findings, the analysis presents extracts from fieldnotes and quotes from interviews. Wards are not specifically identified and respondents are referred to by a single letter to ensure anonymity. Care has been taken to present data from both wards.

## **Findings**

The design principle of “transparency and proximity between functions and people” is fundamental to the architectural proposition of the Slagelse site. Requirements regarding safety and surveillance, visibility and availability, and social interaction and individual retraction co-exist without any declaration of incommensurability. With this architectural assumption in mind, analysis especially focused on examining the reciprocal relationships between the hospital design, and the interactions that the built environment mediates. Especially salient in this regard is the nursing station, rendering staff as visible to patients as patients are to staff, which significantly changes the conditions of possibility to interact. The possibility of mutual observation guided the analysis by drawing attention to the possible lines of sight the design afforded. As such, the analysis first considers the implications of nursing staff being able to see the wider ward environment before focusing on how staff react and reflect upon being looked at by patients when inside the nursing station. Finally, I investigate the impact of this visibility on staff/patient interaction.

## **Looking out at patients: relational distance despite physical proximity**

The transparent nature of the nursing station enabled staff to unobtrusively monitor patients as they inhabit the adjacent Environment, a common area located between the nursing station and the courtyard that is designed to be the ward's most social space. The nursing station is strategically placed in relation to this area as life on the ward predominantly unfolds here. Staff rearranged ward furniture by moving sofas, beanbags and comfortable chairs from the TV room to create a living-room space within the Environment, further amplifying the social dynamic. This encouraged spatial closeness between staff and patients, buttressing the design intentions to reduce physical separation and facilitate easier contact. Staff were frequently observed, however, withdrawing into and remaining inside the nursing station. Spontaneous face-to-face encounters outside formal activities were therefore witnessed with less frequency, with most staff/patient interaction taking place due to direct enquiries, made either by staff or patients. Staff described withdrawing into the office as an important safety measure, while simultaneously being convenient in that: "It's simply easy", as one nurse put it (Fieldnote, 24.08.17). Because visual oversight of ward spaces and knowledge of patients' whereabouts gave staff a sense of control, patients who were out of sight were considered a potential risk. Indeed, when inside the nursing station some staff would actively position themselves to ensure a direct line of sight into the Environment:

Yes, yes, yes, I almost always place myself on this side [facing the Environment], because then I can see out. During a nightshift I always sit so I can look out. I don't like to sit with [my back turned], so I don't have an overview. In that sense you can have an overview without being out there [in the Environment], you might say (Interview, Auxiliary nurse, 2017).

Not seeing is not knowing, and for this reason staff are keen to have patients within sight at all times: "You want to be able to see what you are going out to" (Fieldnote, 30.01.2017), as one nurse put it. The staff generally encourage, if not push, patients to be in the Environment as

much as possible: “I’m asked to hang out in here [in the Environment] so that they [staff] can keep an eye on me” (Fieldnote, 17.02.2017), as one patient remarked. The atmosphere in the Environment was sometimes saturated by a sense of boredom, with patients typically seated in furniture intentionally placed to make the patients visible to staff, and vice versa. The staff office was always busy with activity, as almost every task and activity began and ended in the nursing station. As a result, staff compared working in the nursing station to being in a hornet’s nest: “[...] because it’s like ... a control room. But it’s also a room where you can withdraw, when you don’t really know what else to do. But the nursing station is where everything happens and where we withdraw, hide and receive all enquiries” (Interview, Auxiliary Nurse, 2017).

Compared to the previous quote, which illustrated how staff tended to withdraw into the nursing station because it affords unobstructed visual access to patients in the Environment, this excerpt shows that withdrawal also takes place when the staff does not really know what else to do, making the nursing station an instrument for observation, a place of work and a space of retreat. On such occasions, the nursing station offers refuge from face-to-face-interaction with patients, with staff heading backstage (Goffman 1959) because, as one nurse reported: “Everyone needs room to catch their breath, a place to find relief, right?” (Interview, Nurse, 2017). A different nurse neatly described this at the end of her shift, as she exhaustedly exclaimed when entering the nursing station: “You just can’t cope with being in the Environment – you need to breathe”. She went on to imply that this was a common experience for staff, noting how “a lot of people suddenly [become] office custodians” (Fieldnote, 16.02.17). Some staff, however, felt closed in, even trapped, when inside the nursing station, with the space described metaphorically as, for example: a bunker, glass cage or even as a prison, due to the impossibility of leaving the ward without passing through an area accessible to patients.

While there are different reasons for withdrawing into the nursing station, one important effect is the enactment of relational distance between staff and patients, despite their physical proximity (see also Reavey et al. 2019), turning both patients and staff into bystanders (Goffman 1963:91) to the respective encounters taking place in each other's mutual presence. In interviews, the entire nursing staff highlighted creating contact and building relationships with patients as one of the most important aspects of their jobs. This can be strenuous and exhausting, they reported, which is why they would withdraw into the nursing station, momentarily relieving themselves from interactions with patients. Rather than animate social interaction and contact between staff and patients, the spatial-material arrangement and properties of the nursing station make it possible for staff to retreat into the office space because it makes the occurrence of watching patients relevant without necessarily engaging with or becoming involved with them.

Ward management took issue with the fact that nursing staff stayed in the nursing station too often, sometimes with their backs turned to the Environment, in opposition to the architectural affordances of the glass and management's expectations. Management intervened by rearranging the furniture in the nursing station to alleviate what they saw as too much socialising among staff: "Some people tend to get a little too comfortable once they've sat down" as the deputy head nurse explained, further commenting that by breaking up the long table at the centre of the nursing station into smaller sections, staff would become more attuned to the Environment and to patients, rather than to each other. "The evidence states that all presence is preventive," explained the head deputy nurse, pointing out that if staff are available and visible to patients, less violence and aggravated situations occur (Fieldnote 10, 01.02.17). This visibility, however, had a significant impact on staff.

### **Being looked at: an environment of uncertainty despite transparency**

While staff appreciate the ability to unobtrusively observe patients, being observed themselves, however, is experienced as uncomfortable, intimidating and even unethical. In the following

interview excerpt, a nurse reflects on the proximity between the nursing station and the adjacent Environment and what this entails:

Lately we've talked a great deal about, that we think we're being watched a lot during most of the day, and that it's very intimidating that patients can look at us all the time. From the very beginning we experienced that patients felt they were too far away [from us] when in the living room [at the far end of a ward], so they sought us out, that is, they went to this end of the ward [near the nursing station], where they eat and where staff are. So we made a little living room space out front, right, and in that way we've kind of signaled that this is a really cosy place to be, which also means that they are seated directly on the other side [of the glass wall separating the nursing station from the Environment], where we, for example, sit and do documentation. So they can sit and look at us all the time and I can sit and keep an eye on them, and we have some patients that sometimes ask 'Why are you always laughing at me from inside the office?' for example, right, and just last week we had two patients that were severely psychotic who placed themselves in front [of the nursing station] and looked directly at us, and that was actually, I mean, that made it pretty hard to work when you constantly feel like you're under surveillance. No matter where you are in the building, right, someone is keeping an eye on you [...] I mean, it's actually uncomfortable to be watched the entire day (Interview, Nurse, 2017).

While the nurse does not reflect much on how patients might experience being under constant surveillance, being rendered visible to patients is clearly experienced as problematic. A head nurse also pointed out that: "the entire patient population can see us when we are sad", adding that "there is no anonymity", occasionally leading to potentially unethical situations. Opaque walls normally separate patients from staff, but transparent partitions enable easy access and mobility between front and back regions, causing certain staging contingencies (Goffman 1959) to occur at the nursing station, leaving staff with the task of managing their appearance.

Instances in which staff felt visible were especially problematic, such as when preparing injections, because patients could see the preparation process and the needle without knowing whether or not it was for them. Patients could also see if the police had been summoned to pick up a patient, or if staff needed to practice certain physical positions or grips before entering the Environment to manage an aggravated patient. These situations are not meant to be visible to patients or to cause them concern:

“They can see when there are twenty of us in here,” says L, who explains that leaving them [the patients] to guess what is going on is an issue. “They can see what’s being said,” another nurse continues, referring to the fact that gestures can (and are) interpreted by patients (Fieldnote, 03.08.17).

While the physical boundary between the nursing station and the Environment is visually open, it is soundproof, leaving patients to speculate about what they are witnessing: “What are they talking about – what are they saying about us?”, as one patient rhetorically asked (Fieldnote, 07.08.17). Patients also confronted staff directly: “Why are you always laughing at me from inside the office?” paraphrased the nurse in the previous interview excerpt. Patients concern themselves with what is going on inside the nursing station, with some reportedly finding it comforting to see staff work, while others also find comfort simply in knowing where staff are, as visibility also means being able to quickly get into contact with staff, if necessary. Others however reported feeling somewhat disconcerted about what they observed, leaving them to speculate about whether or not staff were talking about them, or whether or not they were doing something important, as the staff sometimes appeared to be having just “a little too much fun”. Staff took issue with this dissonance, repeatedly reasserting and legitimising their actions towards patients during encounters, something that would not have occurred if staff were not rendered visible to them. This shift creates a new set of interactions between staff and patients as staff are, to some degree, made accountable for how they conduct themselves when

inside the nursing station. This was something one nursing staff member, M, was particularly concerned with, as conveyed to me (T) during an interview:

M: I regularly experience, maybe once or twice a week, patients saying the same sentence over and over: “You just sit on your asses in the nursing station”. Occasionally it might be true because we don’t come out [of the nursing station] enough, but sometimes when we’re obnoxiously busy and need to use quite some time on paperwork, well, then it gives the incorrect impression that we’re just sitting at the computer all the time.

T: Is it important for them to have the correct impression, is it important to you?

M: It’s important to me, I’ve explained that to them [...] but many of the patients here are just so sick that they have difficulty understanding it, so it can be very, very difficult to explain to a patient why you spend so much time in there [the nursing station] (Interview, 2017).

Staff are mainly concerned about how patients interpret what they are doing when inside the nursing station. In a follow-up interview, L elaborated on being seen by patients by shifting the issue from what patients might think towards how she thought she ought to act to project an appropriate image of what was going on. She highlights the need to consider body language and gesturing:

[...] all those gestures you make... they [the patients] can easily follow [them]; sometimes I think about our hands because... but we do that when we speak, right, we do all kinds of things [...] you need to consider what you’re doing, differently than you’re used to. Before, you would think, “well the office is our private sphere where we” ... I mean, this won’t go any further, but it just isn’t that closed anymore, is it? Because

now there are windows all the way around. So, you need to think twice about what kind of gestures you make” (Fieldnote, 03.08.17).

Projecting a certain demeanour, thinking about how patients perceive what is being said, how they interpret gestures, movement and body language, suddenly become important issues for staff to consider simply because they are rendered visible to patients. As nursing staff have nowhere to take a break away from the scrutiny of patients, to relax, as it were, some staff members developed ways of hiding in plain sight. When asked about how she managed to hide inside a transparent glass office, one auxiliary nurse explained that she pretended to be busy:

[...] sure, you can hide, by pretending to be doing something important. It’s not like you make an active decision about hiding. I just think, the more workstations, the easier it is to sit down at a workstation and look like you’re working, where in reality it might be more important to be doing something else, right (Interview, Auxiliary nurse, 2017).

Pretending to be doing something important, as the auxiliary nurse reports, became necessary to momentarily relieve staff of social interaction with patients. While this might be interpreted as a type of make-work (Goffman 1959, 1963), in most instances it might better be understood as an attempt to perform practices of unseeing, that is, avoiding eye contact, thus deterring visual encounters with patients to create a break from interacting with them. Regardless, staff were often seen to ignore patients looking in, treating them in such situations as non-persons (Goffman 1963:84). While these observations are interpreted in a slightly speculative manner here, more tangible was the fact that staff, at the time of fieldwork, had plastered many of the glass walls with sticky notes, posters, timetables, schedules and other information. While these were reportedly too important to be catalogued in a binder or digitally, in practice they functioned as a physical screen between the conference room, the wider ward environment and the nursing station, minimising visibility into and out of the space (Image 6.). Much sensitive patient information, such as names, social security numbers, diagnosis, risk of violent

behaviour, freedom to leave the ward and risk of suicide, is displayed on monitors and laptops, visible to patients outside the nursing station.

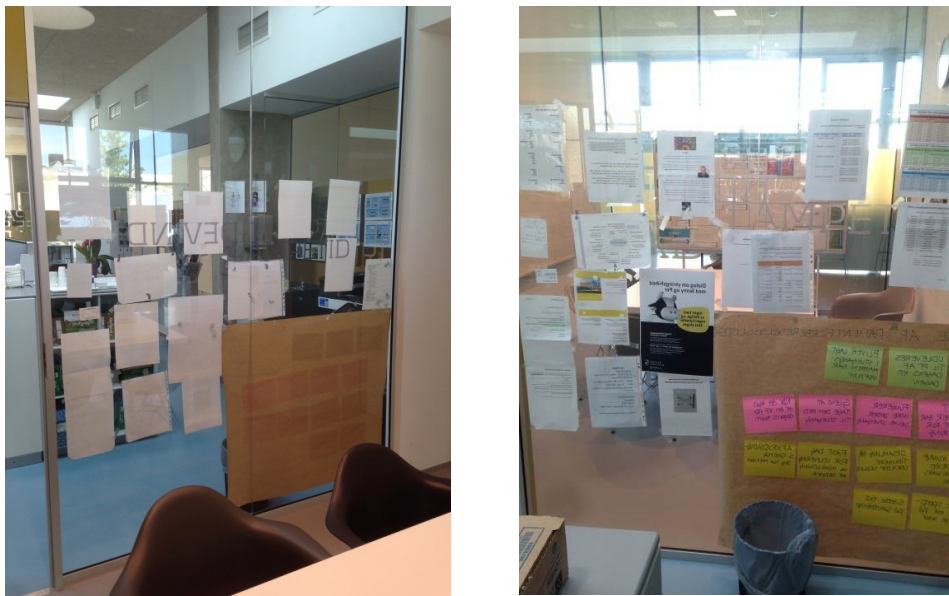


Image 5. Conference room – Photograph by Thorben Simonsen

As a result the materials attached to the inside of the glass walls also represented an attempt to partially reassert the spatial separation of staff and patients, and the more specific distinction between the delivery of patient care and administrative tasks. Simultaneously, however, plastering the glass conference room walls with papers also created a sense of privacy and protection from patient observation for staff during breaks, meetings and consultations. Although creating a private space to avoid being observed by patients was deemed important for everyday interaction between staff, staff also described the materials on the walls as a way of protecting patients during difficult therapeutic sessions. Being rendered visible, then, made the staff reflect on how they conduct themselves inside the nursing station. Despite being visible, they remain inaudible, leaving patients to speculate about what is going on and staff to speculate about those speculations. What kinds of interactions are deemed legitimate is unclear, just like it is unclear when patients can make contact with staff to receive help. With total transparency, but no perceived intelligibility, an environment of uncertainty is enacted, leaving

patients to negotiate the legitimacy of any encounter and staff to manage the amplification of enquiries, especially in nursing station doorways.

### **Staff/patient interaction: doorway transactions**

With nursing staff exhibiting a strong orientation towards the nursing station, encounters between staff and patients predominantly took place in the doorway between the Environment and the nursing station, making it one of the wards' busiest sites. This meeting place is an important point of convergence, with "let's just say 90% of all contact taking place in that doorway [...] from short conversations to longer conversations" (Interview 2017), as one nursing staff member stated. Fieldwork involved numerous observations of such encounters, with patients often hanging out in the doorway, making seemingly mundane remarks, placing requests or asking for help in general, frequently laying claims on staff attention. Within just a few moments, different patients could turn up at the door, slightly transgressing into the office space, trying to make contact with staff. The following fieldnote describes two patients – M, a young female, and A, a middle-aged male – making claims on staff that in this instance were not accommodated:

A is standing in the doorway when he, with increasing volume, shouts to G, a male social worker, "We need to talk today!" "No, not now," G responds, waving his hand at A while continuing directly through the nursing station. A second later, M is standing next to A, who hasn't left his spot in the doorway to demandingly declare into the office space "I want my phone charged", without any response from staff inside the nursing station. A suddenly turns to the secretary working at one of the desks closest to the door and says "Get over here, secretary", with an insisting tone of voice, without clarifying why he wants her to come (Fieldnote, 21.08.2017).

On most occasions, encounters such as these were short-lived, unfolding over just a few seconds, while appeals made by patients, like in the above situation, were snubbed or even

completely disregarded by staff. Patients seeking, requesting, demanding, appealing, wanting or needing something were observed frequently, and nursing staff often conveyed their irritation with these types of enquiries, especially blaming the glass partitions for giving patients a “false sense of [staff] availability”, as one nurse explained. Staff argued that being rendered visible to patients meant a significant amplification of enquiries taking place in the doorway. Staff would often say that patients were interfering with the execution of administrative tasks, but whether or not an enquiry was seen as a disturbance was contingent upon whether or not the patient making the enquiry was making it to the right person, at an appropriate time, and in accordance with the patients’ terms of recovery. For these reasons staff were inclined to disregard patients, maybe even a little too quickly, as this nursing staff member reflects:

I definitely think that staff, and I’ll also admit to doing this occasionally, can sometimes be a bit quick to say, if the patient at the door isn’t their own patient then, “well, I’ll send him or her out to you later, they’re not here right now” and you might not always pass the message along, so they [the patients] are probably quite quickly rejected at the door and I completely understand that it might be a point of irritation for them. So, yeah, I think a lot gets lost because they incessantly make enquiries at the door. And we [staff] also think it’s a point of irritation when they are at the door. I also think, even though we of course work here for their sake, I often think it becomes annoying for them and for us, I know it does” (Interview, 2017).

Requests made by patients are generally seen as a point of irritation or distraction for staff, with staff rejecting them, often on the formal grounds that they are not directly responsible for *that* patient on *that* day. According to staff, these doorway encounters made them function as a service provider, becoming a means for patients to achieve certain ends. Whether requesting more cigarettes, clean clothes or extra medication, or asking for cell phones or shaving kits, patients ventured to encounter staff in the hope of attaining specific outcomes. These objects were managed by staff, and thus kept inside the nursing station to adhere to individual

treatment plans and for safety reasons, creating the need for patients to seek staff out. Some patients were also observed to simply leave staff with a list of requests, reducing interaction to a minimum. In this sense, what gets lost, as the nurse stated in the above quotation, is not only information or messages, but social interaction with patients. While building relationships and cultivating patient contact are reportedly fundamental to promoting individual recovery, these doorway encounters were mainly characterised in transactional terms, with patients forced to ask staff for everything from medication to cigarettes, shifting the nature of interactions with staff. Staff found these encounters unrelated to patients' recovery trajectories, which means they hardly echoed the nurses' own expectations or the intentions inscribed in the design to facilitate social interaction and reduce hierarchies between staff and patients. These doorway encounters, in other words, mediate and transform the relationships between staff and patients enacted in the space, turning them into a supply-and-demand interaction. Despite this irritation, and contrary to security regulations stipulating that the doors remain closed, it is usually kept open. The only time the door is routinely closed is during meetings, conferences or other activities that require privacy. Patients often displayed frustration when the door was closed, some knocking on it anyway, while others understood that the closed door to mean that staff were unavailable. As one patient noted, "When they close the door, it's sort of like it's a forbidden area". While many interpreted the closed door as a sign of unavailability others simply knocked on the door anyway:

It's time for a handover between shifts and the door to the nursing station is closed. Only H and L are present, but S is supposed to turn up at 3:30 pm, I'm told. A patient knocks on the door – "Why do they [the patients] always stand *there* during handover!?" asks H, to which L dryly replies, "They always do that" (Fieldnote, 04.08.2017).

Staff are clearly annoyed by patients when they knock on a closed door. To staff this represents a tangible disregard for their attempts to communicate unavailability. Staff were equally frustrated with patients interrupting them as they struggled to attend to administrative tasks,

especially ones requiring a degree of concentration. Patients, however, are equally annoyed when staff close the door: “Fucking staff, why are they closing the door now?!” as one patient commented (Fieldnote, 07.08.2017). Through each encounter the distinctions between staff and patient, between ‘them’ and ‘us’ are reinforced and the social hierarchies of the ward are reaffirmed rather than reduced. While this is contrary to the intentions of the design, staff seemed to regard distinctions between staff and patients as being crucial to the dynamics of care on the ward. The design, however, challenges this dynamic, leaving staff to communicate availability, in more or less subtle ways. Precisely because the door can open, as opposed to a wall, its closure provides a sense of stronger isolation against everything outside or beyond it. While the wall is mute, the door speaks (Simmel 1994:7).

## **Discussion**

A key goal of the spatial layout at Slagelse, imagined by architects and hospital managers, is to create transparency and interaction; the former ostensibly facilitates the latter in relationships forged between staff and patients, as well as to the abstract outside world that awaits after discharge. At the heart of the nursing station’s design is an apparently virtuous congruence between the dual purpose of encouraging patients to feel safe, while simultaneously permitting staff to unobtrusively monitor patients by affording constant visibility. Yet, of course, glass walls do not discriminate, and staff are just as exposed and visible to patients, as patients are to them, ushering in new conditions of possibility for how staff and patients might encounter and interact with one another. As Caroni and Mortari (2015:414) have pointed out: “the functional and material properties of the glass wall are the conditions of possibility for practices” throughout the ward. Which practices are enacted when, and with which particular consequences are of course a function of a great many factors besides the material aspects – the conscious and habitual activities of staff being obvious examples – yet the particular spatial properties of the nursing station affect the interaction between patients and staff, as well as staff experiences.

One of the most striking findings was the way the glass walls rendered many formerly invisible aspects of the staff's work visible (or legible) to patients. Administrative, clinical and social tasks and interactions that might more routinely happen away from the gaze of patients in other clinical sites are now out in the open at Slagelse, visible to patients and thus available for scrutiny. Staff reflect on their demeanour when inside the nursing station, but, more interesting perhaps, is the fact that they have to perform in a particular way when inside the office space to enact a backstage, making it a task to relax and stay in character to step out of character (Goffman 1959), putting increased pressure on their availability. Of course, patients too are made visible by the glass walls, although this kind of visibility has long been at the heart of panoptic modes of surveillance in psychiatric care (e.g. Salzmann-Erikson and Eriksson 2012). The findings in this paper show a modest reversal of this gaze, and a subsequent disruption in how staff conduct themselves. This sort of visibility challenges the relationships between what is seen and what is known, proving particularly salient for the manner in which staff and patients experience the sense and significance of the inpatient spaces.

Within the Environment the nursing station plays an important mediating role, as it enables an atmosphere of unclear expectations; that is, it facilitates a window to activities not necessarily deemed relevant, nor appropriate, for patients to peer through. This alters the conditions under which staff work and patients recover, changing what Strauss et al. (1963) referred to as the negotiation context. In contrast to the intended design, where transparency was supposed to ensure demystification of activities and afford a sense of safety and assurance, the findings reported here show that transparency instead created a sense of uncertainty, leaving patients to speculate about what staff were doing, and staff to hypothesise about those speculations. These findings add to Mikesell and Bromley's (2012) paper on nurses' experiences of working in a twenty-first-century hospital, which showed how the built environment altered professional roles and staff/patient relationships. They suggested that the design, in some instances, obscured substantial aspects of nursing work, prompting them to question whether or not the new hospital setting was in fact nurse averse.

The findings presented here have implications for research on examining the unique characteristics of contemporary psychiatric inpatient settings (Curtis et al. 2009, 2013; Quirk et al. 2006; Wood et al. 2013a) and are particularly salient for studies on the sense and significance of nursing stations in inpatient settings (Jarrell and Shattell 2010; Riggs et al. 2013; Shattell et al. 2015). The nursing station described and discussed here was designed to promote staff-patient encounters, to combat them-and-us hierarchies between staff and patients, and to promote openness and transparency, particularly in terms of staff practices, to help demystify the work of everyday psychiatric care, but which functioned, in practice, as a point of convergence, passage and controversy. The intentions behind the design of the nursing station at Slagelse are not particularly unique, as nursing stations are designed to make staff feel safe because the patients are visible (Joseph and Rashid 2007) and should, according to Brown (2009), encourage social interaction between staff and patients, as well as provide an area separate from patients to allow staff to withdraw and conduct administrative activities. The physical manifestation of the design at Slagelse is, on the other hand, unique and challenges the balance between private and shared spaces. Enabling positive and productive social interaction between staff and patients is recognised as important (Curtis et al. 2007; Jovanovic et al. 2019), which is why the porous boundary enabled by the glass partitions was designed to encourage this.

Discussions of the merits of open versus closed nursing stations seem somewhat inconclusive, but scholars have pointed out that the nursing station physically establishes a barrier between patients and staff, effectively cutting off patients' access to nurses (Andes and Shattell 2006), impeding the development of interactions (Connellan et al. 2013:153), while marking a "complex set of power relations in which clients are unlikely to feel empowered to engage staff" (Riggs et al. 2013:80). While the current study does not address clinical outcomes or the therapeutic aspects of the built environment, the findings suggest that having a place for staff to physically and visually withdraw from patients is important, as constant visibility appears to challenge staff practices more than support them. The altered environment of the inpatient

setting and the changed relationality between staff and patients show that the spatial organisation of visibilities has a significant impact on nurse-patient relationships, which is in accordance with Malone's (2003) findings on distal nursing. This paper, which has effectively shown that the transparent nature of contemporary inpatient settings shapes and changes the relationship dynamics between nursing staff and hospitalised patients, contributes to the insight that the places of health care provision certainly matter (Andrews 2004, 2006) and do not always perform as expected and in accordance with the design intentions.

## Conclusion

This paper, which focused on how nursing staff reacted to working within a transparent nursing station and on how its design mediated the ways in which staff interacted with patients, provides empirical insight into some of the implications of contemporary hospital design for the situated dynamics between the people inhabiting those spaces. As a result it contributes to the international literature that examines the unique characteristics of contemporary psychiatric inpatient settings (Curtis et al. 2009, 2013; Quirk et al. 2006; Wood et al. 2013a). Drawing inspiration from Goffman (1963, 1961, 1959) and recent studies on science and technology studies took me "right here, inside the institutional walls" (Nord and Högström 2017b:10) of the Slagelse site, prompting an examination of how the built environment makes a difference, and for whom. This study offers a situated understanding of what the architecture *does* and how it *works*, and hence identifies the difference it makes. Situating the nursing station within social interaction makes the mediating role it plays available for analysis, enabling me to show how the design, in many respects, produced outcomes contrary to those intended by the design. By drawing critical attention to the relationship between how the built environment is conceptualised and how the intentions behind the design are actualised, this study provides a stronger foundation for producing more reasonable expectations (Timmermans 2013:4) toward what healing architecture and similar developments can realistically achieve in psychiatric facilities.

## 8. Paper III

### Healing architecture and psychiatric practice: (re)ordering work and space in an inpatient ward in Denmark

#### Abstract

Healing architecture is a defining feature of contemporary hospital design in many parts of the world, with psychiatric inpatient facilities in Denmark at the forefront of this innovation. The approach rests on the contention that designed clinical spaces, and the particular dispositions they express may promote patient recovery. Although the idea that health may be spatially mediated is well established, the means of this mediation are far from settled. This paper contributes to this debate by analysing medical encounters in the context of a new purpose-built psychiatric hospital opened in Slagelse, Denmark in late 2015 as an example of healing architecture for the region. Grounded in qualitative research conducted in two wards between 2016 and 2017, we explore the key material and social effects of the hospital's healing architecture, and the spaces and practices it enacts. Following the work of Michael Lynch, we consider both the designed 'spatial order' of the inpatient wards, and the 'spatial orderings' unfolding therein, with a particular interest in how order is accomplished in psychiatric work. With much of the existing discussion of healing architectures focusing on their impacts on patient wellbeing, we consider how healing architectures may also be transforming psychiatric work.

**Keywords:** Healing architecture; spatial ordering; psychiatric work; mental health; medical encounters; Denmark

## Introduction

Psychiatric spaces in many parts of the world are slowly being transformed with the emergence of healing architectures (Frandsen et al. 2012; Nickl-Weller and Nickl 2013), a model that contends that particular features of the built environment, such as lighting and ambience, access to and/or views overlooking green spaces, accessibility and openness, have a positive impact on patient experience, wellbeing and recovery (Connellan et al. 2013; Curtis et al. 2007; Lawson 2010; Reavey, Harding, et al. 2017). Debates about these impacts have been widely discussed in medical and health geography (e.g. Andrews 2004; Cummins et al. 2007; Duff 2011; Kearns and Moon 2002), medical anthropology (e.g. Dyck and Fletcher 2015; Long, Hunter, and Van Der Geest 2008) and the sociology of health and illness (e.g. Buse, Martin, et al. 2018; Martin et al. 2015), with each field offering unique conceptual and empirical elaborations of the designed, material features of health care settings and their impacts on the health and wellbeing of patients and staff. This paper considers these debates in the context of a new purpose-built psychiatric hospital opened in Slagelse, Denmark in late 2015 as an example of healing architecture for the region (Region Zealand 2012a). Grounded in qualitative research conducted in two acute inpatient wards between 2016 and 2017, we examine some of the key material, social and organisational effects of the hospital's healing architecture, and the spaces and practices it enacts.

We are guided in this analysis by Martin and colleagues' (2015:1015) recent articulation of a novel "sociology of healthcare architecture" capable of elaborating the ways space mediates "forms of interpersonal interactions, medical encounters, and socio-technical practices" in clinical settings. Ongoing discussions of the methods appropriate to this sociology have also informed our analysis (Buse, Martin, et al. 2018; Ivanova, Wallenburg, and Bal 2016; Latimer 2018; VanHeuvelen 2019). Questions of method are critical in our view inasmuch as the notion of healing architecture inevitably introduces a relation between recovery and space, between health and design that defies easy explanation. Although the idea that health may be mediated

by aspects of place and space is well established, the means of this causal relationship are far from settled and continue to generate robust debate (e.g. Bell et al. 2018; Cummins et al. 2007). With respect to the question of healing architectures more directly, this problem becomes even more acute insofar as a direct causal relation is imputed to the designed spatial order of the site. Indeed, it is the design itself that is regarded as therapeutic, as capable of generating ‘healing’ effects. This is the issue that this paper grapples with, as we explore the material, social and organisational effects of Slagelse’s healing architecture. We hasten to add that we are not interested in somehow measuring the extent to which the design of the hospital at Slagelse might have promoted the health and wellbeing of either patients or staff. Our interests are more general as we wish to start with a broader consideration of the material, social and organisational effects of Slagelse’s healing architecture. Understanding these general effects is fundamental, in our view, to the elaboration of more refined methods for evaluating the distinctively therapeutic effects of this architecture. Following the work of Michael Lynch (1991), we treat these effects as a matter of ‘spatial ordering’. We consider both the designed ‘spatial order’ of the inpatient wards at Slagelse, and the ‘spatial orderings’ unfolding therein, with a particular interest in how order is accomplished in and through psychiatric work. Such work might fruitfully be thought of in terms of a continuous ‘tinkering’ (Mol et al. 2010) by which everyday encounters between patients, staff, and spaces are mediated, transformed or disrupted. More broadly, our interests in this paper run parallel with recent discussions of “Caring Architecture”, where Nord and Högström (2017b:10), for example, examine “how architectural space in institutions is involved in processes of complex ordering”.

The idea of spatial order(ing) suggests that the spatial layout of a ward organizes and frames psychiatric practices, distributing individuals and allocating functions, shaping *where* certain activities take place and *how* these activities are rendered appropriate in relation to the spaces they take place in. This notion offers a way of exploring how healing architectures mediate experiences, practices, activities, and encounters in situ, and how these mediations re-order such spaces, creating new, albeit transient, “geographies of care” (Conradson 2003). We will

argue that these geographies should be understood as performative effects of the spatial orderings enacted by staff, as much as they are mediated by the specific architecture of the site. More directly, our findings reveal how the open and transparent spaces of the wards at Slagelse often require staff to enact spatial orderings of safety and control in the everyday management of patients. These orderings, although enacted, are no less objective or real in their effects (Lynch 1991). Our findings indicate how healing architecture mediates the practices and organisation of psychiatric work, as it mediates the spaces, management, and delivery of psychiatric treatment. Before we turn to this argument, we will briefly review recent discussions of spatial orderings and their relevance to our study of Slagelse's healing architecture.

## **Spatial Ordering**

Hetherington (1997:35) argues that “ordering is not just simply something we do; more significantly, it is something we are in”. Social order, in this respect, may be understood as a dialectical function of space and action, and their various convergences and tensions. These insights draw attention to the importance of physical space, and the ways it fashions the settings and contexts in which people live, interact and work, mediating particular social orderings (Söderström 2017). Hetherington is particularly interested in how spaces emerge in particular technologies of governance, in the ways space is formed in action (see also Lynch 1991; Woolgar and Neyland 2013). Space, then, not only constitutes a container *for* action but may also be understood as an effect *of* action (Mol and Law 1994). Action, therefore, creates space, as much as space may be said to mediate or inflect action. Shifting our attention to diverse ‘modes of ordering’ (Law 1994) clears the way for novel investigations of what architecture *does* in different instances and how it is enacted as part of ongoing efforts to accomplish order in psychiatric practice. Following Lynch (1991), we approach these accomplishments as ‘spatial orderings’ that affect and re-order the spaces of the inpatient wards, challenging their designed order. This approach will also enable us to offer renewed insights into the more specific orderings that may affect the work of treatment in clinical settings.

Lynch (1991:51) argues that physical places of work may be defined and understood in terms of what he calls “locally organized topical contextures”, where the place of work is comprised by a complex of materials and action, of spatial orders produced in, and informed by, the knowledge practices of members in that setting (see also Suchman 1996:35). Places of work are organized in contextures of activity and enacted through complexes of action, which are each contingent upon the disciplinary practices of *that* particular setting. Order, then, emerges as a distributed, local property of social practice (Preda 2000:279). It is equally true that situated, local actions may also make use of the structures that the enactment of particular spatial orders provides (Lynch 1991:53). Following this line of argument points to the ways particular spatial orderings are topically tied to spatial and material practices of psychiatric work. How, in other words, do complexes of materiality and human action mediate the spatial order of a ward and its impact on different psychiatric work practices, like ensuring safety, administering medication and delivering care? Psychiatric work, in these respects, may be understood as a specific disciplinary practice, a certain ‘mode of ordering’ (Law 1994) in which architecture, materials, and social relations are enacted (or have effects) as they are organized. Lynch’s (1991:53) focus on the ‘spatial orderings’ of practice suggests a means of interrogating how the orderings of space and practice mediate the delivery of care in psychiatric settings, along with the effects of these orderings. Psychiatric practice may, in these terms, no longer be understood as concerned exclusively with the cognitive, neurobiological or social aspects of patient care, since it *takes place* in particular material settings while simultaneously constituting and (re)constructing those environments. The work of ‘spatial ordering’ alerts us to the relationship between psychiatric practice and the spatial configuration of a psychiatric ward, drawing attention to the way psychiatric work is spatially and materially organised.

With these arguments in mind, the goal of the present paper is to offer a *respecification* (Suchman 1996:35) of the spaces and orderings of the psychiatric ward in general, and the separate rooms of Slagelse in particular, in relation to the work of delivering psychiatric care for

patients. We will treat each aspect as a function of the continuous (re)ordering of spaces by patients and staff alike. We are interested in the work of ordering space for the insights it may offer into the mediating force of healing architecture. Spaces, then, are not so much a *locale* within which the work of psychiatric care simply takes place, but, following Lynch (1991), must be reimagined as a complex habitual field of materiality and action, involving intimate relations of architecture and practice, embodiment, place, and activity. In the following, we consider some of the methodological implications of the ways we have drawn these interests together and specify how fieldwork for the study was conducted.

## Methodology

The study drew from the ethnomethodological tradition to investigate diverse ordering practices and situated actions according to actors' own (ethno)methods (Delamont 2011). Ethnomethodology, as articulated in the work of Garfinkel (1967) and Lynch (1993), involves a strict commitment to members' methods for making sense of the world. Following this lead, and the specific suggestions offered by Pollner and Emerson (2001:118), we treat ethnomethodology as a way to "selectively heighten sensitivity" to the spatial arrangements of inpatient treatment and their impact on ordering practices in psychiatric wards. This approach afforded insights into how these orderings regulate, support and/or enable certain health trajectories, practices and relations while disabling others (Moser, 2017). Our empirical investigation was directed towards the iterative and contingent, but always observable, (spatial) orderings of psychiatric work. Given these interests, we have elected to focus on the orderings that shape a specific event – the administration of patient medication – and the spaces through which these orderings pass. We focus on medication because of its centrality to the observed work of psychiatric treatment. This focus will enable us to tease out relations between the spatial order of the ward as it was designed, and the spatial orderings emergent therein. Rather than offering a post hoc account (Suchman 1996) of the instances of interest here, we will follow the course of events as they emerged in situated actions, in particular spaces within an inpatient ward.

The empirical material from which this analysis is drawn was collected as part of a broader research project on healing architecture and psychiatric practice in inpatient wards in Denmark. Data collection consisted of shadowing intervals (Czarniawska 2007) in which nursing staff were followed during either day or evening shifts, and participant observations (Delamont 2011) of interactions between staff and patients, with particular focus on the spatial arrangements within which these interactions took place. Approximately 200 hours of fieldwork was conducted by the first author at two psychiatric inpatient wards at Slagelse throughout 2016 and 2017. Before fieldwork commenced, information on the research project, its aims, and methods, was circulated among staff, who then informed patients about the project and introduced the first author. Consent to approach staff for interviews was obtained from senior hospital management and then confirmed with individual staff members prior to the commencement of fieldwork. While no formal ethical clearances were required at the site, the first author completed a confidentiality agreement and obtained verbal consent from patients to take notes when in direct conversation. Participant names have been anonymised to protect the confidentiality of patients and staff. Documentary materials were sourced from the lead architect at Karlsson Architects, who also provided permission to reproduce the images presented below. All study data have been stored in accordance with data protection rules at the first author's home university.

## **Field Setting**

In the fall of 2015, approximately 650 employees from five psychiatric facilities in Region Zealand were relocated to the new hospital at Slagelse. Fieldwork commenced shortly after the hospital opened. The new building reflects current trends in health care design, including access to and oversight of green spaces, proximity to the local community, and the use of an advanced lighting system to complement the circadian rhythm. More particularly though, Karlsson Architects and Vilhelm Lauritzen Architects who spearheaded the design of the hospital developed four guiding principles during initial phases of development, which then informed all

phases of the construction. The design-principles guiding the development were: 1. Healing architecture and the principle of recovery; 2. Transparency and proximity between people and functions; 3. Generality and flexibility in rooms and sites; and 4. Hierarchy of spaces and stimuli (Karlsson Arkitekter n.d.). These principles are made manifest through a series of deliberate design interventions, including the widespread use of glass and open spaces. By seeking to promote social interaction and afford freedom of mobility, the design seeks to mirror key assumptions about recovery from mental health problems and the modes of care that may facilitate it. The hospital contains 194 beds across six psychiatric inpatient wards, six forensic units, an emergency reception, outpatient treatment, and facilities for research and education. It is organized for quick patient turnover, with the spatial structure reflecting the site's key psychiatric functions: forensic psychiatry, child and adolescent psychiatry and research. It is particularly important that we highlight the patient Environment, which was explicitly designed as a ward's most social space, encouraging interaction and affording easy access to staff, who are situated in the adjacent and transparent office space, the Dovecote (See. Image 6).



Image 6. Inpatient ward – © Karlsson Architects/VLA, Photograph by Jens Linde

Key to this design is the attempt to devise an architectural solution to the sometimes incompatible clinical goals of encouraging social interactions and reducing perceived staff/patient hierarchies, whilst promoting at the same time a high degree of patient visibility. These spaces feature heavily in the analysis to come. Ward staff include physicians, nurses, educators, social workers, and auxiliary nurses, who are managed by a chief physician and a head-nurse. Ward management is locally organized and wards are staffed continuously with shifts at 8-hour intervals.

## **Findings**

The analysis presented below will focus on one specific instance taken from the wider material, illustrating an important aspect of how ‘spatial orderings’ variously enable and constrain courses of action fundamental to the work of administering psychiatric medications. The instance was observed during a shadowing interval where the first author followed an auxiliary nurse. The instance might be understood as ‘routine trouble’ (Suchman 1996:36), in that it represents the kind of contingency to which the normal order of a ward is perpetually subject. Analysing this instance will also provide an opportunity for broader reflections on the spatial ordering of healing architecture.

### **Managing patient behaviours through spatial orderings**

Staff are discussing how to isolate A from the other patients, when the chief physician intervenes and says: “He isn’t supposed to run around like a madman out there”, to which the head-nurse responds; “He uses a lot of square meters” (Fieldnote, 16 August 2017).

These statements were made at a routine coordinating meeting in the Dovecote prior to the head physician’s morning rounds. Staff were gathered around the long table at the centre of the

room, with the chief physician leading a discussion about whether or not to move A to the Seclusion room. Both the chief physician's and the head nurse's remarks were uttered with some urgency, indicating their frustration at A's misconduct. When the chief physician says *'he isn't supposed to run around like a madman out there'* (ironic, if not insensitive, given A's formal designation as a psychiatric in-patient), she was presumably referring to the disorder in A's behaviour, with the conviction that it should not be tolerated. For this reason, staff discuss the prospect of moving A to the Seclusion room, even though it is currently occupied by two other patients. Staff explore the possibility of moving these patients to regular rooms, though quickly conclude that this option is not viable, and so the chief physician suggests that they might have to isolate A in his room. An hour later, the issue remains unresolved, and the two nurses return to the issue of the Seclusion room being occupied. The following fieldnote highlights the spatial orderings at work in this incident, how they are connected to staff knowledge of prior patient behaviour, along with the tensions between the different spatial orders enacted (or attempted to be enacted) by the staff involved in this discussion:

“It’s completely insane” says one of the nurses, referring to the fact that in practice only one patient can occupy the Seclusion room. I ask about the Seclusion room and its function. They explain that two patients in an ill state cannot simultaneously occupy the room, essentially making it “a two-bedroom apartment for one” as the other nurse sarcastically states. They discuss options for moving M, one of the patients currently in the Seclusion room. M could change rooms with A, but then she would be too close to the exit, which is a problem in that she has tried to escape on multiple occasions, as they briefly discuss. Another room is empty at the bottom of the ward, but they also reject that option because then M would not be visible to staff, which is necessary as she was reportedly having suicidal thoughts. As they are talking, A suddenly passes, wearing only a jacket and a towel around his waist. He has just showered and has come out into the Environment without underwear. He goes out to smoke. One of the nurses follows him and they both walk through the courtyard, where she enquires about the clothes he has

left to dry on the outside furniture. The nurse instructs him to go back to his room and put on some clothes. They agree that the nurse will wash his clothes and A returns to his room without incident.

Space is critical to the varying clinical, logistical and organisational tensions evinced in this passage. First, A has disrupted the (spatial) order of the ward (behaving apparently “like a madman”), leaving his clothes in the ‘wrong’ place, moving about the ward in the wrong ways, disrupting ward orderliness and the orderly conduct of other patients. Staff responses are equally spatial in orientation, first as they consider relocating A to the Seclusion room with all the affordances it offers for surveillance and the ordering of A’s conduct, and then, as they realise that this option is not viable, they briefly consider moving other patients, but decide not to due to their knowledge of these patients’ mental states. The chief physician’s characterisation of A’s conduct *as mad* ostensibly derives from her assessment that A’s conduct has failed to accord to the proper spatial ordering necessary for the management of patients on the ward, insofar as A is failing to conduct himself in the right ways, in the right places. These failures are the explicit focus of the meeting described above; failures that staff usually manage by restricting access to particular spaces, thereby limiting patient mobility around the ward. Key to this tension, and its broader implications for the spatialisation of psychiatric treatment across the wards, is the fact that the designed order of these particular wards enables individual patients to enact their own spatial orderings, which often clash with both the designed spatial order of the ward, and the spatial orderings favoured by staff in relation to how patients are expected to conduct themselves in and around the space. In this case, the spatial orderings to which M and A are subjected are in tension, limiting staff responses to A’s actions. This tension is the implicit focus of A’s subsequent meeting with the chief physician:

The chief physician is already in the conference room. She has her computer and the medication she intends to give A, which he apparently did not take the previous day. Two nurses collect A for his meeting with the physician. He follows them down the

hallway to the end of the ward and they all enter the conference room. The physician is sitting down nearest the Dovecote, but gets up when we enter. She informs A that they need to talk and that he needs to take his medication. We all sit down, except A, who refuses. He does not want his medication. He becomes agitated. The physician tries, in a calm voice, to inform A that he needs to take his medication, and that calling her ‘an ugly bitch’ is uncalled for. He continues to use foul language but then decides to leave the room. We have been in the room for approximately 2 minutes. The staff look at each other with the physician saying that ‘It’s hard to talk to a patient if they don’t want to talk’. While they are talking A suddenly returns in a more conciliatory manner. He apologizes, and the conversation continues. But before long he is agitated once more as the physician insists that he take his medication. “*I DON’T WANT THAT MEDICATION*” he shouts, once again leaving the room. Staff start planning how to give him the medication, when, once again, A returns and apologizes for his behaviour. He recognizes one of the two pills they are asking him to take and agrees to take *that* one. He then leaves the room, this time without returning.

A complex of actions unfolds in this passage according to the different spatial and clinical orderings enacted. Staff enter the conference room and position themselves in a rehearsed manner in order to enable safe passage into the Dovecote and out of the conference room in the event A becomes disruptive. They simultaneously ensure that A is positioned near the side-door affording him easy access to the adjacent hallway and unhindered passage out of the room. By being in the conference room, consulting the patient record on the computer, displaying the medication for A to see, and articulating their intentions, staff enact a particular spatial and clinical order; a locally organized topical contexture informed by their knowledge of A’s failure to take his medication the day before, and actualized in accordance with their intentions to make A comply with their preferred spatial and clinical orderings at this particular time. The material properties of the room, together with the medication and the staff’s utterances, co-constitute the room as a space of treatment, simultaneously offering a trajectory

of care and enacting an element of control. Staff assess that A needs his medication because he didn't take it the day before. The actions that follow accord with this goal, even as they entail a series of spatial interventions aimed at securing A's compliance according to the spatial order of the ward. The aim is to maintain a safe ward environment for staff and patients by maintaining a spatial ordering that regulates movement around, and conduct within, the ward site.

## **Securing the ward**

As such, the spatial ordering of the site and the material layout and design of the ward, introduces unique affordances for patient activity, movement and interaction, some of which, reportedly make the work of providing clinical care and maintaining ward security more straight-forward given, for example, the high degrees of visibility the space affords, and some of which make this work more difficult for staff, such as the possibility for patients to freely move around and between the different ward spaces. With respect to the 'problem' of A's conduct and the ways it affects other patients on the ward, the central issue concerns the spatial interferences between A's conduct and other patients, and the most effective strategies for spatially isolating A from others.

The staff walk into the Dovecote, calling on the aid of their colleagues. "We have a situation" says one of the nurses, informing other staff of what is about to happen with A. The door connecting the Dovecote with the Environment is closed. "I want the other patients to go to their rooms", says the nurse and looks over at the auxiliary-nurse-student – "or else there will be a spectacle". "I want you to go into the Environment – no drama – just go to your room" she says, rehearsing the command she wants to be given to patients. The student and another staff-member walk into the Environment and start moving patients to their rooms.

This fieldnote might be taken to describe a situation of high drama, which in a sense it is, but it also captures a routine aspect of the work staff undertake to enact the specific treatment and

recovery plans prepared for each patient. Staff are mobilized into a 'state of readiness' (Suchman 1996:43) when assembling inside the Dovecote, preparing and planning what to do next. In order to act in concert, staff require a shared understanding of what is going on. Without much elaboration, the commands uttered by the nurse are followed without question, indicating a shared understanding of the situation, its mutual intelligibility (Garfinkel 1967). The key for us, though, is how much of this work involves a spatial ordering of mobility and activity, particularly in instances where patients fail to comply with staff directives. In an effort to avoid 'spectacle', patients are moved to their private rooms and confined there for a time to enable staff to focus on the needs of an individual patient. In this respect, spatial confinement enables an ordering of focus and compliance; it is a crucial means of ensuring that A takes his medication. In order to achieve this goal staff enact a specific spatial order. This order is achieved materially and spatially as staff gather inside the Dovecote, closing the door so no patients can hear what is going on. The open and transparent character of the ward design must in this instance be countered directly. Crucially, moving patients to their rooms enables the simultaneous coordination of clinical activity *and* patient surveillance as staff continue to observe the ward as they speak, periodically peering through the space's transparent glass walls which look out over the patient area. This ordering is then translated into further action as patients are moved to a particular place, determined in advance, and staff coordinate how to move through the ward in order to isolate and secure A in his own room for the purpose of administering his medication. The next excerpt further illustrates this relay between space and action in the work of spatial ordering:

One of the nurses goes down to get A, who incidentally, has entered another patient's room. He has locked the door. "I'm unlocking it", says the nurse and opens the door, admonishing A for being in the wrong place and for locking the door. A follows the nurse out of the room. As they are walking, A starts talking about an earlier situation in which he also did not want to take his medication – "you came with a hundred men – I don't want that" he says and follows the nurse to his own room. The nurse returns to

her colleagues who are still inside the Dovecote, where they are coordinating how to give A his medication. The nurse in charge explains that if the plan doesn't work they will return to the Dovecote to discuss what will be "a new situation", as she says. They all seem clear on what is going to happen next and walk over to A's room. They place themselves in a semicircle around the wide door opening, with A beside his bed. "Now it's serious!" says the physician and shows him that she has the medication. A seems calm. The physician informs him what kind of medication they are giving him and how much. She then hands over the medication, which A promptly takes, with the physician asking A to stick out his tongue to confirm that he has swallowed it. "Should I register that it was by coercion?" asks the physician, to which A replies "Well, that's for you to worry about". Everyone leaves the area around A's room. Inside the Dovecote the physician starts filling out a document on the coercive administration of medication.

Understanding this entire incident as being fundamentally a matter of spatial orderings draws attention to the tensions and negotiations triggered by A's refusal to take his medication. This refusal provokes a set of spatial responses. It starts with a conversation between the chief physician, A, and two nurses in the conference room. The adjacent hallway, accessible through an open door, offers an escape route for A as he paces back and forth, returning multiple times to the conversation, while simultaneously becoming an element of disorder in the rest of the ward. The designed order of the ward makes it possible for A to contemplate whether or not he wishes to participate in the conversation, just as it facilitates a kind of spatial disordering as A's frequent retreats from the discussion disrupt other spatial orderings across the ward. It also creates a situation in which the physician must wait, inducing an element of frustration on her part: "we can't talk to someone who doesn't want to be spoken to" as she put it. The Dovecote may also be seen to function as a safe space for staff in that they can unobtrusively surveil the entire ward while simultaneously planning and coordinating their response to A's refusal to take his medication. The Environment also changes from being a social space for patients into a potentially dangerous place, for it's not yet clear what the forcible administration of A's

medication might entail. Other patients must be removed from the Environment in order to minimise any risk. Once all patients have been sequestered in this way, A is taken to his room, designed as a private space in which A can conduct himself as he chooses, but in this instance, the room is transformed into a space of coercion, a medicalized space, a secure space for psychiatric work. The room's double doors, designed to create more space at the entrance to a patient's room, are opened wide and the staff (seven in total) fan out in a semi-circle around the chief physician, closing off A's mobility and enacting a spatial order of control, security, and compliance. This spatial organisation will enable the forcible administration of A's medication should he continue to refuse to comply. Perhaps in acknowledgement of this spatial ordering, A takes his medication and order is restored according to the ordering of psychiatric work.

Patients are well aware of this spatial ordering and typically comply with staff commands to return to their rooms in such moments. While compliant, patients are not necessarily happy with this spatial directive. Indeed, one patient stated that she didn't feel safe being alone in moments like this, because of a history of self-harm and suicidal ideation. Another patient stated that she felt 'forgotten' during these episodes, with no idea when she might be allowed to leave her room. For these reasons, it is important to stress that the spatial orderings enacted during these episodes transform the patient rooms from a personal space, somewhere thought to be private, into a holding place, a temporary cell, a space of control subject to strict staff direction and oversight. Moving patients to their rooms also transforms the general order of the ward, from a place of activity, sociality, and repose, into a place that is literally off-limits. In these respects, A's seemingly disordered conduct provokes rapid shifts in the spatial orderings enacted and enforced by staff across the entire ward.

## **Discussion**

The 'routine trouble' of administering medication reveals many of the spatial orderings involved in managing 'disorderly' patients in psychiatric settings. It also points to emergent tensions, in this particular setting, between the designed spatial order enacted in the very

architecture of the wards at Slagelse, and the spatial orderings conceived by staff, sometimes in direct response to the effects of this designed order. The concrete practice of ordering thus provides analytical insights into the spatial relations of healing architecture, of the ways designed order and situated orderings may affect the delivery of care in psychiatric settings like Slagelse. The layout of the ward is central to this work, enabling specific patient-mediated orderings, practices, and movements, just as staff seek to enact their own orderings in the work of organising and delivering care. Tensions between these divergent orderings are at the heart of our findings. Partially, tensions derive from the spatial design of the ward. For instance, the openness of the Environment, the transparent nature of the ward's general layout, and the broad hallways all enable spatial orderings that sometimes make the work of providing psychiatric care more difficult, even as they undoubtedly afford greater patient mobility and freedom. Staff respond with their own attempted orderings: patients are returned to their rooms; staff position themselves in space so as to close off options for patient movement; patients are prevented from entering common rooms so as to permit more effective staff surveillance and control. What our analysis of the complexes of actions rendered here demonstrates, then, is that spaces are an effect of local orderings of disciplinary practice that sometimes sit uneasily with the designed spatial orders of the ward. As the analysis above has shown, staff utilize and evoke particular spatial orderings when managing patient conduct. Convening in the dovecote, moving the patients to their rooms while isolating the patient in need of medication describe spatial 'complexes of actions'. These complexes involve situated actions that draw on spatial orders expressed in the designed ward, especially distinctions between inside/outside, close to/separate from, private/social, enabling staff to work in concert in the delivery of psychiatric care.

In these respects, spatial order is not simply determined by the design of a ward and its architectural layout but *becomes ordered* in particular ways through collaborative efforts involving the continuous performance and transformation of a variety of spaces; personal spaces, coercive spaces, safe spaces. These complexes of actions *together with* the designed spatial order

of the ward indicate how competing requirements of care and coercion, of safety and security, of the scrutiny of individual patients and entire ward populations rub against one another in a discontinuous ordering of differentiated spaces. Through interactions with other staff, patients and the ward environment, staff attempt to enact safe and caring spaces, even if, in the process, they also often enact coercive, isolating and medicalized spaces, re-ordering the wider ward environment. Here then is the work of architecture as it is ordered in the experiences of ward life for staff and patients alike. The extent to which this architecture may or may not be healing requires attention to the complex tensions between orders and orderings as they unfold in practice, in place. Gavin Andrews (2004, 2006) has made similar points in relation to nurses' spatial practices and their role in managing ward life (also Andrews and Shaw 2008). In the particular instances analysed above, the spatial orderings enacted by staff are as concerned with the maintenance of patient order on the ward, as they are with specific therapeutic outcomes. It is for this reason that we would conclude that healing architectures have a profound effect on the work of psychiatric care, even if their specific therapeutic effects and properties are more difficult to determine, as they are shaped by particular ordering practices.

Our analysis suggests that the 'healing' properties of the architecture – the extent which the spatial order of the ward may indeed promote recovery – are contingent upon specific spatial orderings that must be continually laboured over. The spaces of the ward cannot, then, be treated as singular places, with clear functional effects. Rather, they should be thought of as effects of particular complexes of activities, of spatial orderings enacted through situated actions. By focusing on the activity observable in the administration of medication to A, we have been able to uncover some of the work involved in ordering ward spaces in this way. As we have noted, the ordering practices engaged in by staff seek a balance between care and control, safety and recovery, which are expressed in specific spatial orderings that are themselves subject to routine negotiation. Sometimes this negotiation involves conflict between incompatible staff and patient orderings, though more nuanced tensions between these orderings are just as common as staff and patients seek to resolve tensions through enduring

negotiation, a kind of spatial agonism. In this respect, we echo Philo's (2017:30) conclusion that "instances of institution-based care are less likely to arrive from pre-programmed care plans (and care spaces) than from more ad hoc 'tinkering' in the lived grain of the spaces involved".

This 'tinkering' (Mol et al. 2010) permeates the clinical management of psychiatric patients, just as it transforms individual recovery trajectories. Perhaps the key focus of this tinkering concerns the extent and autonomy of patient mobility in and around the ward. The wards at Slagelse ostensibly afford more freedom of movement than other psychiatric facilities, even though these affordances are routinely complicated by staff ordering practices aimed at limiting patient mobility in the interests of safety and control. These orderings reveal a potent site of tension between the designed spatial order of the ward (and the healing architecture it expresses) and the clinical work by which patient recovery is partially realised. In certain moments, like those analysed above, the spatial affordances of the ward potentially make the work of managing patient conduct more difficult, and so staff work to enact spatial orderings by which this control might be more reliably sustained.

Our findings further resonate with those offered by Reavey and colleagues (2019:274), who contend that patient experiences in psychiatric settings are deeply shaped both by relationships with staff and other patients and by the very socio-material environment of care itself. These findings offer some interesting reflections on the nature and impact of 'therapeutic landscapes' (e.g. Curtis et al. 2007), and the ways such landscapes manifest in formal clinical settings like Slagelse. However, with Frandsen et., al (2012:1062), we note that this work sometimes adopts a "passive view of the way clinical practice is shaped by space" as if architecture might itself be understood as a therapeutic agent. Clearly space and design matter for health, but how they matter, and the specific ways, means, and relations by which spaces shape psychiatric experiences of care remain far from certain. While healing architecture constitutes a design concept that deals with the relations between space and practice, it does so from a largely functionalist perspective. As a potential alternative, Frandsen and colleagues (2012) argue for a

theoretical perspective sensitive to “the connections between the spatial configuration of healthcare infrastructure and practice beyond space as distance, to consider how infrastructure reproduces specific practices and engages with its users in multiple ways”. We endorse this alternative view and argue for studies of the relationship between space and healing in psychiatric settings that consider both situated actions and spatial orderings.

## **Conclusion**

The notion of healing architecture has only very recently become part of the design of psychiatric facilities, drastically altering the spatialities of psychiatric inpatient care. Our study has explored these spatialities by way of the routine example of the administration of patient medication and its role in everyday psychiatric work. By analysing instances of the administration of medication, we have demonstrated how space, and the ordering of space, are central to the control so often required of psychiatric work, highlighting an occasional tension between the spatial affordances of the site, and the spatial orderings preferred by staff. Our paper should, therefore, be read in relation to other studies of psychiatric inpatient care (Bowers et al. 2009; Quirk et al. 2006; Salzmann-Erikson 2015), and the unique spatial and relational character of inpatient settings (Brown and Reavey 2016; Curtis et al. 2013; Reavey et al. 2019). Together with these scholars, we argue for analyses of healing architecture as alert to the complexes of action and socio-material practice as they are to the physical orderings of design. To the extent that any given architecture may be regarded as healing per se, our work suggests that this therapeutic effect will be more a function of spatial orderings than any simple material causation. Finally, our analysis suggests that healing architectures might have at least as great an impact on the character and organisation of psychiatric work, as they do on patient experience, well-being, and recovery. Indeed, understanding their effects on the work of psychiatric care may prove critical to uncovering the impact of healing architectures for recovery.

# **PART III**

## CONCLUSIONS

## 9. Conclusions

Throughout the entirety of this dissertation, I have been interested in what ‘healing architecture’ *does* in psychiatric practice. Initially, thinking about the relationships between design and architecture I was inspired by Churchill’s suggestion that “first we shape our buildings and afterwards, our buildings shape us.” While both perceptive and intriguing, Churchill’s assertion seems to assume causality between how a building is shaped and how the building subsequently comes to shape us. The Chamber of the House of Commons may indeed afford a combatant style of political practice representative of British parliamentary democracy, but to understand what The Chambers *do*, how the building shapes said practice, requires that we concern ourselves with a wider spectrum of human and nonhuman actors, resources, talk, and spaces that become implicated in everyday processes of ordering *in practice*. We need to conduct empirical investigations sensitive to these processes in order to better understand what buildings do. Coming to terms with what ‘healing architecture’ does, therefore, should be less a question of considering the causal relationships between architectural properties and health outcomes and more about the ongoing, sometimes precarious, but always situated, processes of ordering space and interaction in and through psychiatric practice. This is, in short, what this dissertation has essentially argued.

As indicated throughout the three papers, this dissertation also has some limitations. The psychiatric hospital in Slagelse arguably represents the vanguard of contemporary hospital design, both nationally and internationally, making it a paradigmatic case for studying the spatial organization of contemporary psychiatric practice. However, the single case study approach does call for consideration in relation to the generalizability of the findings presented throughout the dissertation. Does it matter where knowledge is produced, as Livingstone (2003:1) rhetorically questions at the beginning of his book *Putting Science in Its Place*? The answer, of course, is yes. Recognizing that science has a geography entails recognizing the fact that things could be otherwise, a classic STS insight and contribution. The ethnographic

approach applied and appropriated here, however, enables one to develop deep contextual insight, with close descriptions of everyday encounters, interactions, and practical reasoning. This makes it possible, through analysis, to make credible inferences about how space and interaction are ordered in practice that are useful beyond the geographic location within which they were described and discovered. As such, the findings presented in this dissertation are meant to enable articulations that enrich our understanding of what ‘healing architecture’ does rather than debunk existing ones. The decisive advantage of aiming for articulations over accuracy of reference is, as Latour (2004:6) argues, “[...] that there is no end to articulation where there is an end to accuracy.”

Introduced at the onset of this dissertation, the opening quote by the head-nurse suggests that the ‘healing architecture’ of the inpatient setting at the Slagelse site indeed makes a difference. How it makes a difference was, however, unclear. The research presented in and across the three papers of this dissertation contribute with insights into different aspects of *how* space and interaction are ordered in practice, which in this final and concluding chapter will enable me to formulate a proposition as to what ‘healing architecture’ *does* – that is, how it makes a difference in psychiatric practice. In the following, I summarize and reiterate the most significant findings of each paper and discuss these in relation to the overall research question, which, as we recall, is:

### **How are space and interaction ordered in and through psychiatric practice at the Slagelse Hospital?**

Based on this, I propose an answer to the overall research question and subsequently consider the question of what ‘healing architecture’ does in practice. I then consider the contributions that this dissertation can arguably be said to make in light of the somewhat eclectic - some might even say promiscuous – analytical approach taken in the dissertation. Engaging with diverse literatures enables interdisciplinary convergences and allows the juxtaposition of distinct

approaches. However, in the hope of developing new lines of inquiry and interesting cross-fertilizations, taking this approach comes at a cost. The possibility of deep involvement in a particular subject matter, distinct discipline, and particular field of research are lost together with the likelihood of spotting a particular gap in the research that might be filled. Based on the findings, as well as on my experiences with conducting the research for this dissertation, I conclude by considering what some of the practical implications for the professions of architecture and psychiatry might be, respectively.

## Summarizing the papers

The overall proposition of the dissertation is that to understand what ‘healing architecture’ does we need to consider how space and interaction become ordered in and through psychiatric practice. Chapter three of the dissertation described four different approaches to how we might come to terms with and sensitize ourselves towards such processes of ordering, with the subsequent chapter on methodology arguing that a methodological impetus from both ethnomethodological and ethnographic traditions are instrumental for empirically capturing such processes. By considering what it is that is going on *here* in the two inpatient wards of the Slagelse site - shadowing staff through different spaces, into patient rooms, conference rooms, and common rooms, by observing where encounters and interactions between staff and patients take place and paying close attention to the connections between specific locations and the doings of participating agents - different aspects of how space and interaction are ordered in practice come to the fore. As such, by analyzing empirical material consisting of participant observations and qualitative interviews, the three papers of this dissertation contribute with insights into different aspects of these orderings.

## Paper I

Paper I *The Spatial Organization of Psychiatric (Dis)Order* investigated the relationships between nursing work and ward spaces. Nursing staff engage in a variety of more or less mundane activities throughout the course of a shift, e.g. taking care of laundry and dirty garments by

carrying them from one room to another, keeping the ward clean and orderly by removing objects considered out of place, and ensuring a calm atmosphere by correcting and/or sanctioning inappropriate patient behavior. At the same time they are observing how patients conduct themselves, what their present state and demeanor seems to signify, and how they go about interacting with the other hospitalized patients. The paper shows how these activities are animated, shaped, and also challenged by the spatial disposition of the ward. Because of the wide hallways, large open common areas, and unlocked patient rooms, patients have more freedom to move around, with easy access to each other's rooms. All this amplifies the potential for danger and disorder in the eyes of staff, creating what I suggest are 'sites of contention'. Because of the unbounded and transparent disposition of the inpatient spaces, it becomes more difficult for staff to control the actions and whereabouts of patients because they have greater freedom to move around. This made it especially challenging to manage patients during manic phases, for example, as they would constantly be in motion, walking around the ward, in and out of their room, pacing through common areas, disturbing activities, and leaving personal items and clothes all over the place. The open spaces also made it difficult to demarcate place-appropriate conduct and activities. Negotiations about appropriate behavior would often take place in the common area, for example, because it was unclear whether it was a living room space, a dining area, a place for intimate conversations, or a connecting passageway between patient rooms.

The interpretative framework offered by Douglas provided the analytical resources for investigating an aspect of the relationships between space and interaction by detailing the efforts of nursing staff to gain and maintain control over the ward. The paper shows how the spatial arrangement of the inpatient setting is closely connected to the staff's efforts to avoid disorder, animating them to remove objects, resituate patients, and sanction patient behavior all with reference to the transgression of certain socio-spatial boundaries. This is evident in the case of the two patients considered out of place, first because of their co-presence in the seclusion-room, and subsequently because of their confrontational wandering down the wide

hallways of the ward. The literal and symbolic acts of ordering reveal how power and order are enforced and sustained by staff on the wards, evincing how systems of classification shape their practices of ordering. Having focused on the practical actions of staff, the formal organizational aspects of such structure are lost, arguably blinding the analysis to the impact and importance of any policies and guidelines undergirding the professional practice of nursing staff. Instead, the situated and practical efforts to accomplish and maintain an orderly ward come to the fore.

The paper places emphasis on the structural and cultural aspects of how space and interaction are ordered in practice, detailing how the situated efforts of staff to maintain control of the ward can be seen as reflections of a larger structure in place at the site. Drawing out the full range of dangers, beliefs, behaviors, and actions related to the ordering efforts of staff, the paper shows how a particular system of classification is put to work and by inference how the 'healing architecture' of the ward is drawn upon, oriented to, and opposed. Empirically making an inventory of the staff's interventions, sanctions, and corrections, but also of the continuous efforts taken towards managing objects, were taken as evidence of a particular culture. How the 'healing architecture' of the inpatient setting makes a difference seen from this perspective, is that it is embedded in the shared cultural patterns continuously labored over by staff through which social and material order become folded into one another. As such, the paper answers the sub-question posed at the onset of this dissertation: 'how do nursing staff manage what they consider to be danger and disorder within contemporary inpatient settings?', providing insights into one aspect of 'how space and interaction are ordered in and through psychiatric practice at the Slagelse site' by detailing how cultural structures are constitutive for the relationships between space and interaction in practice.

## **Paper II**

Paper II *Unfulfilled Promises? Staff reactions to the 'healing architecture' of psychiatric inpatient wards* investigates the mediating role of the transparent nursing station and attends to the constitutive implications of its relative position to the adjacent common area by directing the primary

analytical attention towards how staff react to the spatial and material circumstances of the ward. Because so much activity was taking place in and around this space it was obvious that it played an important role. Inside the office space, staff undertook a variety of clerical and administrative work - typing on their computers, documenting observations, and filing paperwork. They also conducted meetings, coordinated tasks, made phone-calls, had lunch, and very often they would be seated at a large table at the center of the space talking to each other about patients, tasks, and private matters. Staff would very often be interrupted by patients posing questions, demands, or making inquiries through the door-opening at the center of the space. Patients would typically be seated in the furniture arranged in close proximity to the glass façade, looking in, sometimes seemingly inquisitive and curious, other times more indifferently. Staff, incidentally, would be looking out, sometimes with focused attention towards certain patients and activities, at other times in a more general mode of observation, gazing into the wider ward environment. Because of this mutual visibility, both staff and patients were often very aware of each other's whereabouts.

The paper shows how these spatial and material circumstances created certain staging problems for staff, with subsequent disruption of their conduct. For example, the glass walls of the nursing station challenged the possibility for staff to withdraw into the office - to go backstage, as it were - inciting them to give the appearance that they remained busy and inaccessible to attain momentary alleviation from the sometimes exhausting social interaction with patients. This, in turn, animated what I suggest are certain practices of unseeing, i.e. avoiding visual interaction with patients to enable 'a break', but, in other instances, to create focus for attention towards other tasks, such as administrative and clerical work. In both instances, however, because actions are rendered visible but inaudible to patients, a sense of uncertainty on the ward is produced and sustained, leaving patients to speculate about what staff are doing, and staff, in turn, to speculate about those speculations. This paper places emphasis on the importance of materiality in shaping processes of ordering, with the relationships between space and interaction mediated by the transparent properties of the nursing station,

transforming the relationships between staff and patients, and the nature of interactions, as well as the sense and significance of spaces. The design of the nursing station is a salient expression of the overall intent of the 'healing architecture' of the hospital, developed to afford easier access to staff and better possibilities to observe patients while aiming to deter the social hierarchies between them through the promotion of visibility.

What the 'healing architecture' does in these instances is contingent upon the relative placement and proximity of spaces to other spaces and the relative presence of other individuals to others in those spaces. The nursing station functioned as an obligatory point of passage for nursing staff, with the space in and around the door-opening of the office becoming a point of convergence and often controversy in everyday practices. Despite regulations stipulating the door's closure, it was often kept open in practice, becoming what Goffman (1959:120) would call a sore spot in the organization of work. The nursing staff spent a lot of resources managing that 'sore spot', either through practices of unseeing, i.e. pretending not to be available, or by affirmative action, i.e. rejecting or accommodating patient inquiries. As such, the paper answers the two sub-question posed at the onset of this dissertation: 'how do nursing staff react to the 'healing architecture' of an inpatient ward? And what is the mediating role of the transparent nursing station for staff/patient interaction?', adding a different layer of insight to our understanding of 'how space and interaction are ordered in and through psychiatric practice at the Slagelse site' by showing how the built environment of the inpatient setting, especially the transparency of the nursing station, plays an important role for everyday interactions and work.

### **Paper III**

In paper III *Healing architecture and psychiatric practice: (re)ordering work and space in an inpatient ward in Denmark*, the interplay between ward spaces and action were considered through the analysis of the routine trouble of administering medication to a patient. Staff primarily conduct conversations with patients about their medication in the conference room within the wards.

These rooms have two doors, offering the possibility for staff to make a quick exit into the office space if necessary. The other door, which connects to the ward hallways, remains unlocked during conversations, affording patients easy access into and out of the room as well. On multiple occasions, staff are left to wait because patients tend to leave the room when aggravated due to, for instance, changes made to their treatment-plans with which they do not agree. The option to have easy access into and out of the room is intended by design to alleviate aggression and avoid assault through movement and space. When situations arise, whether in relation to conversations or otherwise, the nursing staff collectively gather inside the nursing station to plan and coordinate subsequent actions while maintaining oversight of the ward because of the transparent walls of the office. They strategically move all patients to their rooms, effectively emptying shared ward spaces, in the interest of ensuring patients' safety as well as their own when handling an aggravated, violent, or otherwise distressed patient. Often, the distressed patient is moved to his or her room, offering staff control of the immediate surroundings, but also to protect the patient in question. Patient rooms have double doors that enable multiple staff to enter or exit at any given time. Only after a situation is fully under control do staff let all the other patients out of their rooms.

Drawing on the work of Lynch (1991), Cameron Duff and I consider both the designed spatial order of the inpatient wards and the spatial orderings unfolding therein, with a particular interest in how order is accomplished in psychiatric work. By displaying tensions between the two we draw attention to the transient nature of different inpatient spaces as well as detail the importance they play as physical locations in relation to the practice of psychiatric care. For example, staff use the individual patient rooms as a resource for managing and controlling the presence of all the hospitalized patients as part of their efforts to safely administer medication to a patient in distress. As a consequence, the patient rooms become spaces controlled by staff rather than by patients, enacting them as spaces of isolation rather than care. While the manner in which this is experienced by patients eludes the analysis, what is clear is that spaces are an effect of local orderings of disciplinary practice that sometimes sit uneasily with the designed

spatial orders of the ward. Patient rooms are designed to be controlled by patients and not in the first instance by staff. However, as the analysis in the paper also demonstrates, these spaces remain institutional spaces and thus controlled by staff. By focusing on the way in which ‘recovery-oriented-spaces’ change sense and significance through local actors’ situated actions, tensions and relations between designed and lived spaces become salient in the analysis. This allows us to draw attention to the importance of physical spaces for the provision of psychiatric care, and especially their effect on psychiatric work. The ‘healing’ properties of the architecture – the extent to which the spatial and material circumstances of the ward may promote recovery – is contingent upon specific spatial orderings that are continually labored over in practice. Here, an emphasis on the relational dynamics between wards’ spaces and professional work is highlighted.

What the ‘healing architecture’ of the inpatient ward does in this instance is contingent particularly upon the manner in which nursing staff draw upon, orient to, and move through the different spaces of the ward. Some of the work involved in ordering ward spaces includes conducting treatment conversations in the conference room, before assembling in the office space to plan and coordinate subsequent courses of action to manage what they consider ‘a situation’ on the ward and moving all the patients to their rooms. As evidenced by the analysis, spaces are not so much a *locale* within which treatment simply takes place. They should, therefore, not be treated as singular places, with predetermined effects. Rather, they are the contingent effects of particular complexes of activities, a mutual accomplishment. As such, the paper answers the two sub-questions posed at the onset of this dissertation: ‘how is spatial order accomplished through psychiatric work? And how does this work shape the sense and significance of inpatient spaces?’, contributing insights into yet another aspect of ‘how space and interaction are ordered in psychiatric practice at the Slagelse site’ by following the practical action and practical reasoning exhibited by staff in the efforts to manage a distressed patient.

## Answering the research questions

Having summarized the three papers of the dissertation and highlighted some of the most important findings, I can now offer an answer to the overall research question and subsequently venture a proposition as to what it is that ‘healing architecture’ does in psychiatric practice. What the papers collectively demonstrate are various aspects of how staff encounter patients throughout different areas of a ward, how they conduct both administrative and medical tasks, and how they coordinate, collaborate, and work to accomplish the task of providing psychiatric care on a ward. Staff convene, write down observations, prepare injections, talk on the phone, and conduct meetings, all within the transparent but confined space of the nursing station. They administer medication, prepare meals, have leisurely as well as treatment-related conversations, conduct morning assemblies, and observe patients while in the large unbounded common area adjacent to the bounded office space. The green courtyard at the center of the ward is to a lesser extent occupied by staff, but one would almost always find one or more patients smoking, making small-talk, or pacing back and forth on the somewhat beaten stone path connecting the two entry points. Staff would refrain from engaging patients here because they considered it to be a potential safety hazard. Similarly, they refrained from conducting activities at the far end of a ward, considering it a risky zone, because they would be beyond visual contact to the office space. For this reason, they would also animate patients to reside in the common area closest to the nursing station, seeing it as a sign of progression when they did insofar as they were capable of conducting themselves in what was considered an appropriate manner. Ward-life, therefore, primarily took place in between the office space and the courtyard.

Through all these practical efforts, professional labors, mundane encounters, inhabitations, and routine movements, space and interaction on the wards become ordered in and through the everyday doings of staff and patients alike. As this dissertation has empirically demonstrated, and in answering the overall research question, space and interaction are mutually shaped, co-constituted in practice, and folded into each other in and through ongoing processes of

ordering. This answer is not a relative one, where an endless list of possible interpretations of how space and interaction are ordered in practice can be given, although many more ordering processes might arguably be detailed and described. It is an answer that pertains to and considers the situated, negotiated, and thus emergent nature of what it is that 'healing architecture' does in practice. There is cause for considering my use of the term 'healing architecture' before proceeding. I remind the reader that I fully accept that the spatial and material arrangement of the inpatient settings at the Slagelse site are a manifestation of 'healing architecture': specific, empirically tangible circumstances within which the practice and provision of psychiatric treatment and care takes place. So, what does 'healing architecture' do in practice? Well, proposing a definitive answer to that question is in a sense moot. While 'healing architecture' may indeed form and shape the conditions of possibility for treatment and care, instantiate certain physical boundaries demarcating one space from another, and afford both centripetal and centrifugal movements by which encounters and interactions are either animated or hindered, this dissertation demonstrates through its empirical engagements with the psychiatric practices of two inpatient wards that the ongoing, routine, sometimes precarious, but always situated, processes of ordering in practice are what determine the concrete effects of what it is that 'healing architecture' does.

## **Contributions, considerations, and future directions**

This dissertation engages with an interdisciplinary body of literature that investigates the impact and importance of mental health spaces, caring architectures, and psychiatric practices. By shifting the analytical orientation from lived experiences of mental health spaces towards the manner in which space and interaction are ordered in practice, this dissertation runs parallel to recent research on caring and practicing architectures (Jacobs and Merriman 2011; Moser 2017; Nord and Högström 2017a), adds insights to the body of work on the impact and importance of contemporary hospital design for mental health care (Curtis et al. 2007, 2009; Gesler et al. 2004), complements recent studies on the relational aspects and mediating capacities of inpatient spaces (Brown and Reavey 2019; Reavey et al. 2019), and furthers our understanding

of the spatial aspects of nursing work (Andrews 2004, 2016; Andrews and Shaw 2008). This is, admittedly, a rather large and diverse body of work to be contributing to, but the aim is to support burgeoning cross-fertilizations within and across these literatures, extend lines of inquiry, and participate in ongoing conversations related to the shared interests in how mental health spaces and purpose-built architecture make a difference. In this concluding section, I revisit the literature reviewed in chapter three in order to consider and discuss more specifically the contributions that this dissertation makes. In addition I propose some future directions for research. In order to structure these contributions, considerations, and future directions for research, the following is divided into three thematic sub-sections concerned with: first, design and moving beyond material causation; second, with the shift from lived experiences to orderings in practice; finally, nursing work as spatial practice.

### **Moving beyond material causation**

Many modern mental health facilities are being built based on a patient-centered care paradigm (Bromley 2012; Vaughan et al. 2018), designed to enable specific spatial experiences in the interest of supporting recovery (Reavey, Harding, et al. 2017), constructed to foster social interaction (Jovanovic et al. 2019), and improve particular health outcomes (Connellan et al. 2013; Hamilton and Shepley 2010; Papoulias et al. 2014; Shepley et al. 2016). As noted in the introduction to this dissertation, the concept of ‘healing architecture’ and the principles of evidence-based design are becoming increasingly influential in relation to such developments (van den Berg and Wagenaar 2006; Frandsen et al. 2009; Lawson 2010), and, as noted by to Curtis (2010), animated a significant upsurge in research on contemporary hospital design. While studies of ‘healing architecture’ have been criticized for taking a largely passive view of the relationships between clinical practice and space (Frandsen et al. 2012), a handful of studies have investigated contemporary psychiatric hospital design and inpatient spaces by applying the therapeutic landscapes framework that moves beyond functionalist assumptions about the impact of design (Curtis et al. 2007; Gesler et al. 2004). The work of Sarah Curtis, Victoria Wood, and colleagues, has been especially salient in examining which elements in the built

environment staff and patients experience as either beneficial or detrimental to health and well-being (Curtis et al. 2007, 2009; Wood et al. 2013a, 2015).

While these insights are substantial for understanding how particular spatial and material circumstances are experienced, we learn less about *how* such circumstances make a difference in everyday practices. Sidestepping investigations of how therapeutic attributes are socially constructed or symbolically significant (e.g. Curtis et al. 2013; Wood et al. 2013b), as well as setting aside considerations of which aspects of the built environment are experienced as supportive for or unfavorable to health and well-being (e.g. Gesler et al. 2004; Wood et al. 2013a), this dissertation contributes to these studies that explore the unique character of psychiatric inpatient units by detailing the manner in which ward spaces and material properties of the built environment become implicated in, oriented to, and drawn upon in and through everyday action and interactions in practice. In doing so, the dissertation extends this work by adding ethnographic insight into the situated, dynamic, and emergent processes through which space and interaction are ordered in practice, indicating how ‘healing’ and recovery will be more a function of these processes than of any strict material causation. Because many of these studies draw on qualitative interviews they automatically forego the possibility to ascertain knowledge about the situated significance of contemporary designs as post hoc accounts inevitably fall short in capturing how, and for whom, spaces come to make a difference in practice and how they might be made to work by staff (see also Water et al. 2018).

These insights enable critical reflections on the design of contemporary hospital spaces by drawing attention to the fact that the sense and significance of inpatient spaces are contingent upon the activities that go on within them. In line with Martin and colleagues (2015), I contend that considering the everyday uses of newly designed spaces is important insofar as we want to understand the role of architecture in and for health care. ‘Healing architecture’ cannot be determined by any intrinsic material properties, but neither can it be determined by any direct, unmediated relationships with those who interact with it. As this dissertation has shown, the

sense and significance of spaces are an effect of ongoing negotiations, interactions, encounters and orderings in practice, and the dissertation has contributed with specific empirical investigations into how architectural spaces might become, and be considered as, agentic (Jacobs and Merriman 2011; Nord and Högström 2017a). Based on the findings of the three papers, this dissertation indicates that greater attention ought to be directed towards analyzing the impact and importance of ‘healing architecture’ and other such novel health care designs, by studying the relational dynamics between space and interaction in practice. This allows an appreciation of how, and for whom, ‘healing architecture’ makes a situated difference, an approach which is in line with recent studies on the materialities of care (Buse, Martin, et al. 2018; Nettleton et al. 2018), where emphasis is placed on a practice-based approach by which materiality and care are considered as dynamic, emergent, and co-constituted (Moser 2017). Understanding the relationships between space and interaction is important insofar as the relationships between staff, patients, and the mental health spaces within which they interact are considered fundamental to psychiatric care.

### **From lived experiences to orderings in practice**

As detailed in the literature review, health geographers have highlighted the salience of both natural and built environments for experiences of mental health, detailing the symbolic, material, affective, social, and relational aspects of a multiplicity of settings and spatial circumstances. Scholars from this tradition have rightly considered a variety of community, rural, and urban spaces. Less attention, however, has been directed towards psychiatric inpatient settings, which, according to Mcgrath and Reavey (2013; see also Symonds 1998), have been somewhat neglected. Whereas institutional geographers have tended to focus on the constraining capacities and detrimental effects of institutional spaces (see Philo and Parr 2000), this dissertation moves the analytical inquiry away from focusing on architectural order to being concerned with the multiple, somewhat transient, but always emergent processes of ordering that are continuously taking place instead. This approach is in line with Nord and Högström’s (2017b:10) suggestion to move inside the walls of institutions to consider everyday practices

whereby an appreciation of the relationships between material matter and human mattering is enabled, something to which Jacobs and Merriman (2011:212) contend scholars ought to direct more sustained attention. Moser (2017:87) furthermore suggests that a thriving discussion on the spatial and architectural conditions of care is missing. By considering different ways in which the relationships between space and interaction become ordered in psychiatric practice, this dissertation builds upon these recent efforts to study the non-representational aspects of care practices and caring architectures, just as it extends the conceptual repertoire for considering these aspects by suggesting an analytical approach sensitive to the situated and everyday organizations of spaces, care, and work. Furthermore, the dissertation offers empirical answers to how such ordering processes are accomplished in practice.

While there might not be sustained discussions on the spatial and architectural conditions of care within STS, the collaborative efforts of Paula Reavey, Steven Brown and colleagues (Brown and Reavey 2019; Brown and Tucker 2010; Kanyeredzi et al. 2019; Reavey, Poole, et al. 2017) advance our understanding of the role of space in psychiatric inpatient settings both conceptually and empirically by taking a psychosocial approach that situates individual experiences within wider social, material, and spatial circumstances. Although these collaborative efforts might be considered as extending insights derived from STS and posthuman geographies to studies of space and place in mental health care, their work remains primarily interested in staff and patients' *experiences* of inpatient spaces. Less attention is, therefore, directed to the *practices* within which they are embedded. Yet, the analytical aim and approach of this dissertation resonates with the contention found in these studies to focus on the interactional capacities and the possibilities for action that emerge as effects of the relational dynamics between patients, staff, and the spatio-material environments of inpatient settings (Reavey et al. 2019; Tucker et al. 2018). As such, the findings reported throughout the three papers of this dissertation should be considered together with the contributions made in these studies of how inpatient spaces make a difference.

Supplementing the situated perspective advocated in this dissertation, future investigations might aim to develop approaches sensitive to the impact and importance of spaces both *in here* and *out there*, mapping the dynamics of different spatialities simultaneously impinging on, affecting, and/or shaping psychiatric practices *in situ*. How do spaces for those pending discharge make a difference to how inpatient spaces are configured? And how do patients and professionals, respectively, relate to, evoke, and act upon such spaces in and through treatment encounters in practice? Such questions would move the analytical point of orientation from mapping *geographies* of care to considering *topologies* of care instead. While this dissertation suggests that spaces are transient and continuously (re)ordered through interactions in practice, exploring the relationships between such orderings and how they become layered (e.g. Street and Coleman 2012), for instance, might offer novel insights into the social topology of psychiatric wards. Some scholars have already engaged such lines of inquiry (Reavey et al. 2019; Tucker et al. 2018), drawing on the joint work of Annemarie Mol and John Law (1994) to seek alternative descriptions of how spatial relations are assembled within ward spaces (Brown and Reavey 2016). Investigating the performance of spaces beyond Euclidian geometry challenges methodological claims to remain in the *terra firma* of interaction. However, it instead affords an assemblage perspective that allows the analysis to account for spaces that stretch beyond the here and now of interaction, enabling the consideration that “presence can be absence: and the absent present” (Callon and Law 2004:3). If we accept that contemporary inpatient settings are indeed becoming more permeable (Quirk et al. 2006) and functioning as spaces of transition (Wood et al. 2013a), then drawing on the notion of topology may indeed offer a strong conceptual entry point for gaining a more complex picture of how both present and absent spaces make a difference for trajectories of care and recovery.

## **Nursing work as spatial practices**

In acute psychiatric care settings, nurses’ duties tend to be quite vague, difficult to discern and commonly without any clear measuring points in relation to success or failure (Andes and Shattell 2006; Bowers et al. 2005). This leaves the question of what constitutes nursing practice

and nursing work in inpatient settings, empirically open. As Strauss and colleagues (1963:151) highlighted in 1963, the rules that govern the actions of the various professionals in psychiatric hospitals as they perform their tasks tend to be neither extensive, exhaustive nor clearly stated or binding. The rationales, logics, and reasons prefiguring any interventions and therapeutic encounters are, in short, open for negotiation. These difficulties in determining what the purpose of psychiatric inpatient nursing is, or ought to be, and its ability to deliver positive therapeutic care continues to spur sustained critiques (Griffiths and Norman 2018; Norman and Griffiths 2018; Sookoo 2018). Some nursing scholars have developed conceptual models to ascertain the role of nursing in inpatient settings (Bowers et al. 2005, 2009), and others have conducted or reviewed qualitative studies to gain insight into the complexities of nursing (Cleary et al. 2011; Delaney and Johnson 2014; Quirk and Lelliott 2001). However, as Deacon (2003) points out, the practical operations of nursing staff remain largely unexamined. She argues that without understanding the mundane and everyday activities of psychiatric inpatient nursing, such activities will continue to be considered as an impediment to the ‘more important’ work that is regarded as therapeutic.

By considering how space and interaction are ordered in psychiatric practice this dissertation contributes with insights into the ‘practical operations’ of nursing staff by detailing what nursing staff do. Given that knowledge in psychiatry is considered both fragile and uncertain (Deacon and Fairhurst 2008), investigating what *prefigures* any intervention should, as STS-scholars have extensively argued (e.g. Mol and Law 1994), be seen as analytically secondary to the actions that *follows*. For this reason, I directed attention to what follows from particular modes of knowing in practice, rather than what prefigures these modes, focusing primarily on the acts of, rather than the reasons for, engaging patients or managing spaces. The enactment of knowledge in practice is a fundamental aspect of the practical and systematic organization of activities, which, as this dissertation has shown, also entails the systematic organization of space. Managing, engaging, and interacting with patients takes place as an effort to organize spaces in particular ways that ensure safety, gain control and accomplish care. Detailing these

spatial practices contributes to a body of work engaged with specifying the geography of nursing spearheaded by Gavin Andrews and colleagues (2004, 2016; 2005a, 2005b; 2008), by moving beyond positivistic and social constructivist accounts to consider more non-representational aspects of nursing (see, Andrews 2016).

Research on the spatial aspects of nursing might fruitfully be considered more directly in relation to literature concerned with the social organization of work (e.g. Strauss et al. 1985). Although not reviewed in this dissertation, the work of Strauss and colleagues vividly demonstrates the complex nature of medical work, reframing our understanding of the various aspects of such work. Building on the notion of articulation work proposed by Strauss, Bardram and Bossen (2005), for example, suggest the notion of mobility work to capture the spatial aspects of cooperative work. The notion of spatial ordering that I draw upon may advantageously be considered in relation to the notion of mobility work (see also Grant, Mesman, and Guthrie 2016; Mesman 2012). Detailing the relationship between: how practical knowledge and reasoning become enacted *in situ*; how different logics or rationales become authorized in and across different types of everyday situations; how formal institutional roles are evoked as opposed to more informal rationalities; and how all of these both inform and reflect back onto the spatial practices performed by professionals, would provide interesting avenues for future research. While this dissertation adds empirical insight to the conceptual claim that doings and interaction, in fact, make a difference to the sense and significance of particular spaces, it offers less insight into differences between staff and patient orderings. A much stronger appreciation of the spatial practices and ordering efforts of patients should, therefore, be considered in future research if we want to know how and if such efforts challenge and clash with those of staff. Here, the potential for future engagements is considerable.

## **Implications for practice**

In this final section, I consider how some of the contributions previously outlined can be translated into more tangible propositions worth considering by practitioners within the fields of architecture and psychiatry, respectively. These propositions should not be taken as practical advice but rather seen as suggestions for further consideration. The focus of analytical attention in this dissertation has not been directed towards architecture and psychiatry as such, but situated somewhere in between, focused on the spatial and material arrangements designed by architects and inhabited by, among others, nursing staff, doctors and patients.

### **Architecture**

While I am sympathetic to and endorse the idea and practice of designing and developing 'healing architectures', especially for psychiatry - as spaces for mental health care have historically been both austere and detrimental to treatment trajectories - the findings presented throughout this dissertation make me question whether the benefits of having an open and flexible spatial disposition together with high degrees of transparency indeed outweigh the costs. Transparency enables staff to unobtrusively observe patients, affording them the possibility for quick interventions if needed. Because the nursing station is transparent, staff can also conduct clerical or administrative work while retaining proximity to colleagues in the wider ward environment. Moreover, they can retain a sense of the atmosphere in the ward. However, as the findings presented in this dissertation suggest, having a transparent nursing station also makes nursing staff more likely to withdraw from the wider ward environment, arguably creating a sense of relational distance to patients despite having physical proximity. This, in turn, amplifies a sense of uncertainty on the ward due to the mutual visibility but lack of audibility, often leaving patients to speculate about what staff are doing, and staff, in turn, to speculate about those speculations. In some instances, this visibility also seems to challenge the code of ethics in place, such as when staff prepare to give a patient an injection while visible to the entire ward population. The transparent nature of the nursing station furthermore challenges staff's need to withdraw backstage to momentarily get relief from trying interactions

with patients. Finally, the transparent nature of the nursing station seems to amplify the number of inquiries that patients make and the volume of claims that they lay on staff attention, which, because staff often reside in the nursing station, transforms the types of interactions staff and patients have, with many encounters taking place as transactions – e.g. patients receiving medicine, mobile devices, or other objects – rather than as focused conversations that are arguably necessary to build the therapeutic relationships deemed important. It stands to reason, then, that future developments might (re)consider what the extensive use of transparent materials in the built environment is thought to enable, and how certain transparent spaces are placed in relation to each other.

The open and flexible spaces of the Slagelse site afforded greater freedom of movement. This was indeed helpful in certain instances, as patients could ‘walk it off’, as it were, i.e. alleviate stresses by physically walking around the central courtyard, sometimes together with staff, who actively used this opportunity to preempt potential aggravation or threatening behavior with certain patients. However, the distance between the far end of a ward and the nursing station made staff consider the TV-room and the living room risky areas because they were too far away from colleagues, which often meant that these areas were completely empty. Despite the high degrees of transparency, staff did not consider the ability for visual contact strong enough. Some patients were, furthermore, confused by the functional flexibility of rooms, complaining that they did not know what to do ‘here’ and that they had enough on their minds already, with no room, so to speak, to reflect on place-appropriate behavior. Only some patients were able to make such reflections, with most simply going about their own business, using the spaces as they saw fit. This meant that staff used significant resources in managing the open spaces, attempting to keep them ordered and clean, and correcting patients who were not able to ‘read the room’. This was especially salient in regards to the space situated between the nursing station and the courtyard, and future developments might consider the balance between form and function, i.e. considering designing spaces more clearly demarcated, making it more obvious what should take place within them.

Many of the ideas found in the concept of ‘healing architecture’, such as incorporating innovative lighting design, ensuring access to green spaces, and enhancing and managing aesthetic experiences through art, are reflected in the Slagelse hospital building. The impact and importance of such architectural elements for health outcomes have been determined by research and later developed in design. However, Karlsson Architects and Vilhelm Lauritsen Architects incorporated and developed a much broader approach to health care design, mirroring the recovery-oriented approach in the spatial disposition of the hospital building in Slagelse. This invariably reflects a process of interpretation, with the architects spearheading the task to translate notions from psychiatry into spatial form. While this dissertation cannot speak to the challenges of translation, it can speak to the implications of its spatial form. As this dissertation has shown, the relationships between space and interaction become ordered in practice, with spaces gaining their sense and significance through situated actions. One consequence of this argument is to caution any attempts at predetermining what ‘healing architecture’ does, which, in turn, defies the possibility to design perfectly appropriate spaces for psychiatric practice. What this dissertation might contribute, then, is that considering practices, especially work practices, is important when developing spaces for psychiatric facilities, as relying on experiences of previous spaces, ideas about patient types, and ideal notions of treatment, do not capture the intricacies of everyday doings, practical actions, and practical reasoning that are arguably significant for how ‘healing architecture’ *works*.

## **Psychiatry**

The findings presented in this dissertation can also arguably be insightful for practitioners working in novel spatial settings such as the psychiatric hospital in Slagelse. While many of the interventions staff make to restore a sense of orderliness and reestablish social order on the inpatient wards are rehearsed, they do not seem to be aware of how spatial in orientation these interventions are. They coordinate interventions that move patients from one place to another to ensure safety, they utilize strength in numbers to territorialize certain areas of a ward during

the administration of medication, they sanction behavior in accordance with certain socio-spatial boundaries, and they refer to different zones as risky, safe, supportive, detrimental, etc. Even if staff are aware of these spatial practices, the implications of such practices are arguably worth considering more closely, especially in relation to the manner in which spaces gain their sense and significance. As evidenced in both Paper I and Paper III, managing patients in one place has significant implications for how patients experience spaces in other places. The focus of staff attention is naturally directed towards one place and often one patient, but the effects of the interactions, encounters, and interventions conducted with this patient potentially have implications for the entire social topology of the ward. For this reason, practitioners might reflect on the extended implications of their interventions for the wider ward environment, and thus for other patients' sense of safety, assurance, and recovery. This insight should be considered by nursing staff in particular insofar as they often manage both patients and spaces based on certain assumptions about their connectedness, i.e. that moving a patient to the common area is supportive of recovery, for instance, or that moving a patient to the patient room affords a sense of privacy and control. This dissertation details incidents to the contrary.

Another aspect of these spatial practices worth considering, I think, is the manner in which staff draw upon, orient to, and challenge the spatial disposition of a ward based on a particular system of classification. Paper I offers insight into the culture of the inpatient setting by investigating how nursing staff manage what they consider to be danger and disorder. Here, the relationships between the spatial arrangements of the inpatient setting staff activity and interventions, and the social order of the ward, become salient. Ward spaces, in other words, function as a normative grid by which staff are animated to do certain things, such as move objects because they are out of place, sanction or correct patient behavior because they are considered place-inappropriate, or displace patients because a space is considered potentially dangerous for patients to be in. For this reason, medical professionals could indeed consider the importance of space in relation to the manner in which they encounter, engage, and interact with patients.

## **Final remarks**

At the onset of this dissertation, I claimed that how architecture in health care settings contributes to the ordering of space and interaction was a mystery, something to be investigated further. While this claim may be somewhat hyperbolic, I framed it as such because the idea of ‘healing architecture’ was indeed somewhat mysterious to me. It was mysterious in the sense that it seemed to evoke a sort of power or transformational capacity that I found hard to comprehend. I wanted to set aside any presumptions I had about the purported special capacities of such architecture and simply investigate, as one does when attempting to solve a mystery. While some pieces have arguably been ‘found’, the investigation should indeed continue. There is much still to uncover and learn.

## 10. References

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# 11. Appendix

## English summary

This dissertation is about the spatial organization of contemporary psychiatric practice, about ‘healing architecture’ in psychiatry. I take ‘healing architecture’ to represent a particular effort to spatially and materially organize contemporary psychiatric practice. The problem motivating my inquiry is not about how architecture and space mediate health outcomes and promote patient recovery, what ‘healing architecture’ is or should be, but rather, what it actually *does*. How architecture in health care settings contributes to the ordering of space and interaction, enabling certain practices, while constraining others is, I argue, largely eclipsed in the social science literature and thus a key point of convergence throughout the dissertation. The inquiry is brought to bear on a purpose-built psychiatric hospital in Slagelse, Denmark, opened in late 2015. With ‘healing architecture’ and the idea of recovery literally built into the bricks and mortar of the building, the new hospital in Slagelse is considered the vanguard of contemporary hospital design, representing the future of psychiatric inpatient facilities. As such, the Slagelse Hospital can be understood as a paradigmatic case for considering the spatial organization of contemporary psychiatric practice. When the subtitle of this dissertation is *a situated inquiry into ‘healing architecture’* it is because I consider the novel spatial circumstances of the Slagelse site based on detailed ethnographic fieldwork and by empirically investigating how the relationships between space and interaction are ordered in and through psychiatric practice.

The dissertation consists of three individual papers. The first paper *The Spatial Organization of Psychiatric (Dis)Order* draws on the work of cultural anthropologist Mary Douglas (1966). Based on the claim that ‘healing architecture’ raises new questions about the demands on, and responses of, nursing staff working within such settings, the paper considers the relations between ward spaces, perceived dangers, and nursing work. The paper shows, firstly, how displacing patients, cleaning spaces, (re)moving objects and correcting patient behavior become

salient tasks engendered by the spatial layout of a ward, and, secondly, how the invocation of the language of danger enables nursing staff to intervene when socio-spatial boundaries are transgressed by patients. In discussing the findings I suggest that the spatial layout of the inpatient setting amplifies tensions between professional interests and designed intentions, creating what I call ‘sites of contention’ where the social order of a ward is openly negotiated.

The second paper *Unfulfilled promises? Staff reactions to the healing architecture of psychiatric inpatient wards* is an empirically driven paper that draws on theoretical impulses found in science and technology studies combined with Erving Goffman’s (1959) approach to studying the presentation of self in everyday life. The paper investigates the mediating role a nursing station plays within an inpatient setting and shows how the transparent glass walls of said nursing station shape the manner in which staff engage and encounter patients, as well as change the way that they conduct themselves when inside the office space. The paper shows how particular staging contingencies arise due to the transparent nature of the nursing station, rendering activities visible which were previously out of sight. An environment of uncertainty is produced due to these contingencies, which is the opposite of the intended design.

The third and final paper, *Healing architecture and psychiatric practice: (re)ordering work and space in an inpatient ward* is co-authored with Cameron Duff from the Royal Melbourne Institute of Technology. The paper draws on the work of ethnomethodologist and science study scholar Michael Lynch (1991). Through the notion of spatial order(ing) the paper explores the key material and social effects of the hospitals ‘healing architecture’ and the spaces and practices it contributes to enacting. By analyzing an instance of the administration of medication the paper shows that the ordering of spaces is central to the enactment of control over patients so often required in everyday psychiatric work, highlighting the tensions that arise between the spatial layout of the ward and the orderings preferred by staff. The paper suggests that ‘healing architecture’ might indeed have great impact on the provision of psychiatric care, but that its instantiation as healing or therapeutic is better understood as a function of spatial orderings

rather than as a strict material causation. As such, the spatial disposition of 'healing architecture' may have at least as great an impact on psychiatric work as on patient experiences of care and recovery.

By redirecting the analytical orientation from lived experiences of mental health spaces towards the manner in which space and interaction are ordered in practice the dissertation contributes to ongoing conversations about caring and practicing architectures, adds insights to the body of work on the impact and importance of hospital design for mental health care and complements recent studies on the relational aspects of inpatient spaces. In relation to recent calls to draw on STS to investigate architecture, this dissertation furthermore offers input on how to come to terms with studying architecture from what might arguably be an STS-perspective. The aim of the dissertation is to further burgeoning cross-fertilizations within interdisciplinary scholarship found in health geography, the sociology of health and illness, and in STS, to extend lines of inquiry already taking place here, and thus to participate in debates related to questions of how mental health spaces make a difference, how we can study the relationships between space and interaction in practice, and offer empirical insights into what so-called 'healing architectures' *do*.

## Dansk resumé

Denne afhandling handler om den rumlige organisering af samtidens psykiatriske praksis, om 'helende arkitektur' i psykiatrien. Jeg forstår 'helende arkitektur' som et særligt forsøg på rumligt og materielt at organisere samtidens psykiatriske praksis. Det problem der motiverer afhandlingens undersøgelse, handler ikke om, hvorvidt arkitektur eller rum medierer sundhed eller fremmer recovery, om hvad 'helende arkitektur' er eller bør være, men snarere om hvad 'helende arkitektur' faktisk *gør*. Hvordan arkitektur indgår i ordningen af rum og interaktion, hvorved nogle praksisser muliggøres og andre begrænses, er generelt overset i den socialvidenskabelige litteratur, og er derfor et centralt omdrejningspunkt for denne afhandling. Afhandlingen tager afsæt i en undersøgelse af et nyt psykiatrihospital i Slagelse, Danmark, der blev indviet i efteråret 2015. Med 'helende arkitektur' og forestillingen om recovery-arbejdet direkte ind i hospitalsbyggeriet repræsenterer det nye psykiatrisygehus i Slagelse givetvis fremtidens psykiatrifaciliteter. Hospitalet i Slagelses kan derved ses som en paradigmatiske case for at undersøge den rumlige organisering af samtidens psykiatri. Når undertitlen på afhandlingen er *en situeret undersøgelse af 'helende arkitektur'*, så er det fordi, at jeg etnografisk og empirisk undersøger, hvordan relationerne mellem rum og interaktion er ordnet i praksis.

Afhandlingen består af tre individuelle artikler. Den første artikel *The Spatial Organization of Psychiatric (Dis)Order* trækker på kulturanthropolog Mary Douglas' (1966) arbejde. Baseret på antagelsen om at 'helende arkitektur' rejser nye spørgsmål vedrørende forventningerne til det professionelle plejepersonales arbejde, undersøger artiklen relationen mellem et patientafsnits rum, personalets opfattelser af hvad der opfattes som farligt, og det psykiatriske plejearbejde. Artiklen viser, hvordan det at forflytte patienter og genstande, rengøre rum og korrigere patienter bliver fremtrædende opgaver frembragt af afsnittets rumlige disposition. Artiklen viser desuden, hvordan personalets brug af et særligt ladet vokabular – *the language of danger* – gør det muligt for plejepersonalet at gribe ind, når socio-rumlige grænser overskrides af patienter. Jeg foreslår på baggrund af disse indsigter, at afsnittets rumlige disposition forstærker spændingerne

mellem de professionelles interesser, patienternes adfærd og intentionerne bag designet, hvorved der skabes det, jeg kalder *sites of contention*, hvor den sociale orden på afsnittet åbent forhandles.

Den anden artikel *Unfulfilled promises? Staff reactions to the healing architecture of psychiatric inpatient wards* er en empirisk drevet artikel, der ikke desto mindre trækker på væsentlige teoretiske impulser fra videnskabsstudier (STS) i kombination med indsigter fra Erving Goffmans (1959) studier af hverdagslivet. Artiklen fokuserer på plejepersonalets transparente kontor, og undersøger, hvilken medierende rolle denne spiller i afsnittet. Artiklen viser, hvordan kontorets glasvægge medierer måden, hvorpå personalet interagerer med patienter, såvel som transformerer den måde, personalet begår sig på, når de er inde på kontoret. Artiklen viser, hvordan særlige iscenesættelsesproblemstillinger opstår grundet kontorets transparente natur. Herved bliver aktiviteter, der tidligere var usynlige for patienterne synliggjorte, hvilket skaber et usikkert miljø med uklare forventninger, hvilket går imod de forventninger, der var til det transparente design.



Den tredje og sidste artikel *Healing architecture and psychiatric practice: (re)ordering work and space in an inpatient ward in Denmark* er skrevet sammen med Cameron Duff fra Royal Melbourne Institute of Technology. Artiklen trækker på etnometodologen Michael Lynch's begreb om *spatial ordering*. Artiklen undersøger de centrale effekter af hospitalets 'helende arkitektur', og de rum og praksisser, som denne arkitektur bidrager til at skabe. Ved at analysere arbejdet med at sikre at en patient tager sin medicin, viser artiklen, hvordan ordningen af rum er centralt for etableringen af kontrol, hvorved spændinger mellem afsnittets rumlige disposition og personalets ordnings-arbejde opstår. Artiklen antyder, at 'helende arkitektur' formentlig kan have en positiv indflydelse på leveringen af den psykiatriske behandling, men hvorvidt arkitekturen rent faktisk *er* helende eller har terapeutiske effekter, bør snarere forstås som en funktion af det rumlige ordnings-arbejde end gennem en streng årsag-virkningssammenhæng.

Vi argumenterer derfor i artiklen for, at den 'helende arkitektur' kan have mindst lige så stor indflydelse på det psykiatriske arbejde som på patienternes oplevelse af recovery.

Ved at forskyde det analytiske fokus fra patienternes oplevelser af psykiatriske rum til måden hvorpå rum og interaktion ordnes i praksis, bidrager denne afhandling til pågående diskussioner vedrørende såkaldt omsorgsfuldt design og 'helende arkitektur'. Derudover bidrager afhandlingen til studier af betydningen af hospitalsdesign for psykiatrisk behandling og recovery, såvel som til nyere studier af de relationelle aspekter af den psykiatriske behandling i institutionelle rum. Afhandlingen bidrager også med input til, hvordan arkitektur kan studeres fra et perspektiv inspireret af STS. Målet med afhandlingen er ydermere at bidrage til interdisciplinære diskussioner i geografien, sundhedssociologien og STS, der fokuserer på betydningen af psykiatriske rum ved at komme med empiriske indsigter i, hvad såkaldt 'helende arkitektur' gør.

## Co-author declaration

<b>Title of paper</b>	Healing Architecture and Psychiatric Practice: (Re)Ordering Work and Space in an Inpatient Ward in Denmark
<b>Journal and date (if published)</b>	Accepted for publication by <i>Sociology of Health and Illness</i> on September third 2019.
1. Formulation/identification of the scientific problem to be investigated and its operationalization into an appropriate set of research questions to be answered through empirical research and/or conceptual development	
<b>Description of contribution:</b>  <p>The paper examines the key material and social effects of so-called healing architecture in a new purpose-built psychiatric hospital in Denmark. Drawing on ethnographic material conducted by the first author in two inpatient wards in 2016 and 2017, we consider both the designed ‘spatial order’ of inpatient wards, and the ‘spatial orderings’ unfolding therein, with a particular interest in how order is accomplished in psychiatric work. By showing tensions between the two we draw attention to the transient nature of different inpatient spaces as well as detail the importance they play as physical locations in relation to the practice of psychiatric care. Given the recent call for a ‘sociology of healthcare architecture’ in the journal <i>Sociology of Health and Illness</i>, we believe that the findings presented in our paper will allow for further discussions on the effects of contemporary healthcare architectures for users and providers alike. By focusing on the way in which ‘recovery-oriented-spaces’ change sense and significance through local actors’ situated actions, tensions and relations between designed and lived spaces become salient. This allows us to draw attention to the importance of physical spaces for the provision of psychiatric care, and especially their effect on psychiatric work.</p>	
2. Planning of the research, including the selection of methods and method development	
<b>Description of contribution:</b>  <p>Done by the first author and Ph.D. student (Thorben Peter Simonsen).</p>	
3. Involvement in data collection and data analysis	
<b>Description of contribution:</b>  <p>The data collection and initial data analysis were conducted by the Ph.D. student (Thorben Peter Simonsen), with subsequent analytical contributions made by Cameron Duff.</p>	
4. Presentation, interpretation, and discussion of the analysis in the form of an article or	

manuscript	
<b>Description of contribution:</b>  Original academic article The theoretical framework, analysis, and contributions were discussed and developed by both authors	
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To whom it may concern

We hereby grant Thorben Peter Simonsen, PhD Fellow at the Department of Organization Copenhagen Business School, permission to use and reproduce pictures and diagrams related to the Psychiatric Hospital in Slagelse, Denmark, for purposes of publication and in relation to his PhD thesis.

Arkitekt maa, partner

Christian Karlsson

A handwritten signature in dark ink, appearing to read "Cln", followed by a short horizontal line.

# Declaration of confidentiality



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