

Vitality and nature in psychiatric spaces: Challenges and prospects for ‘healing architecture’ in the design of inpatient mental health environments

Abstract

Historically, nature has been considered central to healing and recovery in institutional mental health settings, with inpatient spaces designed to mirror the restorative forces nature may afford. Within contemporary healthcare architecture, the discourse surrounding nature’s role has once again become prominent, especially in the concept of ‘healing architecture’. While the literature on ‘healing architecture’ primarily considers how to connect recovery to nature through interventions in the built environment, less interest has been directed towards how nature is configured in design processes and what implications that has for the everyday experiences of patients and staff. In this paper we consider the design and implementation of one particular psychiatric hospital in Denmark to show that the ‘nature’ brought into this healthcare space can be experienced as anything but ‘natural’ and may reduce rather than enhance a felt sense of ‘vitality’ amongst patients. Based on our analysis, we end the paper by suggesting four principles for future healthcare design.

Keywords: healthcare architecture; healing spaces; simulacra; nature-cultures; mental health; vitality

Introduction

The discourse surrounding nature’s role in promoting health has become prominent in shaping contemporary hospital and healthcare design (Lomas, 2019). These designs synthesise functional demands and sensorial affects to find ingenious means to ‘bring nature back’ into psychiatric spaces, which are often considered to be overly clinical, or even lifeless and sterile (Curtis, 2010). This idea of ‘bringing nature back’ has been accompanied by evidence demonstrating that nature positively impacts mental health, thereby establishing a widespread belief in the importance of ensuring psychiatric spaces incorporate natural features such as indoor plants, vegetation, natural materials, access to outside spaces, and views of the external environment (e.g., Berg, 2005; Connellan et al., 2013, 2011; Curtis et al., 2007; Gesler et al., 2004; Reavey et al., 2017; Shepley et al., 2017; Ulrich et al., 2008b). This trend has given rise to the emergence of ‘healing architecture’ (Lundin, 2015; van den Berg and Wagenaar, 2006),

which, according to Johannessen and Holm (2022), redefines the role of architecture as an instrument for healing. Although no shared or operative definition of ‘healing architecture’ exists (Simonsen et al., 2022), work in this area has been highly innovative in creating an atmospheric composite between ‘the artificial’ and ‘nature’ in which ‘the artificial’ both enables nature, and stands in contrast to nature. Indeed, designed elements around lighting, wayfinding, air, safety, and spatial layouts that simulate nature to a greater or lesser degree have become somewhat of a hallmark of the healing architecture approach (Frandsen et al., 2009; Simonsen et al., 2022).

For us, this raises the questions of what is the actual status of the ‘nature’ that is brought back in and how can we distinguish ‘nature’ from the ‘artificial’ (Hartig et al., 2014). Jean Baudrillard (1994) famously coined the term ‘hyperreality’ to refer to circumstances in which a natural thing is simulated by something artificial in such a manner that the artificial can appear to be superior to the natural thing it is simulating, in effect creating a hyperreal simulacrum. While Baudrillard does not problematise the artificiality of such hyperreal simulacra, he does raise concerns about the ways in which they supplant and ultimately erase the things on which they are based. In the case of psychiatric spaces, the past 150 years have witnessed a shift from building large self-sustaining or ‘total’ institutions located in rural environments surrounded by nature towards smaller urban units that import nature, often through technological means (McGrath and Reavey, 2018). The philosopher Peter Sloterdijk has reflected on this modern tendency to inhabit spaces which are elaborately designed to emulate the spectacle of the natural world in the following way:

“When faced with the temple in which I am standing, being-in-the-world virtually means being-in-the-work-of-another, and more still, being consumed by the artificially great.” (Sloterdijk, 2016, p. 495).

There are a great many examples of what Sloterdijk would call the ‘artificially great’ in modern psychiatric hospital spaces, from external fences painted green to blend into the surrounding environment to large internal screens displaying images of trees or skies, and lighting systems which gradually change colour according to the time of day (see Connellan et al., 2013). Such design interventions can sometimes have unintended consequences for both patients and staff. The ‘nature’ they encounter can appear peripheral, be experienced as inaccessible, and may prove to be an obstacle rather than a facilitator of care. To understand the therapeutic potential

of nature, regardless of whether that nature is considered natural or artificial, we need to, as Bell and colleagues (2023, p. 2) argue, “explore how people experience, shape and respond to diverse multisensory qualities of nature encounter. Recognising that multiple parts of the body are important in ‘acting as bridges to the world’.”

In answering Bell et al.'s (2023, p. 7) call for investigating the dynamic “processes and temporalities of intimate, visceral place sensing” in ‘nature-based’ therapeutic encounters, we build on research that examines the social and material aspects (Reavey et al., 2019a), the atmospheric constituents (Kanyeredzi et al., 2019), and the sensory components (Brown et al., 2020) related to experiences of mental distress and recovery in inpatient settings. To do so, we employ Brown and Reavey’s (2019) ‘vital spaces’ framework. We apply this framework in an analysis of the design and use of a new psychiatric hospital in Denmark – designed around an ethos of ‘bringing nature back in’ – by examining the stated intentions of the designing architects and the actual experiences of patients and staff who live and work in the space. We show that, whilst the design intentions may have been entirely laudable, the ‘nature’ that is brought in, can be experienced as anything but ‘natural’ and may reduce rather than enhance a felt sense of ‘vitality’. The framework of ‘vital spaces’ invites us to suspend any judgement about the nature of nature, because, in this perspective, nature is not a distinct domain from the social, but rather something that gains its status as ‘natural’ through the practice and relations that our bodies establish with ‘it’ (see Macnaghten and Urry, 1998). What we encounter is always already an ‘encultured nature’, in that ‘nature’ is discursively, symbolically, and materially shaped by social practices and thus, we do not perceive it as a raw state. This leads us to our focus of analysis. Rather than asking what the effects are of nature within a psychiatric ward space designed to have ‘healing architecture’ and rather than merely describing those effects, we examine how nature is encultured in that space and ask what further modes of enculturation may be made possible in the future design and use of ‘healing architecture’. As such, and in building on our analysis, we end the paper by suggesting four principles that we hope might inform future work on ‘healing architecture’.

In the next section, we outline the conceptual background that underpins the ‘healing architecture’ approach and the ways in which we may understand the interactional processes that give rise to ‘vitality.’ We then describe our methodological considerations in relation to our empirical material. Following this, we present our analysis of the plans and design statements that informed the design and construction of the hospital. Subsequently, drawing

on ethnographic work, we compare our findings on the design intentions with an examination of how nature in the hospital is understood, assimilated, and experienced by patients and staff. Finally, we suggest how designers and architects might engage with the lived experiences of those who reside and work in psychiatric hospitals and what role ‘artificially great’ nature might have in supporting recovery within such settings.

Encultured Nature, Vitality, and Mental Health

A wealth of research is emerging on the relevance and impact of ‘nature’ on health and wellbeing, which includes research on psychiatric spaces that posits nature can play a significant role in facilitating and supporting individual recovery (Bell et al., 2023; Berg, 2005; Connellan et al., 2013). Some theories propose that people that spend time in nature and are exposed to nature exhibit reduced levels of stress (Hartig et al., 2014). Furthermore, exposure to nature has been shown to have positive effects on cognitive and emotional development in young children and can reduce stress among adults with mental health difficulties and among adults in the general population (Berto, 2014; McCormick, 2017). There is also a considerable body of evidence which supports both the general idea of reducing the ‘clinical appearance’ of psychiatric settings (Ulrich, 2006; Ulrich et al., 2008a) and the introduction of sophisticated individual elements such as lighting systems attuned to circadian rhythms (El-Badri and Mellso, 2008), the use of images of nature within ward settings, and access to outside space (du Plessis, 2012) to support patient recovery and wellbeing. Moreover, ample evidence indicates that patients generally favour the introduction of biophilic (Kellert, 2008; McGee and Marshall-Baker, 2015) or ‘green’ aspects of design in the healthcare settings they use (Cherry and Munting, 2005).

While designers take account of and use the above insights, some researchers have criticised approaches to ‘healing architecture’ for assuming that clinical practice is passively shaped by space (Frandsen et al., 2012; Lundin, 2015). Recent studies have shown that the design of psychiatric spaces may not best reflect the complex and contingent interactions that occur between staff and patients, despite the best intentions of the designs to optimize idealised ways of working and delivering care (Højlund and Simonsen, 2023; Simonsen and Vikkelsø, 2022). Moreover, ‘healing architecture’ primarily focuses on simulating the material dimensions of ‘therapeutic landscapes’ rather than the symbolic and social elements, which Gesler (1992) established as critical in the original formulation of the concept. The social elements of therapeutic landscapes are difficult to model within inpatient care as institutions and individual

psychiatric units vary considerably in terms of the culture of interactions between staff and patients – or ‘ward atmosphere’ (Jørgensen et al., 2009). The space alone does not shape whether patients (and staff) feel they are experiencing a ‘healing environment’. Healing is instead an ongoing and provisional outcome of a relational process where patterns of lived experience and social activity interact with features of the built environment (Brown et al., 2020; Reavey et al., 2019b; Simonsen and Duff, 2020). One might argue, therefore, that nature is relational rather than entitative, that is, we should regard nature as more than a mere entity abstracted from all circumstances or relations in the designed space.

For example, psychiatric medication can result in patterns of sleep and wakefulness that may make the use of outside spaces more desirable at times when staff are unable to support patient access to that space (e.g., in the early hours of the morning). We argue that, rather than regarding nature as beneficial simply due to its being present in a healthcare setting, the beneficial effect of nature should be judged in terms of its availability at times required by the patient and in terms of the patient’s ability to engage with nature meaningfully; for example, having the ability to engage in physical activity, playing games, growing plants or isolating themselves within that space (Barton and Pretty, 2010). A further example of how the perception of a seemingly beneficial space in a healthcare setting can change is given by Tucker et al. (2019), who show how a communal area in an inpatient ward can rapidly shift from feeling like a convivial space of social relations to an overwhelming space of threat and aggression, depending on how patients and staff interact with one another, and on whether there is freedom of movement or whether the space facilitates or impedes shared activities. Rather than assume that a space has specific predictable effects or entitative features that benefit patients, we can explore how the architectural and design features are taken up in the various configurations of social relations that unfold in the daily provision of inpatient care.

Cameron Duff’s (2011) work on ‘enabling spaces’ has been significant in the relational understanding of spaces, as it proposes that we suspend judgment on the therapeutic value of spaces in favour of analysing the specific ways in which they afford and inform interactions between discourses, bodies and material dimensions of a setting (Nielsen and Pedersen, 2022). Drawing on Deleuze and Guattari’s (1988) well-established concept of ‘assemblage’, Duff argues that we should analytically view processes such as ‘recovery’ as potential outcomes from the collective embodied, material and discursive relations that constitute a setting. Brown and Reavey build upon this in their conception of ‘vital space’ as:

“the relational nexus of bodies, affects and materials that are assembled together in a specific setting (e.g., a hospital ward, a public space, a forest), and the potential range of trajectories that may be recruited into these settings. Any space can be analysed with respect to how it shapes vitality, not simply those kinds of spaces typically studied as therapeutic landscapes. In this sense, vital space is a lens for addressing vitality ‘in the world.’ It provides a focus on the tensions as ‘life confronts life’ within a specific material and discursive context.” (Brown and Reavey, 2019, p. 5).

From the perspective of vital space, the process of further enculturating nature within ‘healing architecture’ may be studied in terms of the ways that it affords vitality – that is, how Sloterdijk’s (2016) ‘artificially great’ may shape the embodied interactions in a psychiatric ward where ‘life confronts life’ within ongoing lived experience. A key dimension here is the extent to which patients or staff can actively engage with the various simulated forms of nature, or whether they are merely able to passively observe them. Restricting possibilities for ‘ground-feel’, as Brown (2017) argues, can be detrimental to the therapeutic potential of green spaces, which, as she critically notes, is a term that “privileges the visual”, with users, in turn, becoming “little more than vessels for eyes that look effortlessly across outdoor spaces in ways that seem to lead to psychological wellbeing.” (Brown, 2017, p. 307). This ‘effortless visuality’ stands in stark contrast to the work of Stern (2010) on vitality, who argues that ‘feeling alive’ arises from either the experience or the anticipation of being in movement, such as running, jumping, or dancing. Vitality, then, also directly implies movement – which represents a sense of agency and action that research on the relations between green space and health has not addressed (Bell et al., 2014). Vitality has ‘dynamic forms’ with their own patterns of activity, including rising, falling, floating, surging, diminishing, approaching a crescendo and so on. Simulated nature should then manifest effects regarding how it facilitates these dynamic forms, however restrictive or expansive they may be.

Finally, vitality involves a tension between two aspects of living – the need to divide the world in such a way that we can feel enclosed and secure and another need to open up and connect relationally with others and with the environment. In a Baudrillardian perspective, one may contend that the true complexity of nature is lost in ‘healing architecture’ and that all that remains are mere surface-level imitations, drawing on the framework of ‘vital space’ may in

fact reveal how simulated nature both offers potential for remaking divisions as well as providing additional means for social connection within ward spaces.

Methods and context

The qualitative material analysed here stems from a broader research project on the spatial organization of psychiatric practice (anonymized for review). This paper focuses on how ideas around the therapeutic value of nature informed the design and development of a psychiatric hospital, and on how ‘green spaces’ within the inpatient settings of the hospital affect and interact with everyday encounters and practices. The material consists of a range of documents, from architectural documents and drawings to publicly available booklets and municipal reports, seventeen semi-structured qualitative interviews and approximately two hundred hours of participant observations of everyday practices in two inpatient settings. The observations were jotted down in situ in notebooks and subsequently written up to allow for thick description and analysis in Nvivo software. Two groups were interviewed for the broader research project: people with knowledge of and engagement in the everyday work taking place in the inpatient wards where fieldwork was conducted (e.g., nurses, auxiliary nurses, care workers, and physicians); and people who were knowledgeable about the visions underlying the design and development of the hospital (e.g. architect, project director, and hospital management). The last-mentioned group of interviewees, especially the lead architect, provided crucial data for examining the idea of nature in the design of the ‘healing architecture’ of the psychiatric hospital.

Via the architectural drawings, text from the design submission, and the interview with its lead architect, we are able to trace the intentions for the hospital building and subsequently follow this through to its actual use by patients and staff. This movement from early design through to spatial practice enables us to expose some of the tensions that this architectural trend introduces. Because of the ethnographic material documenting how patients and professionals navigate the spatial organization of the site, negotiate the terms of its use, and contest the role nature might play therein, we are afforded the possibility to critically investigate the actual role of nature within the ‘healing architecture’ of the psychiatric hospital.



Image 1. Picture of the Slagelse Hospital, Karlsson arkitekter / VLA.

The psychiatric hospital considered here is located in an urban environment in the town of Slagelse, in the Zealand region of Denmark. It is a large institution spanning 44,000 square meters across multiple, interconnected, smaller buildings and a main center reaching five floors high. The psychiatric hospital is placed next to the city's somatic hospital. While unique, the design of this hospital reflects a development in the design of hospitals across Denmark and Europe – with multiple, evidence-based design programmes establishing the importance of nature as a means to facilitate recovery (Van Hoof et al., 2015). Developing the hospital resulted in the restructuring of psychiatric care for the entire Zealand region, moving approximately 650 employees from five different facilities across Zealand to relocate them to the new hospital. The hospital comprises an emergency reception, 194 beds, six inpatient wards, outpatient treatment functions, research facilities, and education and training facilities. The hospital is designed to promote quick patient turnover. The six inpatient wards each accommodate seventeen patients and are organised to support patients admitted voluntarily and patients compulsorily detained. Ward staff include physicians, nurses, educators, social workers and auxiliary nurses managed by a chief physician and a head nurse. Wards are staffed twenty-four hours a day, divided into eight-hour day, evening and night shifts.

Bringing 'nature' in: Designing the hospital

In contrast to the architecture of the late Victorian asylums, contemporary developments in inpatient psychiatric care tend not to reflect any one dominant building type (Bruun Petersen et al., 2013). However, the assumption that architecture and space are important to the provision of mental healthcare and the enablement of individual recovery remains central to contemporary developments in the design of buildings for psychiatric care. This assumption is

clearly demonstrated in the vision statement of the healthcare authority Region Zealand in their competition programme that invited design proposals for the construction of the psychiatric hospital in Slagelse:

The physical surroundings have a large impact on our psyche and wellbeing. 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, 2010).

The language of ‘frame’ used here implies a view of space as a container in which ‘treatment and recovery’ happen. Such ‘framing’, as Dovey (1999) has argued, implies both the construction of a particular world and a way of seeing those who are expected to live in that world. The task of framing the ‘future of psychiatry’ (Danske Regioner, 2009) in the Zealand Region of Denmark befell the joint winners of the Slagelse hospital design competition Karlsson Architects and Vilhelm Lauritzen Architects. The winning architects designed a ‘frame’ that followed the motto ‘the building in the park, the park in the building’, making the importance of the park, that is nature, the heart of their design proposal:



Image 2. Rendering of the winning concept ‘the building in the park, the park in the building’ (Karlsson Arkitekter/Vilhelm Lauritzen AS, 2011).

The rendering in image 2 shows how the hospital is situated, almost nested, within the landscape, making it one with the surrounding green park in an urban area. This design allowed

for a variety of spaces within the main design, whilst creating an overall sense of unity from an external perspective, as stated in the notes accompanying the design proposal:

The main idea of the proposal is to incorporate the building into a unified, modulated landscape that in varying, slightly sloping sequences is pulled up around building facades and courtyard walls. Visually, the height and scope of the building is reduced, and the building is integrated as a natural element into the landscape. The concept gives great freedom in the development of a scale and with a flexible and varied interaction between indoor and outdoor spaces – building, courtyards and garden spaces. From a distance, on the other hand, the building is perceived to be clear and unified. Lovingly integrated into the park, as a stylised hill landscape of low grassy slopes, with a few precise building volumes visible. (Karlsson Arkitekter/Vilhelm Lauritzen AS, 2011, p. 2).

On this basis, the hospital is both a part of nature – ‘the park’ – and an architectural form – ‘the building’ – into which nature is invited. However, as the above notes show, nature must first be worked on and enculturated to achieve this, such that it is systematically ‘pulled up’ around the building, which becomes ‘integrated’ into the park as a ‘stylised hill.’ This is not nature in its ‘raw’ state, but an already fashioned and styled nature. Attractive as it was, this idea did not come to fruition, as placing the hospital at this level made it too easy for patients to abscond. The final design concept came to be reformulated as below, with the ‘building’ now placed on top of rather than within the ‘park’:



Image 3. Representation of the Slagelse Hospital (Karlsson Arkitekter/Vilhelm Lauritzen AS, 2011)

During initial phases of development, the design office sought inspiration at other sites, nationally and internationally, but, as the lead architect 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 (Lead architect in Region Denmark, n.d.).

As a result, the design office developed its own interpretation of what 'healing architecture' might look like and which treatment ideals 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. 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 eating outside or a barbecue. Getting out – in nature – is the best of all. So that became our starting point, culminating in the theme the building in the park, the park in the building. (Lead architect in Region Denmark, n.d.).

What is noticeable here is that the natural world is presented as 'ready at hand' to entertain the recreational activities of the (rather privileged) individual – a spontaneous barbecue, a pleasant jaunt to a second home (summer cottage), a nice stroll in the neighbourhood. This is nature as entirely subordinated to the needs of an affluent, urban and urbane sociality. Moreover, the individual assumed here is able-bodied enough to use nature easily, enjoying sufficient time and resources to engage in recreation. Indeed, the imagined patient becomes a self-referential image of the architect (Imrie, 2003), with the built environment designed to 'fit' this particular image (see also Garland-Thomson, 2011). Furthermore, nature is not just enculturated but reimagined by the architect in specific and narrow sociocultural terms. It is clear from the quotation above that the architect renders 'healing architecture' open to interpretation, plainly drawing on notions about the healing qualities of nature, but now, as he explains, nature is moved inside, made accessible, observable, and ostensibly less terrifying (Region Denmark, n.d.). The trope about 'what is good for all of us – is also good for those of us who are sick' permeates the conceptualization of the design, with nature highlighted as 'best of all'. This

view is, as Imrie has shown as part of his critical investigation of architects' conceptions of the human body, rather commonplace. As one of the architects that Imrie interviewed for instance noted: "well, I think the first thing you inevitably do when you're designing is you think about yourself and the way you want things to be, but also how things would feel comfortable, or wouldn't feel comfortable, inevitably relates first of all to self" (Imrie, 2003, p. 64). Here, as in the case of Slagelse, the point of departure for design, is not the imagined user, but the architect himself. As Imrie poignantly argues, this self-imaging of architecture might develop into a "heterogeneity of bodily images and knowledges based on architects' experiential understanding of their bodily interactions with(in) diverse built environments." (Imrie, 2003, p. 56). The design of the psychiatric hospital in Slagelse is saturated with highly normative ideas about how to gain access to, and interact with, 'nature', with nature conceived as simultaneously beyond control and as something that can be shaped to become fit for purpose, a good example of what Sloterdijk (2016, p. 496) identifies as the "uncanniness of constantly or occasionally belonging to an environment molded by humans." Somewhat paradoxically perhaps, the architect imagines his design of nature to be both 'wild' and 'safe' at the same time (Karlsson Arkitekter/Vilhelm Lauritzen AS, 2010, pp. 19–22).

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 to not only reflect circadian rhythms but also to improve spatial conditions through variation in lighting. By explicitly drawing together the notion of recovery with the concept of healing architecture, the design arguably represents a new synthesis of ideas around healing, nature in the service of sociality, and the capacity to simulate an, in the sense of Sloterdijk (2016), 'artificially great nature' within a hospital setting. However, neither do the architects' design notes nor the development of the project as a whole give any clear sense of the embodied interactions which might inhabit 'nature' within this built environment, nor do they indicate how these interactions might take up aspects of the architectural design in diverse ways. Likewise, there is no mention of how 'sickness' can be defined and how individuals experiencing acute distress might interact with nature and the built environment in ways specific to their life histories or modes of distress (see McGrath and Reavey, 2015).

The vitality of encultured nature: Experiencing the hospital

A key design feature of the hospital was the plan to construct individual wards around a central open space or 'courtyard'. This would allow the 'park' to enter directly into the heart of the

‘building’ and enable patients to transition between a clinical space to a natural, relaxing space. The design notes describe the courtyard in the following way:

The wards’ patient rooms and shared spaces are primarily organised around a centrally placed courtyard, which functions as the setting’s identity-creating element. The courtyard functions as the near-outside space for residents both inside and outside the community, with quieter activities in connection with the communal areas. There must be room for common social activities, such as a barbecue, card games or a cup of coffee, but it must also be possible to just go out and smoke in peace and quiet. With reference to the traditional garden of a detached house, the courtyard is decorated with a terrace and herb beds, and possibly potted plants that can be taken into the common room during winter. The terrace area is designed so that it moves between the greenery, making it possible to stay on the edge of the community. The greenery is kept simple, with small flowering trees and fragrant shrubs in a base of different grasses. In this courtyard a special lighting is created at night (Karlsson Arkitekter/Vilhelm Lauritzen AS, 2010, p. 12).

The courtyard is emblematic of the project of bringing nature back in and acts as the ‘identity-creating element’ of the building in the park/park in the building concept. The courtyard is described as an attractive green space, partly referencing the symbolic values of a ‘garden of a detached house’ that can support a range of collective and individual recreational activities. Standing or sitting in the courtyard, patients will be able to feel temporarily transported from a hospital environment in a manner similar to when stressed city dwellers get out for a walk or invite their neighbours over for a garden barbecue. But in practice, the experience of the courtyard was markedly different for both patients and staff. In the following extract from field notes, two patients, ‘Jessica’ and ‘Maria’, explain the somewhat complicated procedure that they have developed to smoke in the courtyard (smoking not being permitted within the ward itself):

Jessica explains that she and Maria have a shared routine related to their smoking habits; Maria always ignites her cigarette in the apparatus mounted on the wall in the corner of the courtyard – ‘the sucking machine’ – as they call it, after which Jessica lights her cigarette on Maria’s. They call it the ‘sucking machine’ because one has to put the cigarette into a hole in the apparatus after having pushed a small red button and

then, well, suck. Jessica thinks the apparatus is disgusting and Maria seconds that by saying “yeah, super disgusting.” Cocoa has been poured over the apparatus and I comment that the tiles on the ground are really sticky as well. They explain that ‘Ralf’ is to blame. He pours cocoa all over the place and leaves all the cups as well. On the table in front of us, at least five cups have been left behind by Ralf. “Once, he also pissed on the floor” Maria says, and Jessica offers another example where he apparently also urinated in the courtyard.

In common with many inpatient psychiatric settings, cigarette lighters are not permitted on the ward to avoid either damage to persons or to the environment (McGrath and Reavey, 2018). This creates a dilemma. If we assume it is desirable that patients should have the opportunity to ‘smoke in peace and quiet’, then there should be a means of lighting cigarettes that does not involve gaining the attention of busy staff members, who may not be able to assist at any given time. The solution is a remarkable piece of technology – the ‘sucking machine’ – which can light a cigarette safely, but requires the user to manually insert the cigarette into an aperture and suck repeatedly until it is burning well. This is an unusually intimate form of embodied interaction with a technical device that seems to be at odds with the intended aim of being ‘in nature’ and one which Jessica finds to be ‘super disgusting’.

The issue here is that whilst the machine affords patients the freedom to smoke in an unsupervised way, it breaks up the flow and rhythm of the activities around smoking. When offered the opportunity to smoke without restrictions, some patients may experience a sense of ‘being alive’ and, very importantly, connecting with others (Ringer and Holen, 2019; Wood et al., 2013) and having a degree of personal freedom. However, this comes at the cost of having to engage in an unpleasant and potentially humiliating technologically mediated interaction. To make matters worse, another patient has spilled hot drinks over the machine and surrounding area, heightening the unpleasant tactile and sensory engagement with that area of the courtyard, an important aspect of animating any therapeutic effect (Bell et al., 2023). In this sense, rather than having an experience with nature that is unmediated and partly unrestricted, Jessica and Maria must open themselves up to the aftermath of Ralf’s actions, which have further encultured the space in a specific and sticky way.



Image 3. Inside ward space looking outside onto courtyard. Source: XXX

Nature is not ‘just there’ as an extension of the park within the building but is shaped and modified through interactions with patients. The potential vitality that Jessica and Maria might experience through making use of the courtyard is tempered and altered by the need to navigate the residue of Ralf’s cups and, potentially, his urination. Staff also feel that the courtyard does not entirely provide an encounter with nature in an unmediated way. In this extract, a nurse describes how over time the courtyard has had to be progressively modified because of the specific embodied activities that patients wish to engage in within the space:

Then there is the whole garden which, uh, that little smoking shed has been set up and there can be two people inside and over half of our patients they smoke. So they often stand out there in the rain and wind and that is of course because it was planned that you should not smoke here at the hospital at all, but it did not really turn into anything, and then there is that with that garden and the tile paving, which has been laid out - it is so dangerous – and then we have patients who have run out, so we always have to wait for them to come in, because it is simply too dangerous for us to go out on those tiles. We have also had patients who have fallen on them, if you just step on the edge,

then you simply fall, so the whole safety, I think, is not really taken into account.
(Interview 2017, Nurse)

The ‘smoking shed’ is a new structure that was not in the original design. Since the courtyard is open to the elements, climatic conditions can be a barrier to patients who wish to smoke. But since so many need to do so despite the weather, a small structure which can only shelter two patients at a time has been erected. The existing design features have also become a problem. The paving tiles, which were used to symbolically reference the ‘traditional garden of a detached house’, have proved to be slippery and unstable. This creates a problem when staff feel that they need to manage the behaviour of a patient who may be agitated and restless. If they run into the garden, staff have adopted the policy of not following, out of fear that they will injure themselves on the paving stones. The ‘nature’ of the courtyard space no longer signifies ‘relaxation’ and ‘autonomy,’ but rather ‘danger’ (for staff) and ‘escape’ (for patients). This is clear in the following interview extract:

Yes, out in the courtyard, yes, yes, yes, yes, that’s also where things are being exchanged...now, nothing has been proven, but sometimes we suspect that there is something...distribution of something...drugs or some medicine or...some cigarettes and there’s some money or something...something is going on out there. I have no doubt about that. After all, they are not allowed to go to each other’s rooms so that’s [the courtyard] the only place they really have the opportunity, yes. And that was actually at one point one of the reasons we closed [the doors at the far end of the ward], we had a couple of patients who were looking for a lot down there, like that. But it is not a conscious decision that it’s closed, it’s just closed now, so that... a whoopsy-solution again (Interview 2017, Nurse)

Nature can be symbolically coded in all manner of different ways, including as a liminal space of potential threat and disorder that lies on the fringes of sociality (see also Reavey et al., 2019b). In the extract above we see how the courtyard starts to take on some of these associations for nurses because of their unwillingness to enter the space for safety reasons. They are then left with suspicions as to what patients are actually doing in the ‘artificially great’ space, with various illicit activities being suggested. In this sense the courtyard is not necessarily a space of vitality, where patients are able to explore embodied activities that would contribute to a sense of ‘aliveness’, but rather a convenient opportunity to potentially engage

in activities outside of surveillance which could as well be done in any other space within the unit where staff were not present.

Discussion

Contemporary design and architectural practices within psychiatric spaces reinforce a division between the natural and the cultural that was substantial in the large asylum system in the nineteenth century. At that time, it was still possible to imagine a state of nature located away from the social, offering people some respite from the toils of life and regenerative possibilities. However, most contemporary mental health facilities no longer sit on the edge of urban areas, they are firmly embedded within them - offering limited opportunity for extended green spaces due to rising property values and built-up urban environments (McGrath and Reavey, 2018). Instead, and as the design of the psychiatric hospital in Slagelse shows, green spaces are folded into the building itself, with the centrally placed courtyard constituting an ‘outside inside’. Although the use of courtyards is very traditional in architecture, in the ‘healing architecture’ of the hospital considered here, they are perhaps designed to be more reminiscent of that age-old therapeutic intervention known as a ‘healing garden’. Indeed, such gardens were established to enable a transactional connection to nature (Verderber and Refuerzo, 2006, p. 36), a function which, as we have shown, the architects of the psychiatric hospital in Slagelse designed the courtyards to have.

Nonetheless, in this new urban setting for mental health facilities, one can regard the design approach of ‘healing architecture’ - which aims to prioritise the lived experiences of patients in relation to how psychiatric spaces are imagined and constructed - as a positive step forward. For example, for over ten years, the UK-based Design in Mental Health Network (DIMHN) has brought together mental health service users, clinicians, architects, manufacturers and constructors to explore how the relationship between the built environment and service delivery can better support patient recovery under the rubric that ‘good design can heal’ (DIMHN, 2023). When service users are invited to participate in imagining what psychiatric spaces could be, their visions are typically completely at odds with the sanitised, clinical spaces of traditional ward designs.

While ‘healing architecture’ is arguably a step forward, the project of ‘bringing nature back in’ does have a fundamental paradox at its core. Classically, nature stands in opposition to culture, it is the ‘other’ of everyday sociality, of all the rhythms of labour, care and obligation that

define daily structures. For instance, in a recent piece of stakeholder engagement work conducted by DIMHN, clinicians and service managers were asked to select images that represented ‘calm’. The majority chose pictures of natural scenes (e.g., forests, shorelines, vegetation) and spoke of the feeling of taking time out. But patients within a secure mental health setting are already taken out of the everyday and subject to new and unfamiliar routines far removed from everyday life, as Goffman (1961) already so poignantly showed in his seminal contribution. Ward staff follow the structure of a regular (albeit challenging) working day and return home. Patients stay in the same place, with the consequence that they experience spatial and temporal boundaries in a very different way. Outdoor spaces, for example, are sometimes disliked by patients because they can be felt to be ‘super disgusting’ (in the case of the Slagelse courtyard), or ‘boring’ or an unwelcome reminder of what has been lost through detainment (Brown et al., 2020). The nature that is brought inside the hospital is then already a complex amalgam of nature-culture. It is, to use Baudrillard’s term, a simulacrum of the binary of the everyday and escape that does not function in a context that is already, for patients, far beyond the normative rhythms of the everyday.

So, what was brought back inside in the design and building of the new psychiatric hospital in Slagelse? In one sense, what was brought back inside corresponds to Sloterdijk’s (2016) notion of the ‘artificially great’, a version of the natural which is ‘even better than the real thing’ since it can be experienced and managed without the need to travel and with an apparently minimum degree of effort and risk. For some patients, the ‘outdoor’ courtyards indeed offered a space of respite, a slightly calmer place. And yet, the ‘greatness’ of the artificial outside came with a cost. When patients began to interact with nature in the courtyard, it became further enculturated and transformed into something potentially unpleasant and risky. This resulted in spatial restrictions being imposed which resulted in nature only being observed by patients rather than directly engaged with, an engagement which many have argued to be central in supporting processes of wellbeing and recovery (Bell et al., 2023, 2014; Brown, 2017).

The issue, then, is not necessarily with how nature is introduced into design, but rather that the dynamic interaction of patients with their space exceeds the narrow range of activities that were anticipated in the project design. However, there are, nevertheless, cracks within the implementation of the project through which something ‘other’ enters. The design of the courtyard, for instance, allows rain and wind to enter the community in unexpected ways, leading to the construction of the smoking shed in which patients huddle together if they wish

to smoke in all weathers. This would be an example of what we might call an ‘epistemic glitch’ or an unplanned challenge to the distinction of the real and the artificial, the natural and the cultural (see also Ringer and Holen, 2019). Rather than seeing the smoking shed as an unfortunate ‘technical fix’ to unplanned circumstances, it can instead be seen as an instance of creativity and experimentation as life (of wanting to smoke together) responds to life (the inevitability of rain). Arguably, the shed is no more artificial than the carefully planned simulacrum of nature in which it now sits. The rain is an interruption to the simulacrum that forces it to transform in ways that offer other possibilities for engagement. From the perspective of vitality, life responds to life through expressive means, and often in ways that create tension and dissensus. The challenge is then of imagining a space in which lighting and smoking cigarettes, throwing cocoa, and engaging in illicit conversations or transactions can exist with the project of containment and care that defines the institution – and that, of course, feeds into the dominance of risk-averse practices that define all psychiatric institutions (Slemon et al., 2017).

Lived experiences easily ‘get lost in translation’ in the process of design. Taking lived experiences seriously, when developing architectural designs arguably requires other forms of experimentation and alternative forms of representation. Bypassing renderings like the architectural blueprint, as Högström (2017) argues, and shifting the design focus from solutions – nature as an entity – towards problems – nature as vitality – might just productively unsettle normative assumptions about imagined users (see also Imrie, 2003) as well as existing forms of architectural planning in healthcare developments. Allowing alternative forms of problem-solving in architectural design would entail allowing alternative forms of spatial practice to take place. As Högström (2017, p. 162) furthermore argues: “Promoting a more open-ended way of working with recommendations for the future would be to displace “solutions” to provisional principles and let in other voices than only “the institutional voice”. Two good examples of what Högström calls ‘other voices’ are found in the artistic work of David Parkin’s and James Leadbitter, who experiment with how life might begin to confront life in inpatient settings.

In the artist and service user David Parkin’s installation *Delusions of Grandeur*, a novel design for a seclusion room is staged. In contrast to normal plain white walls, the room has huge white clouds painted against a blue sky and the floor is covered with artificial grass. Bird song is then piped through overhead speakers, whilst the room itself is lit not with a faux-natural lighting

design, but rather with an anachronous freestanding brass lamp. The room design is truly ‘artificially great’ in that it plays with the appearance of nature whilst deliberately presenting an artificial space in a truly ‘unnatural’ environment. The difference between this room and the designs typical of ‘healing architecture’ is that the patient is offered the option of making this room what it can be through their interaction with the space. Rather than versions of sociality being prescribed, the patient can work with the simulacrum of nature to whatever ends they can imagine. The point is not to provide some respite from the often profoundly boring rhythms of life on an inpatient ward, but to offer up a space of experimentation that could be something other.

Similarly, the project OH MY GOSH, YOU’RE WELLCOME...KITTEN, a collaboration between artist and service-user James Leadbitter and young people at Great Ormond Street Hospital’s mental health unit, invited patients to re-imagine what inpatient spaces could be. This included, amongst many other things, a room where baby robotic rhinos would live within the hospital. Rather than looking at the grey streets of central London, the young people wanted to see mountains instead. Bedrooms were redesigned to incorporate dog beds (as well as many dogs). The technical skills that inform ‘healing architecture’ could equally well be turned to realising such fantastical ‘artificially great’ visions. If it is possible to create a simulated garden of a detached house, then why should it not be possible to create a space for robotic baby rhinos? If the lighting can be made to follow the hues of the day, then surely window displays of the Alps are technically feasible? If the argument can be made for communal barbecues, then how much further is it to push for dogs on the ward? Indeed, some units already have an animal petting scheme or animal-assisted therapy with farm animals that aims to engage patients in empathy and care practices and improve quality of life (Berget et al., 2008)

Conclusion: Co-produced experimentation in psychiatric spaces

Researchers have recently called for investigations of the dynamic processes of “visceral place sensing” in ‘nature-based’ therapeutic encounters (Bell et al., 2023, p. 7). Our study answers this call through an analysis of the stated intentions of designers responsible for the designing of the psychiatric hospital in Slagelse on the ethos of ‘bringing nature back in’ and the actual experiences of patients and staff who lived and worked in the hospital once it was operational. Drawing on the ‘vital spaces’ (Brown and Reavey, 2019) framework, we have shown how we can analyse the effects of nature within ‘healing architecture’ in terms of the ‘potential range of trajectories’ ‘nature’ affords. As argued, to ‘bring nature back in’ to psychiatric spaces can

only mean simulating an already encultured nature. However, rather than viewing this as an obstacle to supporting recovery, we posit this simulating of an already encultured nature could instead be treated as an opportunity to creatively engage with a simulated form of nature that could be fashioned according to the needs and taste of the service user. Echoing Imrie (2003, p. 64), there is a need for a form of architecture that is both reflexive and open-minded, an architecture that is sensitised to the corporealities of the user.

As others have also pointed out (e.g., Imrie, 2003; Nord and Högström, 2017), architects and designers should pay close attention to the needs and requirements of patients and practitioners when designing purpose-built architecture. Indeed, the success of healthcare architecture depends on collaboration (Yaneva, 2017). Resonant with these arguments, and based on our analysis, we present four principles that we hope might inform future work on ‘healing architecture’. We suggest that researchers, designers, hospital managers, healthcare staff, policy makers, patients and other stakeholders that work on or interact with ‘healing architecture’: 1) work with an unfinished vision of ‘nature’ that is open to further modification; 2) do not entirely anticipate the forms that sociality might take, but provide the spaces in which these might be explored; 3) ensure that all aspects of the design are co-produced with patients and staff and that further co-construction of the space is both possible and encouraged following implementation; and 4) ensure that the dynamic of containment and care is supplemented with that of ‘life confronting life’ – the point is not to distract patients from the fact that they are detained, but rather to support them in figuring out what potential there is for ‘feeling alive’ in the midst of their current distress and journey into recovery.

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