

# **‘Therapeutic Landscapes’ and the importance of nostalgia, solastalgia, salvage and abandonment for Psychiatric Hospital design.**

## **Abstract**

We examine emotional reactions to changes to medical spaces of care, linked with past experiences. In this paper we draw on findings from a qualitative study of the transfer of psychiatric inpatient care from an old to a newly built facility. We show how the meanings attributed to ‘therapeutic landscapes’ from one’s past can evoke emotions and memories, manifesting in ideas about nostalgia, solastalgia, salvage and abandonment, which can impinge on one’s present therapeutic experience. We reflect on how consideration of these ideas might contribute to better future design of psychiatric inpatient facilities and the wellbeing of those using them.

## **Key Words:**

Therapeutic Landscapes, Health Geography, Nostalgia, Solastalgia, Psychiatric Hospital Design, UK

## **Introduction**

The concept of therapeutic landscapes (Gesler 1993;2003; Williams 2007) has framed a growing body of work exploring how the material, social and symbolic attributes of places may be perceived as beneficial for one’s health and wellbeing. Places constituting a therapeutic landscape may include medical settings for care of serious mental illness, where the therapeutic experiences of patients can be influenced by attributes of the built infrastructure, relationships that patients experience and the meanings they attribute to these aspects of the caring environment (Curtis et al. 2007; Gesler et al. 2004; Author et al. **Details removed for peer review 2013**). In this paper we contribute to this literature by exploring the significance for emotional wellbeing of *change* in landscapes of hospital care and the ways that meanings attributed to therapeutic landscapes from one’s past can evoke emotions and memories impinging on one’s present therapeutic experience (Curtis 2010; Gastaldo et al., 2004). We examine in particular the potential to expand the theory of therapeutic landscapes with reference to theories regarding nostalgia, solastalgia, salvage and abandonment.

The English National Health Service (NHS) has recently invested significantly to update and enhance mental health care hospital buildings, many of which originated in the 19<sup>th</sup> Century, making them fit for contemporary care models in the 21<sup>st</sup> Century. Although modern care models emphasise community-based care, repeated and sometimes lengthy periods of inpatient care are often still required for patients needing frequent intensive medical treatment and for those who are legally detained in hospital because their condition presents serious risks to themselves or others. When new psychiatric facilities are constructed, long-term patients, informal carers (family and friends providing support) and hospital staff relocate from one facility to another, experiencing changing therapeutic landscapes in the process. Here we draw upon our findings from an English case study involving the transfer of psychiatric inpatient care from old premises to a newly built facility, to explore how this change was experienced.

### **Emotional geographies provoked by past experience in landscapes**

This discussion of a changing therapeutic landscape draws on theories used more generally to interpret positive or negative emotional response to environmental change, which invoke emotional feelings of nostalgia and solastalgia in relation to memory, and responses seeking either to *salvage* aspects of the environment associated with positive emotions or to *abandon and escape from* landscapes which invoke negative emotions.

A substantial body of geographic literature has addressed emotions in places (Anderson and Smith 2001; Davidson, Bondi and Smith 2007; Davidson & Milligan 2004; Bondi 2005; Urry 2007; Milligan 2007). Of particular relevance to our study is the way in which emotions are often experienced, made understandable and symbolised in architecture (Lees and Baxter 2011; Bosco 2006; Blunt 2003). Positive emotions, including feelings of being loved and belonging, a sense of safety and security, identity and self-worth, may be tied to the built environment of one's home or community. Negative emotional experiences may also be linked to particular settings, involving senses of rejection, isolation or association with a stigmatised place. Such interpretations may move us closer to the approach to emotional geography advocated by Pile (2010) arguing (p11) that 'Emotions may take on social forms of expression, but behind these forms of expression lie genuine personal experiences – that are seeking representation' and (p17) that 'emotional geography must know *why* emotions are important and interesting'(our added emphasis).

Rose employs psychoanalytic theory to explore how feelings about physical landscapes can be therapeutic through 'the encounter between the mind of the individual and landscape in a particular kind of visualized place' (Rose, 2012, p. 1382). Memories of such encounters enable the individual 'to identify and interpret interior affective states and

understand feeling-states ..., forming the basis of the therapeutic experience” (Rose, 2012, p.1384). Such perspectives highlight the importance of focusing on the social and symbolic as well as the physical aspects of the therapeutic landscape.

A number of studies demonstrate the relevance of emotional geographies for therapeutic experience in healthcare spaces. Brown (2003) noted the paradoxes involved in *where* terminal caregiving takes place (hospice or home) and how this impinges on meanings and emotions associated with death and dying, while Rigby et al (2014) highlight how spaces of hospice care can contribute to patient’s feelings of loneliness. English et al. (2008) showed how the interaction between emotions and places of care play an important role in shaping healing environments. Milligan (2005) considers the emotions experienced by informal caregivers as frail older people are obliged to move from their own homes and into care homes.

Other research has examined emotional responses of people to change in the landscape of care (Cornish 1997; Edginton 1997; Parr et al. 2003; Philo and Parr 2000) reporting how patients retain established emotional attachments to psychiatric institutions that have been closed. Here we explore further how experience of change in hospital care settings can be interpreted through theories of *memory*, *nostalgia* and *solastalgia*.

*Memory* often focuses on specific places (Rose-Redwood 2008; Hoelscher and Alderman 2004), and can be strongly influenced by the history of a site (Clifford 1998; Edginton 1997; Pohl 2000). Memory may be practiced through material memorialisation, or narrative remembrance of past experience in a place (Kearns et al. 2010) reinforcing senses of place involving ‘attachment’ and ‘identity’ (Lewicka 2008; Rishbeth and Powell 2013). Memory is a collective, as well as individual phenomenon, often evoking *shared identity* (Hoelscher and Alderman 2004; Johnson 2005). Such ‘collective memory’ can result in ‘productive nostalgia’ orientated ‘towards the present and the future as well as towards the past’ (Blunt 2003, p. 717), and shaping the ways one engages with certain places (Bonnett and Alexander, 2012).

While earlier usage of the term ‘nostalgia’ was equated with psychological illness and distress, currently it is associated with more positive past experiences such as senses of home and ‘homeliness’ (Sedikides et al. 2008). We focus here on *Nostalgia* arising from positive sentimental attachments to a real or imagined past, often serving to create a sense of continuity and meaning in one’s life. Among various interpretations in the literature we

note especially the emotional strength gained through nostalgic memory: *'[t]he psychological significance of nostalgia may reside in its capacity to counteract distress and restore psychological equanimity'* (Sedikides et al. 2008, p. 305). Nostalgic feelings are often expressed during times of change, as when people move from one place to another (Fried 1963). Kellet and Collins (2009, p109) studied a rebuilding project in a general hospital, highlighting how their participants focussed on *'nostalgia towards the "lost home" of the older hospital'*. Similarly, Cornish (1997, p107) highlights how, for some, institutional asylum settings can also be thought of as homely spaces, imbued with a sense of community and nostalgic memories.

Related to ideas of nostalgia is literature on *Solastalgia* (Albrecht 2005; Albrecht et al. 2007; Warsini et al. 2014) which *'refers to the pain or distress caused by the loss of, or inability to derive solace, connected to the negatively perceived state of one's home environment'* (Albrecht et al. 2007, p. 496). The concept originated in studies by Albrecht et al. (2007), on processes such as persistent drought or industrial activity causing transformation and loss of landscapes that offer solace. It is also employed in other research considering diverse processes producing changes in the physical and social landscapes: climate change (Tschakert et al. 2013; Warsini et al. 2014); industrial environmental change and psychoterratic geographies (McManus et al. 2014); impacts of supermarket trade on rural communities (Dixon and Isaacs 2013); effects of political violence (Sousa et al. 2014); and the diagnosis of 'mental illness' (Glackin 2012). Theories of solastalgia are relevant here to understand how emotional reactions occur when one moves to new surroundings or one's habitual environment is radically altered, so that a landscape one has left behind or 'lost' can no longer offer beneficial feelings of solace. Distress caused by solastalgia is often accompanied by feelings of powerlessness to change one's altered circumstances, and may have negative consequences for wellbeing. Thus, even if a new setting offers comfortable contemporary conditions compared the lost home environment, these may not entirely outweigh the loss of emotionally reassuring symbolic links with the past.

In contrast, emotions associated with memory of certain environments may be unwelcome. For service users and their carers, an emotionally significant, symbolic attribute of mental health facilities is *stigma* (Smith and Giggs, 1998). Persons or places subjected to stigma are socially marked, violated, stereotyped and excluded (Broto et al. 2010; Wakefield and McMullan 2005). Processes in wider society contributing to stigma may include ignorance, malicious gossip and the creation of a 'mythology of fear' (Parr et al. 2003). The 'carceral' and controlling functions of asylum institutions (Curtis et al 2009: 341) have often seemed to set them apart socially, creating what Goffman (1961) referred to as 'total institutions', cut off

from the wider social environment in a way that stigmatizes those who live there (Goffman, 1963: 50). To an extent, recent changes in mental health care have made psychiatric inpatient facilities more 'permeable' to the wider community, (Curtis et al 2009; Quirk et al 2006; Author et al. Details removed for peer review 2013), and Moon, Kearns and Joseph (2006) discuss how private asylum institutions are reviving the idea of a 'therapeutic community' (Edginton, 1997) where people work together for healing. Nevertheless, some of the material attributes of landscapes associated with the controlling and subordinating functions of these institutions, such as high boundary fences and heavily guarded entrances (Cornish, 1997), remain powerful symbols of the stigma associated with treatment in psychiatric hospitals.

When environmental change occurs, invoking emotions linked to memory of place, these may prompt a response to *salvage* (rescue and retain) landscape elements linked with past positive experiences such as nostalgia and to *abandon* (discard or leave behind) those elements associated with negative emotions such as stigma. New therapeutic landscapes may be designed to selectively remember one's positive experiences, and strategically forget undesirable ones, sometimes by reconstructing, reinterpreting or reusing historical settings in new, more socially acceptable ways (Kearns et al. 2010, 2012; Joseph et al 2013). A place that has been so transformed may be viewed as a site for new beginnings, intended to build a therapeutic landscape from the legacy of the past, as well as the potential of the future.

### **From old to new: re-provisioning the psychiatric hospital**

The Private Funding Initiative (PFI) between 1992 and 2012 in England (Department of Health 1999), led to the transfer of many mental health inpatient facilities into new or renovated premises. Government ministers, NHS planners and managers, architects, and hospital staff and patients participated in designing new facilities, raising hopes for improved care (Gesler et al. 2004). Studies of individual hospitals have assessed to what extent these hopes were realized (Quirk et al. 2006, Curtis et al. 2007). Here we make an original contribution to these evaluations by exploring the emotional experiences of staff and informal carers, as well as patients affected by these changes.

The 'Old Hospital' in our case study opened in the late 1800s and was called an 'Asylum'. Architecturally, it was typical of nineteenth century asyla, standing out from its surroundings as a large, red-brick construction of Victorian design and formidably topped by an old clock tower. By 2000, the Old Hospital was deemed unsuitable for modern requirements, and a new hospital was planned. The Old Hospital was subsequently demolished after being replaced by the 'New Hospital' on an adjacent site, opened in 2010

and accommodating both acute and long term psychiatric inpatient care previously provided in the Old Hospital and two mental health care wards in nearby general hospitals. This development provided a modern, purpose built setting for inpatient care. Patients, carers and staff experienced new living arrangements such as individual bedrooms with *en suite* facilities and altered access to shared space in common rooms and enclosed courtyard gardens, changes to the organization of care within the hospital including enhanced security, management of the building by a company external to the NHS under a PFI contract, and new patterns in routine movements to and through the space of the hospital for patients, carers and staff.

## Methods

Our research took place between March 2010, shortly before the new facility opened that summer, and June 2011, after participants had relocated and had time to settle in. The research was approved by research ethics review committees in the NHS and by the University. Following requirements of the ethics committees, we have disguised the location details and identity of the institutions we studied.

We used purposive sampling to recruit participants including patients, carers and staff using the hospital. We recruited via key contacts within the hospital and with the assistance of the Patient Advice Liaison service. Other community organisations were also involved in the recruitment of some of the carers taking part in the project. We report here on material gathered from 127 research participants who took part either in an individual interview or a discussion group. Thirteen of these took part twice, before and after the move to the new hospital, giving scope to assess changing perceptions over the study period. Table 1 provides further details of the discussion groups and interviews that we have drawn on for this paper. Our reported findings below refer to these groups by the letter code in square parentheses (e.g. [A] for the first group in the table).

**Table 1 Summary of participants taking part in the research.**

CODE	DATE	Interview or Discussion	Role/Type	Number of participants
A	11/02/2011	Discussion	Staff	4
B	09/07/2010	Discussion	Staff	2
C	27/04/2010	Discussion	Patients	4
D	07/04/2010	Discussion	Staff	6
E	23/04/2010	Discussion	Staff	5
F	21/05/2010	Interview	Carer	1

G	27/08/2010	Interview	Carer	1
H	09/04/2010	Discussion	Staff	7
I	10/06/2011	Discussion	Staff	5
J	06/08/2010	Discussion	Consultants	4
K	06/07/2010	Interview	Patient	1
L	18/01/2011	Interview	Site Manager	1
M	22/4/2010	Discussion	Carer	7
N	03/03/2011	Discussion	Patients	3
O	21/09/2010	Discussion	Staff	3
P	06/04/2010	Discussion	Staff	2
Q	07/04/2010	Discussion	Staff	2
R	26/01/2011	Discussion	Staff	2
S	11/08/2010	Interview	Patient (discharged)	1
T	12/04/2010	Discussion	Staff	3
U	21/01/2011	Interview	Carer	1

Our approach corresponds to Gatrell's (2002) definition of social interactionist methodology. Interviews and discussion groups were semi-structured, and initially focused around a single introductory question: *Which features of the old or new hospital building are good or not so good for wellbeing?* This provoked wide-ranging discussion, allowing participants to interpret the salient aspects of a 'therapeutic landscape' in their own terms. In follow up conversations with some participants we were also able to summarise the ideas that had been raised previously and explore these in more depth and in light of experience in the course of transfer to the New Hospital.

Interviews and discussion groups were digitally recorded and transcribed verbatim. A thematic analysis was conducted by three of the authors, grounded in the topics raised by the respondents and drawing on a therapeutic landscapes framework reviewed above to examine how the physical (natural and built), social relational and symbolic (meanings) dimensions were perceived to relate to wellbeing for patient, staff or informal family and friends who were carers. Participant's nostalgic recollections of past experience in the old hospital and other emotions associated with symbolic aspects of the care landscape, such as stigma, were among various themes to emerge and are the focus of this paper.

Research results were fed back to our research participants, giving them the opportunity to comment and make our interpretations more robust.

## Findings

Emotional responses were framed in terms of memories of the hospital environment, especially certain spaces or features perceived by patients or staff to be beneficial for their sense of wellbeing, evoking expressions which we interpret below in terms of nostalgia and solastalgia, reflecting on how our participants felt they would like to salvage and retain these elements of the material and social landscape when they transferred to the new hospital building. Other attributes of the old hospital engendered a more negative response, associated with distressing memories and represented as material and symbolic attributes of the hospital that people were glad to 'abandon'. We describe how these negative feelings were often expressed by participants in terms of stigma associated with the old hospital building.

## Nostalgia

Nostalgic feelings were frequently related to the ways that the old building had fostered a *strong sense of community*. For several staff, the layout of the building meant that they had frequent and close contact with each other, facilitating teamwork and mutual support. As they suggested: '*everybody knew each other*' and '*you were all in the same building so you knew what was happening*' [A]. The 'recreational hall' was a feature of the Old Hospital building, greatly appreciated by staff, patients and carers as space where they could meet and socialise:

The old hospital used to have a recreation hall that was open during the evenings, that patients could access, the charity ran the coffee shop there and they used to do things at night, and I know from talking to patients and nursing staff that it is really missed. There isn't the space to come together on an evening here [at the New Hospital] [B]

The recreation hall was an inclusive space in several ways. The relatively affordable price of refreshments sold in the coffee shop was mentioned by patients, carers and staff. Ex-service users were able to work in the coffee shop as volunteers for the community-based charitable organisation running it. Ex-service users and outpatients would return to the space because '*it was somewhere to come*' and they '*knew that there would be people who understood [...] it was a place that they felt comfortable*' [B]. Features like these affirmed the link between the hospital and the wider community setting.

The Old Hospital building was described by participants as '*homely*' and it was suggested that the Old Hospital '*oozes character*' [C]. Particularly important for patients' sense of a homely space was the freedom to personalise their own rooms by decorating them with their pictures and other items. Being able to put their own artwork on the walls was also an important feature of the occupational therapy room:

The walls were covered [in the old hospital] where we were, and patients really like that. If they did something in art, they were like "Right, I want to stick it on the wall" and permanently stick it on the wall; and you would get people coming and saying, "Oh I did that four years ago when I was in, I can't believe it's still here". And I guess for us you've got good memories with some of the work that you've done, and often other patients would ask "Oh, that's really good, who's done that?" [B].

In this way, the display of artwork contributed to positive emotional reactions through '*continuity between past and present selves*' (Sedikides et al 2008, p306).

We recorded other instances of feelings of *continuity*, closely linked with a sense of *personal history*, evoked by the old Victorian building. One group of patients wished that the Old Hospital had been modernised rather than building a new one. A member of staff suggested that the hospital should be preserved because: '*It's over a hundred years old, and they are going to flatten this, it has got so much history, you would think that they would keep one ward open*' [D]. Another member of staff recalled how '*I went to [work at the old hospital] from school, so it's seen me change, get married, have me kids*' [E] and went on to reminisce about the Old Hospital being festively illuminated at Christmas time. For this participant, the building was so significant for her personal identity that she planned, as the building was demolished, to take one of the bricks home to keep as a souvenir thus '*salvaging*' a material memorial.

Before the new facility opened, some staff anticipated salvaging and incorporating in the New Hospital design certain features of the Old Hospital, such as the clock tower:

...they're going to make some sort of sculpture out of that [the clock tower] and it's going to be in the pit in the middle of the courtyard, so there will be some of it kept, but it is just sad to see the place demolished' [E].

This plan did not materialise, however, perhaps because of the felt need for total transformation of the hospital space by creating a building that was entirely modern and less institutional (as discussed below).

Our findings nevertheless suggest that responding to a sense of nostalgia could have been a valued approach in recreating a therapeutic landscape and this could have been achieved by greater sensitivity to the ways that, for some of our participants, memories of

the old building evoked a sense of nostalgia and a recapturing of beneficial 'feeling states' by visualising past encounters with features of the old building. These responses induced a longing to 'salvage' certain elements in order to preserve the sense of being at home in a community with a history associated with one's personal identity.

### **Solastalgia**

At the new hospital some patients and staff expressed negative emotions, focused on aspects of the Old Hospital that they were missing, showing how the move from one building to another provoked a sense of solastalgia. Several staff members commented that the sense of community in the Old Hospital was lacking in the new facility. Participants described a feeling of not knowing anyone, and being more 'isolated', working in wards segregated into blocks, with very few opportunities for social exchange:

It's such a big place now [the new hospital]. I don't know if you ever went to the [Old Hospital], it was a smallish place... you were in one door and out. Whereas, at this [New Hospital], now, because we are physically in the locks [double security doors], you don't get to see anyone anymore...whereas in the other place you would normally... bump into them and say "are you alright?"... that does not happen anymore, you can go for months without seeing staff over here... it's not good for teamwork and things. [A]

They missed spaces like the old recreation hall in which people could meet and socialise, and hold evening events to bring people together. The café in the new hospital was found to be too expensive for many carers, as well as patients, so they could not afford to use it as a space to socialise [F, G, C]. Ex-service users could no longer work as volunteers because the new café was run by a private for-profit company instead of a local charity [B], and a link between the hospital and the wider community had in this respect been weakened.

The sense of homeliness present in the Old Hospital was also largely felt to be absent. Rather than being described as a homely space with character, the New Hospital building was described as '*very functional*' [H]. One staff member said: '*It's not a home is it, it's not a nice place to be in, everything is square, there is no form in there, it's a block*' [D]. The acoustics were also unhomely; the internal spaces were '*echoey*' and the acoustic discomfort was exacerbated by the sound of the doors that slammed shut as people passed between rooms.

Perhaps the most pervasive aspect of solastalgia was provoked by the sense that the new building engendered a 'clinical' feel; a sense of whiteness and sterility. Related to this was the carceral 'institutional' impression of the high walls surrounding the complex. A member of staff commented: '*if you see a photograph [of the building] it's like a Spanish holiday resort, but then when you get inside it looks like a prison*' [D]. The leasing agreement

for the building imposed restrictions that prevented patients from personalising their own space, and this even extended to the Occupational Therapy unit, where *'we're not meant to put anything [e.g. pictures] on the walls [at the new hospital] ... because the building doesn't belong to us'* [B]. Other staff members mentioned the difficulty of *'...not being able to make it a bit more homely, 'cos you can't put anything on the walls...a lot of our patients like to have pictures and things, and... there's nowhere to put them'* [I]. Thus, in the New Hospital, participants regretted the loss of opportunities to personalise the space and develop a sense of 'ownership', attachment and belonging within the building. This caused some participants to regret the loss of spaces and activities in the Old Hospital through which they used to derive solace.

### **Stigma – escaping the past**

Although, for many of our participants, the old building was seen as homely, for others this was not the case, and they were happy to abandon it. For instance, some made particularly negative comments about physical characteristics of the Old Hospital, describing the building as old fashioned and decrepit. One of the consultants suggested it had a *'musty, old-fashioned kind of smell'* [J]. Staff also described how the security fences *'had ugly bits stuck on top'*, how the place was dark and dingy and made some feel claustrophobic, and that *'it has outlived its purpose...and they have just put sticky plasters on it for the past ten years at least'* [D].

Participants felt the Old Hospital building *'reinforced the whole stigma attached to mental health'* [F] and was known locally *'as some kind of loony asylum'* [T] (similar observations were made by a carer [U]). Consultants [J] commented that the Old Hospital *'had that sort of myth around it that it was a bit sort of medieval'; 'you kind of think of rattling chains and things'*, and it was: *'very reminiscent of that feeling... in Stanley Kubrick's [film] "The Shining", you know, where you get the very long corridor...that's what the old hospital was like [...] people are walking towards you and not knowing "Are they patients? Are they staff? What's going to happen?"...its scary!'* [J]. Thus a disturbing sense of stigma seemed to be provoked through memories of 'scary' attributes of landscape, perhaps referring to Freudian ideas of the 'uncanny' and those which are 'abject' and excluded or 'out-of-place', which have also been explored by geographers (e.g. Hook, 2005; Wilton 1998; Sibley 1995).

For these participants, the physical features and aesthetics of the Old Hospital building offered no sense of homeliness or nostalgia. Instead, the building was outdated and shrouded in stigma, reflecting many negative connotations associated with mental healthcare establishments, which they felt glad to leave behind. In this sense, for these

participants, the stigma attached to the place very much subverts the notion of the psychiatric hospital as one which can be considered to be a 'therapeutic landscape'. When this is contrasted with some of the more positive perceptions of our other participants highlighted above, we found support for Conradson's (2005: 338) ideas about the 'relational dimensions' of the landscape, and how individuals can experience and interact with environments in quite different ways.

### **Creating community and homeliness – embedding a sense of nostalgia**

This desire to move away from the negative perceptions and stigmatisation of the Old Hospital, and create a more modern institutional identity was reflected in the design of the New Hospital. The site manager suggested: '*we knew that it was important to get an identity for the new hospital*' [L]. When the new building was designed planners made attempts to engage with local ideas of community identity and homeliness, including an open invitation to patients and staff to help to choose the ward names [L]. For example, the artwork chosen to decorate the walls of the hospital, and the names of wards evoked familiar and picturesque aspects of the nearby local landscape. Carers were asked to help choose the design of some of the soft furnishings and features of the building such as a stained glass window [M].

This type of inclusion in the design process was appreciated by some of the participants, including carers [M] and patients [N]. However, there were questions over the degree to which patients and nursing staff could significantly influence the building design, with some suggesting that '*we were not involved at the design stage*' and '*you could not influence anything because the design was there; you could not change it, you just provided information and support on operational issues, but even then some of the things you put forward they chose to ignore ... Decisions were being made out of our hands really.*' [O]. Thus inclusion was seen as a token gesture, in which staff, patients and carers were consulted only over minor aesthetic features of the design, not in the overall building design process.

Despite these reservations, the overall appearance of the new building did impress many of our participants. A carer told us that she thought the new building was '*beautiful, and it's modern and it's welcoming*' [M]. On a tour of the building before it opened a member of staff also said '*it looked modern, was bright and had a nice ambiance*' [P]. Others felt that it was larger and more spacious and offered a more open environment [Q]. One of the consultants claimed that the New Hospital gave the impression of being non-threatening and non-institutional, describing it as '*almost like a holiday village*' [J]. Echoing these sentiments, a member of the forensic staff declared that:

If you look out of that window there you think you are in a villa in Spain because of the plantation and the way the colour scheme is, it's just the feeling that you get, especially when the sun comes out 'coz on a nice day you get the shadows as well, like you do on holiday. [R]

Similarly, a patient exclaimed: *'the building design was a beauty, oh god yeah, it was like walking through a different world'* [S].

Other participants commented that the hospital grounds were well landscaped and pleasing to the eye, with attractive internal and external gardens. According to one member of staff a lot of money had been spent on making the new hospital *'look pretty, and arty'* [D]. Respondents commented approvingly on the furniture, the lighting and how the new café menu offered more choice compared to the one in the old recreation hall. Better facilities for patients and staff, including more spaces for therapeutic activities were also mentioned. Several patients and staff also thought that the new building would help to remove the stigma attached to mental health.

### **Conclusions: emotions, collective memory and design of therapeutic settings**

Therapeutic landscapes are seen through the case study reported here as dynamic, changing environments, reflecting developments over time in models of care and changing social constructions of illness and its causes. Our research illustrates how this creates tensions that render the idea of a therapeutic landscape a disputed concept, rather than the subject of mutual consensus. Our study particularly emphasises differences in perception among individuals and social groups, underlining Conradson's (2005) interpretation of therapeutic landscapes as contingent on personal attitudes and experience.

These tensions arise partly from the motivation to innovate and improve therapeutic landscapes and to move away from the stigma and fear associated with some of the older mental health hospitals. Such attempts to abandon this 'spoiled identity' conflicted with emotions of nostalgia and solastalgia, prompting the desire for continuity of valued social bonds and memories of place, accumulated over the life course. Although contemporary practices, aesthetics and physical comfort are important, they may not be sufficient to support senses of place associated with feelings of homeliness, social inclusion and personal identity, established through past experience and provoking the desire to salvage emotional links to the past through material remains. These motives of salvage raised issues of abandonment, nostalgia and salvage also examined in other geographical literature by Desilvey and Edensor (2012), who explore how ruins and material remains can be variably interpreted. The same relict may invoke traumatic recollections for some, or nostalgic feelings for others. As they put it: 'One person sees a painful reminder of a colonial past

another sees affirmation of a glorious history' (Desilvey and Edensor 2012: 479). Material remains may also open up new perspectives, encouraging 'alternative and sensual and imaginative engagements with the past' and standing as 'symbols of consequential histories that open to differential futures' (Deslivey and Edensor 2012. Pp 471-472). To ensure the environment of mental healthcare is a therapeutic landscape, a place in which good health and healing are promoted (Liggins et al 2013), these issues should perhaps be taken into consideration so that a good balance can be achieved in preventing feelings of loss whilst also reducing stigma that some people experience arising from association with the sometimes dubious history of mental healthcare institutions.

In terms of recommendations for good practice in hospital design, a key message from this research is that 'history matters'. For those planning new mental health care facilities it is important to recognise that people often have strong emotional reactions, both negative and positive, to medical spaces of care that are linked with past experiences. Consultation about new hospital design could helpfully incorporate exploration of more positive nostalgic feelings and elements of disappearing environments that service users and carers wish to 'salvage'. Examples included spaces for social interaction, personalisation of the space and salvage of physical artefacts to memorialise the past. Tokenistic consultation may miss important design opportunities that are impossible to rectify later under PFI-build constraints and ultimately may be counter-productive to functionality. Consideration of negative connotations associated with historical care settings can make a valuable contribution to wellbeing and better building design for the future. This could be achieved by drawing on concepts of 'therapeutic landscapes' from health geography, to determine and more clearly understand the emotionally significant, physical, social and symbolic features of environments where inpatient mental health care is provided.

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