

Organizing the sensory: Ear-work, panauralism and sonic agency on a forensic psychiatric unit

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Abstract

How are relations of care and security between hospital staff and patients organized through sound? This article argues that a shifting distinction between meaningful sound and noise is fundamental to the lived experience of immersion in an organizational acoustic environment. Based around a qualitative study of listening practices and ‘ear work’ at a medium-secure forensic psychiatric hospital, using interview and photo-production methods, the article positions the organizing of the sensory as central to formal organization. Analysis of empirical material demonstrates how the refinement of key listening practices is critical to the ways in which staff and patients orient to the hospital setting. It also details how the design process for the unit has undermined the capacity to manage and control through sound, or ‘panauralism’, rendering it as a reversible and contested struggle to make sense of the acoustic environment, and describes the attempts by patients to create alternative acoustic spaces and exercise ‘sonic agency’. We contend that ‘acoustic organizational research’ offers

an experience-near means of mapping organizational space and power relations and invites a renewed questioning of the role of the sensory as form of organizing in itself.

Keywords: Sensory organization; Lived experience; Foucault; Sound Studies; Attunement

Introduction

Recent work on sensory modes of organizing (Riach & Warren, 2015; Shortt, 2015) has argued for a ‘multi-modal’ approach to the lived experience of organizational space (Jack et al, 2013; Styhre, 2013). Here the senses are seen as central to making meaning from and orienting to organizational settings. This work explores the ways in which sensation is a means of organizing experience that transcends a clear distinction between persons and their environments (Tomkins & Eatough, 2013). Whilst vision is often considered the primary mode of sensorial experience, due to its classical associations with rationality and objectivity (Styhre, 2008), there is a growing concern within Management and Organization Studies around other more immersive senses such as the olfactory (Riach & Warren, 2015), the haptic (Ott, 2018) and the gustatory (Driver, 2008). In this article, we contribute to this emerging body of work by demonstrating how hearing is a critical modality through which relations of care and security are organized between staff and patients in a psychiatric hospital.

Despite the widespread interest in the social dimensions of sound and noise across the social sciences and humanities, with some noticeable exceptions (e.g. Payne et al, 2017; Korczynski, 2014; Shortt 2013; Kaulingfreks, 2011; Styhre, 2013), the role of sound as a source of meaning at work remains under-studied and under-theorised in Management and Organization Studies. For Corbett (2003), this neglect stems from an ‘optocentrism’ (i.e. bias towards the visual), which he proposes be redressed by an ‘acoustic organizational research’ that is sensitive to the ‘organisational cacophony’ constituted by everyday sounds in the workplace. Here we can distinguish between sounds that are deliberately produced and

managed, such as music played in factories and retail settings, and sounds that incidentally occur within organizational life. Harriet Shortt (2013: 343-4) points toward 'unmanaged' auditory phenomenon such as 'the clicking of heating pipes in a radiator, the gentle whir of a laptop, the bubbling boil of the kettle, the hum of the photocopier or the sound of the traffic outside'. Managed and unmanaged sounds come together to form an organizational 'acoustic environment', defined by Kaulingfreks as an encapsulated 'social, meaningful, reality' which the hearer experiences through sound (2011: 40). It is the shaping of this acoustic environment within the hospital, and the ways in which this becomes central to the lived experience of the setting, that is of central concern for our discussion.

As Shortt (2015) demonstrates, sound plays a role in the enactment of the spatial borders and divisions of organizational life. These divisions define particular kinds of sounds as meaningful and significant, and others as interruptions or background noise. Drawing on the work of Michel Serres (1982a; 1995), we argue that the distribution of sound into distinct orders of meaning and noise constitutes a work of ordering that is fundamental to formal organization. For Serres, this ordering is ongoing and rarely secure; noise can suddenly take on significance within the acoustic environment, and sounds that were previously meaningful can transform into background sonic irritants. It is then important to understand the specific ways in which sound alternates between meaning and noise in an organizational setting, and how hearers manage their relationship to this. Developing the capacity to both recognize and grasp the meaning of discrete changes in the organizational acoustic environment is a key skill for members. This can be clearly seen in other domains, where sensory discrimination is a key aspect of the work itself – e.g. 'noses' in the perfume industry (Latour, 2004), bespoke shoe makers (Ott, 2018), wine and craft beer tasters (Smith Maguire, 2018) etc. But in relation to the auditory, we argue that all kinds of organized work practices depend to some degree on a perceptual work of tuning into the acoustic environment, involving a practiced

cultivation of listening. This ‘ear-work’ can also be deployed as part of regimes of auditory surveillance, termed ‘acoustic discipline’ by Kaulingfreks (2011), either through techniques to exercise control through sound, or as within the emerging embodied practices through which acoustic discipline is resisted.

This contribution of this article is threefold. We develop a conceptual framework for treating sensory organization as the constituent feature of formal organization, and offer an empirical instantiation in support that delineates the specific formal and informal listening habits that members come to acquire. In doing so, an approach to power relations in terms of sound rather than vision is mapped out, and the implications of this shift away from classical Foucauldian thought are sketched out. Finally, the value of studying closed institutional settings, such as psychiatric hospitals, through what can be heard rather than what can be seen is described. The article begins by considering how the organization of the sensory gives rise to range of ear-work practices, and describes the forms these take in a hospital context. Our empirical site – the medium-secure forensic psychiatric unit ‘Sharphill’ – is then introduced, along with the methodological details of the study. Findings are then discussed in relation to four key ‘acoustic’ themes – immersion, earwork, panauralism and sonic agency. The relevance of these themes for acoustic organizational research is then discussed, along with some practical recommendations for the design of the built environment in psychiatric healthcare that may better support both staff and patients.

Knowing Through Sound

The concept of ‘soundscape’ developed by the composer R. Murray Schafer (1994) has been used to refer to the immersive nature of the acoustic environment formed by both ‘natural’ and ‘human’ produced sound. A soundscape becomes meaningful to listeners through a gradual interaction with a given ‘acoustic community’. For example, the tolling of church bells developed as a sonic practice for organizing Christian rural communities from the

twelfth century onwards (Corbin, 1999). Becoming a member of the community involves a 'sensory education' or 'aural socialization' in order to recognise and respond to the bell toll as a 'summons'. In this way, the organization of the soundscape is a key part of constituting forms of social order and associating particular meanings and values with the local environment. This can be done through either the deployment of specific sounds as social markers (e.g. bells, sirens, calls) or more elaborate techniques such as music and singing (see Korczynski et al, 2013 on rural laboring 'work songs'). Soundscapes can also be sites of interruption and contestation. Chuengsatiansup (1999) describes how older villagers in rural Northern Thailand experienced sounds such as 'blasting motorcycles' and 'quarrelling neighbours' as powerful 'embodied symbols' of changing social relations that were beyond their control. The soundscape is then a means for the transmission of both stable and emerging cultural values (Classen, 1997).

In institutional settings, such as hospitals, prisons or schools, the soundscape is partly defined by the presence of particular 'archetypical sounds', such as the sound of keys in locks, ringing bells marking the division of the day, or the reverberation of massed steps and loud chatter in large open corridors (Traux, 2001). These are sounds that are heavy with particular cultural and emotional significance, and can be powerful markers of institutional life for members. Brown et al (2015) also point to 'keynote sounds', such as machines, fans, computers, or clocks ticking, which make up the continuous background noise, and distinct 'sound signals' such as the rattle of a moving food trolley, panic alarms, telephones ringing or footsteps approaching. To the 'untrained ear' these sounds are unpredictable 'noise' that interrupt daily activities. However, as Brown et al (2015) describe, members come to develop a set of 'listening habits' that convert this noise into meaning. Cyrus Mody (2005) refers to these techniques as 'ear-work', involving practiced forms of 'listening, hearing, attuning' (p.176). Ear-work is the capacity for sonic discernment relative to a particular acoustic

environment, which includes both cultivated skills learned ‘on the job’ and formally trained procedures. These latter form the basis of what Ashmore et al (2004), drawing on Goodwin’s (1994) concept of ‘professional vision’, call ‘professional hearing’ - a range of ‘auditory-analytic practices’ that enable the trained listener to stake a claim to having a privileged epistemic perspective, of literally being able to hear and make sense of sounds in a way that others cannot.

The relationship between sensory practices, knowing and cultural values is strongly developed in the work of Michel Serres. In *The Five Senses*, Serres argues against an approach to knowledge where the knower is treated as an enclosed vessel for sensory impressions, which become subsequently elaborated as thought. He argues that vision both reinforces this view and is typically elevated above the other senses because it affords a false impression of clear perspective and control, where we can turn on or shut out the world by simply opening and closing our eyes. In its place, he offers an account of knowing as an active process of opening the person to what is outside of themselves:

“I only really *live* outside of myself; outside of myself I think, meditate, know; outside of myself I receive what is given, enduringly; I invent outside of myself. Outside of myself, I exist, as does the world. Outside of my verbose flesh, I am on the side of the world. The ear knows this distance all too well. I can put it out the window, project it far away, hold it distant from my body” (2008: 94)

For Serres, knowing is the direct outcome of a sensuous engagement of our body with the world around us. To know is to become immersed or ‘mingled’ with the world, to be ‘outside’ of oneself. Hearing is emblematic of this immersion and of a non-Cartesian sensory relation to the world (see Brown, 2002; 2011). The localization and discrimination of sound operates differently to vision. In part this is because sound arises from the vibration and interaction of objects; their volume and movement is involved rather than simply their

surface (Gibson, 2015). Since sound is often transitory and sometimes unpredictable, we are exposed to it rather than able to seek distance. Hearing is also 'always on', even when we are asleep. Whilst we might be able to temporarily physically remove ourselves from the noise of the city, or the others around us, we are ultimately unable to escape the noises made by our own bodies, from the beats of the heart to the rhythms of inhalation and exhalation:

"I hear without clear frontiers, without divining an isolated source, hearing is better at integrating than analyzing, the ear knows how to lose track. By the ear, of course, I hear: temple, drum, pavilion, but also my entire body and whole of my skin. We are immersed in sound just as we are immersed in air and light, we are caught up willy-nilly in its hurly-burly." (Serres, 1995: 48)

Whilst hearing is more diffuse than the other senses, it nevertheless does involve sensory discrimination between meaningful information and noise. Serres (1982a) argues that this distinction is not a prior given, but rather emerges in the relationship between the hearer and the producer of sound. For example, in ordinary conversation, the meaning the speaker wishes to imbue in their utterance may not be received by the listener in the same way, who may in fact find the hesitations, redundancies and interruptions in speech to be of greater significance. Serres takes this to be a general model of all hearing, where the ongoing discrimination between meaning and noise depends on the evolving dynamics of the relationship of sound emitter and receiver. Knowing then proceeds from an immersion in the sensory, to a relational back and forth between sound producers and listeners, where the senses become gradually inculcated and attuned around a specific distribution of meaning and noise.

The organization of the sensory is, for Serres, central to all kinds of formal organization, from the biological to the social, in that it is the means through which an orientation to meaning and order is extracted from the wider world - 'the background noise is permanent, it

is the ground of the world, the backdrop of the universe, the background of being' (Serres, 1995: 62). However, there is a tension here. The senses require training and education as part of the work of organizing, but this leads to a progressive hardening and valorization of existing distributions of meaning and noise, such that a focus on clarity and precision are promoted over multiplicity and indeterminacy (see Serres, 1982b; 2017). However, this apparent sensory precision can become insensitive to the actual mixture of noise on which it depends and vulnerable to being subsumed within the broader 'noise of the world' from wherein it has emerged - a phenomenon that Dale & Burrell (2003) call the 'anesthetic'. As a corrective, Serres (1997) proposes a kind of continuous 're-instruction' or experimentation with different embodied techniques, akin to learning to write with a non-dominant hand. One must re-immense oneself in the world and learn to hear differently. The capacity to silence existing sounds, even albeit briefly, as a means to hear other meaningful sounds in the acoustic environment, is particularly important in this regard (see Serres, 2008: 85-90). In summary, Serres offers a model of sensory practices where 1) immersion in the 'noise' of the sensory field is the primary means of knowing and sense-making. From this immersion, 2) the organization of senses emerges, through practiced attunement and inculcation in particular sensory discrimination, which acts the basis for broader kinds of organizing. The risk however is that 3) these forms of attunement will come to occlude other other kinds of sensory engagement, resulting in 4) the need to find practical alternative ways to re-instruct the senses which allow them to become open to other forms of meaning and order. With this model serving as our basis of our approach to acoustic communities and their relation to their environment, we will now describe the particular concerns sound raises in psychiatric hospital settings.

The Acoustic Environment of the Psychiatric Hospital

Psychiatric hospitals are noisy and sometimes unsettling places in which to find oneself immersed. The acoustic environment of an inpatient psychiatric hospital setting has a wide range of effects on the persons who work or are cared within it (Summers & Happell, 2003; Holmberg & Coon, 1999). Wards are intended to be spaces of care, where staff can support patients in their recovery, and where patients in turn can seek understanding and come to terms with their current mental health. But many are also secure spaces, where the reduction of risk is paramount. A ubiquitous institutional culture of risk management, which seeks to balance safety, security and therapy is reflected in the design of the space (Curtis et al, 2013). This is particular exacerbated in secure forensic psychiatric care, such as that provided at Sharp Hill, where patients have both an 'index offence' (i.e. a criminal conviction or charge) and a mental health diagnosis, that have jointly resulted in their detention under a specific section of the Mental Health Act (i.e. 'sectioned').

Levels of background noise or 'unwanted sound' on the ward are the biggest single acoustic environmental concern (Holmberg & Coon, 1999). Many secure psychiatric units adopt the common feature of long corridors converging on a central open area (a 'cruciform' design) in order to maintain clear sightlines. This creates a highly reverberate space which can exacerbate perceptual distortions experienced during distress amongst some service users (Karlin & Zeiss, 2006). Long corridors are particularly problematic at nighttime, during which time staff conduct regular checks on patients within their bedrooms positioned down the length of the corridor, because of the magnification of perceived sound.

Patients and staff are not simply immersed in the soundscape of the hospital, they are also, to some extent, held 'captive' within it. Tom Rice's (2013) ethnographic work in general hospitals shows how the acoustic environment is composed of a wide range of unusual and uncontrollable noises, from the banging metal lids of pedal bins placed on wards for the disposal of rubber gloves to the unpredictable vocal exclamations of fellow patients and staff.

Efforts to create a visual sense of privacy, such as screens, do little to block these sonic intrusions – ‘sound is no respecter of the privacy curtain’ (Rice, 2013: 41). Attempts at blocking out noise through the use of headphones or imagining more pleasant associations for sounds are rarely successful. Whilst it may be possible to become ‘habituated’ to various routine sounds, disruptions such as nurses talking loudly at nighttime or early morning are felt particularly acutely as signs of an authoritarian presence.

Nurses and other psychiatric ward staff become attuned to the soundscape in different ways to patients. Their ear-work is primarily concerned with distinguishing acoustic signs of distress, potential aggressive behaviour or inappropriate conduct (e.g. sexual activity, self harm). There is also an explicit concern with the collective mood of patients. This is typically subsumed within the idea of a general ward ‘climate’ or ‘atmosphere’ (Moos, 1968), expressed as patient and staff perceptions of safety, therapeutic gain, responsiveness to needs etc. However, in practice, many staff describe ward atmosphere as a highly variable collective emotional tone, ranging from ‘settled’ to ‘unsettled’, which is usually ‘felt’ by experienced staff members rather than formally assessed. Ward atmosphere is not localized in any one particular aspect of the environment, but is continuously shifting in character, like variations in the weather (see Kanyeredzi et al, 2019). Staff seek to acoustically attune to and anticipate changes in the atmosphere whilst they are engaged in routine tasks.

Kaulingfreks (2011) notes that such practices of managing and engaging with the organizational acoustic environment parallel the forms of visual surveillance that characterize the well-known Foucauldian conception of ‘panopticism’ – ‘one could rewrite Foucault’s famous work on discipline from an acoustic point of view’ (p.46). In fact, as Markus (1993) notes, Jeremy Bentham had included ‘listening tubes’ to ensure one-way auditory surveillance within one draft of his famous designs for the Panopticon prison. Rice (2013) proposes the term ‘panauralism’ to describe how control of the hospital space is maintained

through the listening practices of staff. Since the design of modern psychiatric wards – which include individual patient bedrooms – makes complete visual surveillance impossible, the auditory is drawn upon to accomplish a ‘psycho-sonic management’ (cf. Corbett, 2003) of hospital space. Ward staff engage in ear-work practices to anticipate and detect patient behaviours that they judge to require intervention and control. However, panauralism is to some extent reversible, in that staff members are themselves surveilled by patients, who listen in to conversations within ward teams.

The possibility that panauralism, as the dominant regime of ordering the auditory, can be contested, by turning surveillance back on itself, indicates that those who are subject to acoustic discipline are not entirely powerless. Brandon LaBelle (2018) formulates the notion of ‘sonic agency’ to refer to processes of resistance and emancipation enacted through sound. Sonic agency is a form of ‘critical listening’ or ‘listening from below’, where hearers attempt to develop a ‘different sensibility’ to their acoustic environment. For LaBelle, sound is ‘inherently relational’, in that it is a ‘medium enabling animate contact that, in oscillating and vibrating over and through all types of bodies and things, produces complex ecologies of matter and energy, subject and object’ (2018: 7). The relational nature of sound means that to speak is always to render oneself visible, and hence a potential object of acoustic discipline. But there are sounds that come from outside any given acoustic environment, which appear initially as noise. These ‘sounds without a visible source’ can provide the basis for a collective critical listening, allowing listeners to become open to meanings and forms of community that come from the outside. There is resonance here with Serres’ notion of ‘re-instructing’ the senses by turning that noise which has been excluded into a source of new meaning, and potential form of organizing.

As we will demonstrate, there are overt conflicts between and within patients and staff on forensic psychiatric wards that take the form of attempts to dominate the acoustic

environment. There is also a continuous alternation between meaning and noise, of the kind suggested by Serres, as ward atmosphere fluctuates. Ward staff are obliged to maintain a regime of acoustic discipline, even though they inevitably become enmeshed within it. But there are also possibilities for the emergence of sonic agency, where patients can come to identify with acoustic communities outside of the hospital. In this way, sound can allow for the experience of being somewhere else, whilst remaining within secure care. As Serres claims, 'the ear knows how to lose track'. In what follows we will provide empirical illustrations of the ways in which sound defines these relations between staff and patients on the ward, after a discussion of the methods used in data collection.

Context and Method

The qualitative material analysed here was collected as part of a broader project with 40 staff and patients on a medium-secure forensic mental health unit ('Sharphill') in a large city in the South of the UK. The wider aim of the study was to examine the relationship between the organizational space of the unit and experiences of distress and recovery amongst patients (we refer to 'patients' throughout because it is technically correct in this instance but would usually prefer the term 'mental health service users'). The unit is located in a large well-established hospital site, which includes a number of other locked wards, and low-secure pre-discharge wards, along with a range of other mental health services. Sharphill is a facility within the forensic pathway of the hospital that was recently purpose built to accommodate the specific needs of forensic patients and staff ('Sharphill' and all participant names throughout are pseudonyms).

All interviews were conducted either on the wards or within administrative spaces of the unit, providing the research team with extended opportunities to both observe and experience the sensory environment of Sharphill, which were captured as fieldnotes. All of the interviews were digitally recorded and transcribed verbatim. The research team collectively coded and

analysed the data, using the overarching research question of the relationship between specific forms of experience and the design of the organizational space as central concern. Subsequent iterative re-organization of the data into themes surfaced 'sound' as a key sensory issues that was shared across both staff and patient interviews. The analysis presented here incorporates our reflexive experience of ward space and numerous presentations and discussions of the data with mental health clinical and care staff, the Design and Mental Health Network and at Continuing Professional Development sessions at other hospitals. The patient interviews were conducted using a photo-production visual methodology (see Reavey & Johnson, 2017) that involved discussion of their experiences of living in detention within the hospital, whilst referring to photographs they had produced themselves of their everyday lives in hospital. Adopting this methodology was a way of enabling participant 'voice' within the research process by providing the means 'show' some of the aspects of their experience of ward life (see Warren, 2002). The value of this was confirmed by the majority of participants requesting an individual album of printed copies of the photographs they had taken following the interviews. At a pragmatic level, by providing a common visual point of reference it also mitigated against the some of the issues around sustaining conversation that are experienced by persons on high levels of psychoactive medication. Producing and subsequently discussing images encouraged participants to bring into focus aspects of the sensory environment in which they were immersed which might have been difficult to otherwise express (see Reavey et al, 2019). Warren (2012) describes the 'iconographic' function of images as a lure for subjective experience. Whilst this method was not able to directly address auditory experience (or indeed, other kinds of non-visual sensory experience), the multi-modal approach was successful in engaging participants in self-description of sensory experiences of the ward and hospital space. Given the interdependent nature of sensory experience, the invitation to discuss the self-produced images led

participants into a wide-ranging consideration of other senses. For example, a discussion of an image of an armchair led rapidly into description of the feel of the chair, what could be heard when sat in it, the noises of the ward etc. Moreover, conducting the interviews in situ on the ward provided participants with immediate reference points to elaborate and expand upon their sensory experiences.

Findings: Organising Care and Security through Sound

Immersion in the Soundscape

Sharphill is set within the grounds of a large hospital complex. Approached from the access road, the initial impression is of a carceral space. The building is encircled with a high security fence and gates. Entry is through a series of airlock doors, following a lengthy signing in process. For many patients, arriving from the prison estate, the unit is marked with familiar signifiers of detention, from omnipresent CCTV cameras to flat, compact architectural design. However, during the design process for this recently built unit, significant efforts were made to address this issue. As one senior member of staff puts it 'we've tried really hard to soften that prison element and to keep that as far as we can in the background and to blend that in, you know' (Elizabeth, Nurse Manager). These efforts include grouping many administrative functions within a separate block positioned as a de facto wall around the wards, and painting the security fence green so that it blends into the tree lined background. Wards also feature large open communal spaces, where possible, rather than tightly demarcated public areas.

Organizing the sensory is here key to balancing the provision of a therapeutic atmosphere with the management of risk, achieved through a secure space of detention or 'technical security' (see Curtis et al, 2013). This has primarily been accomplished by attempting to manage the visual experience of the unit. By contrast, the acoustic environment has offered a greater challenge. The legal requirements for secure care mandate the use of heavy, fire

resistant doors with few internal windows, arranged to create controlled areas with an extensive locking system. The way this was implemented in the design process has been one of the principal complaints about the build of Sharphill since opening:

“It's door after door after door after door after door, you know, and they all have to be unlocked and locked, unless, of course, it's got on it 'this door is always unlocked', or some of them are only locked at certain times, you know ... I get lost coming in here. It's a pain with the locks. Yeah. I think the staff have complained about it since the day it opened.” (Bernard, Technical Supervisor)

Whilst there are alternative systems available, the locks at Sharphill are, for the most part, traditional mechanical cylinders, which require staff to carry large bunches of keys attached to their clothing. These keys create continuous rhythmic jangling as ward staff move through the unit. Drawing on Brown et al's (2015) terminology, we note that two of the key 'archetypal sounds' of the ward are the ceaseless noise of keys and the thump of airlock doors opening and closing, inevitably lending the unit the feel of a custodial environment. This is further exacerbated by the use of high ceilings throughout Sharphill. The design process sought to emphasise the therapeutic by creating a sensory experience of relative freedom of movement, and of connection with the outside world (on the importance of this in mental health care, see Reavey & Harding, 2019). This 'airy' atmosphere was intended to mitigate the sense of containment that accompanies detention and maximize the amount of external light coming into the building through high (but inaccessible) windows. However, the acoustic properties of the materials used in the build, coupled with the echoic tendency of large open spaces, have had the result of excessive noise generation on the wards:

“This ward is very big. If someone shouts, you hear it everywhere. So it's very tight, the building, yeah? It's airy and it's spacey but it's not as cosy as it – as it could be I mean, and you know, it doesn't feel like a community, or feel like a home, yeah? And it's really hard

sometimes to talk when someone shouts, so in a way I think that's not very nice in terms of the space here." (Helen, Occupational Therapist)

The sensorial organization of the unit to make it *look* and *feel* less like a prison has had the result of making it *sound* more like a prison. The balancing act between care and security has become complicated through the unmanageability of sound, such that the overall levels of noise can significantly shape the atmosphere on the ward – the ongoing co-production of collective feelings and sense of what is happening. As Serres describes, the relationship between meaning and noise is variable and dependent on the perspective of the listener. A sudden shout can be just part of the background noise of the ward, or it may be an indication of distress or of escalating aggression and violence. Through their ear-work, staff discern at a not entirely conscious level whether the sound is potentially meaningful or not, and thus worthy of their proper attention and response:

"If there's an argument in the dining area which is often, you know, a place where there will be an argument, with all the patients coming together in that one space at the same time and, you know, if somebody says no I didn't want this, I didn't order that, this food is disgusting or whatever they might say, it's kind of hard to avoid experiencing that, so, you know, within that space everybody is affected by that argument or the outburst. So, those are downsides to having this really loose boundary around the shared space ... But, yeah, we have to manage those sometimes very difficult situations that can, that can kind of, spill out into the whole space and affect everyone." (Elizabeth, Nurse Manager)

As Elizabeth observes, meal times are a common flashpoint, where the inability to contain noise results in rapid escalation, with the entire ward being drawn into the conflict. Patients also point to televisions situated in common areas as problematic – "in the big telly room there's a lot of people here that are argumentative and stuff like that really. Um, just sitting there arguing and stuff like that" (Peter, patient). On some wards, patients are allowed to

have small televisions in their bedroom. But as a medium secure unit with more stringent risk management over what personal possessions patients can keep in their rooms, many have to share the communal television. This can facilitate the kind of collective listening that LaBelle (2018) sees as underpinning sonic agency, by fostering positive relationships through shared pleasure in music or joint ownership in programming the acoustic environment – “We sit down, there’s a TV, flat screen TV in there. We can put it on the music channel, music videos. Beyoncé and Jay-Z and all of the music what’s going on, videos, it’s them singing it. Or you can watch the news” (Vincent, patient). But when there are disagreements, the atmosphere can shift dramatically. One nurse provided an account of how a newly admitted patient managed to rapidly ‘unsettle’ the ward atmosphere by ‘taking control’ of the communal television, insisting that it be tuned to the news channel Al-Jazeera. Having the technical means to dominate the acoustic environment allowed a single patient to transform a source of meaningful sound into noise for their fellow patients, and to use that shift as a means to territorialise the ward space – “and I can tell you one person can change a ward” (Claire, Nurse). Conflicts around control of sound can escalate as staff members become drawn into a struggle to maintain order and ‘calm’ on the ward:

“Over a period of one month, they’ve smashed four of their tellies [televisions]. So if you are well on that ward, how are you expected to cope? There are some who can’t do with a telly because their mind is telling them that their telly has been abusive to them. So you keep smashing the telly. And someone who wants to watch the World Cup and he can’t have a telly in his room—oh, so, they’re not allowed.” (Claire, Nurse)

One apparent solution to this issue of rapidly changing atmosphere would be for staff to be routinely present and available to patients within the large open areas. In fact, the wards at Sharpshill were designed with ‘half moon desks’ centrally placed, where it was envisaged that staff would spend a proportion of their shift engaged in spontaneous interaction with patients.

This was intended to facilitate an atmosphere where patients could feel that they would be listened to, that staff would be continuously present to address their needs. However the structure of care delivery on the unit and associated staffing patterns make this unworkable. Staff typically operate in an ‘anticipatory’ mode where they may be reassigned to any number of tasks as their shift progresses. Moreover, being readily available to patients places staff in the position of being seen to be responsive to a range of requests that are not immediately manageable. This amounts an immersion in the acoustic environment without the means to properly attend to and respond to any of the simultaneous sources of sound. Given this, it is unsurprising that most staff formed the view that spending undirected time in the communal areas would actually worsen the atmosphere, since it proves frustrating to both patients and themselves:

“So I try not to go onto the ward just for the sake of going. It has to be meaningful going, like I’ve already got an appointment with the patient, or, I’ve got certain things to address. Otherwise you’re just going to be bombarded with so many different requests. “Oh, have you done that yet? Have you got my referral in yet?” And all that kind of stuff. So it’s quite tasking when I go on the ward.” (Josephine, Social Worker)

Professional Hearing and Cultivated Attunement

As medical and social work professionals, staff at Sharpill are trained in a range of formal techniques for listening and responding to patients, such as the use of verbal cues and prompts to ‘de-escalate’ potential aggression. These techniques constitute forms of ‘professional hearing’ that are taught during induction to ward work. But there are also a number of other ‘listening habits’ (cf. Brown et al, 2015) that are part of the ear-work performed by staff. These habits are not formally trained, but arise from a cultivation of audition that is gradually developed through informal socialization. They involve modes of

attunement to the acoustic environment that provide fine-grained sensory discrimination. In the following long extract, a Senior Nurse describes how this practiced sensibility operates: “And we had a particularly difficult day up there, um, I’d run to the alarms in the morning, first thing, and I think I’d been there all morning. And it was one incident after the other, and then we’d gone to another ward and then come back, so it was like a really busy day. There was lots of different patients who were really unsettled. And, you know, I think people had been hurt as well, there’d been injuries and stuff. And I walked back eventually at about two o’clock or something and I come into this part and I walk past the staff room and there must have been about twelve members of staff. I think they were all occupational therapists or psychologists, you know, sort of the therapy staff who had their offices based down here. And they were all having lunch together. Somebody had been to the chip shop so they all had these nice lunches. They’re all sitting down and having a chat and, you know. And I’d been in Helmand Province for, you know, there was a load of really stressed out people up there and the alarms had been going, people had been hurt, it was a really bad day. And it hadn’t affected this part of the building at all.” (Robert, Senior Nurse)

Here, Robert describes a particularly challenging day. Alarms, which usually signal some form of trouble on a ward, are another ‘archetypical noise’ commonly heard at Sharphill. For staff, they are also a ‘sound signal’ indicating the necessity of a response. On the day in question, Robert had been responding ‘all morning’ to alarms, immersed in the possibilities of what he might encounter as he raced between wards from ‘one incident to another’. This demonstrates a high level of attunement to the acoustic environment, a developed sensibility or ‘feel’ for what might happen next. But as the story progresses, Robert described passing a group of staff who appearing completely detached from what has been happening. He contrasts their ‘nice lunch’ and ‘chat’ to his feeling of being in an institutional ‘war zone’

("I'd been in Helmand Province"). Unlike Robert, these therapy staff are 'tuned out' from the volatile affective atmosphere of the wards and have no sense of what is actually 'going on'. The design of Sharphill involved co-locating administrative functions in one part of the building to form a non-carceral seeming extra wall around the wards. But this has had the unintended consequence that a proportion of the staff are unable to readily hear alarms sounding in the most distant parts of the unit. The built environment itself blocks the spread of 'sound summons' across Sharphill. Robert describes this problem succinctly with the phrase "stress doesn't flow well around the building". What he means by this is that the acoustic environment effectively 'bottles' trouble and distress in particular parts of the building because sound signals cannot travel far enough, with the result that some staff are highly attuned to the acoustic environment, whilst others are blissfully un-attuned.

Robert's story exemplifies Serres' sensorial epistemology. To know is to be immersed within the 'noise of the world', and to develop the means to orient to what is meaningful within it. By contrast, Robert frames detachment from the noise as a failure to grasp how the unit actually works and what patients really need, which is an accountable matter. Hearing is then both an epistemic and ethical practice. As Rice (2013) points out, hospital nurses tend in general not to like near-silence on a ward, because it usually indicates that patients are deliberately trying not to be noticed (and therefore arouses suspicions as to what patients may be seeking to do in private). The optimal level of noise on a ward is one where staff can reassure themselves that nothing out of the ordinary is happening as well as being able to be attuned to the possibility of emerging sound signals. One key moment where this becomes particularly important is on initially entering a ward. The heavy doors and airlock system at Sharphill mean that very little sound travels beyond the ward. All of the entrance doors to wards open onto a corridor linked to the main communal area. Staff enter into an unknown situation when they open the door, with the additional possibility that a patient may be

waiting on the immediate other side. Most experienced staff learn the technique of holding the main door ajar briefly and momentarily listening to gauge the atmosphere on the ward before properly entering. Key indicators are if the ward appears to be either ‘too noisy’, or perhaps even worse, ‘too quiet’. However, this strategy for becoming attuned to the affective atmosphere has become problematized within the build of Sharphill. The materials chosen for the walls of the corridor have very poor acoustic properties, such that sound tends to be reflected in ways that make it difficult to localize. The building itself then ‘dis-attunes’ staff from what they are walking into – it disrupts the exercise of this key listening habit.

Panopticism and Panauralism

The technique of listening at the door and responding to alarms are both instances of a broader regime of monitoring and surveillance by staff accomplished through attunement to the acoustic environment. Rice (2013: 24) coins the phrase ‘panauralism’ to refer to the ‘acoustic surveillance’ performed by nurses as a ‘reinforcement or complement to visual surveillance’ (i.e. ‘panopticism’). At Sharphill, both auditory and visual monitoring are deployed. The ward design is structured around clear lines of sight, allowing nurses to observe the vast majority of the common areas from the central area. In fact, one senior member of nursing staff who was involved in the design process baldly stated that “what we wanted was to build a panopticon”. However, as described earlier, staff tend not to sit at the centrally placed half-moon desks because they will be continuously approached by patients with requests and spend time instead in the nursing station – a small office with windows onto the ward – positioned behind the desk. Auditory monitoring then becomes a necessity due to the impracticality of maintaining continuous visual monitoring whilst working in the locked station:

“But you’re behind a door and they’re knocking; you’re not gonna ignore them, so you – you get disturbed a lot there. And what might take you ten minutes to do, ends up taking you

probably about twenty minutes to half an hour because of those constant – they can be constant – interruptions. And obviously if you're hearing things going on, you're not just gonna sit in a room and just ignore it all cos you – potentially your colleagues are – are at risk or in danger, so that's the thing.” (Patricia, Ward Manager)

In the classic Foucauldian (1977) formulation, panopticism is a one-way process – the surveilled cannot turn their gaze back on those who monitor them. But the spatial design of the ward means that there is a certain degree of reversibility to the regime of auditory surveillance. Staff are continuously interrupted by both patients and by one another.

Anecdotally, practically every interview we conducted with staff at Sharphill was interrupted either by an urgent telephone call, a summons from another member of staff or by an alarm sounding. More significantly, patients actively monitor conversations between staff, especially when they are within the nursing station:

“Most nursing stations are like fishbowls, and once you're in there, er, there – you haven't got any privacy so you even though you're behind those doors, behind that glass, you do have to be very aware of what you're discussing and what you're saying. And sometimes I think because you – you've crossed that threshold, you think, “Oh right. This is a non-patient area” so you can discuss, you know, confidential things, but you still have to be mindful that the patients do tend to congregate outside and sort of stare through the windows and stand outside the doors, and things like that.” (Patricia, Ward Manager)

Despite the aim to ‘build a panopticon’, the nursing station does not really resemble the infamous darkened central observation point of Bentham's design. Staff may be able to maintain lines of sight across the ward, but their conversations with one another and on the telephone can be closely surveilled by patients gathered outside the station. Whilst staff may sometimes feel that they are removed from the ward as a consequence of the physical barrier of the locked door, patients are continuously monitoring what they say and do within the

station. As well as monitoring staff, some patients will actively monitor one another. One patient, Leon, described conflicts with staff arising from his blocking of the eye-hole on his bedroom door because of his discomfort at being observed, particularly at night. However, his principal issue was not with staff performing their mandatory checks, but rather with other patients looking in. His preference would be for staff to knock on the door and enter at set times, because he is able to distinguish 'staff knocks' from 'patient knocks'. In this way, the patient would be able to use his own listening habits as a means of avoiding surveillance by other patients:

"I know they have to check, but they should check maybe every hour, they knock on the door firm so you know it's staff not a patient. The rest is confusing, you see, I block it up, I don't know if it's a patient or a staff. But staff should make it clear when they're doing their checks, say it is them, so you can take it down, acknowledge them and then put it back."

(Leon, Patient)

Panauralism is not entirely successful as a form of 'psychosonic management'. It serves to provoke patients into cultivating their own capacity for sensorial attunement, where surveillance is met with counter-surveillance. Monitoring the sounds of the ward provides a means for both staff and patients to position themselves in relation to one another. The inescapable nature of sound remarked upon by Serres - the inability to shut out noise, even at nighttime - means that life on the unit is predominantly lived in an anticipatory mode, listening out for what may be about to happen.

Sonic Agency and Silence

Sound is central to how patients experience current detention in forensic psychiatric care and their future prospects:

"Um, in terms of the design of the wards, like, it looks like a prison, like you can't come out of. And the doors are double locked. I came to the assumption one day, it was just a thought,

like I was living in hell, you know, because there's so many doors, so many keys that the nurses carry around that they have to open and then it's like you get the sense that am I imprisoned here forever, for life?" (Christopher, patient)

The archetypal sounds of banging doors and clinking keys are deeply threaded into how this patient is attuned to the ward setting. His inability to block out these sounds, coupled with the indeterminacy of length of his detainment under a section, creates a feeling of 'living in hell'. Whilst this is at the extreme end of the views expressed about Sharphill, many patients compared the experience of secure hospital care unfavorably to that of being within the prison estate. One of the key issues was the difficulty of finding respite from the overall soundscape, of finding a way for the ear to 'lose track' within the acoustic environment. Finding a quiet place, whether in a private bedroom or elsewhere in the unit, was highly valued:

Christopher: Yeah. Well that's where I sleep. That's—Sort of away from everyone else. Yes, for quietness. Yeah. Sit on my bed, or lie on my bed.

Interviewer: And is it important to be quiet here?

Christopher: All the time - basically there's times when I don't want to come back to hospital any more. I'm not gonna do any silly thing to be in hospital any more.

On most wards in Sharphill, patients are free to spend time in their bedroom as they choose, and are able to close (and in some cases lock) their door. Whilst, in general, patients are encouraged not to isolate themselves too much, bedrooms can act as private spaces of retreat. Quietness is not equivalent to silence, which is often considered to be as problematic as uncontrollable noise for many patients. This is notably the case for patients who hear voices. Their experience of the ward differs in that there is an additional source of sound that is not heard by other people. Hearing voices is a multifaceted phenomenon (see Romme et al, 2009), which need not necessarily be distressing for the individual concerned. However,

many patients can feel that they need to be able to control their immediate acoustic environment in order to effectively manage their voice hearing:

“When I, when I don’t feel right and I – when I start hearing voices. And getting stressed out with the voices and stuff. I lock myself away in my room. Which I can lock the – lock the door. The only people what can come into your room is yourself.” (Lisa, patient)

For patients such as Lisa, there are ongoing acoustical relationships which are not immediately observable to other people and but which nevertheless form part of their particular sensory experience of the ward. Lisa is part of a complex acoustic community, where several of the speakers and listeners who are members are ‘within her’. Being able to withdraw from the shared communal areas allows Lisa to manage the relationships she has with her voices. Patients who hear voices then have very particular positions with regard to what constitutes signal and noise. For example, the clustering of administrative functions in one part of the building creates the potential for the sounds emanating from that space to take on a particular significance for some patients:

“To be honest with you they’re sort of isolated from the rest of the hospital. Because as you come down the corridor here you’ve got the first unit and then you’ve got to go through the Healing Garden to get to the main part of the hospital. And that’s where all the admin is and the offices are, and you hear people talking, you don’t know – you’re not sure if they’re talking about you or not. And then if you say anything untowards [clears throat] they might take offence.” (Leon, patient)

As we heard in Robert’s story of his ‘really bad day’, there are parts of Sharphill that seem isolated from the main acoustic environment, and which have been designed to blend into the background. But for Leon, the admin block is a continuous emitter of troubling sonic signals. He is highly tuned into the fleeting words he hears as he walks nearby. As Serres (1995) argues, we are differentially disposed towards background noise, depending on how we have

come to be attuned. Patient's acoustical histories, the sounds that have become meaningful for them in the past, are critical. For example, the sound of bedroom door being opened at night by a member of staff making a routine check can have enormous emotional significance for a patient with a history of childhood sexual abuse. Whilst staff are demonstrably sensitive to issues of prior abuse and towards voice hearing experience, there is a tendency to assume that directing patients towards 'calm spaces' that are either quiet or provide 'relaxing music' will be of itself beneficial:

"sometimes somebody gets aroused and you're moving somebody from a particular area and probably he doesn't want to go to his room, so you are telling him, 'Go in the quiet room and there's music there.' Those are the things that help." (Scott, Team Leader)

Physical separation from the sounds of ward is certainly necessary, but it is not sufficient grounds to accomplish a detachment from the acoustic atmosphere. Silence of the kind described by Serres and LaBelle is difficult to accomplish. Patients can neither find a place on the ward that is truly silent, nor can they themselves refuse to make noise, because this will be taken as evidence of a worsening of their mental health by staff. Given the difficulty of accomplishing near-complete silence, the alternative is to create 'micro-soundscapes' within the ward. This can be done through the use of broadcast or recorded sound:

"Um, and I mean this is a space where I like to just kind of just – I have music and I have my TV and I have things that I get pleasure from. But it's also my home. Um, and outside of my room is my work area and my room for me is my home, represents my home. So there's my nine to five and when I go home I just like to do some of the things that I enjoy doing to relax. Um, but it's my little space." (Derek, patient)

Music enables Derek to demarcate his bedroom from the ward, and to further establish a distinction between 'home' and 'work' as separable micro-soundscapes, with different qualities. There is modest body of literature on the use of music and televisions in secure

settings that adds to our understanding of these kinds of practices. Music can be deployed territorially to project a private space outward into public space (e.g. by playing aggressive sounding music at loud volume) (Rice, 2016), or alternatively simply as a marker of cultural distinction (Baade, 2016). The use of televisions in prison also has been described as a means of normalizing the confinement of prisoners of cells for prolonged parts of the day (Knight, 2016). However music may also enable a kind of ‘detuning’ or ‘restructuring’ of the senses that provides a way out of the closed acoustic atmosphere of the ward. Here Vincent describes the pleasures of listening to his radio in his bedroom:

“That’s my radio there. So when I put it on, when the news comes on, I listen to what’s going on. So it’s a way to keep contact, keep up with things what’s going on outside ... I’m no longer a DJ, but used to be when I was younger. Now I’ll be enjoying the music in the crowd, instead of having to worry about what goes on next or what to play next. I worry about it because some of these DJs, some of the music is crap. Some of it’s good. But I just listen to it because it’s reggae and I like reggae ... but there’s three stations. There’s City Lock 89.60. There’s Genesis 91.60. FM 90.40. I need to support them because some of it’s alright, but I like reggae music. I like the seventies and the eighties. Those are the times when things was alright, apart from when the riots happened, everything was running smoothly, apart from the stop and search, and things like that going on and everything like that. Then you wouldn’t have to worry about police, even though they would still arrest you but you wouldn’t have to worry so much.” (Vincent, patient)

By tuning into reggae music stations, Vincent is able to connect to an acoustic community outside of the unit. By imaginatively placing himself in the position of a member of the crowd, he sees himself as able to provide support and guidance to the DJs. This ‘critical listening’, as LaBelle calls it, or opening up to fluctuations in sound, also allows Vincent to connect to past acoustic communities, and to renew a relationship to his own acoustical

history. Music is a way out of the hospital, and indeed a way out the present moment, to some extent. In a manner not dissimilar to the hairdressers in Harriet Shortt's (2013) study, exposing oneself to a different sound source becomes a way of 'tuning out' the demands of the present. The relationship of panauralism to panopticism suggests that the means of resisting psychosonic management would be to avoid 'being heard' in the same way that minimizing 'being seen' interrupts visual surveillance. But sonic agency here involves counterposing one acoustic order to another, finding a means of transport outside of the immediate acoustic environment whilst simultaneously remaining in the same space. Whilst Vincent cannot see far beyond the walls of Sharphill, he can travel, through sound, across time and space to very distant places and communities. A closed institution becomes permeable (see Tucker et al, 2019).

Discussion

We have followed Serres (1982a; 1995) in arguing that the organization of a field of potential sensorial experiences, in which members of an acoustic community are socialized into practices of discriminating distributions of meaningful sound and noise, is at the core of what we know as formal organization. As Riach & Warren (2015) and Shortt (2013) have demonstrated, the 'tuning in' of a particular sensory practice to an organizational environment occurs in all forms of work, not simply those that clearly involve a professional training of one or more senses. In fact, Serres (2008) argues that the very division of the senses into discrete, separate modalities – what Dale (2001) calls the 'anatomical' dissection of the senses – is an outcome of organizational processes, rather than a prior given. If this is so, then it becomes crucial to understand how the shaping of this sensorial field and its subsequent division into distinct regimes of visibility, audibility, tactility, olfaction and gustation grounds subsequent organizational and work practices. Robert Cooper (1989) once

eloquently referred to this analytic distinction as that of the ‘labour of division’ that precedes a ‘division of labour’.

Our focus has been on sound and listening practices. We recognize that the experiences of working at, being detained on or merely visiting Sharphill are multi-sensorial (taste and food, for example, are incredibly important issues on these kinds of wards – see Brown et al, 2019). There is something of the kinesthetic in vision, reverberation in taste and visual cues in olfaction. Despite the demands of particular settings, organizational life is, in principle, synthaesthetic. Nevertheless sound and hearing provide a very particular route into Sharphill because they raise fundamental ontological questions that can be occluded when vision is the default mode of analysis. Tim Ingold (2011) proposes that the inescapably immersive nature of sound troubles the idea of a person who is clearly located ‘in’ a soundscape. Instead he suggests that we consider that ‘sound, like breath, is experienced as a movement of coming and going, inspiration and expiration. If that is so, then we should say of the body, as it sings, hums, whistles or speaks, that it is *ensounded*’ (p.139). We see this as an apt description of how staff and patients experience ward space – the changes in the acoustic environment fill their bodies in way akin to climatic or atmospheric changes (see also Kanyeredzi et al, 2019). Becoming attuned to the space is an opening up (or closing down) in relation to these fluctuations that scrambles any absolute distinction between person and setting. Sound then provokes us to question the status of the perceiving subject in relation to organizational life. How do we become members through an ‘ensounding’ of the acoustic field? How might we recognize one another through our mutual envelopment in sound?

Approaching an institution from the perspective of sound reveals very different aspects. Sharphill looks like a ‘total institution’, a place of detention and formal administration, where power relations are arranged to ensure a separation of staff and patients. But as we have shown, exploring the ‘sounds of the unit’ leads us towards a different account of the

institution. Despite the best efforts to design a space where carceral features are softened, Sharphill sounds like a prison. But with a crucial difference that it is not absolutely clear who is actually being ‘held captive’ to the greater extent by the acoustic environment. Whilst patients cannot readily leave the unit, their daily movements are far less controlled than that of staff, who spend the majority of their time retreating to the nursing station to avoid being interrupted. The institution routinely summons staff through telephones, radios and alarms, keeping them in a perpetual anticipatory mode. To some extent, the relations of power realised through the management of this acoustic environment are reversible and non-localised. Much like sound itself, power relations are not concentrated in a single site, but rather become diffuse and inchoate as they permeate throughout the institution.

Moving beyond the immediate setting, the concepts we have grouped and refined in this article – ‘immersion in the acoustic environment’, ‘ear-work’, ‘panauralism’, ‘sonic agency’ – provide an analytic basis for the further development of ‘acoustic organizational research’.

The acoustic environment, defined as the reach of meaningful sound within an organized setting, constitutes a specific field of empirical enquiry. Mapping the limits and thresholds of this field, and exploring the ways in which it is demarcated, as we have done in the case of Sharphill, can begin to unravel a level of ongoing sensorial organizing that undercuts formal social relations and the material division of labour. Since sound is inherently uncontainable, it overflows formal boundaries, creating zones of resonance that are experienced as tensions, problems and dilemmas (e.g. sounds which may be potential ‘summons’, sounds that act as invasive noise, sounds which are meaningful but ‘unwanted’). These zones may prove to be particularly important in understanding the lived experience of organizational life. There are strong links here with the emerging work in the ‘new phenomenology’ or ‘atmospheres’ of organizations (e.g. Julmi, 2017; Böhme, 2017; Borch, 2009; Brown et al, 2019).

As we have shown in the experiences of staff and patients at Sharphill, the relationship between meaningful sound and noise is provisional and reversible. Whilst there is an existing literature on the acquisition of formal listening skills, or ‘professional hearing’ (Rice, 2013; Mody, 2005; Ashmore et al, 2004), what is needed is greater depth of understanding of the informal, cultivated sensibilities of hearing that are required for organizational membership. Of particular importance here is the ways in which becoming a member is intertwined with unstructured socialization into specific regimes of sound and noise, how ‘ear-work’ is refined and culturally transmitted between generations of professionals, and how the relationship between formal and informal listening practices is legislated in a particular setting (i.e. the extent to which one can be held accountable for not hearing or not responding to a given sound).

Foucault’s (1977) notion of ‘panopticism’ has clearly had a significant impact on how Management and Organization scholars have posed questions around power for some time now, despite the widespread problematisation and reframing of this figure of thought elsewhere (e.g. Lyon, 2006). Rewriting this approach in the way that Kaulingfreks (2011) proposes does not simply add the auditory to visual surveillance (see Styhre, 2008). Because of the very different physical properties of sound transmission, hearing involves a more intense relationship to the source of sound, which disrupts the division between ‘hearing’ and ‘being heard’. Sound connects us to one another at an embodied level that is difficult to either ignore or evade. On one level, there is a clear empirical programme to be realized which explores psychosonic management, including practices such as surveilling and recording talk, enforcing silence or otherwise restricting sound in the acoustic environment, and using noise and sound as an organizational marker or barrier. But more broadly, there is a conceptual challenge here to re-imagine an approach to relations of power that takes the potential reversibility of panauralism as its root metaphor. What happen to the capillaries of power

when they are immersed in noise, subject to the reverberations of fluctuating and unlocalisable sound?

Part of this renewed approach to power would doubtless be a greater concern for how sound informs strategies for creating different kinds of acoustic communities and for drawing upon meanings and relations from ‘outside’ of a given setting. As LaBelle proposes ‘sound teaches us to be weak, and how to use that weakness as a position of strength’ (2018: 20). In empirical terms, this might mean exploring techniques where persons isolate themselves from the acoustic environment (e.g. wearing headphones and listening to music whilst navigating public and organizational space; training oneself to habituate to or perceptually ‘tune out’ from particular sound sources; adopting silence as a strategy of refusing sound summons), along with analysing their intended and unintended consequences. But LaBelle and Serres also point towards a more challenging conception of ‘listening from below’ or letting ‘the ear lose track’. This experimental form of listening involves attempts to turn background noise into meaning. To explore this might mean adopting some of performative techniques used in sound studies, where interventions are made in acoustic environments as a means to examine their capacities for transformation. Examples here include Brian Eno’s ‘escape space’ sound installations at the Montefiore Hospital (see Hajdu et al, 2017), Katherine Herrity’s (2018) use of ‘soundwalking’ for prison ethnographies, and Brandon LaBelle’s (2016) own sound art experiments with public gathering and interruption. The methodological challenge here would be find ways to deploy sound itself as a research tool (ideally using a co-production framework) in order to experiment with different modes through which the acoustic community might relate to their environment.

Conclusion

If we are to have forensic psychiatric hospitals at all – which is significant debate in itself (see Drennan & Alred, 2012; McGrath & Reavey, 2018) – then they should be constructed as

working and living spaces that promote genuine care and recovery. The design and construction of Sharphill was a very well thought through process, with extensive consultation of users and drawing upon decades of experience built up at the hospital site. But despite all these efforts, the acoustic environment does not work particularly well as a space of recovery for either staff or patients. Much existing hospital architectural and design practice around sound is focused on the reduction of excess noise and improving the acoustic quality of the care environment (see Blomkvist et al, 2005; Berg, 2001). However there is an increasing concern with the ambient qualities or ‘atmospheres’ that may be facilitated within the built environment (see Böhme, 2017; Griffero, 2018; Zumthor, 2006). In healthcare, this has included explorations of using ‘natural’ sounds within the acoustic environment (Iyendo, 2016) and the use of sensory environments (Sutton & Nicholson, 2011). Based on our findings, we recommend pushing this further and making consideration of the acoustic environment central to the design of the entire hospital space. Both staff and patients at Sharphill would likely be prepared to tolerate a reduction in the overall spatial footprint of the unit if it allowed for a more flexible acoustic environment, where sound did not reverberate through the entirety of the ward space. This is possible through the use of curved walls and sound-insulating materials within the built environment (Daykin et al, 2008), which can be positioned in ways that do not compromise the technical safety concerns of forensic psychiatric care (i.e. need to maintain sightlines) (see Sykes, 2016)

For patients, the most important consideration would be the facility to create enhanced micro-soundscapes within the overall ward space. This could be accomplished through bedroom designs where the threshold space adjacent to the door is extended to create greater gradations in ambient noise and a sense of transition from one part of the soundscape to another, or by allowing patients to control an acoustic programming of the bedroom (e.g. generative ambient sound, birdsong, white noise). Our study reaffirms the need for service-

user led initiatives in the design of psychiatric hospital space, such as the artist David Parkin's art installation *Delusions of Grandeur*, which presents his 'dream' ward bedroom and seclusion space, and the Madlove collective's *A Designer Asylum*, which daringly recuperates ideas such as the 'padded cell' but re-imagines them as spaces of comfort and auditory calm (see Zorwaska, 2019; Reavey & Harding, 2018).

For staff, continuous immersion in the acoustic environment of the ward is also highly problematic, along with the inability to be able to retreat to a space where they are not subject to auditory surveillance by patients. Whilst to some extent, making the acoustic environment more variegated, and allowing patients greater control over some aspects, would reduce the demand on staff, ultimately a space of detention requires staff to engage in continuous auditory monitoring. But our study has shown numerous unanticipated consequences of acoustically-relevant design decisions made at Sharpill which could be readily addressed in future builds. Digital locking systems should be used by default to reduce excess noise and the need to carry multiple keys. The acoustic properties of internal wall materials should be regarded as a priority investment in order to facilitate ear-work practices. If staff are to be required to spend undirected time on the ward space, there should be appropriate mechanisms for triaging patient concerns, including the use of breakout spaces, that prevent staff from being unable to deal with multiple, simultaneous requests.

This article has contributed, at a wider level, towards a multi-modal approach to organizing. Teasing apart the various sensorial aspects of experience – how organizational space is heard, touched, tasted – presents new empirical challenges and demands for how researchers and participants together can explore settings (see Riach & Warren, 2015; Styhre, 2008). Although we accessed the auditory through a combination of visual, interview and observation methods, the field is ripe for methodological experimentation, which might include, but is not limited to, auditory ethnographies, sound installations, experience-sampling methods and

participatory action research efforts to redesign acoustic environments. Rather than see the outcome of this approach as a renewed effort at the study of ‘sense making’, we would characterize this instead as the study of the ‘making of senses’: How are forms of order accomplished through the design and shaping of sensory environments? What kinds of attunement are possible in such environments and how do organizational members develop them? Where does agency sit in relation to multi-sensorial relationships and how might this be exercised and supported? The answers to these questions may nudge organizational analysis away from a concern with the mechanisms of formal organization and further towards the lived experience of organizing.

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Biographies

Steven D. Brown is Professor of Social and Organizational Psychology at Nottingham Business School, Nottingham Trent University. His research interests are around social remembering amongst ‘vulnerable’ groups and service user experiences of mental health care. He is author of *Vital Memory and Affect* (with Paula Reavey, Routledge, 2015), *Psychology without Foundations* (with Paul Stenner, Sage, 2009) and *The Social Psychology of Experience* (with David Middleton, Sage, 2005).

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Laura McGrath is Lecturer in Mental Health at the Open University. Her research concentrates on the role of the environment in experiences of mental distress, care and recovery. She draws on community, social and ecological psychology to explore psychosocial and material aspects of mental health experiences. She was co-editor of the recent edited collected ‘*Handbook of Mental Health and Space: Community and Clinical Applications*’.

Paula Reavey is Professor of Psychology and Mental Health at London South Bank University and research and education director of the Design in Mental Health Network, UK. She has co-edited *New Feminist Stories of Child Sexual Abuse* (with Sam Warner, Routledge, 2003), *Memory Matters: Contexts for Understanding Sexual Abuse Recollections* (with Janice Haaken, Psychology Press, 2009) and *Mental Health and Space* (with Laura

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McGrath, Routledge, 2018). She is also editor of *Visual Methods in Psychology: Using and Interpreting Images in Qualitative Research* (Routledge, 2011 – now in preparation for its second edition) and the commercial book series *Design With People in Mind* – a series focusing on mental health and space for architects and designers.

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