Lived experiences of space in secure mental healthcare environments

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Abstract

Focusing on the lived experiences of patients[1] and staff within low and medium secure mental healthcare facilities in the UK, the research examines experiences of space through an exploration of occupants' affective experiences in these settings.

Whilst a body of research examining healthcare settings exists in the fields of health and environmental psychology, the literature commonly focuses on measurable effects concerning physiological and cognitive responses to environments, with limited focus on embodied experience and meaning making in relation to space. Research examining mental healthcare is also frequently approached from predominantly clinical perspectives and psychosocial research exploring patient perspectives and experiences of inpatient settings is more limited, particularly within secure mental healthcare facilities where occupants may typically be hard to reach.

In the context of limited empirical exploration in relation to everyday experiences in secure mental healthcare environments, the primary aim of the study is to expand understanding of how patients and staff make sense of their affective experiences within low and medium secure inpatient settings and the ways in which these experiences might be spatially mediated. Through investigating how patients and staff inhabit the organisational spaces of institutional care, the research also aims to explore how these institutions can constitute supposedly 'private' spaces within their own 'public' spaces.

The theoretical grounding to the research integrates a psychosocial process account of experience with a narrative-psychological approach to enable exploration of relationships between space and affective experience in secure mental healthcare

[1] The term 'patient' is used for technical accuracy in this study to describe participants detained in secure mental healthcare services under a section of the UK Mental Health Act, however, the difficulties associated with the use of this term are acknowledged and 'people who use services' or 'people who live with distress' may be used in other contexts (see Cromby et al., 2013).

services. The research objectives are supported by the chosen qualitative research methodology, which combines a narrative-based approach with visual research methods to access participants' stories about their experiences and the settings in which they take place.

Nineteen interviews in total were carried out with patients and staff from low and medium secure wards within a large mental healthcare facility in the UK. Semi-structured interviewing was used alongside the photographs produced by participants to illustrate the spaces or objects that were relevant to their everyday experiences of the environment and narratives were constructed together with the researcher during the interview. Through this approach, the study explored how participants made sense of their affective experiences within secure mental healthcare environments using narratives that were spatially grounded by their photographs. Following a narrative-based approach to analysis, participants' stories were interpreted using a conceptual framework of narrative levels of analysis alongside narrative analytic tools to identify spatially situated storylines and significant aspects of the accounts.

Approaching the analysis through the transdisciplinary concept of liminality as a theoretical perspective enabled exploration of how tensions relating to the conflicting priorities and paradoxical functionality of secure settings as both places of carceral containment and therapeutic spaces were experienced through participants' interaction with the institutional environment. Ongoing relationships between space and experience were observed, alongside engagement with 'liminal affective technologies' (Stenner, 2017, 2021) by both patients and staff to manage their affective experiences and distress, including the discomfort of feeling 'stuck' in liminal situations. Similarities observed in patient and staff accounts also included experiences of 'public' spaces as typically uncomfortable and a wish for more 'homely' environments to assist in enabling positive social interaction.

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Preface

By instinctively drawing on personal human experience to inform how spaces might be shaped or understood, designers and architects can be seen to presuppose associations between environmental conditions and the experiential qualities of people's everyday lives. My own early appreciation of the built environment, materiality and the sensorial aspects of everyday interactions with spaces and objects evolved through a career in design. Later, alongside my ongoing work as a designer within an architecture and interior design practice, a longstanding interest in human experience, space and mental health developed into a decision to undertake a postgraduate conversion course in psychology. These studies at London South Bank University included inspiring teaching in the field of mental health and distress from scholars whose research expertise and interests include exploring associations between psychosocial processes, relational experience and environments.

Building on an interest in the relationships between space and mental health, a small empirical study undertaken in my final year was concerned with exploring women's affective experiences in domestic environments, with a focus on experiences of low mood and depression. Participants' photographs of home settings grounded their stories in particular spatial contexts and revealed how these everyday domestic spaces or the objects inside them were closely intertwined with their accounts of embodied and psychosocial experiences. Alongside studies in psychology and my continuing work as a designer, a voluntary placement undertaken in a high-support housing setting for people using forensic mental health services in the community contributed to furthering this interest in exploring relationships between residential spaces and mental health.

The current research was accordingly developed with the aim of exploring occupants' lived experiences in the very particular context of forensic mental healthcare settings, where 'home' spaces are typically closely monitored and highly

restrictive environments that are co-inhabited by members of staff. In this context the research aims to investigate the shaping of patients' perceptions of private space by institutional care and explore how co-managing a relationship to 'home' spaces may be implicated in the joint constitution of 'recovery' as a personal and organisational goal.

A body of research examining occupants' experiences of healthcare spaces exists in the fields of environmental and health psychology, however, the literature is typically focused on measurable effects in terms of occupants' physiological and psychological responses to the environment. Whilst research examining the perspectives of people using services and the experiential, psychosocial or symbolic[2] aspects of healthcare spaces is more limited, particularly within forensic mental health, research exploring the experiences of patients and staff in relation to the environment has been undertaken in secure psychiatric settings (see Donald et al., 2015; McGrath, Brown, et al., 2021; Olausson et al., 2019, 2021; Reavey et al., 2019). Building on this and focusing on the lived experiences of patients and staff, the current research explores how both groups experience low and medium secure mental healthcare environments and make sense of their affective experiences in these settings. The thesis is organised around the following chapters:

Chapter One outlines the scope and focus of the research and provides an empirical background to the project through a review of the literature examining associations between space and mental health, with a focus on healthcare settings. The potentially therapeutic or untherapeutic role of environments in healthcare and psychiatric services specifically is explored.

Chapter Two presents the theoretical grounding of the thesis within an embodied psychosocial approach, through which a relational understanding of space,

[2] The words 'symbolic' or 'symbolism' occur throughout this thesis in relation to meaning making and the significance of lived experiences and not in reference to psychoanalytical understandings of these terms.

experience and mental health is explored, with particular attention to affect, subjectivity and the concept of liminality.

Chapter Three provides a rationale for the methodological and analytical approaches chosen for the research. The empirical study is outlined to include accounts of the ethical considerations and processes involved, alongside descriptions of the data collection methods which comprised visual methods and semi-structured interviews. The data set was analysed using a narrative-based approach and the analytical process is also described.

Chapter Four is the first analytical chapter and proposes that participants' accounts of negotiating uncomfortable spaces in the hospital environment can be understood in terms of the experience of being caught in an enduring transitional situation, or 'liminal hotspot'. The discomfort experienced by staff and patients is elaborated in relation to the ongoing indeterminacy of being suspended in liminal circumstances between contrasting worlds.

Chapter Five explores how patients and staff engage with spaces and objects to mediate discomfort or distress experienced within the everyday environment. Drawing further on the theoretical perspective of liminality, participants' processes of managing difficult experiences are explored in relation to the self-production of liminal affective experiences that can enable transition between affective states.

Chapter Six examines the role of space and objects in shaping relational dynamics between and amongst patients and staff. This involves exploring how interpersonal relationships are spatially distributed in the environment and examining the borders that material aspects of the hospital can be seen to create between contrasting worlds of patient and staff activity.

Chapter Seven contains a discussion of the overall findings of the research, including reflections on the research process. The key insights and implications of the study and considerations for future research are also discussed.

Chapter 1: Space and mental health

This introductory chapter will initially situate secure psychiatric environments within an overall context of inpatient mental healthcare and provide a background orientation to secure services in the UK. An examination of the literature exploring patient and staff experiences of the environment, atmosphere and social milieu in psychiatric inpatient settings will be drawn on to evidence an argument that a series of inherent tensions are at play in these spaces. This includes an exploration of the contrasting operational objectives and priorities within psychiatric services, such as the requirement to balance risk management with the provision of a therapeutic environment. The associated contradictions that have been identified in mental healthcare spaces and secure psychiatric settings specifically are understood to be mediating factors in the everyday lived experiences of patients and staff.

Taking account of these contradictions, the chapter will turn to the literature concerned with the potentially therapeutic role of the environment itself within general and mental healthcare settings. Theoretical understandings of how aspects of the environment might contribute to the perceived therapeutic value of healthcare spaces will be examined. Alongside this, the chapter will explore the literature studying the use of theoretical frameworks and evidence-based design to optimise the therapeutic potential of spaces through environmental interventions. This includes research examining the role that exposure to aspects of nature and multi-sensorial experiences might play in mediating health and well-being in healthcare environments.

1.1 Asylum spaces and mental healthcare

Mental healthcare services in the UK can be traced back to the foundation of the monastic Priory of St Mary of Bethlehem in London in 1247 (Killaspy, 2006; Sendula-Jengić et al., 2011). The Bethlem Hospital, known also as 'Bedlam', which was established at the priory in 1330 and later evolved in a series of subsequent buildings,

is recognised as being the first psychiatric hospital in Europe (Sendula-Jengić et al., 2011). Asylums were systematically developed in the UK during the 19th century and The County Asylums Act of 1808 permitted the establishment of public asylums to provide care for pauper or criminal 'lunatics' outside the workhouse or prison (Unsworth, 1993). Following the Lunacy Act of 1845, the construction of county asylums became compulsory and the numbers of people detained within asylums proliferated. Such institutions formed the primary context for mental healthcare treatment until the second half of the 20th century when the shift towards de-institutionalisation and community care brought about the closure of most large psychiatric hospitals in the late 1980s and early '90s (T. Turner, 2004).

1.2 Secure mental healthcare services

This study focuses on the contemporary context of medium and low secure mental healthcare inpatient facilities in the UK[3], as environments in which patients with mental health difficulties may be detained for assessment or treatment under a section of the Mental Health Act. Commonly described as 'forensic'[4] wards or units, secure services exist within the 'post-asylum' landscape of de-institutionalised mental healthcare as a remaining form of institutional inpatient setting in which patients may be detained, often for significant periods of time (Hare Duke et al., 2018; Holley et al., 2020). Patients are typically detained due to the potential risk that they may present to themselves or others and depending on perceived levels of risk, patients may be

[3] Undertaking a second parallel study to explore the lived experiences of staff and people using forensic mental health services within supported accommodation in the community was also planned and pursued originally. Due to protracted approval processes, however, participant recruitment and data collection were not progressed in community settings as this was no longer deemed practicable within the overall project programme.

[4] Whilst the term 'forensic' is commonly used to describe secure mental healthcare services and users of these services, not all people detained in 'forensic' wards have had offended or had contact with the criminal justice system. The settings where this research was undertaken are generally described here as 'secure wards/facilities/units', or 'secure services'.

admitted to inpatient services in healthcare settings that are categorised as high, medium or low secure environments (Kennedy, 2002).

Secure services intersect the mental healthcare and criminal justice systems and work predominantly with people detained on what are commonly referred to as 'forensic sections' under Part III of the Mental Health Act. These patients have had involvement with the criminal justice system and might have been transferred to hospital direct from prison, or may be subject to a hospital order imposed by the courts (Rutherford & Duggan, 2008). Whilst the majority of patients are detained in secure environments under forensic sections (Coid, Kahtan, Gault, Cook, & Jarman, 2001), patients who have had no involvement with the criminal justice system may also be detained in secure services on what are typically known as 'civil sections' under Part II of the Mental Health Act (Galappathie et al., 2017). Individuals who are receiving care in secure environments under civil sections are typically there due to concern about significant risk that they may pose to themselves.

Amidst widespread de-institutionalisation of general mental healthcare provision (Thornicroft & Bebbington, 1989; T. Turner, 2004), secure units exist amongst a reduced number of institutional inpatient psychiatric environments (Shen & Snowden, 2014). Whilst the number of beds in general psychiatric settings diminished as a result of community-based care, capacity in secure services has increased significantly in recent decades (Chow & Priebe, 2016; Jansman-Hart et al., 2011; O'Donahoo & Simmonds, 2016; T. Turner, 2004) and there is increasing need for new secure facilities (Mclaughlan et al., 2021). This process of 're-institutionalisation' and growing demand for secure services can be seen to reflect unintended consequences of de-institutionalisation, including increased visibility within the community of problematic behaviour expressed by people with serious mental health difficulties and the use of the criminal justice system to manage this (Jansman-Hart et al., 2011; O'Donahoo & Simmonds, 2016; T. Turner, 2004). Alongside this, there has been a

decrease in sites of community mental health service support, such as day centres, that may help to prevent more serious problems from arising (McGrath & Reavey, 2016; Pilgrim & Ramon, 2009).

Patients may be detained in secure facilities for indefinite periods of time and whilst length of stay may typically be between 2 to 5 years, more than a quarter of people in high or medium secure settings may spend upwards of 10 years within secure services (Rutherford & Duggan, 2008; Shah et al., 2011). During their pathway through secure services patients may typically transition between levels of security or between units in different geographical locations. Facilities are commonly located at significant distances from a patient's family, home or community (Durcan et al., 2011) and this physical distance can in turn contribute to patients' perceptions of disconnection from social networks (Coffey, 2012a).

Movement within secure facilities is restricted and to leave the ward or visit places including the hospital grounds or wider community, patients require permissions from a Responsible Clinician and where relevant, the Ministry of Justice. Subject to levels of risk, patients may require staff escorts when accessing spaces off the ward and closed-circuit television (CCTV) is generally used throughout the environment. Staff, patients or visitors enter and exit the facilities via airlock door systems and posters displayed in reception highlight stringent rules about items that are banned or restricted within the units. Visitors may be provided with a personal alarm for use inside the facility and any prohibited personal possessions, including mobile phones, must typically be stored in lockers before entering.

By their nature secure psychiatric services typically constitute isolated and highly restrictive environments where visiting is regulated and patients' contact with the wider world, including internet access is limited (Tomlin et al., 2020). Because patients may be involuntarily detained in secure services for prolonged periods of time, such restrictions can also be in place for many years (Hare Duke et al., 2018). Secure

psychiatric settings can consequently be understood to be less 'permeable' or connected to the world outside hospital than other contemporary forms of inpatient mental healthcare environment, where patients may be admitted voluntarily and length of stay may typically be shorter (Quirk et al., 2006).

1.3 Environmental tensions in psychiatric settings

Whilst length of stay may mean that inpatient mental healthcare units represent 'home' for some patients, these residential spaces also comprise workplace environments that are continuously co-inhabited by staff. Environmental or atmospheric tensions may then exist in psychiatric wards, where both workplace and residential functions are combined in a hybrid setting that can be seen to represent both 'hospital' and 'home'.

Studies exploring patient and staff views about these shared spaces have highlighted how the ward environment and atmosphere can be experienced in different ways by both groups (Brunt & Rask, 2005; Rossberg & Friis, 2004; Shattell et al., 2008). For example, Rossberg and Friis' (2004) examination of staff and patient assessments of a psychiatric facility found that perceptions of the ward atmosphere were more important in relation to satisfaction with the ward for patients than for staff. In addition, whilst the working environment was strongly linked to the satisfaction of staff members, it appeared to be unrelated to patient satisfaction. Rossberg and Friis (2004) also point out how disparities in the everyday experiences of both groups can give, "[…] the impression that patients and staff live in "different worlds," even though they share the same physical and social environment" (p.798).

Research examining staff and patient viewpoints has also exposed ways in which the priorities and expectations of both groups in relation to inpatient psychiatric settings may overlap or differ on aspects of the environment including the therapeutic milieu (Livingston et al., 2012; Shattell et al., 2008) and the ward design (Csipke et al., 2016; Curtis et al., 2007). Shattell and colleagues' (2008) exploration of the therapeutic milieu in an acute psychiatric setting found that although staff and patients reported

parallel perceptions of feeling constricted within a prison-like environment, they had greatly contrasting experiences regarding the passing of time. Within this environment, time was felt to be rushing by for the busy staff, yet it stood still for patients, who were typically bored and also reported that not having enough to do to occupy their minds promoted rumination and a sense of anxiety. Such differences in staff and patient experiences within the same spatial context have also been described by researchers as a "split milieu" (Nicholls et al., 2015 p.292).

In a post-occupancy study of a new build psychiatric facility, Curtis et al. (2007) highlight how an ongoing discussion about the potential inclusion of an aquarium on the ward provides an example of the disparity between patient and staff perspectives in relation to the built environment. Whilst it was staff members' opinion that the aquarium glass would pose a safety risk in the environment, patients disagreed with this view. This debate also highlights a fundamental tension regarding the design of psychiatric wards, which will be elaborated in the following section, whereby the creation of therapeutic or home-like spaces to facilitate 'recovery' or rehabilitation must be balanced with predominant concerns about safety, security and risk management (Curtis et al., 2013).

1.3.1 Balancing risk and rehabilitation

Despite growing aspiration for person-centred approaches to care in mental healthcare settings, existing design models for psychiatric environments typically focus on risk reduction protocols and creating spaces that enable efficient patient management and observation by staff (Golembiewski, 2015). The inherent environmental tension between managing risk and creating therapeutic spaces is especially pronounced in secure psychiatric settings that are situated between the criminal justice and mental healthcare systems, whilst not being fully located in either (McGrath, Brown, et al., 2021). Livingston et al. (2012) highlight how, from a healthcare perspective, people detained in secure facilities are 'patients', for whom the system is there to provide care

and support in a process of rehabilitation. Yet, conversely, for those involved in the criminal justice system, from this perspective they are also regarded as 'offenders' for whom the system and environment are concerned with containment in order to reduce the risk of recidivism or control potentially dangerous behaviour.

Paradoxically, secure psychiatric services are thus simultaneously required to provide robust levels of security in a high-risk setting to maintain the safety of patients and the wider community, whilst also creating a therapeutic context within the least restrictive environment possible (Seppänen et al., 2018; Shepley et al., 2016). Reflecting the challenges presented by this paradox, Curtis et al. (2013) point out how the Department of Health (2011a) design guidelines stress that the balance in secure psychiatric settings is, "[…] between maintaining the safety and security of patients and staff, providing an effective, beneficial therapeutic environment, and protecting the public" (p.7), yet provide limited guidance on how to achieve this. As a consequence of these tensions and the predominant focus on risk mitigation, studies examining patient and staff perspectives have found the environmental attributes of psychiatric inpatient spaces to be commonly perceived as non-homely or clinical, with limited therapeutic quality (Csipke et al., 2016; Donald et al., 2015).

Csipke et al. (2016) employed participatory methods in a psychiatric ward to explore staff and patient views about the physical environment and created a questionnaire with patient-generated measures to assess the ward design. In addition, patient participants were invited to take two photographs to capture their perspectives on the best and worst physical aspects of the environment. Both groups described the overall environment as being "institutional" and "bland" and participants' accounts suggested that a visual "brightening up" of the ward environment, including the integration of artwork, would help improve perceptions of well-being (p.118). Patients' appraisals of the therapeutic value of a psychiatric inpatient unit examined in research by Donald et al. (2015), similarly included perceptions of the environment being,

"sterile" and requiring a greater sense of comfort, or "confused" and "weird" in terms of lacking a clear spatial identity (p.65). The authors sum up the awkwardness of the indeterminate and paradoxically 'doubled' environmental characteristics by highlighting how participants found the ward to be, "[…] somewhere between a hospital and a home, without being either" (p.65).

1.3.2 Privacy, choice and control

As environments designed to accommodate detained patients in a residential setting, yet simultaneously comprising a workplace context for non-resident staff, psychiatric wards constitute hybrid spaces with both 'private' and 'public' operational objectives and priorities. Within these settings and especially so in the highly restrictive and monitored spaces of secure mental healthcare services, patients may commonly experience a loss of autonomy or control and an associated loss of privacy (Koller & Hantikainen, 2002). Patients' loss of privacy can be seen to relate to environmental experiences in secure psychiatric settings, including sharing a residential space with many other people and being continually observed by staff. Due to primary operational concerns about safety and risk management, patients are closely monitored in communal areas of psychiatric wards and are routinely checked during the day and night in the more 'private' spaces of their bedrooms. In instances where there is significant concern about risk, patients may also be observed by staff when using the bathroom. CCTV cameras are used throughout the hospital environment and provide a technical form of surveillance over the behaviour of both patients and staff members (Curtis et al., 2013).

Perceptions of privacy in psychiatric settings are also linked to spatial or social density and comparisons between contemporary mental healthcare facilities and historic asylum buildings suggest that patients may be confined in modern wards that occupy around 70% less space than their Victorian equivalents (Johnstone, 2004). Correspondingly, issues concerning crowding and privacy are prevalent themes across

the literature in studies exploring relationships between environmental design and the experience of mental healthcare spaces (Connellan et al., 2013; Kumar & Ng, 2001). In a review of the literature concerned with violence and crowding in psychiatric settings, Kumar and Ng (2001) highlight how density, privacy and control are three interrelated variables that can contribute to crowding on wards being a risk factor for safety issues or aggression. The authors argue that social density can increase stress and frustration by reducing patients' sense of privacy and control over their immediate environment. Accordingly, crowding on an acute psychiatric unit, as studied by Ng et al. (2001), was found to be significantly associated with the occurrence of aggression, particularly incidents of verbal aggression. Aggression related to crowding stress in psychiatric wards is hence understood to reflect attributes of the physical environment that restrict patients' access to privacy and ability to regulate imposed interaction with others, or avoid environmental stressors, including noise (Lundin, 2021; Ulrich et al., 2018).

Congruently, perceiving a lack of control over the environment in hospitals has been found to promote anxiety or stress responses in patients and a key principle in Ulrich's (1991) theory of supportive design centres on enabling patients to experience a sense of control over the physical-social surroundings. Choice, control and tailored services for hospital patients are also promoted in the personalisation agenda set out within the UK health system (Department of Health, 2011b). However, research findings suggest that opportunities for patients to exert control over their everyday environments in mental healthcare settings are typically very limited (Lawson et al., 2003; Papoulias et al., 2014). Karlin and Zeiss (2006) highlight how perceptions of choice and control are entwined with social experiences in psychiatric wards and argue that design interventions, including zoned seating in communal spaces, can offer choice and flexibility to allow patients greater control over levels of social contact.

Privacy is also significant to how staff, patients and visitors manage interpersonal relationships within psychiatric wards, including patients' romantic or intimate relationships with partners, or other patients and expressions of sexuality that may take place alone. For reasons including lack of privacy, patients have limited opportunity for sexual expression within inpatient psychiatric settings (McCann, 2010), yet it is acknowledged that sexual activity takes place, despite policies prohibiting sex commonly being in place on psychiatric wards (Warner et al., 2004). Facilities do not allow for patients to have intimate relationships with a partner or other patients and there is a lack of formal policy concerning patient sexual relationships across UK secure services (Dein & Williams, 2008).

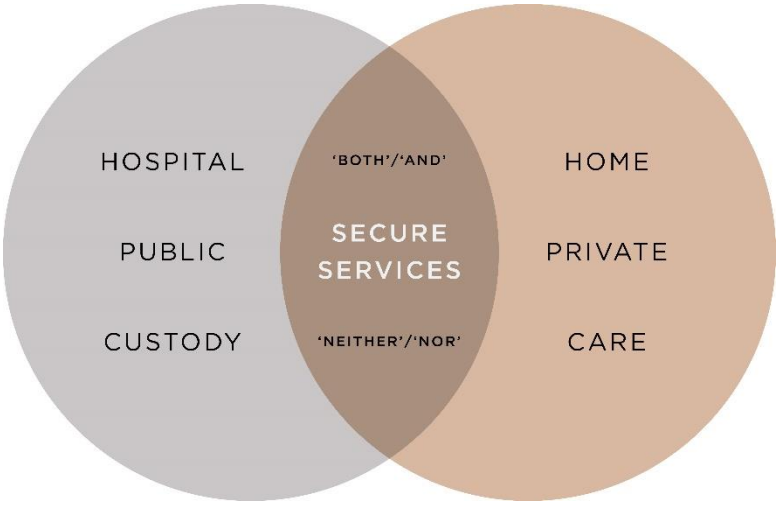
Many complex considerations around sexual expression and relationships, including patients' health, safety, ability to consent, or offending behaviour where relevant, present dilemmas to providers of secure services and staff are often reticent about discussing sexuality with patients (S. D. Brown et al., 2014). Whilst acknowledging the concerns and challenges associated with facilitating patient relationships in secure services, staff and patients also recognise how closeness, companionship or intimacy might be beneficial and help to promote patient health and well-being in these environments (Quinn & Happell, 2015a). Accordingly, accounts of patient and staff perspectives towards patients' experiences within secure services suggest that both groups recognise a need to provide private and dignified spaces for sexual activity (Quinn & Happell, 2015b). However, the complex issues around patient sexuality are commonly neglected in the guidelines or policies within psychiatric institutions and further research on patient sexual behaviour is required to assist with clear and inclusive policy making (Anex et al., 2022; Reavey et al., 2022).

1.3.3 Hybrid environments

The environmental tensions that have been explored thus far reflect some of the contrasting and typically conflicting operational objectives and priorities around which

mental healthcare and secure psychiatric services in particular are organised. As indicated diagrammatically in Figure 1, it has been argued that these dualities present a sense of paradox that brings 'both/and' and 'neither/nor' qualities to the physical and psychosocial environment that can mediate the everyday experiences of patients and staff within the spaces of secure psychiatric care.

Figure 1
Environmental tensions in secure mental healthcare settings



Secure hospital spaces function as busy workplaces for staff members and are also accessed by external visitors, yet these same spaces simultaneously constitute residential settings where patients live out the day-to-day experiences of domestic life. As custodial environments in which patients are involuntarily detained, secure psychiatric spaces have dual functionality as highly restrictive places of containment, yet also existing to provide supportive, caring environments in which to facilitate processes of rehabilitation and community re-integration for patients. Resulting from these hybrid attributes, secure psychiatric services occupy an indeterminate zone between different functional priorities, in spaces that can be seen to be fully fulfilling neither one set of priorities, nor the other.

In light of these tensions, the following sections explore the literature that is concerned with examining how the therapeutic potential of the environment might be optimised through design within healthcare contexts. This includes reference to the increasing awareness of the role that exposure to natural environments and multi-sensorial experiences can play in mediating health and well-being.

1.4 Therapeutic environments

Before exploring contemporary thinking about therapeutic environments in mental healthcare, it is helpful to return to the historical asylum context and specifically, the York Retreat, a small private asylum where the 'moral treatment' approach was pioneered at the end of the 18th century. In a turn against prevailing punitive attitudes in traditional places of confinement, the moral treatment philosophy was based on compassionate principles and aimed to afford comfort and dignified, humanitarian care in a carefully designed environment (Edginton, 1997, 2003). The physical context and design of the built environment was accordingly a key concern and the concept that an institution in itself could possess therapeutic potential was integral to the approach (du Plessis, 2012). Examples of how consideration of the therapeutic environment was built into the architectural design of the Retreat include the discreet concealment of windows bars within the window frames and door locks encased in leather to muffle the disconcerting sound of bolts (Fennelly, 2014; Laffey, 2003). Moral treatment principles had a widespread influence on 19th century asylum architecture, alongside the external landscape design, in which the active role of the natural environment in treatment was prioritised (du Plessis, 2012; Edginton, 1997, 2003; Hickman, 2009, 2014).

From the second half of the 20th century, the 'post-asylum' era saw a reduced focus on the therapeutic role of the physical environment in mental healthcare, with significant contributing factors including the development of psychopharmacology, de-institutionalisation and the introduction of community care (T. Turner, 2004). Recent

decades have, however, seen renewed interest in and increasing recognition of the potentially therapeutic role of the environment within healthcare contexts. The notion of 'therapeutic landscapes' (Gesler, 1992, 2005) provides a conceptual framework for examining how the physical, social, or symbolic attributes of environments might interact and contribute to experiences of physical and mental health and well-being in different places (Curtis et al., 2007). Applying this perspective to healthcare environment design, Gesler and colleagues (2004) thus argue that, "the therapeutic value of hospitals is related to their physical, social and symbolic design" (p.117). Correspondingly, research examining the therapeutic value of inpatient psychiatric environments suggests that perceptions of the physical, atmospheric, social, cultural and symbolic aspects of these spaces are intertwined and can be equally significant to staff and patient experiences (Connellan et al., 2013; Curtis et al., 2013; Donald et al., 2015; McGrath & Reavey, 2019). It can hence be argued that assessments of how mental healthcare spaces might be considered to be healing should consider not only physical attributes, but also social and spatial affordances of environments, such as the extent of free movement or social interaction that occupants may be offered (Simonsen & Duff, 2020).

Drawing on the combination of psychosocial and spatial qualities that may contribute to positive environmental experiences, healthcare organisations have also generated approaches towards developing therapeutic services and environments. Stichler (2008) outlines the relationship-based philosophy of the international, non-profit organisation, Planetree, which aims to create therapeutic healthcare spaces based on nine key principles: "human interaction; consumer and patient education; healing partnerships with patients' family and friends; food and nutritional nurturance; spirituality; human touch; healing arts and visual therapy; integration of complementary therapies; healing environments created in the architecture and design of the healthcare setting" (p. 506). Staff culture and attitudes are highlighted as being

integral to the organisation's relationship-based approach and having an association with both user and staff satisfaction.

The 'Enabling Environments' (EE) initiative developed by the UK Royal College of Psychiatrists similarly draws on relational factors that are understood to contribute to positive psychosocial environments and centres around ten core values: belonging, boundaries, communication, development, involvement, safety, structure, empowerment, leadership and openness (Royal College of Psychiatrists, 2019). The EE approach is applicable to a range of different sectors, including healthcare and criminal justice environments and offers a set of standards and criteria to provide guidance on how the 'enabling' values might be achieved and implemented in practice. As an off-shoot of EE, the associated concept of 'Psychologically-informed Environments' (PIEs) forms a flexible framework to promote shared reflective practice within services and encourage tailored, therapeutic environments informed by psychosocial perspectives (R. Johnson & Haigh, 2011). The parallel concept of 'Psychologically-informed Planned Environments' (PIPEs) draws on similar principles to PIEs, whilst also acknowledging the robust security considerations required for approaches in high-risk settings, including prisons and secure environments (Haigh et al., 2012).

Researchers examining the geography of health have drawn on the notion of therapeutic landscapes to explore relationships between the characteristics of mental healthcare environments and the experiences or well-being of occupants (Curtis et al., 2007; Gesler et al., 2004; Wood et al., 2013b). Curtis et al. (2007) undertook a post-occupancy evaluation of a new psychiatric facility based on interviews and discussion groups with staff and former patients. Whilst participants made a range of positive and negative appraisals of physical aspects of the environment, including air quality, light, materiality and food quality, the symbolic and social characteristics of the environment were referred to with equal frequency. Participants' reflections about social features included issues of privacy and the need to empower patients to have greater control

over decisions regarding their treatment or environment. Accounts of the symbolic environment included references to specific characteristics, such as the hospital's location on a waste site adjacent to a busy road and the tall fencing around the secure unit which was perceived to have prison-like associations.

Similarly, Payne and May (2009) explored the relationships between the environment and occupants' perceptions of well-being in an evaluation of a psychiatric intensive care unit refurbishment undertaken as part of the 'Enhancing the Healing Environment' initiative in the UK supported by the King's Fund (Department of Health, 2008). Patients' perceptions of homeliness in the new ward were associated with a combination of positive physical, social and symbolic features, including the overall quality and cleanliness of the environment compared with the original ward, private spaces for visitors, comfortable furniture, natural light, openable windows, high quality food and staff attitudes. Staff described the new environment as being calmer than the original ward, in addition to having a greater sense of light and feeling more open. The average length of stay for patients reduced by 20% following the refurbishment and a significant reduction in physical assaults on staff and other patients was also reported. Such findings can be seen to offer support for the argument that the environmental context in itself can be considered a key health intervention in mental healthcare settings (Golembiewski, 2013).

In the specific context of secure psychiatric services, Lawson et al. (2003) compared an existing facility with a new build medium secure mental health unit to explore the relationships between patient behaviour or health outcomes and the environmental conditions. Rates of verbal or physical aggression remained the same in both sites, however, in the new facility the severity of incidents reduced, alongside a two thirds reduction in patient self-harm. Seclusion use reported in the new unit also reduced by 70% and there was a 14% reduction in patient length of stay. Patient participants' comments suggested that greater provision of tactility and texture in the

material qualities of the hospital and variation in lighting and use of colour would afford an increased sense of homeliness in the overall environment. As Lawson and colleagues (2003) point out, these suggestions are situated in direct contrast to the conventional appearance of hospital wards, where smooth, bland or clinical finishes and bright, uniform lighting are typical.

Overall, research specifically examining relationships between the design of psychiatric wards and patient outcomes or experiences is limited (Liddicoat et al., 2020; Papoulias et al., 2014). In general healthcare, however, an increasing body of literature has examined ways in which environmental design based on research evidence may influence the impact of healthcare provision, including patient outcomes, length of stay and quality of experience (Devlin & Andrade, 2017; Devlin & Arneill, 2003; Iyendo, 2016; Reavey, Harding, et al., 2017; Ulrich et al., 2008). The therapeutic value of exposure to nature is frequently cited within this literature (Reavey & Harding, 2019; Ulrich et al., 2006, 2008) and is pertinent to the current exploration of secure psychiatric spaces, where patients typically have limited access to natural spaces.

1.4.1 Creating connections to nature

The associations between natural environments and mental health are long established and research findings suggest that exposure to aspects of nature can afford restorative and protective health benefits by mediating psychological and physiological stress (Berto, 2014). From an evolutionary perspective, the principles of Ulrich's (1983) Stress Recovery Theory (SRT) assume an inherent human predisposition towards natural environments. Accordingly, within the SRT framework, Ulrich argues that non-threatening natural environments can produce positive feelings and enhance perceptions of well-being by reducing stress and physiological arousal. Similarly, the biophilia hypothesis proposed by Wilson (1984) contends that humans have an innate need for contact with nature and other forms of life. Biophilic principles thus presuppose associations between human affinity with nature and an evolutionary

dependence on the natural environment to provide essential resources for survival, such as sunlight, shelter, food and water (Heerwagen, 2009).

Amidst the context of rising global urbanisation, the amount of time that people typically spend in natural environments is reducing (W. R. Turner et al., 2004). Whilst decreased contact with nature may be associated with increased mental health difficulties (Bratman et al., 2012), research findings also suggest that access to natural or environments or 'green space' can help promote psychological well-being (Ulrich et al., 2008; Ward Thompson, 2011; Ward Thompson et al., 2012). The therapeutic potential of exposure to water has also been explored in the emerging area of research concerned with experiences of 'blue space' (Foley & Kistemann, 2015; Gascon et al., 2017; Völker & Kistemann, 2011). Exposure to bodies of water has been linked to lower levels of psychological distress (Nutsford et al., 2016) and the presence of water has been found to enhance the positive influence of natural spaces on mood and levels of self-esteem for people with lived experience of mental distress (Barton & Pretty, 2010). Natural landscapes, are accordingly argued to be vital public health resources that can provide accessible, affordable and effective means of health promotion in general society (Maller et al., 2006).

Healthcare environments are commonly felt to be detached from nature and a body of literature has examined how exposure to aspects of nature can be restorative or promote patient, staff and visitor well-being within general hospital settings (Iyendo et al., 2016; Joseph, 2006; Ulrich et al., 2008). Ulrich's (1984) influential study found that hospital window views containing natural scenery were associated with reductions in patient post-operative recovery time and use of pain-killing medication, when compared to hospital rooms with windows overlooking a brick building. Views of nature have also been associated with health benefits including stress reduction (Ulrich et al., 2006) and an increased sense of connection with life beyond hospital for inpatients (Douglas & Douglas, 2005; Lawson et al., 2003).

Studies have also examined the influence of exposure to natural light in healthcare settings and in comparison to dull rooms, bedrooms with natural sunlight have been found to reduce length of stay in psychiatric hospital settings for patients experiencing low mood (Beauchemin & Hays, 1996; Benedetti et al., 2001). Similarly, Lewy et al. (1998) found that the effect of exposure to morning bright light treatment was at least twice as effective as evening light in reducing measures of depression for people with a diagnosis of seasonal affective disorder. Correspondingly, the design recommendations proposed by Joseph (2006) drawn from research examining associations between light quality and health outcomes in hospital settings include orienting windows to optimise exposure to early morning sunlight, alongside making provision to facilitate temperature and glare control in patient bedrooms.

Although research examining the use of interior finishes in healthcare environments is limited, an experimental study by Zhang et al. (2017) compared participants' experiences of inhabiting rooms with plain white walls, to rooms with varying extents of timber panelling. Measures of participants' mean blood pressure and heart rate variability levels were lower in rooms with timber panels, suggesting that less stress and tension were experienced in these spaces where timber was visible. Similarly, Nyrud et al. (2014) compared hospital staff views towards images of the same patient room depicted with either no timber in the design, or differing amounts of timber finishes on the floor, walls and ceiling. The rooms at both ends of the 'no timber' to 'fully timber' continuum were the least preferred, while the most favoured design contained an intermediate amount of timber, applied only to the floor, loose furniture and a single feature wall. These findings can be seen to be supportive of arguments for facilitating exposure to potentially stress-reducing and restorative natural elements or materials within mental healthcare spaces, which in turn might contribute to reduced aggression by helping to minimise environmental stress (Ulrich et al., 2012).

In the context of designing mental healthcare environments, Shepley et al. (2016) draw attention to the significance of providing access to therapeutic outdoor spaces with multiple functions, such as vegetable gardens, sports and recreation facilities, as key environmental features that may benefit patients and staff. Likewise, Dvoskin et al. (2002) outline the approach to designing a new build secure mental health facility and recommend providing patients with freely accessible outdoor space. The day areas that were designed in the project are accessible to patients at any time and directly connected to outdoor spaces to form indoor-outdoor day rooms that are fully visible to staff from indoors. Studies have also examined the therapeutic value of active physical engagement with nature and a review of research evaluating gardening-based interventions in mental healthcare found that positive benefits were associated with interventions in all the studies reviewed, including significant reductions in symptoms of depression and anxiety (Clatworthy et al., 2013).

1.4.2 The sensory environment

Recent years have also seen increasing interest in trauma-informed approaches to care and design, including the use of sensory environments in psychiatric settings (LeBel et al., 2010; Procter et al., 2017). Trauma-informed practice is grounded in an awareness of trauma and lived experience and seeks to actively empower patients in approaches to care and avoid re-traumatisation through a set of guiding principles that prioritise safety, trust, choice, collaboration, empowerment and cultural consideration (Office for Health Improvement and Disparities, 2022; Procter et al., 2017). Difficult or traumatic experience can have lasting neurological, biological, psychological and social effects (LeBel et al., 2010; Procter et al., 2017; van der Kolk, 2015) and exposure to adverse life experiences or trauma is common amongst people receiving treatment for severe mental health problems (LeBel et al., 2010; Rosenberg et al., 2001). Research also suggests that people experiencing mental distress may be hyper or hypo sensitive to sensory stimuli including noise, touch, light and vestibular input relating to movement

and balance (Abernethy, 2010; LeBel et al., 2010; Lloyd et al., 2014; Sutton & Nicholson, 2011). Whilst sensory processing difficulties may contribute to symptoms of distress, including anxiety or the negative symptoms experienced by some people with a diagnosis of schizophrenia, problems in regulating sensory input are understood to be a corollary of mental health problems (Sutton & Nicholson, 2011) and traumatic experience (van der Kolk, 2015). Sutton and Nicholson (2011) also highlight how sensory modulation issues are intensified by the response of the sympathetic nervous system which is frequently overly reactive in people experiencing acute distress.

Sensory rooms in healthcare settings are environments that can be tailored to suit individual needs and typically include therapeutic elements to engage different senses, such as optic lamps, scenic pictures, weighted blankets, music and aromas that are used to promote sensory modulation and emotional regulation or soothing (Champagne & Stromberg, 2004; Costa et al., 2006; Sutton et al., 2013). Within an acute mental healthcare environment, Sutton and Nicholson (2011) found that a variety of multi-sensory stimuli were felt to be effective in reducing distress and promoting calm for patients with a broad range of clinical diagnoses and lived experiences, including anxiety, voice hearing and paranoia. In the same study, sensory environments were also typically perceived to afford safe, quiet spaces away from ward activity and sensory approaches enabled patients to develop tools to self-manage distress and reduce the need for *pro re nata* (PRN) treatment (medication which is dispensed as needed).

Scanlan and Novak's (2015) scoping review examining the emerging field of sensory approaches within mental healthcare found that patients and staff in the majority of studies perceived sensory rooms to have a positive effect on the overall ward environment. The authors highlight how studies have predominantly examined sensory interventions in relation to reductions in either the use of seclusion and restraint, or levels of patient distress and the review found that sensory interventions

were generally associated with reduced levels of distress for patients. Whilst some evidence suggests that sensory approaches can contribute to the reduced use of seclusion and restraint in psychiatric settings (Champagne & Stromberg, 2004; Cummings et al., 2010; Lloyd et al., 2014) findings across the literature are mixed and further research is required to test initial findings (Scanlan & Novak, 2015).

Alongside increasing interest in the use of designated sensory rooms within healthcare settings, there is growing awareness of the potentially therapeutic influence of interior design and sensory interventions in the hospital environment more widely (Connellan et al., 2013; Iyendo et al., 2016; Schweitzer et al., 2004). However, guidance or information available to assist with developing the design of the visual environment in hospitals, including psychiatric settings has generally been very limited (Dalke et al., 2006). In a report focusing on the use of colour and lighting in hospitals, Dalke and colleagues (2004) argue that enclosed spaces with intense colours can be threatening or overly stimulating to people experiencing distress. Accordingly, it is recommended that colours and lighting are used to allow spaces to appear as light or open as possible and suggested that palettes of muted colours, which are 'greyed-off' to include a percentage of black, can aid relaxation and reduce stress. Karlin and Zeiss (2006) similarly report that bright colours may be over-stimulating to people experiencing agitation or distress and suggest that colours which are closely matched in terms of intensity and tone can have a calming quality.

Mazuch and Stephen (2007) argue that touch is a significant sense for patients with mental health difficulties as it can help individuals to re-engage with the materiality of the world around them. The authors also highlight the importance of avoiding perceptual confusion in psychiatric environments, such as using timber grain finishes on metal doors which would be surprisingly heavy and colder to the touch than timber doors. The tactile experience of materials is explored in Sakuragawa and colleagues' (2008) study examining participants' physiological and subjective

responses to touching samples of timber, aluminium or acrylic stored at different temperatures. The study found that the sensation of touching timber stored at room temperature and cooled timber was perceived to be 'natural' and neither condition prompted an increase in blood pressure. In contrast, contact with cooled acrylic or aluminium at room temperature induced sensations described as "artificial", "flat", "dangerous" or "uncomfortable" (p.110) and was associated with a significant increase in blood pressure, suggesting a close connection between the subjective evaluation of materials and physiological responses. Despite a lack of research examining experiences of touch in relation to the built environment and materiality in psychiatric settings, these findings suggest that the tactile qualities of architectural finishes could be as meaningful as their visual properties.

Regarding the sense of smell, commonalities across the literature examining patient experiences and sensory responses to general healthcare environments suggest that pleasant aromas may contribute to reducing blood pressure, lowering pain perception levels and slowing respiration, whilst unpleasant smells may prompt stressful responses (Connellan et al., 2013). Mazuch and Stephen (2007) accordingly emphasise that air quality and movement is especially important in secure settings where windows are generally of a small size and are kept closed.

1.4.3 Hospital soundscapes

Psychiatric hospitals are typically noisy environments and sound levels recorded in mental health wards have matched or exceeded the levels shown to affect cardiovascular or cognitive functioning in workplace and community settings (Holmberg & Coon, 1999). Multiple mechanical and human sound sources contribute to high hospital noise levels and research in general medical settings suggests that noise can have effects on patient health, including sleep disruption and raised blood pressure levels, in addition to increased length of stay and increased probability of re-admission (Hsu et al., 2012; Joseph & Ulrich, 2007). Despite the adverse effects of hospital noise

pollution on both patient and staff health (Hsu et al., 2012; Ryherd et al., 2012), Lawson et al. (2003) point out that contemporary healthcare design has typically focused on visual or spatial aspects of environments, with limited emphasis on sound control and overall acoustic quality.

As people experiencing mental distress may have increased sensitivity to noise (Stansfeld, 1992; Sutton & Nicholson, 2011), patients' experiences of the acoustic environment are particularly significant in mental healthcare settings. Sound control is also relevant to patients' sleep quality in psychiatric wards, since people with mental health difficulties may commonly experience disturbed sleep (Abad & Guilleminault, 2005; de Niet et al., 2008; Kamphuis et al., 2013), or have an increased need for sleep (Southwell & Wistow, 1995). Despite this, reports of disturbed sleep associated with noise on the ward and disruption from nursing observations at night time are widespread amongst patients in psychiatric care (Veale, 2019). Studies also suggest that patients' vulnerability to the emotional dysregulating effects of sleep disturbance could be a potential risk factor for aggression and violence in secure psychiatric settings (Kamphuis et al., 2012). Accordingly, Kamphuis et al. (2014) found that higher levels of insomnia and lower levels of sleep quality, as reported by patients in secure settings, were associated with higher levels of self-rated aggression or impulsivity and higher levels of clinician-rated hostility.

Rice (2003) studied the soundscape in a general hospital environment and in reference to 'panopticism' as a theorisation of visual surveillance by authorities (Foucault, 1975/1991), Rice uses the term 'panauralism' to allude to the monitoring function of listening for hospital staff. Similarly, research undertaken with patients and staff in a newly built medium secure psychiatric unit highlights how such listening practices are typically used by staff to attune to the atmosphere on entering a ward and sound out unrest in advance of seeing it (S. D. Brown et al., 2019a, 2019b). Staff participants in Brown and colleagues' research reported, however, that high ceilings

with skylights, which were designed to optimise a sense of space and light, also contributed to sound reverberation that disrupted listening practices, as the reflected sounds were not easy to localise. Alongside this, the associated exacerbation of specific sound sources in these spaces, including jangling keys and slamming doors, was found to contribute to patients' perceptions of being incarcerated and created associations with punitive environments.

Acoustic quality and environmental conditions are also significant to issues surrounding privacy or confidentially in hospital environments (Joseph & Ulrich, 2007). Wood et al. (2013b) found that the absence of designated visiting rooms in a new psychiatric facility affected visitors' experiences and courtyard gardens afforded a more comfortable and relaxing place for visits than communal areas where the acoustic conditions generated unpleasantly high noise levels. Isobel, Foster and Edwards (2015) similarly highlight how the provision of designated family visiting rooms in psychiatric settings affords respite from high noise levels on the ward and acknowledges patients' needs for privacy and connection with friends and family, including children.

1.5 Expert experience and mental healthcare research

Policy makers and researchers are increasingly concerned to draw empirical knowledge directly from the lived experiences of people accessing healthcare services (Beresford, 2002). Valuing this expert experience can help moderate misalignments between user and clinician perspectives and qualitative research to facilitate accounts of lived experiences and service evaluation can also expose clinical outcomes which could not be easily articulated purely through quantitative measures (Naylor et al., 2008). Although user involvement in the planning and delivery of mental health services has been promoted over recent decades by the Department of Health in the UK (Rutter et al., 2004; E. L. Simpson & House, 2002), there remains a lack of recognition for user-led and survivor research in mental health as an entity in its own right (D. Rose et al., 2018). There is also limited existing research evidence about what is

important to inpatients within the experience of psychiatric services to help inform recovery-based approaches to care (Staniszewska et al., 2019).

According to the nature of being detained, patients within secure psychiatric services are not easily accessible and concerns in relation to access, ethics and security present particular challenges to undertaking research in secure environments (Spiers et al., 2005). Evidence relating to the efficacy and quality of secure services has typically been drawn from clinical viewpoints and studies exploring patients' narratives about their lived experiences within secure settings are underrepresented in the literature (Askola et al., 2016). The benefits of user involvement in research are widely recognised in the context of forensic mental health (Brooker et al., 2007), yet studies exploring users' experiences and views about the impact of forensic mental healthcare services are limited (Coffey, 2006). Furthermore, despite recognition of the importance of collaboration between designers, patients and staff in relation to the development of secure services (Dvoskin et al., 2002), there is only a limited evidence base available to inform the design of secure mental healthcare environments, for which there is increasing demand (Mclaughlan et al., 2021; Shepley et al., 2016, 2017).

Within this context, the current study aims to contribute to the literature concerned with exploring patients' accounts of lived experiences in secure psychiatric settings to inform approaches to care (Tapp et al., 2013) and extend understandings of the experiential significance of secure spaces for patients and staff (S. D. Brown et al., 2019b, 2019a; Simonsen & Duff, 2020; Tucker et al., 2019). The study integrates the expert knowledge and experience of patients and staff and the research specifically aims to help expand knowledge of how both groups experience secure psychiatric environments and make sense of their affective experiences within these settings. Accordingly, it is envisaged that insights gained from the research might help inform the management and development of secure psychiatric services and increase awareness of connections between the design of secure environments and how

patients and staff experience these settings day to day. The study therefore looks to address the following overarching research question:

- **How do patients and staff experience everyday spaces in low and medium secure mental healthcare environments and make sense of their affective experiences within these settings?**

The research is also concerned with exploring how patient and staff accounts of inhabiting the ward environments may expose disconnects or dilemmas in the ways that spaces are experienced by both groups. Alongside this, the question of how secure psychiatric institutions are able to constitute supposedly 'private' spaces within their own 'public' spaces and the formulation of subjectivities in relation to these spaces will be examined. The study consequently also aims to address the following secondary research question:

- **How do patients and staff negotiate and manage 'public' and 'private' space within secure mental healthcare environments?**

These questions will be considered from a theoretical perspective in the following chapter, while the study design and methodological approach that were developed to address them will be discussed in Chapter Three.

Chapter 2: Psychosocial experience, process and space

The introductory chapter examined relationships between space and experience and considered how environments can be understood not to simply provide a passive backdrop for events, but instead to have an active role to play in shaping everyday experience, including perceptions of health and well-being. Accordingly, the literature examining associations between space and health was explored, including empirical studies investigating relationships between the spatio-cultural milieu and occupants' embodied emotional experiences with a focus on healthcare spaces (e.g. Connellan et al., 2013; Devlin & Andrade, 2017; McGrath & Reavey, 2019; Ulrich et al., 2008). The built environments, spaces and atmospheres that constitute the institutional sites of inpatient mental healthcare are therefore regarded as being closely associated with both the shaping of occupants' lived experiences and the delivery of services in these settings (Reavey, Poole, et al., 2017).

Within the of de-institutionalised era of mental healthcare provision, secure psychiatric units represent an institutional form of inpatient care, where patients may be detained for extended periods of time in a highly restrictive environment (Hare Duke et al., 2018). Occupants' experiences of the atmospheric, spatial and material qualities of these settings are of interest within the current research, where a focus is placed on how relationships and interactions with these very particular environments may contribute to shaping affective experience and everyday management of mental health and distress (Reavey et al., 2019). The study is consequently situated within an area of psychosocial research concerned with examining relationships between the social, cultural or material aspects of human experience and the management of mental distress, within spatial contexts that include inpatient psychiatric environments (e.g. Fenton et al., 2014; Reavey et al., 2019; Simonsen & Duff, 2020; Tucker et al., 2019), domestic settings (e.g. Tucker, 2010a, 2010b; Tucker & Smith, 2014) and community or public spaces (e.g. McGrath & Reavey, 2013, 2015).

Within this chapter, a rationale will initially be presented for why a transdisciplinary psychosocial process approach to understanding experience (Stenner, 2017) is helpful to enabling exploration of the affective experiences of patients and staff who live and work in secure mental healthcare spaces. A theoretical background to this approach will be outlined, with a focus on examining how the concept of liminality can offer a processual account of psychosocial experience and affectivity (Stenner, 2013). Before drawing together conclusions from the overall chapter, a relational understanding of space and embodied experience will be discussed with respect to mental health and distress.

2.1 Exploring experience through a psychosocial process approach

Reflecting on the 19th century beginnings of psychology alongside the social sciences, Stenner and Taylor (2008) observe that the close link between the social and the psychological is fundamental to the issues studied in psychology and sociology, yet paradoxically, the division of these concerns into separate disciplines obscures this bond. Over recent years increased interest in the relationship between subjective experience and societal processes has given rise to psychosocial approaches to research that aim to avoid the abstraction of subjective experience from its social, cultural, material or historical context (Stenner, 2014a, 2017). Through engagement with the influential work of philosophical process thinkers, including Alfred N. Whitehead, William James and Henri Bergson, contemporary psychologists have accordingly contributed to the development of critical alternatives to mainstream experimental psychology, alongside critical approaches to social psychology (see S. D. Brown & Stenner, 2009; Stenner, 2008). Drawing on this work, a process-oriented theoretical framework will be explored in the following sections to support a transdisciplinary psychosocial account of experience, that enables thinking about the social and the psychological together and seeks to avoid separating psychological processes from their overall context (Stenner, 2014b, 2017).

2.1.1 Experience and process

The rationale for a process-oriented approach to thinking about psychosocial experience can be situated in relation to the 'crisis' concerning the nature of social psychology in the 1970s, that responded to the focus on objectivity and abstraction of human experience from its wider context (S. D. Brown & Stenner, 2009). The overshadowing of subjective experience by the study of objective behaviour within mainstream psychology forms what Brown and Stenner refer to as a 'foundational paradox' for the discipline, in which the exclusion of subjectivity from objective scientific study paradoxically precludes the objective study of subjectivity itself.

Recognising, however, that psychological experience exists everywhere and is not purely confined to experimental examination in laboratory-like conditions, Brown and Stenner accordingly propose that a 'second-order' psychology should instead focus on a process of continually exploring and following human experience within all its forms, across all disciplines and contexts. Therefore, rather than seeking fixed 'foundations' for psychology, the authors propose a 'reflexive' foundationalism, in which the 'foundations' can be seen to be constantly evolving through a process of construction and re-construction, whilst still maintaining an identity over time. This approach reflects the concept of transdisciplinarity which is elaborated in the following section and recognises that the psychological is present in all aspects of human activity, including realms of psychological enquiry that exist within disciplines beyond academic psychology.

2.1.2 Transdisciplinarity

As a theoretical and practical approach to addressing the limitations of disciplines and disciplinarity, the concept of 'transdisciplinarity' is associated with efforts to transcend the epistemological boundaries of recognised disciplines within which specialist forms of knowledge are typically organised (Stenner, 2017). Transdisciplinary approaches to research may also be concerned with rethinking relationships between theory and

practice to allow collaboration between scientists and lay people on 'real-world' problems, by moving beyond 'pure/applied' or 'lay/expert' borders in relation to knowledge (Stenner, 2014b). Accordingly, transdisciplinarity has been defined as, "[…] a concept that has been used in efforts to describe integrative activity, reflection, and practice that addresses, crosses, and goes through and beyond the limits of established disciplinary borders, in order to address complex problems that escape conventional definition and intervention" (Stenner, 2014b, p.1989).

Within a hypothetical spectrum between disciplinarity and transdisciplinarity, further distinctions may also be made between the associated concepts of 'multisdisciplinarity' and 'interdisciplinarity' (Stenner, 2014b). Multidisciplinarity can be understood as a co-ordinated approach to dealing with problems from a number of discipline-based perspectives and therefore within multisdisciplinary research collaborations, each discipline is focused on its own area of specialism or abstraction (Stenner & Taylor, 2008). As Stenner and Taylor (2008) point out, this bringing together of findings from multiple disciplines can enable enhanced understanding of problems, but without necessarily requiring a discipline to change or transcend its boundaries. By contrast, interdisciplinarity is concerned with collaborative approaches to problems that involve the transferral of concepts or methods between disciplines and interdisciplinary processes may also at times give rise to new disciplines (Stenner, 2014b).

Multi and interdisciplinary approaches can therefore both be understood as 'disciplinary' in the sense that the research objectives are discipline-based, while transdisciplinarity is concerned with what lies between disciplines and the opening up of new spaces of knowledge and practice (Stenner & Taylor, 2008). Whilst an interdisciplinary approach to psychosocial research may combine psychological and sociological findings to address a problem, transdisciplinary psychosocial studies are concerned with hybrid psychosocial spaces that are not currently dealt with

sufficiently by either discipline (Stenner & Taylor, 2008). Correspondingly, Stenner and Taylor (2008, p.431) suggest that, "[…] if interdisciplinarity were the careful setting up of trade-routes between pre-established disciplines, then transdisciplinarity would be the invention of new spaces of knowledge and practice that transform the existing territory by opening it up to the new". Accordingly, within a process-oriented perspective, the concept of disciplinarity can be understood to represent well-organised patterned arrangements and by contrast, transdisciplinarity can be conceptualised as a process of *transformation* occurring prior to the *emergence* of new patterned arrangements (Stenner, 2017).

A theoretical framework grounded within a transdisciplinary psychosocial account of experience is drawn upon within the current study to explore the multiple perspectives of patients and staff in secure mental healthcare settings and examine relationships between spatial and affective experiences in these environments. Transdisciplinary concepts can also enable the assimilation of ideas that may be considered unrelated when addressed purely within the boundaries of individual disciplines (Stenner et al., 2017). The current study accordingly engages with varied areas of research and practice including, psychology, geography, architecture and design, health and organisational studies.

2.1.3 Relational process ontology

Interpreting the work of philosopher and mathematician Alfred N. Whitehead, Brown and Stenner (2009) and Stenner (2008, 2017) provide a rationale for a 'relational process ontology' that promotes the exploration of human psychological processes within their social and cultural contexts. Brown and Stenner (2009), highlight that Whitehead's process ontology includes two essential relational principles. Firstly, that things (which may be biological, physical, psychological or cultural), can be defined in terms of their relevance to other things, or how other things are relevant to them. Secondly, that the existence of these things is not independent of time, but instead all

things are brought into being through processes, or in other words, through a series of specific situated encounters. In terms of its relevance to social psychology, this mode of ontological thinking emphasises the inherently relational nature of subjectivity and supports the view that human experience is interwoven with the wider material, social, cultural or historical context.

For Stenner (2008, 2017), engagement with a relational process ontology and Whitehead's processual perspective on subjectivity enables a 'deep' form of empiricism. This is presented in contrast to a 'shallow' form of empiricism that resembles traditional empiricist principles in which all knowledge is seen to derive primarily from sensory experience. Accordingly, Stenner argues that a 'shallow' empiricism implies a split within nature between a 'materialist aspect', composed of meaningless substance that excludes subjectivity and an 'idealist aspect' in which subjectivity is attributed to high-grade human mental processes. Within this perspective, reality is not seen to exist independently of the mind and a distinction is implied between the 'known' and 'knower', such that matter is viewed objectively and forms the objective focus of the human 'knower' or subject. Subjectivity is then attributed to the 'knower', who 'knows' through their sensory experience, however, subjectivity is also understood to be separate from and therefore excluded from matter.

Whilst such distinctions between subjectivity and objectivity maintain a dualistic approach to nature, by contrast, a 'deep' form of empiricism suggests that there is always an interaction between subject and object (Stenner, 2017). Accordingly, Stenner highlights how subject and object are thus intrinsically relational since the subject experiences an object and the object results from a process involving subjective experience. Within a deep empiricism, subject and object are also argued to be inherently processual, as they do not pre-exist experience, but instead are brought about through experiential processes.

Accordingly, within Whitehead's philosophy, (1933/1935 p.226, as cited in Stenner, 2008), "[..] the subject-object relation is the fundamental structure of experience". Correspondingly, in Whitehead's terms, an 'actual entity' or 'actual occasion' refers to the basic unit of what can be seen to really exist within the world. For Whitehead, an 'actual occasion' or 'actual entity' thus represents the 'concern' of a subject towards an object, such that the object is a component of subjectivity within the occasion and the subject *comes into being* through having concern with the object. The material can be understood to participate in the production of subjectivity and Whitehead's 'actual occasion' of experience can thus be defined as the synthesis of subject and object within an integrated event of experience (Stenner, 2008).

A 'deep' empiricism consequently shifts the perspective from 'known' and 'knower' towards a process ontology that extends the realms of subjectivity and avoids what Whitehead terms the 'bifurcation of nature' into 'matter' as the primary essence of reality and 'mind' as a secondary side made up of ethereal 'projections'. Accordingly, a 'deep' form of empiricism resists splitting the world into outer 'objective reality' and inner 'subjective experience' and instead enables an account of experience in which nature is not reduced to insignificant matter (S. D. Brown & Stenner, 2009; Stenner, 2008). Process thinking is thus grounded in the principle that psychosocial reality is made up of the assembly of multiple processes or events and following Whitehead's principles, process can be understood as 'the 'becoming' of 'actual occasions'. Correspondingly, reality can be conceptualised as a process made up of transient occurrences. Therefore any 'being' can be understood as a temporary realisation composed from multiple individual events that come together in a 'form' that can sustain its structure or pattern through continual construction and re-construction (Stenner & Zittoun, 2020).

2.2 Experience and liminality

Paul Stenner's development of process-theoretical thinking in relation to liminal experience is drawn upon in the following sections, with a focus on the proposition that liminality provides a useful transdisciplinary framework to support a relational process account of psychosocial experience (see Stenner, 2017). Liminality derives from the Latin word 'limen' which describes a threshold or border and the term 'liminal' was initially given meaning within anthropology in the early 20th century by Arnold van Gennep (1909/1960), to describe the middle phase within a rite of passage (Thomassen, 2009). The concept of liminality was later taken up and developed during the 1960s by the process anthropologist Victor Turner and more recently it has been further extended within the social sciences (e.g. Stenner, 2017; Szakolczai, 2009; Thomassen, 2016).

2.2.1 Rites of passage and liminal experience

Considering rituals and ceremonies to be significant processes of transition within societies, van Gennep (1909/1960) first used the term 'rites of passage' to describe such events and identified 'rites of separation', 'transition rites' and 'rites of incorporation' as three phases or processes that take place within a rite of passage. Accordingly, van Gennep argued that a pre-liminal phase occurs initially during a rite of passage and comprises a process of uncoupling from a preceding state of affairs or routine practices (*rites of separation*). This is followed by the middle phase, or liminal period, in which the preceding rules of play or usual limits are temporarily suspended (*transition rites*). The liminal period is concerned primarily with passage and transitional processes occur within this phase prior to a final post-liminal stage in which a new status is established and the rules or limits of a new state of being are integrated (*rites of incorporation*) (Stenner, 2013, 2017).

Through his anthropological fieldwork examining ritual practice and symbolism, Victor Turner developed van Gennep's work and placed particular focus on

the liminal phase within rites of passage to expound the transitional and paradoxical qualities of liminal rites (V. Turner, 1967). Turner's use of the term '*betwixt and between*' therefore captures the ambiguous threshold, or period of limbo in the liminal phase that is experienced during the transition to a new state of being. Correspondingly, Thomassen (2009) highlights that whilst liminality can be understood as a transitional threshold between different states or spaces, it also constitutes a passage through time, such that spatial and temporal dimensions are both relevant to liminal experience, at various possible scales of magnitude. Subjectivity represents a further core component of liminality and although liminal situations might apply to individuals, they may also be experienced collectively by groups of people or by wider societies (Thomassen, 2009).

2.2.2 Liminality and process

Following a processual understanding of experience, in which the world is understood to be a 'form-of-process' (Whitehead, 1929/1985, as cited in Stenner, 2017), the concept of liminality presupposes a taken-for-granted sense of stability in everyday flows of human experience, or in what might also be termed 'worlds' or 'circles of activity' (Stenner, 2017). Within this logic it is reasoned that disruptions within our everyday flows of experience may lead to liminal situations or transitions *between* different forms-of-process or circles of activity. Accordingly, Turner (1969/1996) provides a conceptualisation of liminality in process terms as an 'interstructural' situation that constitutes an unstable threshold where structural ruptures or voids occur through the breaking down of existing structure, prior to new structure being created. Turner accordingly refers to the fluid and indeterminate position of liminality as 'anti-structure', or a state where it is as though the usual conventions or limits are melted down before taking on a different form, with the emergence of a new order. Turner's (1969/1996) specific use of the Latin term *communitas* within anthropology further defines a component of anti-structure, to describe an unstructured and non-

hierarchical state of being. Within the transitional state of *communitas*, members of a community are understood to have become equal through the shared experience of liminality, typically by taking part in a rite of passage.

Liminal experience can hence be understood as a transformative process and can be seen to represent a 'process of becoming', or the experience of a 'world-within-a-world', which itself takes place between worlds (Stenner, 2021). By pointing to the 'doubled' nature of such a world-within-a-world, it is also argued that the suspension of limits within the liminal zone between worlds creates a form of paradox in which two worlds or states that might otherwise be considered 'either/or', become combined as, 'both/and' and yet simultaneously, 'neither/nor' (Kofoed & Stenner, 2017; Stenner, 2017). The liminal passage of adolescence represents an example of such a paradoxical state of being, whereby a young person going through this transitional period of life could be considered *both* child *and* adult, but also at the same time, *neither* a child *nor* an adult. Similarly, in the context of secure psychiatric environments, as the focus of the current study, secure services and the institution itself represent a transitional zone situated between patients' lives before and after hospital. Within these terms, a patient could then be understood to be in a transitional and 'in-between' position, in which they are no longer 'well', but not yet 'recovered'.

Focusing on the transformative nature of liminality, McGrath et al. (2021) accordingly theorise that secure psychiatric institutions could also be conceptualised as a form of 'rite of passage' as a means to explore how their organisational practices might promote or obstruct transformative processes for patients. McGrath and colleagues found that a therapeutic graffiti arts initiative undertaken by patients in a secure hospital setting gave rise to a transformative environment that was characterised by a sense of *communitas* (V. Turner, 1996). However, whilst this creative environment was found to facilitate therapeutic transformation, by contrast, it also exposed how the usual practices of secure psychiatric institutions can hamper

transformative processes. Although secure psychiatric institutions must accommodate the seemingly contradictory functions of maintaining order and stability whilst facilitating change, it is argued that the requirement for order dominates the necessity for change. Consequently, since the highly structured and hierarchical characteristics of secure settings do not typically afford states of anti-structure or *communitas,* these environments do not readily offer a liminal space to facilitate transitional processes. Hence, according to the authors, secure facilities could also be conceived as a form of failed rite of passage.

Drawing attention to both the spatial and temporal characteristics of liminality, Greco and Stenner (2017) highlight the analogy made by van Gennep (1909/1960) to compare societies with the structure of a house composed of separate rooms and corridors. Within this comparison, formal transitions made between the different rooms and progression through the house are likened to rites of passage undertaken within the traditional societies studied by anthropologists. Continuing the analogy, however, van Gennep suggests that modern societies, by contrast, can be conceptualised by houses that have a greater sense of interconnection, with wider doorways or thinner walls. Accordingly a sense of passage is perceived less distinctly within 'open plan' house layouts and as such is likened to societal shifts from passage constituting a highly structured, formal and temporary occurrence, towards liminal states becoming an increasing typical and central feature of modern society (Greco & Stenner, 2017).

2.2.3 Affectivity and liminality

The increased overall interest in affect, emotions and embodied experience across the social sciences in recent years is reflected by what has been termed a 'turn to affect' or 'affective turn' within the literature (Clough, 2008). Whilst social constructionism and a turn towards discourse and text emerged in response to dominant traditional empiricist and cognitivist perspectives within the social sciences (Gergen, 2004), the

'affective turn' is generally seen to follow on from and also critique the 'discursive turn' associated with social constructionist approaches. The 'affective turn' within the social sciences consequently reflects a critique of the overriding focus on structure that set limits for social constructionism and prompted a turn towards affect as a way to explore experience that cannot be readily expressed through discourse, or in other words, to examine what exists beyond structure (Stenner, 2013).

As Stenner (2013) points out, the transitional events occurring within liminal situations have affective qualities that can be appreciated through the 'affective turn' literature, such that the concept of liminality can also assist in clarifying the agenda and development of the turn towards affect. Alongside this, it is argued that integrating the transdisciplinary concepts of liminality and affectivity can enable examination of the intense affective experience that Stenner terms 'liminal affectivity' i.e. the interplay of emotional experiences within liminal situations created through processes of transformation. Furthermore, the integration of thinking about liminal and affective experience can facilitate exploration of the mechanisms used to produce 'liminal affectivity' and also the ways in which this experience is managed (Stenner, 2013, 2020).

Building on Turner's (1982) distinction between 'un-staged' and 'staged' liminal experience, Stenner (2017) makes a similar contrast between forms of liminal experience described as 'spontaneous' (i.e. events that fall upon us, which may be unanticipated and beyond our control) or 'devised' (i.e. contrived events that we perform on ourselves). According to this logic, rites of passage constitute a form of *devised* liminal experience and represent processes that have developed to assist with navigating the transitions brought about by disruptions to experience created through situations of *spontaneous* liminality. Rituals are processes designed to stimulate and intensify emotions within those taking part and Stenner hence employs the expression 'liminal affective technologies' to describe mechanisms, including rites of passage, that

are purposefully employed to generate devised liminality and arouse affective experience (Stenner, 2017; Stenner & Zittoun, 2020). Moving beyond ritual and the anthropological origins of liminality, however, it is also argued that liminal experience could encompass any form of passage during which a process of becoming or transformation takes place. As a result, such forms of 'ontological liminality', as Stenner describes it, can provide a transdisciplinary extension of the concept across the sciences, within which anthropological liminality can be understood as a specific category (Stenner, 2020; Stenner & Moreno-Gabriel, 2013).

Consequently, whilst rites of passage comprise one of the earliest types of liminal affective technology, it is also reasoned that diverse cultural forms exist, including music, art, theatre or play, that can be employed to promote liminal affective experience and assist with psychosocial transformation (Stenner, 2017, 2021). Such technologies therefore provide a means to self-generate liminal affectivity and facilitate the process of becoming that occurs at the point when individuals transition from one state to another (Stenner, 2020). Similarly, from a cultural psychological perspective, Tania Zittoun's use of the term 'symbolic resources' describes symbolically mediated processes, such as engagement with art, film, music or literature that are made use of by individuals during what Zittoun terms 'life transitions' (Zittoun, 2007a). Drawing on such cultural and symbolic resources can hence be regarded as especially relevant for young people as a means to address and make sense of unfamiliar circumstances experienced during periods of uncertainty or biographical transition (Stenner & Zittoun, 2020; Zittoun, 2007b). To exemplify this in the context of the current research, patients' experiences of mental health crises, or being detained in a secure psychiatric hospital, represent disruptive and transitional life events that could be conceptualised as forms of 'spontaneous' or unplanned liminal experience. To negotiate or make sense of the disruption or unfamiliarity associated with this imposed transitional experience,

patients might then be seen to engage with liminal affective technologies, or symbolic resources, to self-generate 'devised' forms of liminal experience.

Stenner's (2020) interpretation of Baruch Spinoza's philosophical thinking (1677/1989, as cited in Stenner, 2020) also proposes that affect constitutes experience that is 'on the turn' and consequently points to liminality as a mechanism for conceptualising the turning point between 'raw' affective sensations and their meaningful articulation as emotions. Within this thinking, affect can be regarded as a liminal transition or the turning point between different orders of affective experience. In contrast to the discursive turn's concern with discourse, meaning and structure, the affective turn can be seen to emphasise 'event' over 'structure' and to be concerned predominantly with affect, intensity and event (Stenner, 2013). Stressing the inherent relationship between structure and event, however, Stenner proposes that a process-oriented account of experience allows the re-thinking of 'structure' as forms-of-process and the re-conceptualisation of 'event' as occurrences that result in transformation between forms-of-process. According to this logic, event can be seen as a turning point or a liminal period of transition that takes place between forms-of-process or circles of activity, such that event can be understood to occur *between* structure.

A process-oriented account of affect thus requires a focus on both structure and event and avoids a polarised split between affect and discourse, with the result that the affective turn does not necessarily need to be understood as a dismissal of the discursive turn, but is argued rather to represent its further development and deepening (Stenner, 2020). Integrating the transdisciplinary concepts of liminality and affectivity can hence be seen to offer a conceptual and relational understanding of experience within which thinking about 'structure' and 'event' are combined. Furthermore, in terms of exploring psychosocial experience, the integration of affectivity and liminality enables an understanding of affective experience as a phenomenon of liminal transition (Stenner, 2013).

2.2.4 Imagination and liminal experience

As discussed in the previous section, in liminal terms, the experience of mental distress or hospital admission can be understood to represent significant transitional life events that may cause disruption to an individual's everyday 'flow' of experience or sense of self. The ways in which liminal affective technologies or symbolic resources, including creative or imaginative processes might be used to mediate such transitional experiences are accordingly pertinent concerns for the current study (Stenner & Zittoun, 2020). These processes may include engagement with physical or imagined environments and consequently participants' use of imaginative processes involving space or objects to facilitate liminal experience is also of interest.

Imagination is a vital aspect of human experience and drawing on Vygotsky's thinking (e.g. 2004), Zittoun and Cerchia (2013) propose that imagination can be understood as an expansion and enrichment of psychological experience that is essentially social and cultural in its nature. This 'expansion' model of imagination is presented in contrast to alternative 'deficit' perspectives (e.g. Pelaprat & Cole, 2011), which view imagination as a response to 'gaps' in our fragmented experience of the world that must be filled to provide a sense of stability. Zittoun and Cerchia instead contend that imagination is prompted by a temporary disruption within a stream of thinking, brought about by a rupture in the given flow of one's embodied experience of the world. Imagination is therefore conceptualised as a 'loop' of thinking processes that expand human experience before returning to 'reality' and re-joining an ongoing flow of thinking. From this perspective, imagination is described accordingly as, "[…] a process unfolding in time: in a person's current apprehension of reality, something triggers imagination, imagination develops on its own, and eventually the person comes back to reality, usually having gained something from that excursion" (Zittoun & Cerchia, 2013, p.313).

Imagination can therefore be understood as a process of becoming, or a liminal situation characterised by the creation of a transitional zone of experience where pragmatic everyday rules and reality are temporarily suspended (Stenner & Zittoun, 2020). Correspondingly, Stenner and Zittoun also highlight how imaginative processes can be seen to possess a similar tripartite framework to van Gennep's (1909/1960) rites of passage, whereby following 'separation' from a flow of experience, a liminal phase of imaginative transition occurs, prior to a stage of 'reincorporation' when a typical flow of thinking is re-joined.

Liminal occasions typically evoke a form of emotion, whether positive or negative (Szakolczai, 2017) and the temporary suspension of limits within liminal situations may also give rise to novelty or creativity (Stenner, 2021). Correspondingly, Stenner and Zittoun (2020) suggest that unplanned liminal situations can also prompt self-generated liminal experience, creating a rich environment where creativity and expression become more vital and imagination may be used to enable processes of liminal transition.

2.2.5 Enduring liminality and health

Whilst liminal occasions have been defined in process terms as the transitional phase between forms-of-process or circles of activity, the associated concepts of 'permanent liminality' and 'liminal hotspots' may also be used to offer an account of extended or enduring liminal experience (see Greco & Stenner, 2017; Stenner et al., 2017; Szakolczai, 2017). The term 'liminal hotspot' thereby defines the experience of being caught within the intermediate space between forms-of-process, or in other words, an occasion of suspended transformative transition that results in an extended phase of liminality between circles of activity (Greco & Stenner, 2017).

Although liminal experience may be associated with imaginative processes which may engender novelty or creativity, Szakolczai (2017) points out that liminal situations can also be construed less positively and be characterised by a sense of

anguish and uncertainty. In the case of extended liminality, the experience of being caught in a suspended state of transition between forms-of-process, i.e. being suspended within a liminal hotspot, generates a paradox that disrupts flows of experience and in turn can bring about a sense of paralysis (Greco & Stenner, 2017; Stenner et al., 2017). Alongside this, Greco and Stenner highlight how liminal hotspots may also be characterised by 'polarisation' that occurs when individuals attempt to escape the paradoxical and indeterminate state between forms-of-process by finding a solution that best aligns with one of the worlds between which they are suspended. In instances where when a liminal paradox cannot be readily avoided, however, the paralysis experienced may also potentially give rise to 'pattern shift' or novelty, thus sparking the emergence of a new form-of-process that integrates the existing forms-of-process as a way to move forward (Greco & Stenner, 2017).

As it is argued that transitional situations bring about forms of affectivity, the concepts of liminality and liminal hotspots are pertinent to exploring lived experience in the field of health, whereby health challenges can be understood to represent transitional life events (Greco & Stenner, 2017; Stenner, 2013). Liminal experience is also typically associated with identity transformation and in relation to ritual processes, Beech (2011) defines liminality as, "[…] a reconstruction of identity (in which the sense of self is significantly disrupted) in such a way that the new identity is meaningful for the individual and their community" (p.287). In the context of mental healthcare, detention in secure psychiatric institutions may commonly imply labelling in respect to both criminal offending and mental health, such that the management of transitions to other 'non-deviant' identities can be an ongoing endeavour for patients upon discharge to the community (Coffey, 2012b). Coffey (2012a) accordingly highlights how patients released from hospital on conditional discharge might frequently perceive their sense of identity to be in a liminal state of *betwixt and*

between (V. Turner, 1967) when seeking to re-integrate into communities, whilst also being positioned as an 'offender'.

In relation to the current study, the concept of enduring liminality is argued to be significant to exploring patients' experiences of detention within secure mental healthcare environments, typically for indefinite periods of time. Experiences of being caught in an indeterminate state of transition for an extended period may then influence patients' perceptions of moving forward, that in turn may have implications for 'recovery' processes, including the construction of alternative identities.

2.2.6 Liminal space

As the representation of passage through a threshold or boundary, liminality possesses an intrinsically spatial dimension and liminal space can incorporate both physical space and psychological or imagined space. Within the context of organisational studies, Shortt (2015) draws attention to the spatial characteristics of liminality through an exploration of how everyday 'in-between spaces' or 'liminal spaces' are experienced and given meaning by the occupants of a workplace environment. Shortt makes reference to Dale and Burrell's (2008) definition of 'liminal space' as being, "at the boundary of two dominant spaces, which is not fully part of either" (p238), to highlight how the 'spatial turn' literature exploring workplaces has typically focused on 'dominant' physical environments and less so on 'in-between' spaces such as corridors, staircases or cupboards. Such seemingly inconsequential areas, however, were captured in photographs taken by hairdresser participants in Shortt's research and identified as significant aspects of their working environments.

These in-between spaces were found to offer a sense of respite from the expectations of professional or social 'performance', in both the front of house (salon spaces) and back of house areas (staffrooms). Following the terminology of Erving Goffman (1959, as cited in Shortt, 2015), these spaces can be seen to be positioned between the 'front-stage' and 'back-stage' and Shortt extends the concept of liminality

to consider the significance of such transitional spaces for those who dwell within them. According to Shortt, when occupants find meaning within 'in-between' environments, beyond their essential function, they can be seen to change from purely liminal spaces to what might be termed 'transitory dwelling places'. Correspondingly, 'in-between' places such as smoking areas within inpatient psychiatric settings have been found to possess psychological and social significance for patients and staff. Notwithstanding conflicts between smoking and physical health, such spaces are seen to hold meaning and thus may contribute to the creation of 'therapeutic landscapes' in psychiatric care (Wood et al., 2013a). In the context of secure psychiatric settings, the focus of the current study similarly involves an exploration of meaning making by patients and staff members in relation to experiences of everyday spaces in the hospital environment.

2.3 A relational understanding of experience and space

A relational understanding of psychological experience and space will be further examined here, including exploration of topological accounts of experience that have developed within social psychology. This exploration is grounded in topological theories of psychology previously proposed by the gestalt-influenced psychologist Kurt Lewin (1936), as interpreted by contemporary social psychologists (see S. D. Brown, 2012; S. D. Brown & Reavey, 2015; Goodings & Tucker, 2019; Tucker & Smith, 2014).

2.3.1 Topology and life space

The concept of topology involves the mathematical study of spatial properties that are conserved when geometric objects undergo deformation and Kurt Lewin engaged with the principles of topology to rethink relationships between person and environment within psychology (S. D. Brown, 2012). Kurt Lewin's *Principles of Topological Psychology* (1936) thus explores the interaction between psychological experience and the spaces that people inhabit to offer a framework which avoids the traditional

subject-object dualism that separates 'outer' environments from 'inner' cognitive processes. Lewin argues accordingly that behaviour is a function of a person in their environment and suggests that "every psychological event depends upon the state of the person and at the same time the state of the environment" (1936, p.12). This statement implies an intrinsic relationship between human experience and the environment and points to a need within psychological study to recognise both person and environment as integrated parts of a 'whole' situation.

Lewin's application of topology to psychology accordingly offers an alternative relational understanding of space and lived experience, in contrast to prevailing models of space as an external 'container' for activity (S. D. Brown & Reavey, 2015). Lewin (1936) expresses this concern with the removal of boundaries between people and the world through the topological concept he terms 'life space'. For Lewin, life space represents interactions between the environment and a person's sphere of action, such that psychological experience can be regarded as not simply occurring 'in space', but instead to be interwoven with the spatial distribution of everyday activities (hence the use of the term 'relational'). Within this perspective the mind is therefore understood to reach beyond the confines of the brain and be extended into the world through spatially distributed experience (S. D. Brown & Reavey, 2015). Life space is hence more concerned with connections and relationships between people and events than with measurable temporal and spatial distance, or the dimensional properties of space such as size or scale (Reavey, 2017).

As Brown and Reavey (2015) highlight, a relational understanding of space as expressed through the concept of life space consequently encompasses physical, external understandings of space, in addition to psychological space and internal processes such as memory and imagination. Within this perspective, it is the relationships between events that create meaning for people and these connections extend across divisions between physical and psychological to become relevant to

current experience at any point within an ongoing 'flow' of experience (S. D. Brown & Reavey, 2015). Life space therefore comprises multiple connections that link a person's current actions with other people or events across time and space. As such, the relations and context that are outside the current 'scene' of activity can have influence and effect on a person's feelings or behaviour within the present moment. According to this perspective, whilst events or relations might be both temporally and spatially distanced, they can be understood to be 'acting' in the present moment (Reavey, 2017). For Lewin, such actions from a distance comprise 'quasi-physical facts' and his associated term 'quasi-conceptual facts' refers to the topological expansions that have potential to bring about future possibilities or influence the future. Within this logic, life space can be seen to constitute a topological manifold of possible and non-possible events (S. D. Brown, 2012).

Through the emphasis on the spatial distribution of experience, including memory and anticipation of the future, topology and life space have been employed to expand understanding about the management of mental health and distress by patients in secure psychiatric settings (Reavey et al., 2019) and in the home spaces of people who use mental health services in the community (Tucker & Smith, 2014). In a new-build medium secure psychiatric facility Reavey et al. (2019), draw on the concept of life space in an exploration of how the ward environment might contribute to shaping transformative processes of 'recovery' through mediating patients' experiences of social interaction and agency. Accordingly, rather than being conceptualised as a set of 'inner' cognitive processes, patients' subjective experience is examined in relational terms, both with regards to other people and the social or material context. Agency was seen to be associated with the expansion or contraction of patients' psychological life space, as mediated by staff-patient relations and the affordances of the environment, such as enabling patients to experience a sense of control. Life space was found to be compressed through experiences including a lack of regular social activity, or patients

perceiving they were ignored by staff and thereby feeling relationally distanced, despite being in a newly built space designed to bring people together physically. In contrast, the bedroom spaces were found to be relationally richer than the shared areas of the ward and the extension of patients' life space was made possible through engagement with activities including listening to music or the radio. Although patients' experiences in secure psychiatric settings might be seen to be bounded by the physicality of the institutional environment, a topological understanding of experience as life space recognises that relationships transcend physical barriers, for example via means including photographs, letters, phone calls and music (S. D. Brown & Reavey, 2014).

2.4 Concluding comments

A transdisciplinary psychosocial process account of experience has been explored in this chapter as a framework that enables an understanding of human experience as the embodied convergence of social, psychological and spatial processes. Accordingly, it has been argued that a relational process approach to the psychosocial provides an account of subjective experience that is intrinsically interwoven with the wider social, material, historical and cultural context. The concept of transdisciplinarity is concerned with the exploration of hybrid spaces located between disciplinary borders, or beyond the boundaries of individual knowledge and experience. Correspondingly, transdisciplinary approaches can help integrate diverse knowledge or the experience of different stakeholders. In the current study this includes exploring the perspectives of patients and staff who occupy shared environments within secure psychiatric settings and for whom the same spaces may have differing functions or meanings.

Liminality has been examined alongside this as a conceptual mechanism for exploring affective and embodied experience in process terms. Integrating the transdisciplinary concepts of liminality and affectivity can accordingly enable exploration of the affective experiences generated by processes of transformation. It

has consequently been argued that the concept of liminality provides a theoretical framework that assists with exploring the less tangible aspects of experience, including perceptions of health or identity. Liminality also provides a theoretical perspective in relation to imaginative processes and the role of imagination in facilitating self-produced liminal affectivity that can assist in mediating liminal situations.

Furthermore, the notion of 'liminal hotspots' offers a way of conceptualising the processes at play when liminal occasions become extended or sustained and it has been argued that the concept of enduring liminality is pertinent to exploring experiences of mental distress and detention in secure environments. The spatial dimension of liminality is also relevant to the study of 'in-between' and seemingly insignificant or mundane spaces which may play a part in mediating subjective experience and facilitating affective transformation. Alongside this, a relational understanding of space and lived experience has been explored, in which boundaries between people and the environment are removed and psychological experience is understood to be intertwined with the spatial distribution of everyday activity.

Chapter 3: Methodology

The methodological approach to the research will be outlined within this chapter, alongside an exploration of how the methodology and data collection methods employed are situated within the theoretical framework that has so far been discussed.

The first section of the chapter sets out the theoretical orientation of the study and methodological approach. This includes a rationale for grounding the study within a qualitative research paradigm that was informed by and developed in conjunction with the research questions. The narrative psychological orientation of the study and the empirical significance of examining narrative accounts of lived experiences within secure hospital settings are also discussed.

The second section outlines the research design and provides a detailed account of the work stages and activities involved throughout the study. This includes information relating to processes and considerations regarding research ethics, participant recruitment, data collection, audio data transcription. Reflexivity will be discussed in the final chapter of the thesis.

The interpretative process and analytical concerns relating to the data are detailed in the third section of this chapter. The conceptual structure supporting the chosen narrative-based analytical approach is outlined here and the processes involved in interpreting the data are described. This final section concludes by detailing the process of developing and collating the analysis to determine the content of the three subsequent empirical chapters, within which the findings that were found to best address the research questions are presented and discussed.

3.1 Qualitative research and narrative psychology

A qualitative research paradigm was chosen for this research due to the emphasis placed on exploring participants' perspectives alongside the texture and quality of their lived experiences. Through its concern with meaning, qualitative research seeks to

expand understanding of 'what it is like' in relation to participants' experiences of specific situations or conditions (Willig, 2013). Accordingly, qualitative research methods are used to gain in-depth understanding about how people make sense of the world and their experiences of events within specific naturally occurring contexts. Qualitative studies can thus offer insights into psychosocial phenomena alongside the social and cultural contexts in which these may be grounded. This is significant to the study of patient and staff experiences of secure psychiatric environments which, as discussed in the introductory chapter, are highly complex and particular environments. In relation to exploring experiences of hospital settings, qualitative research can also help integrate different stakeholder perspectives to further understandings about the therapeutic potential of the built environment and design in healthcare (Curtis et al., 2007). The remainder of this section will outline narrative psychology as a qualitative framework for the research and examine how narratives function to enable people to make sense of their lives and experiences.

Interest in narrative theory emerged from the general turn to language in the social sciences during the 1980s and the study of narrative has become increasingly widespread across all disciplines (Murray, 2003, 2008). Murray (2008) highlights how Sarbin's (1986, as cited in Murray, 2008) edited volume entitled, *Narrative Psychology: The storied nature of human conduct* was an influential text in marking the specific turn to narrative in psychology. Within this work, Sarbin presents narrative as an alternative metaphor for psychology, in contrast to the dominant mechanistic, context-free and laboratory-situated metaphors perceived to underpin the majority of mainstream psychology (Kirkman, 2002; Murray, 2008). Through this perspective Sarbin suggests that narratives have an ontological status, since it is argued that people actively construct the world through stories and live through the stories they tell. Accordingly, narrative psychology is concerned not only with research methods, but also with wider ontological issues and is focused on the content, structure and function

of the stories that people tell in social interaction (Murray, 2003). Informed by a social constructionist epistemological orientation, narrative psychology thus aims to produce knowledge about how people create meaningful stories from their experiences (Silver, 2013). Correspondingly, Mattingly and Garro (2000 p.1) note that, "[n]arrative is a fundamental human way of giving meaning to experience. In both telling and interpreting experiences, narrative mediates between an inner world of thought-feeling and an outer world of observable actions and states of affairs". As narratives play a central role in helping people structure or understand experiences, a narrative psychological approach can thus contextualise human action.

3.1.1 Narratives and identity

Ricoeur (1979) argues that the primary function of narrativity is to bring a sense of order and temporality to human understandings of a world which is in constant flux. Storytelling is hence a means through which human activity is organised and narratives are thereby used to construct a sense of self (Crossley, 2000a, 2000b; McAdams, 1993). Alongside this, Polkinghorne (1991) argues that thinking about 'self' in terms of a narrative, rather than as a substance or thing, emphasises the temporal and relational dimensions of human existence. This perspective also underscores the constructive and interpretative nature of 'self', such that self-concept can be understood as a temporal process of becoming. Polkinghorne accordingly suggests that "self-concept is a storied concept, and our identity is the drama we are unfolding" (p.149). Social life is consequently argued to be produced through stories and narrative is seen to constitute an "ontological condition of social life" (Somers, 1994 p.614). Somers correspondingly highlights how this perspective suggests that people construct identities (which may be multiple or changing) within diverse intersecting relational storylines amongst which they may find or locate themselves.

Whilst narratives enable individuals to draw together distinct life events to create a meaningful whole, self-narratives may become fragmented under stressful

circumstances, resulting in a loss of meaning and a break-down in the unity and integrity of a person's self-concept (Polkinghorne, 1991). For example, health challenges can disrupt a person's prior expectations about how the story of their life might unfold and accordingly, the effects of chronic illness on self-narrative and self-concept have been described as "narrative wreckage" (Frank, 1995 p.53) or "biographical disruption" (Bury, 1982 p.167). As serious health issues can cause significant disruption to the flow of a person's everyday life, storytelling may then assist in making sense of ever-changing personal experiences (Crossley, 2000b) and perform a therapeutic role (Frank, 1995). Murray (2000) correspondingly suggests that storytelling might also be considered an act of self-care or a natural response to health challenges. Crossley (2000b) similarly argues that, "[…] when disorder and incoherence prevail, as in the case of trauma, narratives are used to rebuild the individual's shattered sense of identity and meaning" (p.527). This is significant to exploring patients' lived experience in forensic populations, within which exposure to trauma, including neglect and childhood abuse is prevalent (Adshead, 2012; Coid, 1992). In the context of secure psychiatric services, the generation of alternative self-narratives, that can enable patients move beyond 'psychiatric patient' or 'offender' identities is also understood to play a significant part in processes of 'recovery' (Adshead, 2011, 2012; Gardner-Elahi & Zamiri, 2015).

3.1.2 Visual storytelling

As a form of visual storytelling, images can contribute to narrative inquiry (Stephens, 2011) and the use of visual materials in research can enable participants to convey stories through non-verbal means (Keats, 2009). Visual research methods include a diverse range of techniques that involve engagement with visual materials in the process of generating empirical data (Reavey, 2011; Reavey & Johnson, 2017). Materials may comprise a variety of media, including drawings, photographs, film or objects and artifacts that are either made or collected by participants. The strengths of

visual research methods include facilitating access to topics or experiences which may be unnoticed or difficult to express in purely verbal interviews (Reavey, 2011). These experiences might include sensorial or physical phenomena that are less easily articulated solely through words (Boden & Eatough, 2014), or reflections on the more ordinary aspects of life that may easily be taken for granted (G. Rose, 2014). Visual materials can hence help people to access and articulate the complex emotions and details grounded in everyday experience that might otherwise be overlooked (Reavey, 2011).

Visual research methods have consequently been found to help elicit rich narrative accounts within research interviews (Reavey & Johnson, 2017). Active engagement with imagery can also encourage greater narrative contribution from participants who may be verbally reserved, or may have limited capacity to maintain concentration for reasons such as medication use (Reavey, 2011). This is significant to the secure mental healthcare context of the current research, in which patients may commonly experience side-effects from psychotropic medication, including drowsiness or mental clouding (Seale et al., 2007). Visual methods have accordingly enabled in-depth examination of health and well-being related narratives (Frith & Harcourt, 2007) and exploration of the everyday life experiences of people who use mental healthcare services (K. Johnson, 2011; McGrath et al., 2008; McGrath & Reavey, 2013, 2015).

As spatial and psychosocial experiences are inherently interwoven, the physical environment is a fundamental aspect of everyday lived experiences. Environments play an integral role in storytelling as the contexts within which events and emotions are experienced and visual research methods can assist in exploring the spatial dimensions of experience. The combination of visual and verbal methods can thus facilitate narrative accounts that are grounded in very specific spatial contexts (McGrath & Reavey, 2013; Reavey, 2011), in contrast to narratives produced through verbal

research methods alone, which tend to be organised within more temporal structures (Reavey & Johnson, 2017).

The medium of photography can facilitate creative expression and the use of photo-production as a visual research method, whereby participants create photographs for discussion in an interview, has been shown to offer a meaningful and creative activity for participants (Reavey, 2011). These aspects of photo-production are particularly significant for the current research exploring experiences in secure psychiatric settings, where patients do not typically have access to cameras and may commonly spend long periods of unstructured time on the wards between activities.

Engaging with photographs can enable access to the embodied sensations evoked by environments or atmospheres that may be beyond immediate conscious awareness or discursive accessibility and facilitate their transformation into emotions or narratives to articulate experience. In process terms, the use of photographs within qualitative research could then also be conceptualised as a form of 'liminal affective technology' (Stenner, 2017, 2021). Photo-production processes may accordingly help research participants to explore the more 'intangible' aspects of their experiential worlds, including perceptions of identity (Reavey, 2011).

Studies involving photo-production techniques also demonstrate how participants can shape the research process by guiding how the images are used in interviews (Radley & Taylor, 2003b). This in turn can adjust the power dynamics of traditional research interviews to allow participants a greater sense of perceived control (Radley & Taylor, 2003b; Ray & Smith, 2012) and foreground participants' voices in the research process (S. Warren, 2005). This is pertinent to the restrictive context of secure psychiatric settings, where patients may typically have a limited sense of choice or control and whose lived experiences are underrepresented in the literature (Coffey, 2006). Furthermore, photo-production techniques can also afford wider visual exposure to 'marginalised' environments, such as the spaces within secure

mental healthcare settings, which are typically accessible only to limited groups of people (Kanyeredzi et al., 2019; Reavey et al., 2019).

3.2 Research methods

The multi-modal approach chosen for the study combined visual research methods with semi-structured interviews as a means to generate verbal data for transcription and interpretation using a narrative-based analysis approach (Silver & Reavey, 2010). The visual research methods used in the research comprised photo-production (Del Busso, 2011; Radley & Taylor, 2003a, 2003b), whereby participants produced photographic data which were later discussed in semi-structured interviews.

Photo-production was chosen as a method that could enable participants to share the everyday spatial contexts of the research settings, including the spaces or objects which may not be readily accessible to visitors in a secure setting. The images produced were not treated as visual data for analysis, but typically formed prompts during the interviews which helped elicit participants' accounts of their experiences within specific spatial contexts (Reavey and Prosser, 2012).

Radley and Taylor (2003a) demonstrated how photo-production techniques enabled patients to explore the hospital environment as an immediate emotional landscape in which to construct 'recovery'. Similarly, photo-production was used in the present study to facilitate the active exploration of secure psychiatric spaces as an emotional terrain in which occupants' spatial experiences can be understood to be fully interwoven with psychological experiences (Tucker & Smith, 2014). The use of photographs enabled participants to have control over creating the image content and in turn, greater choice and influence in how narrative accounts of spatial experiences were constructed during the interview (Radley & Taylor, 2003a).

The combination of photo-production with semi-structured interviews in the research was designed to support the narrative-based approach to the data analysis as the images encouraged storytelling and became entwined with each participant's

narrative during the interview. This approach reflects a broadly social constructionist perspective and recognises the role of social interaction and language to the construction of thinking and experience (Burr, 2003; Willig, 2013). The processes involved in designing and implementing the research are summarised in the following sections and include detailed accounts of the ethical considerations, participant recruitment, data collection and transcription. Copies of the supporting documents that were used in the study are attached in Appendices A-H.

3.2.1 Ethics

Ethical concerns were a central and ongoing focus throughout all stages from the inception of the project and involved the following key considerations and processes.

i) Ethical approach and approvals

The research was designed and undertaken in line with ethical guidance included in the British Psychological Society Code of Human Research Ethics and the London South Bank University Code of Practice for Research with Human Participants, in addition to guidance provided by the research setting and NHS Research Ethics Committee. Before commencing participant recruitment, ethical consent for the project was confirmed with the NHS Research Ethics Committee (reference number: 16/NW/0114) and the Research Ethics Committee at London South Bank University. To enable contact with patients in mental healthcare facilities, the necessary disclosure and barring service clearance (DBS) certificate was also obtained prior to commencing data collection. Whilst the approvals and coordination processes required to facilitate participant access and data collection took considerably longer than originally envisaged, following written confirmation of all necessary approvals, the participant recruitment and data collection for the study took place between May 2016 and July 2018.

ii) Use of cameras

For reasons associated with confidentiality and patient protection, camera use is generally prohibited in secure psychiatric settings and cameras typically constitute a form of 'contraband' that cannot be brought onto a ward. Consequently, it was also necessary to gain permission from the research setting to allow the use of a digital camera for research purposes on the participating low and medium secure psychiatric wards. Digital cameras were generally supplied by each ward for use in the research, however, permission was also obtained for camera equipment to be supplied for research purposes in some instances where a ward camera was not available. As required by the research setting, patient camera use was risk assessed on an individual basis by the nurse in charge on each ward and patient participants were supported by staff throughout when using cameras. It was explained to all participants that they should avoid taking photographs which included people and that any photographs produced which show people who could be recognised would be deleted in the interests of protecting the anonymity of others. Participants were also advised to use the camera very sensitively when around other people.

iii) Participant and researcher well-being

Through the process of meeting with potential participants to introduce the research and subsequently meeting again to discuss the project in further detail or confirm consent, time was typically spent together on at least two occasions before the interview. These individual encounters with participants benefitted the process by enabling initial familiarity, such that a sense of rapport could be developed together as far as possible before meeting again for the interview. The possibility of participants becoming upset whilst reflecting on difficult experiences was a key consideration and due attention was given to ways in which participant distress might be mitigated throughout the research. Before the interviews, it was made clear to patient participants that no direct questions would be asked about their mental health or the

reasons why they were receiving care in a secure psychiatric setting. Care was also taken to consider potential sensitivities around exploring participants' experiences of their immediate working or living environments. Whilst for some patient participants these spaces may also constitute 'home ', it was recognised that for some people the contexts of home environments might also be associated with difficult experiences. It was explained to participants that they could refuse to answer any questions or to request that any responses provided be removed from the interview transcript.

In practice it was not necessary to end or pause an interview due to participant distress, however, in the event of a person becoming upset, the recording would have been paused, subject to the participant's agreement, or discontinued entirely as appropriate. Members of the multi-disciplinary team (MDT) were also aware that patients had participated in a research study and were available to provide support in the event of distress occurring during or after the research process and interview. Participants were asked afterwards how they had found the interview experience and the debrief sheet that was provided and talked through directly after the interview included details of independent organisations that could offer confidential support if required (see Appendices G & H for copies of the debrief sheets for patients and staff respectively). Following the debrief, a little time was also typically spent talking more generally with each participant before concluding the meeting.

Interviews with patients and some staff participants typically took place within side rooms or meeting rooms on the wards in which CCTV was installed. Some staff interviews were also undertaken in meeting rooms within staff office areas that were located outside the wards. When undertaking interviews with patient participants, a personal alarm was typically provided by the research setting and staff were on hand nearby to provide support in the event of any emergency. Any distress experienced personally during the process of undertaking the research was generally discussed with the academic supervisory team in the first instance. Informal reflexive notes were

also used at times as a tool through which to mitigate personal distress by promoting self-awareness as a first step to seeking support from the supervisory team, or other support as and when required.

iv) Confidentiality and data protection

All potential participants were made aware that the parameters regarding confidentiality were such that information provided would remain confidential, unless criminal activity was disclosed, or a participant suggested that future harm may occur to themselves or others. In such cases, disclosures would have been reported as appropriate to staff within the research setting in the first instance. Participants were made aware that pseudonyms would be applied by the researcher during transcription. It was also advised that potentially identifying features, such as place names, would be redacted in the transcribed data. Similarly, potentially identifying features were also redacted or cropped from the visual data that were included in the reported findings, as part of efforts to support participant anonymity.

The digital data collected were encrypted and stored on password protected equipment. Any hard copies of data produced, such as printed photographs, or project information were locked in a filing cabinet within an access-controlled office at the university. Only the researcher listened to the audio recordings and transcribed the interviews. The files created were coded numerically without reference to participants' real name and the data from each interview was given a successive participant number. The files were organised such that data could easily be retrieved if participants subsequently wished for any data to be removed from the study. Participants were made aware that the data would be retained for a period of 10 years after completion of the study before being destroyed.

3.2.2 Participants and recruitment

Contact with potential participants and the process of recruitment involved the following key stages and commenced after all ethical approvals and permissions had been confirmed in writing.

i) Initial contact with wards and potential participants

Initially contact was established with the wards that the research setting had identified as being appropriate to the study. Meetings were held with members of the multi-disciplinary team (MDT) as required on each ward to discuss the project in further detail and confirm that participant recruitment could take place. Following guidance from the research setting, the study was then typically introduced initially to patients and staff by the researcher during a community meeting[5] on each ward. During the meeting a short verbal introduction was given to outline the study and patients and staff were invited to ask questions, during or after the meeting, such that they could consider whether they might be interested in taking part. It was made clear at this stage that there was no obligation to participate and that there was no financial or commercial benefit offered for taking part.

Patients and staff were invited to confirm interest in the study, or to ask any questions individually with the researcher after the meeting. A copy of the relevant participant information sheet containing further detailed information about the research was given to those who expressed interest in taking part (for copies of the patient and staff information sheets, see Appendices A & B respectively). At times, separate introductory meetings were also arranged with staff, for example, to enable

[5] The community meetings provide a forum for patients and staff members to discuss any issues or concerns relating to the ward. These weekly meetings are generally chaired by a patient and where possible, attended by all patients on the ward and available staff members.

the research to be introduced to staff members who were not on shift when the community meeting took place.

ii) *Informed consent*

Potential participants were allowed at least 24 hours after expressing interest in the research to decide if they would like to take part and typically several days were allowed before meeting again for the process of confirming written consent to participate. During the intervening period, liaison took place with the relevant Responsible Clinician (RC) and MDT members to confirm that any patients who had expressed interest were deemed to have capacity to provide informed consent and it was considered appropriate for them to participate, should they decide to.

Individual meetings with potential participants were then scheduled and typically took place privately in a side room on each ward. Whilst it was possible to communicate directly and arrange meetings with staff participants, it was necessary to liaise with staff members on each ward to coordinate the meetings with potential patient participants. During these individual meetings with staff or patients, any questions raised about the study were answered and the participant information sheet was read through together to assist with clarity. If a potential participant decided to proceed at this point, the consent form was also read through and signed together (see Appendix C for a copy of the consent form). As part of this process, it was made clear that signing the consent form did not bind participants into taking part and that they had the right to withdraw completely from the study without giving a reason. Photocopies of the signed consent form were made such that both parties retained a copy and in the case of patient participants, a copy was also retained by staff for the patients' medical files. Consent was revisited verbally when meeting with participants throughout the research process and participants were reminded that there was no obligation to take part.

iii) *Participants*

A purposive sampling strategy was employed to enable access to a mix of patient and staff experiences across medium and low secure inpatient mental healthcare wards within a large psychiatric hospital in the United Kingdom. In total[6] 19 patients and staff participated in the study. The inclusion criteria required participants to be patients or staff within a secure forensic mental health inpatient setting and to be over 18 years old. Exclusion criteria included potential patient participants being deemed by the care team to be lacking capacity to provide informed consent, or if participation was considered inappropriate, or presented a potential risk to the well-being of the individual or others.

The study was introduced to medium and low secure wards identified by the research setting and ultimately the participants were recruited from six individual same-sex secure wards located in several different buildings within the overall facility[7]. These six wards comprised three medium secure and three low secure settings. In total, nine patients participated in the study, of whom three were women and six were men. The participating patients were recruited on two medium secure and three low secure wards. Ten staff participated in the study in total and were recruited on three medium secure and two low secure wards. The staff participants comprised seven women and three men within the multidisciplinary team, whose professions included nurses, healthcare assistants, occupational therapists and psychologists.

Although direct questions were not asked to elicit specific demographic information, some participants provided personal details during the course of discussions, which included their age, ethnicity and sexual identity, or where relevant,

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[6] Due to a technical anomaly, data for one of the interviews were not available.

[7] On the wards where participants were recruited and on other wards where the study was introduced but no participants were recruited, a small number of additional patients and staff expressed interest in the study but were unable to participate due to aspects of the inclusion/exclusion criteria or subsequent changes in their personal circumstances.

details of their length of stay in hospital and mental health diagnoses. However, as part of the efforts to protect participant anonymity in the reported findings of the study, these data were not systematically collected. A summary of the research participants in terms of their gender and ward level of security is provided in Table 1.

Table 1
Research participants

	Medium Secure		Low Secure		
	Patients	**Staff**	**Patients**	**Staff**	**Total**
Women	Patricia	Vicky Felicity Ingrid	Alice Hazel	Jo Karen Estelle Wendy	**10**
Men	Sal Darren Tom Carl	Gavin Mike	Leon Bradley	Nathan	**9**
Total	**5**	**5**	**4**	**5**	**19**

Note: All names listed are pseudonyms

3.2.3 Data collection

Data collection took place after consent had been confirmed with each participant. A photo-production process was undertaken individually by participants and followed by a semi-structured research interview. On average each interview typically lasted between 40-60 minutes approximately. The photo-production and interview processes are outlined in the following sections.

i) Photo-production process

Participants were invited to take up to ten digital photographs of their everyday environment for discussion in a research interview. It was explained that the images produced should include spaces or objects that they might encounter during a typical day on the ward or other accessible parts of the overall facility. Participants were asked to produce images that could help to capture a range of the emotions that they might

experience in relation to spaces or objects in the everyday environment. To maintain the anonymity of other people within the research setting, participants were advised to avoid taking photographs that included people. Appropriate timescales were agreed with each participant as convenient to allow the photographs to be produced and a date was scheduled accordingly for the interview.

Patient camera use was facilitated and supervised by staff members and the period of time required for the photographs to be produced varied depending on staff and patient schedules. For logistic and organisational reasons relating to staff and patient availability, it was not always possible to hold the interview directly after the photographs were taken, but the interviews typically took place as soon as possible afterwards. In advance of the interview, the photographs taken by participants were printed where possible, usually via printer equipment on the ward, where this was available. As it was generally necessary for the photographs to be printed on ward equipment, the physical copies of the images were typically black and white prints on A4 paper.

ii) Interview process

The interviews were undertaken individually and privately in a room with each participant. The interviews were recorded with the participants' consent and prior permission was obtained from the research setting to allow a small digital audio recorder to be brought onto each ward for research purposes. Before each interview started, participants were asked to arrange all available prints as they wished on a table in the room, such that the images could be easily reviewed individually or collectively as required. In some instances, where it had not been possible for images to be downloaded from the ward camera for printing, it was necessary for participants' images to be reviewed on the camera screen during the interview.

Taking each image in turn, participants were invited to discuss why they had chosen to take the photographs and describe their feelings and range of emotions

experienced in relation to the spaces and objects captured in the images. An interview schedule was also prepared and questions drawn from this were threaded into the course of the dialogue where appropriate. In contrast to fully structured interviews, in which the agenda is prescribed through specific questions posed by the researcher, the interviews were semi-structured to encourage storytelling and afford participants greater power and control in shaping the interview content (Murray, 2003). The parts of the interview in which patients and staff talked through their photographs had especially strong narrative characteristics, as the participants took the lead on what was discussed. Following this, remaining questions from the schedule were also asked by the researcher as appropriate to elicit further reflections about participants' psychosocial and spatial experiences.

The questions on the interview schedule were grouped around different aspects of psychosocial experience (e.g. 'well-being' or 'privacy') and aimed to help address the research questions by prompting participants to talk about their experiences and affective responses to the everyday environment. Whilst the schedules for staff and patients were similarly constructed, the questions were tailored accordingly for each group to reflect their different occupational experiences e.g. in reference to the ward as a workplace or as a residential space. The same interview schedule was used with patient participants on both medium and low secure wards, although for organisational purposes it was necessary to label the schedule separately as Group One (medium secure) and Group Two (low secure). Copies of the patient interview schedule for Groups One and Two are therefore included in Appendices D and E respectively and the schedule for staff participants is attached in Appendix F.

In several instances, a pause in recording was required due to different types of interruption that occurred during the interview. These included staff participants responding to enquiries from colleagues and events on the ward, or the interview being relocated because the room was needed for another purpose. After the interview,

each participant was thanked and fully debriefed about the rationale for the study and a hard copy of the debrief sheet was provided and read through together. Where available and with each participant's permission, the photographs discussed were retained for reference following the interview. In all instances participants in the study gave permission for their images to be retained and reproduced in reported findings of the research, however, in the event of this not being the case, the relevant images would have been removed from the data set.

Throughout the research process, in addition to time spent in the interviews, a significant amount of time was spent more generally on the wards in spaces such as the ward office. Naturalistic observation of staff and patient interaction and inhabitation of the ward spaces therefore took place during the course of visits to the hospital and notes were also made at times as an informal resource.

3.2.4 Transcription

Transcription of the audio data was undertaken by the researcher and took place throughout the data collection process. The audio data were transcribed verbatim and each line of transcribed speech was numbered for reference. The transcription did not follow the detailed conventions of approaches such as conversation analysis, however, additional information was included in the transcripts to assist the contextualisation and understanding of discussions. For example, any non-word sounds such as laughter or pauses were noted in the transcripts and any emphasis placed on particular words was highlighted. A summary of the conventions that were used during transcription is included in Appendix I.

The first few interviews carried out with patients and staff were transcribed initially and preliminary readings of this initial data were undertaken and discussed during academic supervision. This process was helpful in assisting personal reflection on the experience and evolving process of carrying out the interviews. It also enabled

supervisory feedback to be discussed, based on initial assessment of the data generated thus far. Each subsequent interview was then also transcribed in the same way.

During the transcription process the digital files were played back via specialist software installed on university computer equipment, using an associated foot pedal to control and adjust the speed of audio playback. Throughout the process the transcribed data were checked back against the audio record for accuracy. It was generally possible to clarify most instances of ambiguous or unclear speech through the process of slowing down and replaying sections of the recording, although in a number of cases background noises such as slamming doors or loud voices on the wards rendered some words or short sections of speech incomprehensible.

The process of repeated listening to the audio recordings and reviewing participants' photographs, where available, whilst personally transcribing the interviews provided a helpful initial familiarisation with the data. This process also enabled a nuanced appreciation of the interview context, including any interruptions or background sounds, alongside providing an awareness of the subtleties in how the dialogue was spoken by both parties within each interview. The processes of data transcription and narrative analysis are not easily distinguished (Riessman, 2008) and reflecting on recollections of each interview when listening to the recordings and note-making during transcription formed a valuable part of the preliminary analytical and interpretative process (Esin, 2011).

3.3 Narrative analysis

Narrative analysis represents a theoretical approach to interpreting stories and this overarching term covers a diverse range of perspectives through which to conduct an analysis (Esin, 2011; Stephens, 2011). Narrative-based approaches to analysis enable exploration of how individuals story their experiences and can allow researchers to gain understanding about the intricacies of social relations (Esin et al., 2014; Sharp et al., 2018). Whilst there is no single or definitive form, narrative-based analytical

approaches typically focus on the different features of narratives as a theoretical perspective for interpreting stories. Accordingly, different approaches to narrative analysis may focus on aspects such as the content (e.g. Riessman, 2008) or structure of narratives (e.g. Labov, 1972, as cited in Frost, 2009), or the performative function of stories (e.g. Langellier & Peterson, 2004) and social processes involved in storytelling (e.g. Clark & Mishler, 1992). Pluralistic approaches may also apply a number of different theoretical models of narrative analysis to the same data in order to generate a multi-dimensional interpretation (e.g. Frost, 2009). Within the widely ranging versions of narrative analysis, a commonality in approach is the typical focus on interpreting narratives as whole entities as opposed to breaking down stories into individual discourses (Murray, 2003; Riessman, 2008). Consequently, in narrative-based approaches to analysis, stories are understood to represent the unit of analysis (Esin, 2011) and the analysis is concerned with both the 'what' in terms of a story's content and the 'how' in relation to how stories are constructed (B. Smith, 2016).

As storytelling can be a way to make sense of the disruption to life associated with health challenges, it is also argued that narrative-based approaches are well suited to social and health-related psychological research (Murray, 2008; Stephens, 2011). Alongside providing understandings of people's lived experiences of health and healthcare, narrative analysis may also help to illuminate the social contexts around health, including social justice and inequalities (Stephens, 2011).

3.3.1 Narrative levels of analysis

Murray (2000) builds on concepts developed by Doise (1986) to outline an approach to narrative data interpretation in health psychology research using a conceptual framework of narrative levels of analysis. Within this approach, four levels of analysis which are defined as, 'personal', 'interpersonal', 'positional' and 'ideological' are proposed as analytical perspectives through which to consider narrative data. Stephens (2011) highlights how this framework of narrative levels also maps onto approaches

occurring elsewhere in the literature, including Somers' (1994) approach to understanding how identity may be constructed through narrativity and Langellier and Peterson's (2004) examination of the performative functions of narratives.

Within the conceptual framework of narrative levels put forward by Murray (2000), the 'personal' level of narrative analysis considers individual stories as an immediate focus and offers a phenomenological perspective to understanding accounts of lived experiences. Consideration is given to the functions served by telling stories, including the use of narratives to bring a sense of order to personal experiences (Ricoeur, 1979). Such narrative functions may also include mitigating perceptions of disruption or incoherence which might be felt by people when experiencing challenges to health (Frank, 1993; Radley & Taylor, 2003b). This 'personal' level of analysis may hence be concerned with the ways in which narratives are used to construct a sense of individual identity or self (Crossley, 2000b; McAdams, 1993). Similarly, Somers (1994) describes such personal stories as 'ontological narratives' and highlights how individuals may use stories to construct narrative identities as a means to make sense of their lives and actions.

Working with narrative data at Murray's (2000) 'interpersonal' level of analysis acknowledges the co-created nature of research interviews, wherein the stories produced are constructed as part of an evolving conversation between participant and researcher (Silver, 2013). At this level of interpretation attention is given to how the interpersonal processes within these social contexts and potential audiences may influence how and why stories are told. In acknowledging the researcher to be an active participant in a dialogue and not simply an onlooker within an interview, the analytical process is also concerned with the role played by the researcher in shaping how narratives may evolve in this context.

As an extension of the 'interpersonal' level, the 'positional' level in Murray's framework is concerned with social characteristics and the relative positioning of

researcher and participant within the interview context. Narrative interpretation at this level considers how commonalities or differences between social characteristics of both parties, including health status (Radley & Billig, 1996), gender (Phibbs, 2008), age, or moral position might be relevant to social interaction and the production of narrative accounts.

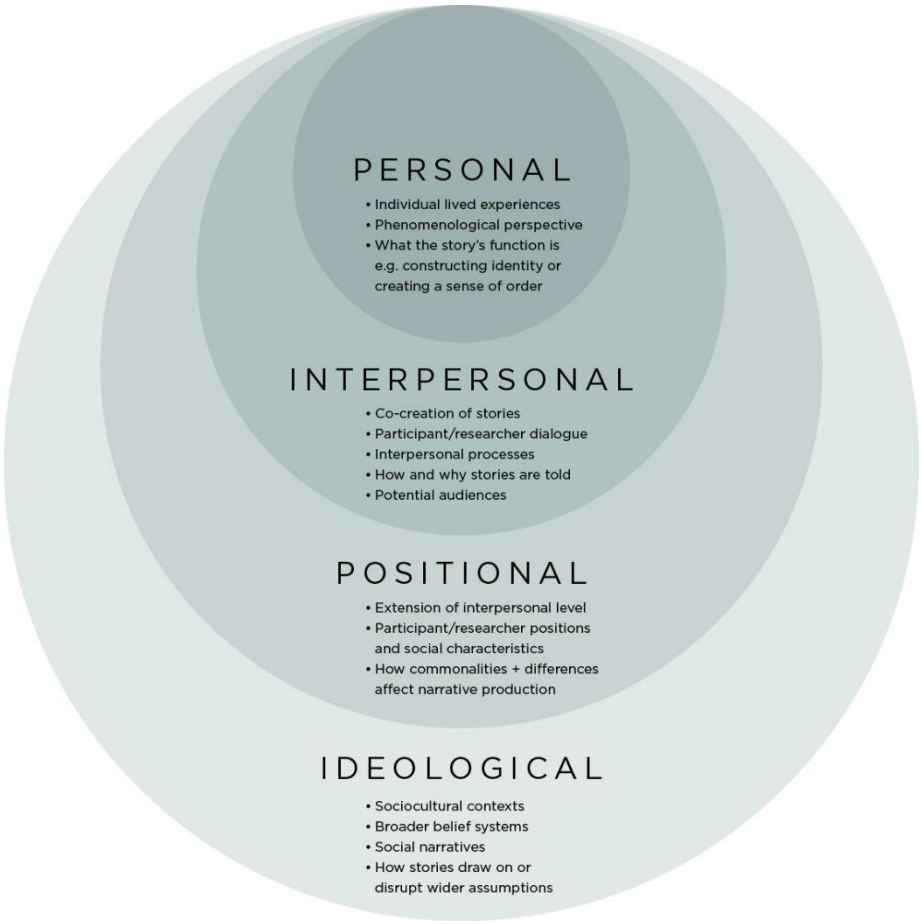
Finally, interpreting narratives at the 'ideological' level proposed by Murray (2000) focuses on the ways in which all social interactions are situated within wider sociocultural contexts that permeate and shape the structure of everyday stories. Interpretation at this level is concerned with how narrative accounts may draw on or disrupt these broader assumptions and belief systems, which Somers (1994) also refers to as the 'public narratives' shared within societies and cultures.

Building on Murray's (2000) conceptual framework, Stephens and Breheny (2013) describe a similar approach to narrative analysis in psychological research based on integrating narrative levels of analysis. Stephens and Breheny's (2013) approach includes 'personal' and 'interpersonal' narrative levels, alongside a third 'public' level of narrative analysis, representing a combination of Murray's (2000) 'positional' and 'ideological' levels. This 'public' level of analysis is thus concerned with openly available social narratives and how these may shape shared understandings or disconnects within societies. Within the analytical process, it is therefore of interest to consider how such shared social narratives might be used to position moral or social identities, alongside how these wider public narratives may be drawn upon or challenged in social interaction during the co-construction of interviews (Breheny & Stephens, 2011; Murray, 2000; Stephens, 2011; Stephens & Breheny, 2013; Wong & Breheny, 2018).

With reference to Doise (1986), Murray (2000) emphasises that these four outlined levels of narrative analysis do not constitute four different versions of reality, but instead comprise a conceptual framework within which to organise the different

levels considered by researchers across the various differing narrative-based approaches to analysis. As stories may typically be considered from the perspective of several narrative levels simultaneously, Murray (2000) highlights how integrating levels is of particular interest in the data analysis process. This integrated approach to narrative levels of analysis is summarised diagrammatically in Figure 2. Accordingly, Murray (2000) argues that the challenge for researchers is to be able to articulate connections in the telling of narratives across the different levels.

Figure 2
Analytical approach using integrated levels of analysis



Note:
Diagram based on Murray's (2000) *Levels of Narrative Analysis in Health Psychology*

3.3.2 Analysing and interpreting the data

The transcribed data collected for the current study were subjected to rigorous qualitative data analysis, using a narrative-based approach. This interpretive approach focused primarily on Murray's (2000) framework of narrative levels of analysis, with reference to variants of this conceptual model as described by other researchers (e.g. Breheny & Stephens, 2011; Stephens, 2011; Stephens & Breheny, 2013; Wong & Breheny, 2018). Alongside analysing the data through an integrated framework of narrative levels, a series of analytic devices was also engaged with to assist in building an analysis from the data (Crossley, 2000a; Wong & Breheny, 2018). The remainder of the chapter provides a detailed account of these processes to explain how the analysis was undertaken and describe the activities involved throughout. Whilst the approach to the data analysis is described as a series of stages, the process was flexible and iterative (B. Smith, 2016; Wong & Breheny, 2018). Building the analysis involved moving fluidly back and forth between processes as required and writing the analysis was an integral part of the analytical process.

i) Familiarisation

Initially the data were reviewed several times both during and after the transcription process to gain in-depth familiarity with the content of each interview. Whilst the images generated by participants were used primarily as visual aids during the interviews and were not formally analysed independently as visual data, where available, the images were reviewed again for reference during the transcription process and when reading the corresponding transcripts. Each transcript was read through several times to increase familiarity and any initial observations or responses to the data were noted down for reference or elaboration and refinement during the further stages of interpretation that followed. The narratives and visual data produced by staff and patient participants were reviewed as a single overall data set.

ii) Identifying narratives

Whilst stories may often be based around a developing plot with clearly defined characters, scenes and sequences of events, it was recognised that accounts may also be unstructured and diverging or incomplete (Wong & Breheny, 2018). Therefore, a comprehensive approach was taken to identifying different stories told within each transcript. In line with a narrative-based focus on examining the use of storytelling to make sense of lived experiences, each story was considered as a whole entity rather than being broken down into individual discourses (Murray, 2003; Riessman, 2008). As argued by Wong and Breheny (2018), a flexible approach to analysis based on integrating narrative levels, as used in this study, also enables the same interpretative process to be applied both to complex narratives and to the more mundane or unstructured stories that people may tell. Stories within each transcript were identified by looking for new beginnings marked by a noticeable shift in the content of the talk and endings signalled by declarations or concluding events (B. Smith, 2016). The transcripts were also reviewed as a whole to try to get a feel for any stories that were in development across the overall interview. Storylines drawn from the narratives identified within each transcript were summarised and grouped into a set of overarching storylines for each participant. Each overarching storyline was given a name that captured the combined essence of the individual storylines. For reference the storyline synopsis for Wendy, one of the participants, is included as an example in Appendix R. The overarching storylines for each participant were also collated into main storylines across the data set and a diagram summarising this is included as Figure 3 within chapter four. The storylines for each of the participants were reviewed across the data set and those considered best able to address the research questions were identified, alongside corresponding extracts from the data. During this process attention was paid to common storylines and prominent features within the narratives,

in addition to considering stories which were significant or striking for reasons that included seemingly not fitting with other narratives across the data set.

iii) Interpreting narratives

As the levels of narrative analysis are intertwined within stories, the integrated approach to interpretation involved coding the data in reference to the different levels simultaneously and the process was repeated across the narratives. When interpreting the data at a personal level of analysis, the stories told were perceived as an expression of each participant's lived experiences, with consideration given to how narratives might also be used to outline a sense of identity to others (Somers, 1994). Riessman (2008) argues that narratives do not necessarily reveal an 'essential' self and attention was accordingly given to how participants' stories may be used to position a sense of self. This can be contextualised via the extract below in which Carl, a patient participant, is invited to give some information about himself to the researcher at the start of the interview.

> **"R:** Great. Well thanks ever so much for, um, taking the time to meet and um, I just wondered if you could possibly just start by just telling me a little bit about yourself, you could include, um, you know, any information that you'd like. **C:** (*Little laugh / outbreath*). Er, my name's [*name*] I've been on [*name of ward*] since [*name of month*] so that's been about [*number*] months is it? I'm [*age*] and I've been in the service, er, as a whole since [*name of year*], so nearly [*number*] years. But luckily, I've come here and they've realised I don't need to be in the service and I should be moving on very quickly. [**R:** Mm] But it's really not been easy."

Carl stories his entire journey through the healthcare service in this narrative which although brief, can be seen to have a beginning, middle and end. This short story includes characters (i.e. the authorities or staff within the institution) who play a significant part in the narrative and it also contains a form of resolution (i.e. that Carl will now be moving on quickly from the hospital). Through highlighting the length of time that he has been detained on the current ward and the number of years spent within the service overall, Carl positions his experiences of moving through psychiatric

services as a lengthy process. In presenting himself as someone who does not need to be detained in secure services, Carl can also be understood to be storying an account of how he would like to be seen by others. Whilst the narrative conveys some optimism and alludes to a sense of his changing fortunes, Carl's concluding comment stating that, "it's really not been easy", succinctly summarises to the listener that his journey so far has been a testing process of endurance and a difficult experience.

When interpreting the data at an interpersonal level, the analytical process focused on relational aspects of the narratives and considered how the stories were co-created through dialogue and social interaction between the participant and researcher within the interviews (Silver, 2013). This included consideration of how the characteristics of the researcher and participant and the relationship between them could influence both the content of the stories produced and how they were told. Attention was given to how questions were presented and the ways in which the researcher's responses, including pauses or silences, may have contributed to how participants' stories were produced (Esin, 2011; Murray, 2003). Additionally, narrative devices employed by participants and the researcher were also examined, including the use of humour or phrases repeated for narrative effect (Breheny & Stephens, 2011; Wong & Breheny, 2018). An example of the interpersonal level of analysis can be illustrated via the following extract in which Darren, a patient participant, responds to the researcher's question about his experiences of enjoyment within the environment.

1. **R:** [...] Alright, just, we've touched on it really, some of these points while you've
2. been describing the photos, but I just wondered whether you could perhaps
3. tell me about any, um, whether you might experience any sort of sense of
4. enjoyment or pleasure, um, in the physical qualities of um, the, the spaces here,
5. or from any of the objects within it at all? If there are any spaces that you
6. (*slight pause*)
7. **D:** Er.
8. **R:** enjoy particularly?
9. **D:** What, is this inside the building or outside the building?
10. **R:** It could be either, yeah.

D: Um, I quite enjoy going to the gate. Because I can smoke there.

R: To the where sorry?

D: To the gate.

R: The gate, OK.

D: Yeah, so.

R: Yeah. The entrance gate?

D: Yeah, yeah.

R: Yeah, yeah.

D: 'Cause we're allowed to smoke there.

R: Ah, OK.

D: So it's,

R: Yeah.

D: you know, it's relaxing. You know, you can become quite tranquil you know.

R: Mm, mm. Er, do, why do you think that is, is that part of being outdoors, um?

D: A little bit, plus, it's just, I don't know if you smoke yourself, but it can be quite relaxing you know.

R: Yes, yeah, yeah. And would and you can go there ev-, when-, several?

D: Yeah, not all the time,

R: Mm.

D: you know they do try to get us out as much as they can.

R: Mm, yeah, yeah. How do you find being outdoors, is that, is that something that's positive?

D: I, I, I love being outside the building.

R: Mm. Yeah, are there particular (*slight pause*) places that you would go to out-, outside?

D: Yeah, er, [*name of café on site*].

R: Yeah.

D: [*Name of café on site*] café. I don't know if you've been there?

R: I have yes, yeah, that's nice. Yeah.

D: I quite like it down there.

R: Mm.

D: Yeah, it's nice down there. It's, plus it's a public place, you know, it's not [*name of hospital*] controlled environment if you like.

R: Mm. Yeah, yeah. Does that and that (*slight pause*) has an impact on how you feel,

D: Yeah.

R: when you're in that space?

D: Makes you feel normal.

In this extract, the researcher is initially confused about the reference Darren makes to his enjoyment of visiting the "gate". Despite Darren's explanation from the outset that the reason for his enjoyment is because he can smoke there, it requires several stages of clarification before the researcher understands the story. Eventually the researcher grasps that patients are able to smoke by the hospital entrance gate and by implication, also realises that smoking is not allowed within the hospital grounds. This exchange between Darren and the researcher highlights how the contrasts in their individual characteristics as patient and visitor influence the dialogue and points to differences in their respective experiences and operational understanding of the hospital environment. Additionally, as the relational dynamics in interviews imply that participants' experiences are the primary focus of interest, researchers may not necessarily anticipate receiving questions from participants during an interview. Darren's query here about whether the researcher smokes could also be interpreted as an attempt to create a greater sense of balance within the interpersonal dynamics of the meeting and prompt dialogue that is reflective of a more typical and naturalistic conversation. However, by asking the question rhetorically using the pre-fix, "I don't know if", Darren poses the question to the researcher indirectly, without necessarily expecting or requiring an answer. Following on from this, Darren similarly frames another question, "I don't know if you've been there?", in relation to the on-site café. In asking this question he is again opening up a more conversational form of dialogue and is seen to be inviting the researcher into a more equal exchange of information.

When analysing narratives at the positional level of analysis, consideration was given to the social characteristics of the participants and researcher, in addition to their relative positioning in the context of the interview. Differences or commonalities in their positions were identified, including the relative liberty of both groups. The analysis was accordingly concerned with how such characteristics were relevant to social interaction within the interview and the narratives produced. In the above

extract, Darren concludes by stating how he feels "normal" when spending time in the public café on the hospital site and this story can also be used to illustrate the positional narrative level of analysis, as an extension of the interpersonal level. In contrast to spending time amongst members of the public in the café setting, his narrative implies that he does not typically feel "normal" in other spaces (i.e. in the areas he describes as hospital-controlled environments). Through the narrative Darren is highlighting perceived contrasts between his position and self-identity as a detained patient and the positions of members of the wider public, including the researcher. In addition to the example from Darren's narrative, the following extract from the interview with Karen, a staff participant, provides a further illustration of the positional narratives that may be used to shape individual stories.

> **"R:** […] I was also just wondering, er, if you, if you could describe any ways in which, um, you might think that having a sense of choice is important to you when you're considering the sort of details of your working environment at all? **K:** Um, (*slight pause*) for me, I dunno, I've never been considered in that decision (*little laugh*), I'm a HCA. Um, I'd like to see the walls, I'd like to see more, um, pictures and things on the walls in the lounge, but again with it being a secure building it's difficult to get them, I mean, it's, it is a phone call to maintenance for them to put things up on the wall, but um, I don't know whether that comes down to budgetary constraints or not, um, we have a project at the moment where we're, we do-, which we're doing ourselves, by painting an inspiration tree."

Karen's pause and her initial response, combined with her short laugh that follows this suggest that she is slightly perplexed by the researcher's question about experiencing a sense of choice within the environment. Her next comment, "I'm a HCA" (healthcare assistant), is presented to the researcher as a self-explanatory statement and is used to qualify the preceding remark that she has not typically been involved in decisions regarding the hospital environment. By implicitly positioning her role at the lower end of a decision-making hierarchy Karen can also be understood to be making a wider statement about how the position of HCA might be regarded or valued by the

institution. Karen presents herself as having opinions about ways to improve the environment aesthetically, yet the story positions her sphere of influence over decision-making or effecting change to be very limited. In contrast, however, Karen's conclusion to the story restores a sense of agency to her role by highlighting to the researcher how a ward-driven initiative to enhance the environment is currently being implemented. Karen's positioning of herself in relation to the researcher is also evident at the end of the interview when she is invited to share her thoughts about taking part in the study.

> **"R:** That's great and I just wondered if I could just finally ask you if, if you could just tell me something about why you were interested in taking part and also how you found the interview? **K:** Um, honestly, 'cause no one had me to take part in anything before, ever, really *(laughs*), I've done sort of ward-based surveys and things that have gone round on a bit of paper to help people out, but, um, not something on this sort of scale and um (*slight pause*), yeah it was just nice, it's nice to be involved in something like this and um, hopefully (*slight pause*), hopefully, um, what I've said is important and is relevant and yeah."

In this short account, Karen builds on her earlier allusion to how the institution might value her opinions about the environment, or how input from staff members in the role of HCA may be regarded. Whilst this story can be seen to reinforce Karen's perceptions of a lack of institutional interest in her perspectives and experience, by contrast, taking part in the research study is presented as a meaningful activity through which she feels valued. The researcher is therefore situated through the narrative in a contrasting position to the institution and is understood to be interested in hearing about Karen's experiences and what she has to say.

Approaching the data analysis at an ideological or societal level of analysis took into account the shared public narratives, or 'master narratives' that can inform and position individual accounts at broader social and cultural levels (Murray, 2000; Stephens, 2011). Accordingly, consideration was given to the ways in which participants' stories might reveal social processes and reflect or challenge dominant

master narratives (Murray, 2000). The exchange between Darren and the researcher in the earlier extract can also be used as an example to contextualise how the data could be interpreted at the ideological level of analysis. Here, Darren's account of feeling "normal" when spending time in a public place rather than inside the hospital draws on broader social or moral narratives about the types of people or circumstances that are considered to constitute 'normality' within society. Alongside this example, a further illustration of the ideological level is provided via the following story in which Leon, another patient participant, describes his perceptions of how the ward furniture is associated with how people might feel in that environment.

> **"L:** […] so a lot of stuff we get here, is like the chairs we're sitting on now, are clinical, they're heavy, they're weighted. There's nothing homely about them. I mean like a three-piece sofa with like, nice, like, footstools, just normal stuff. [**R:** Mm, mm.] And to be fair, it's like, especially this is like a low secure, or even a medium secure, I've, we had the same problem there. It was just like, I understand there's risk, but if you make a place more homely, yeah, even that, we are all not family, we're not blood, or anything [**R:** Mm.] if you feel at home [**R:** Mm.] doesn't matter who's there, you're gonna be naturally more relaxed, the ward's gonna be more relaxed, the, the atmosphere's gonna be calmer. [**R:** Yeah.] There'd be less situations. But where everything's sort of clinical it's just feels so tense."

Leon draws on social and cultural understandings of homeliness and domesticity for narrative effect in this story to present a jarring contrast between wider societal expectations of residential spaces and his own experiences of the ward environment. Accordingly, his narrative builds on shared cultural beliefs that a physically or atmospherically comfortable 'home' environment can facilitate rest and support relaxation. By situating the "clinical" qualities of the ward environment within this social narrative, Leon disrupts the notion of home comfort to position the ward as non-homely and actively uncomfortable. The narrative image of utilitarian and clunky ward furniture presented in his account is accordingly contrasted with imagery of traditional domestic sofas and the added sense of comfort implied by "footstools". Leon uses this

story to propose an intrinsic relationship between the ward environment and the behaviour of occupants, such that creating a "calmer" atmosphere and a more homely space might lead directly to a reduction in relational friction. Drawing on wider understandings of "clinical" spaces as being cold, stark or sterile, Leon's final sentence concludes this story by suggesting that these pervasive and undesirable characteristics of the ward are closely connected to an underlying sense of atmospheric and relational tension experienced within the environment.

Alongside approaching the data analysis through these narrative levels, several analytical devices were also used throughout to assist in highlighting social processes, or the performative and functional qualities of the stories told (Crossley, 2000a; Wong & Breheny, 2018). These analytical mechanisms included paying attention to the stage and setting, i.e. the places where stories are set and the spaces in which the stories were told. In addition to this, significant details in the stories, such as characters, places, objects or events were highlighted to enable examination of their role within the narratives. Participants' narrative tone and the imagery generated through their accounts were also examined. Further analytical devices included observing tensions within the narratives, examining the function of humour and exploring how aspects of language or refrains were used to create narrative effect.

iv) Building the analysis

Analysing the data and writing interpretations of participants' narratives across the data set was an integrated and ongoing process to build the narrative analysis (B. Smith, 2016). The process was approached inductively, in that it was grounded within the data, but the interpretation was also influenced by theory (Murray, 2008). The analysis drew upon literature identified in the first stages, with a focus on liminality (Stenner, 2017) as a theoretical concept within the overall perspective of a relational process ontology (S. D. Brown & Stenner, 2009). When building the analysis, the coding applied through the process of analysis using the narrative levels of analysis, analytical

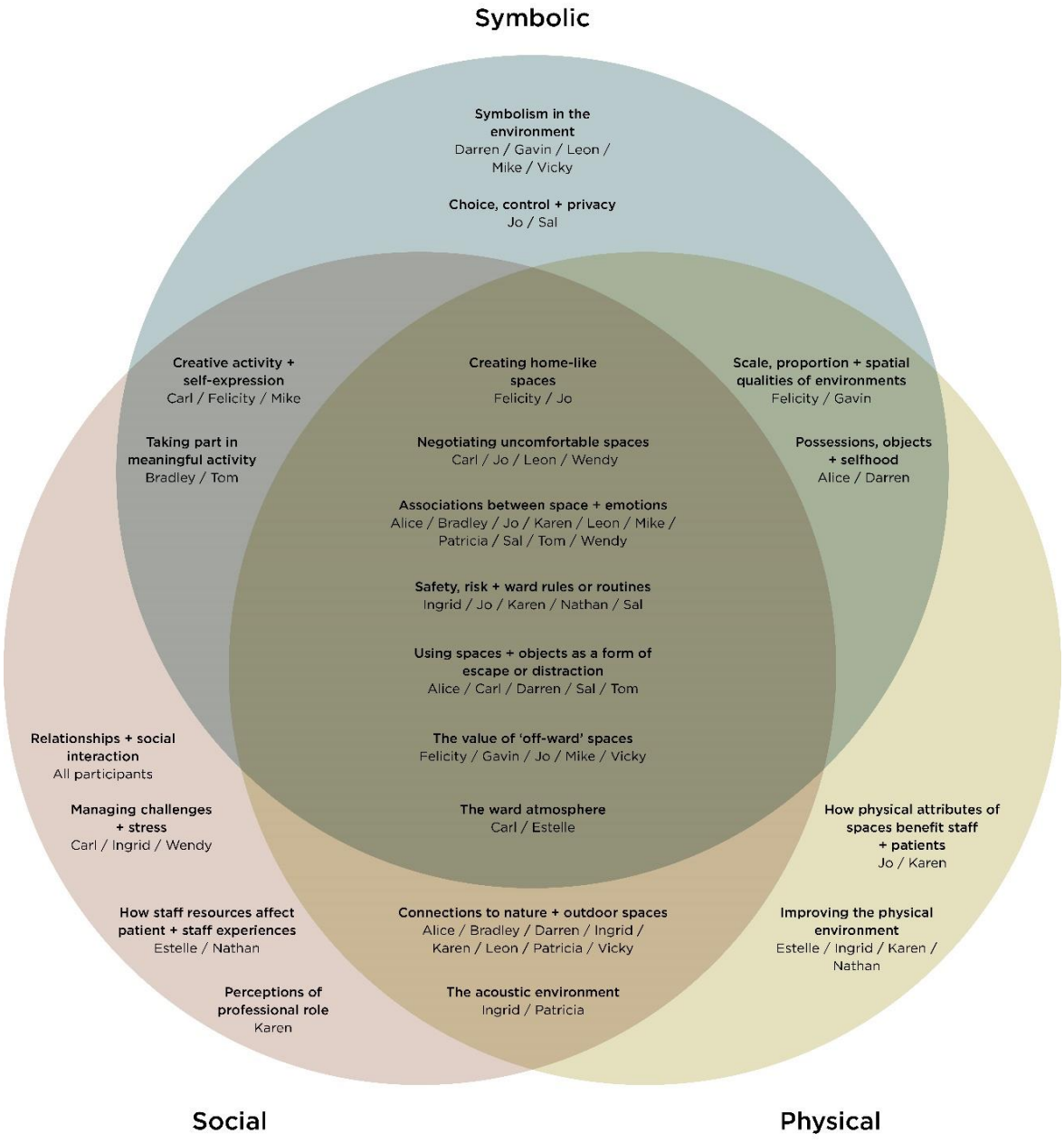
devices and theoretical perspectives described above was elaborated into an interpretation of the participants' narratives, focusing on selected extracts. Consistent with a narrative-based approach, the data analysis is presented through several individual participant narratives. As part of this process a pen portrait was created for each participant, including a summary of their main storylines and the images discussed in the interview. The portraits for participants who are not featured individually within the empirical chapters are attached in Appendices J-Q. The analysis was organised around three key narrative interpretations of the data, exemplified through extracts from the individual participants' accounts which are presented and discussed within the following empirical analysis chapters.

Chapter 4: Negotiating uncomfortable spaces

As discussed in the preceding chapters, a psychosocial process account of experience has been integrated with a narrative-psychological approach in this research to explore relationships between space and affective experience in secure mental healthcare environments. The visual-qualitative study design combined verbal and visual research methods to explore staff and patient stories about their experiences in secure settings and the spaces where events take place. Participants produced photographs to reflect their experiences of the everyday environment for discussion during a semi-structured interview and a narrative-based method of analysis was employed to interpret the data, drawing on Murray's (2000) narrative levels of analysis. Participants' main storylines were collated across the overall data set, as summarised diagrammatically in Figure 3 in terms of 'physical', 'social' or 'symbolic' aspects of environmental experience. Whilst the storylines typically reflected a combination of all three aspects, this illustrative visual overview reflects the prominent focus of each storyline.

The analysis will be presented across three chapters and each is organised around a key interpretation of the data. Each chapter focuses on a set of narratives that are explored as individual 'case studies'. Participants' individual storylines commonly overlapped across the overall data set and the choice of extracts selected for inclusion in the analytical chapters represent examples of those that were most illustrative and able to address the research questions. The narratives were also selected to include a mix of staff and patient perspectives within each chapter. This chapter focuses on stories told by participants about negotiating uncomfortable spaces within the environment. The analysis presented in Chapter Five will focus on participants' accounts of engaging with spaces or objects to create strategies for coping with difficult affective experiences within secure hospital environments. Chapter Six is concerned with how spaces and objects in the everyday environment might affect social interaction and relationships between and amongst staff and patients.

Figure 3
Summary of participants' main storylines



The analysis presented in this first empirical chapter explores stories told by participants about experiences of physical and psychosocial discomfort in relation to spaces or objects in the everyday environment. The analysis focuses on the narratives of three participants, Leon, Carl and Wendy. Carl is a patient on a medium secure ward, whilst Leon and Wendy are based in low secure settings, as a patient and staff member respectively. The participants' accounts also illustrate how experiences of negotiating uncomfortable spaces in the environment may be shared by both patients and staff.

4.1 Leon

Leon is a young man who at the time of meeting was detained in a low secure ward from which he had not been granted leave for several months. Leon had recently moved to the current ward from another low secure environment in the hospital and prior to this had also spent time in medium secure and prison settings. He describes having had very difficult experiences in early life, referring to himself as someone who had grown up fighting for his life. Leon mentions he grew up in a different town to the place where the hospital is located and describes having moved many times throughout his life.

From the outset of the interview Leon describes being actively concerned about patients' lived experiences in hospital and highlights how he has regularly contributed to initiatives within the organisation to promote patient perspectives. The narrative conveys a sense of how Leon's ongoing concern with seeking to improve patient experiences is reflective of his own determination and strength of character. However, the general narrative tone throughout suggests that he has become disheartened and exasperated to an extent, perceiving that his voice as a patient is not being valued or heard, specifically in relation to perspectives about the ward environment. Leon's overarching narrative is thus imbued with a tone of frustration relating to how he experiences his everyday surroundings and a sense of increasing desperation about his

current personal situation, having been detained on the ward for a significant time without any leave.

Whilst Leon's narratives about his experiences are intertwined, his main storylines focus around: (1) negotiating uncomfortable spaces, (2) perceiving a lack of choice or control over the environment, (3) having emotional relationships with possessions and objects, (4) needing connections with outdoor or natural spaces, (5) perceiving spaces as clinical or institutional and (6) negotiating relationships with the hospital system, staff and patients.

In the interview Leon reflected on photographs of: (a) his bedroom, (b) bedroom window, (c) en suite bathroom and (d) outdoor courtyard for the ward.

The interpretation of Leon's narrative is focused on the first, second, fourth and fifth storylines, as interwoven narratives which recur throughout the interview. Through these storylines Leon describes negotiating difficult spaces within an institutional environment over which he perceives very limited control and an acute sense of being separated from the wider external environment and nature. In the first extract that follows, Leon considers the affective responses associated with everyday experiences of his bedroom environment, which is presented as a significant emotive terrain within the overall context of the ward.

Leon: Extract 1

R: [...] Thanks very much and thanks ever so much for taking the, um, time to take the photos, um, here and I just wondered if you could just start perhaps, just taking me through them one by one, taking your time and just to tell me something about why you chose to take those

L: Yeah.

R: photos and what, what meanings or feelings, um, are attached to, to those spaces?

L: Um, what I'll probably do is I'll start with the ones that have caused the, what have more of an emotional response for me than the ones that, less likely to.

R: Great.

L: But, um, for me, I would go with the window spaces, as you can see here

R: Mm.

L: is very (*laugh*), very depressing. It's basically, I like, if you like, a good view like surroundings, trees, nature, that type of stuff.

R: Mm.

L: And these windows on [*name of previous ward*] used to open, the ones here don't, so you don't get fresh air, it's constant aircon, it's just not as nice. Especially when you wake up in the morning, you always wake up groggy

R: Mm.

L: 'cause the aircon. But um, it's like, having a wood panel to look at right, soon as you wake up just (*slight pause*), so I've got to that point now, where a lot of the time I just cover it up.

R: Mm. What is it that you're looking at there?

L: Um, at the minute this is like, basically, just a general layout of the room and that's where the windows are.

R: Uhum.

L: So I thought it would be easier to have the general layout, then, when like these type of pictures, will fit in these here.

R: The detail, yes. No exactly. And what's, what's the view from the window? What is it?

L: It's a wooden panel. Basically it feels like you're buried underground, it's easy way to describe it. Um, it's about 35-degree angle going up, and all it is, it's literally dirt in between these two panels, you can see there.

R: Mm. So, it's like a retaining, er,

L: Yeah.

R: wall for the, for the, the grounds?

L: Yeah. Well, it's not nice.

R: Mm. Yeah and is, are all the rooms, um…?

L: On this ward, yes.

R: Mm.

L: A lot of us, keep our like blinds down and we cover our windows 'cause it's just, it's even, having a dark room's like, can be depressing for some people, but it's less depressing than looking at that. To be fair, when we came over that's probably the main thing that annoyed a lot of us.

The window is a dominant aspect of the bedroom space in the images produced by Leon and its significance is reflected in his choice to highlight this at the start of his narrative journey through the photographs. Leon's account draws on wider societal understandings of windows as commonplace architectural elements that are typically

perceived positively and generally provide a sense of connection between internal and external spaces. Windows are widely understood to afford outward views from an interior, or to provide access to natural light and Leon's narrative builds on commonly held beliefs that, "a good view" from a building may contain greenery and natural elements, including trees[8] (R. Kaplan, 2001). These assumptions are disrupted by the image of timber slats and soil directly adjacent to the bedroom window and Leon's description of having this view as, "soon as you wake up", suggests this to be an especially poignant experience within the space where he begins each day. In contrast to wider cultural understandings of opening up bedroom curtains in the morning representing daylight and the optimism of a fresh start to the day, the imagery used by Leon instead positions the window content as "depressing" through its dark and imposing influence over the space.

Figure 4
Leon's photograph of the bedroom window

[8] Whilst they are not visible through Leon's window, there are many mature trees situated within the hospital's grounds.

Within this extract, the researcher's repeated questioning to clarify the content of the window view conveys a sense of it presenting an unfamiliar and unexpected image that is not readily identified or associated with the bedroom context.

The metaphor used to suggest that Leon's embodied experiences are like being "buried underground" creates a disturbing image of the external landscape as an enveloping and smothering force. This imagery thus evokes a sense of threat being associated with Leon's dislike for the window view (Ulrich, 1983) and highlights his perceived lack of control over the ward's physical environment (Lawson et al., 2003). Through the horrifying narrative image of potential suffocation being inflicted by the built environment, Leon can also be seen to be making a powerful statement about his interpretation of the hospital as an overpowering institutional force and his own relationship to it as a detained patient.

Leon's narrative draws on broader societal understandings about light and health, including widespread perceptions that environments with poor light quality can have the potential to influence mood or be "depressing". Alongside the benefits of sunlight and fresh air for controlling infection in hospital environments (Hobday & Dancer, 2013), sunny bedrooms in psychiatric inpatient settings have also been found to reduce length of stay for patients with low mood, when compared with dull rooms (Beauchemin & Hays, 1996; Benedetti et al., 2001). Daylight exposure regulates the circadian rhythms that can improve patients' quality of sleep and accordingly, design recommendations drawn from studies examining light quality in healthcare facilities include positioning windows to maximise exposure to early morning sunlight (Joseph, 2006). Mental health problems are typically associated with disturbances in sleep-wake cycles (Foster & Wulff, 2005) and the poor sleep commonly experienced by patients in psychiatric inpatient settings can also be attributed to the sensory qualities of the ward environment, including lighting conditions (Novak et al., 2020; Veale, 2019). Light plays a significant role in regulating sleep-wake cycles and evening

exposure to blue light from artificial light sources in mental healthcare settings can disrupt the circadian system and affect patients' quality of sleep (Scott et al., 2021). Accordingly, trials of dynamic lighting systems that include blue-depleted light sources in the evening have been found to improve sleep duration within psychiatric ward environments (Scott et al., 2021; Vethe et al., 2021).

By stressing a preference for minimal levels of natural light in the bedroom with the blind pulled down, rather than face the window view, Leon underscores the strength of his negative feeling towards the window and its contents. This depth of feeling is further emphasised by Leon's use of the expression, "I've got to that point now" which recurs throughout the interview and suggests that his exasperation with the environment has been heightened by being detained on the ward without leave for some time. The description of typically choosing to keep the blind down during the daytime could be interpreted as a strategy for adapting the bedroom that Leon and other patients have used to cope with and gain control over undesirable environmental attributes. In this action the materiality of the blind facilitates a sense of separation between the oppressive external environment and Leon's personal space. Control over the blind also provides Leon with some opportunity for choice, albeit a limited choice between what he expresses as two unsatisfactory options afforded by the space.

Notwithstanding the troubling content of the view, the bedroom window affords Leon a visual connection to the external environment, yet at the same time, the window represents an impenetrable barrier that prevents access to multisensorial interaction with the natural world. Previous research has similarly highlighted how the use of glass within the built environment can present barriers that 'speak' to the occupants of mental healthcare facilities and convey potentially ambiguous messages (Connellan et al., 2015). In a new build psychiatric unit, Connellan et al. (2011) observed that full-height glazing afforded internal-external connections in communal ward areas overlooking garden spaces, yet windows on a secure ward presented

patients with views of outdoor spaces that were inaccessible to them. Similarly, in another study within a refurbished psychiatric intensive care unit where patients did not have direct access to outdoor space, staff expressed concern about the view of an inaccessible rooftop garden and perceived that this offered patients the experience of, "you can look but you can't touch" (Payne & May, 2009, p. 82). The potential for windows to both offer up the natural environment to patients, whilst at the same time creating a barrier to access, is therefore argued to require careful ethical design consideration in mental healthcare settings (Connellan et al., 2011).

As a threshold between the internal world of the ward and the external world beyond, the sealed window unit thus presents a paradoxical situation for Leon, who is both connected to and yet simultaneously separated from the outside world and nature by the window. Following Stenner, Greco and Motzkau (2017), these circumstances can be elaborated in relation to the concept of a 'liminal hotspot', or a situation in which Leon is caught in a suspended state between these two worlds. By keeping the blind down and obscuring the outside world, including natural light, Leon's actions could be interpreted as a form of 'polarisation' that can characterise attempts to avoid the paradox and sense of paralysis typically experienced in a situation of ongoing liminality (Greco & Stenner, 2017). By shutting out connections to nature and the external world as an attempt to avoid an indeterminate liminal state, Leon can be understood to be forcing a polarised solution that aligns most closely with the conditions of the internal world. Leon's account provides an image of intense affectivity associated with his experience of enduring liminality and his actions can be interpreted as an approach to alleviate the intensity of his affective discomfort in the space.

The disconnect Leon perceives between internal and external spaces is conveyed throughout the interview as a multisensorial experience. The description of non-openable windows and poor air quality evokes an impression of the ward as being a sealed, almost airtight environment within which a heady affective atmosphere can

build up. Leon's account of waking up feeling "groggy" contributes to the narrative imagery of how his embodied experiences may be associated with the built environment and underlines his perceptions of the air quality as a devitalising and pervasive force within the ward. Previous research in hospital settings has similarly identified close associations between health outcomes and characteristics of the sensory environment, including air quality (Schweitzer et al., 2004; Ulrich et al., 2008). The provision of adequate ventilation in psychiatric settings can therefore optimise health by affording fresh air and also controlling unpleasant odours that may generate negative emotional responses (Karlin & Zeiss, 2006; Mazuch & Stephen, 2007), including stress, fear and anxiety (Connellan et al., 2013; Schweitzer et al., 2004). The need for fresh air, as highlighted by Leon, could also be understood to be especially pronounced in a mental healthcare setting, where patients commonly experience mental clouding or sedation associated with the use of psychotropic medication (Seale et al., 2007).

Within this extract and throughout the interview, Leon's repeated use of the phrase, "to be fair" positions the evaluation of his experiences and contribution to the research interview as measured and rational. Leon's concluding observation that the windows were "probably the main thing that annoyed a lot of us", conveys his depth of feeling and offers a source of validation to the researcher in suggesting that his experiences are widely shared by the other patients on the ward.

Later in the interview, Leon elaborates further about his perceptions of the bedroom and his emotional relationship with the space. The following account implies that his adaptive processes, which include manipulating the blind and rearranging possessions within the space, can mediate his affective responses to the environment by attempts to conceal its institutional qualities.

Leon: Extract 2

L: But it's still sometimes, it's like, uncomfortable. The window view's, is very like, claustrophobic. I literally have to like, I black out my windows, just to really, just let the room dark, so I don't really see all the clinical things.

R: Mm.

L: But, after a while that gets a bit boring. You have to find something else to like, spicen your room up a bit.

R: Mm.

L: I rearrange my room about 2, 3 times a week. Just because, literally, it's just so clinical (*laugh*). It's like this whole shelving system and those cupboards up there, it's sort of, it's what I used to have in prison.

In contrast to Leon's earlier account of his appreciation for the natural qualities of the external world, the narrative here presents an image of the ward interior being imbued with an undesired tone that Leon perceives as both clinical and carceral. The narrative reiterates Leon's perceptions of the bedroom window view as an oppressive force that can generate psychological discomfort and distress. Earlier Leon describes using the blind to cut off the troubling connection to the external world outside the window and it is noteworthy here that the associated reduction in natural light is also used to diminish the clinical qualities of the internal bedroom environment. This account of keeping the room dark to ameliorate the institutional tone that pervades the space emphasises Leon's strength of negative feeling and conveys a sense of his need to protect himself from the unhelpful cues he perceives in the built environment. The functional design of the robust joinery fittings is also understood to evoke a punitive environment that serves as a reminder to Leon of his time previously spent in prison.

His account therefore suggests that the process of re-ordering possessions and updating his bedroom is a further strategy employed in resistance to the draining forces of the institutional and carceral qualities that he perceives within the environment. Elsewhere in the interview, Leon similarly describes feeling like he is, "in prison again" when walking on the homogenous flooring material in the ward's open-

air courtyard. In contrast, he expresses a desire to experience the sensation of natural materials such as, "real grass or real turf" within that outdoor space. His accounts therefore suggest that authentic, natural materials are perceived to be psychologically supportive, whilst artificial materials and utilitarian design contribute to his perceptions of an unhelpful institutional tone being ingrained within the built environment.

In the following extract Leon expands upon the storylines already discussed and further explores the ways in which he perceives that a clinical and institutional ambience is pervasive within the ward environment.

Leon: Extract 3

L: Um, generally, we are trying to make this ward better, as, as patients we are asking for more stuff, but generally, the problem is the clinical and I mean like, bog standard sink and that's it

R: Mm.

L: type looks and feel to things is depressing. It annoys people. It doesn't, even though it's such a minor and I realise sub-consciously we pick this stuff up, that, it's like, if you're pissed off or you're angry, you wanna sit down in a nice comfy chair and think about things carefully, but most fresh, most like oxygenated room, is enjoy that fresh air, not aircon. 'Cause aircon's not helping anything.

R: Mm.

L: Normal fresh air, the smell of rain after it's rained. Just simple pleasures in life

R: Mm.

L: that we are cut out, we're cut off from, because this place was designed poorly.

R: Mm.

L: 'Cause like [*name of previous ward*] is an older building, it was designed before [*name of another building on the hospital site*]. We had windows that opened, even though it had like a grille.

R: Mm.

L: Now, I preferred to have that little grille, than what we've got here.

R: Mm.

L: Just because, the, the smell of the rain when you wake up in the morning, it just, it wakes you up, it makes you feel happy. You know it's gonna be a good day.

You know it's going to be good like by the weather.

R: Yeah, yeah.

L: It is, it's just, as you can see from this room, there's none of that.

R: Mm. I think we've got the same view [*the orientation of the window in the room used for the interview is similar to the bedroom, although the content is largely concealed by a window covering*]. Yeah.

L: Yeah. They even tried putting bird boxes up at some point just to try and entice animals, so make it look more inviting, but, even the birds don't come, so that explains everything. (*Laughs*). The animals aren't willing to come to this part.

Following on from the previous extract, this narrative continues to build up an impression of the overall ward space being permeated with a sense of medical starkness. Whilst Leon comments that patients are, "asking for more stuff" to enrich the ward, his perception of a "clinical" quality being inherent in the material and symbolic fabric of the space repeats throughout the interview and is presented as being problematic and restricting the potential for environmental improvement. This story suggests that the physical attributes and aesthetic components of the environment including furniture and fixtures, convey meaning to occupants and combine with atmospheric conditions to set the institutional tone that Leon perceives throughout.

Figure 5
Leon's photograph of the bathroom

Leon's account of the "bog standard sink" in his bathroom evokes the sense of a utilitarian or cost-driven approach to the specification of fixtures, which in turn implies a lack of care or consideration for the end user and the prioritisation of functionality over aesthetics. Leon's observations hence suggest that his bathroom environment and the design of the sanitary fittings within it are communicating with him more widely about how patients might be valued or regarded within the mental healthcare system.

Within this narrative, Leon's description of desiring a "comfy chair" evokes imagery of domesticity and ease. His account suggests that perceptions of comfort or homeliness within the material or atmospheric characteristics of an environment can be psychologically supportive and have the potential to assist with relaxation (Duque et al., 2019). In contrast, Leon's observation that the air conditioning is, "not helping anything" implies a sense of the environmental conditions and air quality being unsupportive and actively working against him by hindering the potential to experience comfort and in turn, his ability to relax.

Leon's account of appreciating the experience of "fresh air" and "the smell of the rain" through an open window expands the storyline of his desire for greater sensory connection between the ward interior and the external environment. Through these examples Leon illustrates his perceptions about the potential to gain pleasure or vitality from modest and ordinary sensory experiences. Whilst such everyday interactions with the natural world may commonly be taken for granted in other contexts, Leon highlights that their absence is especially significant when detained as a patient without leave within this ward environment. Leon's description of being "cut off" from these experiences emphasises the image of sensory isolation imposed by the architectural features of the building. Whilst the account suggests that window grilles were perceived as undesirable features of the previous ward architecture, Leon's statement of preference for grilles over the current non-openable windows underlines the extent of his wish to experience greater sensory connection with external spaces.

When considered in conjunction with his earlier account of the non-desired visual content of the bedroom window, Leon's narrative also underscores the significance of his wish to have sensory connections with the external environment that are beyond purely visual experiences. Leon reiterates his desire for openable windows to provide fresh air elsewhere in the interview and there he also describes how his room can be "very stuffy" and "like a sauna sometimes". The imagined multisensorial experiences which might be made available via an openable bedroom window are presented as being invigorating and Leon's account implies that being attuned with, or having exposure to the external environment and nature can enhance his mood and perceptions of vitality (Iyendo et al., 2016; Ulrich et al., 2008). The narrative also highlights the positional contrasts between the researcher, who is permitted to freely access such experiences and Leon, who has been detained without leave from the ward for a significant length of time and for whom the need for connection with external spaces is now especially pronounced.

Dry humour features throughout the interview and is used by Leon to emphasise key points within the narrative. Leon's wry conclusion that, "even the birds don't come" and "the animals aren't willing to come to this part" to make their homes, despite attempts of enticement, is presented as evidence to the researcher of how the environment may be more widely perceived as unnatural, inhospitable, or non-domestic. As with his earlier reflections about feeling "buried underground" by the oppressive window view, Leon can be understood to be making a statement here about the broader messages he receives from the built environment regarding his place as a patient within the institution. Accordingly, his observation that "even" animals feel uncomfortable in this space evokes an image of how the physical environment might potentially convey a message to patients that they are regarded as less than human.

4.2 Carl

At the time of meeting Carl was detained in a medium secure setting and had recently been granted leave from the ward for the first time in several months. Carl is a young man who has been a patient within mental health services for a number of years, however, he is hopeful that he will soon be discharged. The overall tone of his narrative conveys a sense of resilience and Carl describes having struggled with many aspects of being detained in hospital and his journey through the mental health system. Whilst the narrative is infused with a range of Carl's emotional responses to his experiences of being in hospital, including fear and frustration, it contains an underlying tone of optimism and a sense of looking forward to future possibilities. The hospital is located at a significant distance from Carl's family and his concerns and considerations about the future and life beyond hospital include the potential of moving in with his partner.

The level of nuance and detail included within Carl's accounts of the social, atmospheric and material qualities of the ward imply that he is a perceptive and sensitive person who is attuned to the subtleties of ward milieu. His stories of lived experiences within the hospital environment commonly draw on visual metaphors that are used to convey his emotional responses to everyday spaces. Using this narrative device throughout, Carl also builds up an impression of his affective ambivalence towards many of the spaces encountered within the hospital.

Throughout the narrative Carl presents himself as an imaginative and creative person who enjoys artistic activities, including designing and making hand crafts. Creativity is described as a form of self-expression and the narrative also suggests that Carl's creative activities have a therapeutic quality, in addition to facilitating a sense of connection with other people.

Carl's main storylines focus around: (1) negotiating uncomfortable spaces, (2) being attuned to the environment, (3) negotiating the hospital environment and

system, (4) using space as a distraction or escape, (5) connections between space and social relationships, (6) creativity and self-expression.

Carl reflected during the interview on photographs of[9]: (a) crafts room, (b) off-ward café, (c) off-ward café courtyard, (d) hospital corridor, (e) hospital grounds, (f) hospital grounds juxtaposed with the large hospital building, (g) occupational therapy kitchen, (h) day area skylight, (i) his bed with homemade blanket, (j) his desk, (l) his bedroom door, (m) ward telephone booth, (n) ward courtyard and (o) day area.

The interpretation of Carl's narrative will focus on the first four interwoven storylines, through which he expresses an awareness of associations between his emotional experiences and the everyday hospital environment and describes ways in which he negotiates these spaces and the hospital system overall.

Carl: Extract 1

C: Er, the next one is a shot of the, the skylight in the day area. Which is a really, looks lovely, lovely to have the daylight shining in, floods the room full of light, but then the next shot, is a z-, a close up of just how shabby it is at the edges and for me it sums up my entire experience of being, just, of being in the, in the environment. Everything looks great until you look a bit deeper. And it just, it looks like, for me, it sums up how much is available to us and how good the service can be, but then if you just zoom in and just take it a little bit closer, you can see, the edges are, aren't there, it's not refined, it's not right, it's just, shoddy and dirty. And that for me, that sort of, these two shots in parallel convey.

R: Mm. Yeah. And do you think that, that has an impact on um, how you feel

C: Yeah.

R: within, within the spaces?

C: Definitely, when you're sat, when you're sat there and you look and you think it's a lovely thing and you notice the extra details, it's just, it just bugs you, just something else to play on, you're sat there, to play on your mind.

R: Mm.

C: I'm a big day dreamer, I love sitting on the floor looking up at the ceiling, at the

[9] The photographs taken by Carl were reviewed on the camera screen during the interview as they could not be printed. The images are not available for reference here as the digital files could not be transferred.

clouds when it's a nice day.

R: Yeah.

C: I just find it really relaxing. But then the little details, for me just ruin it. But it depends on what you focus on, if you're on a good day, you see the whole nice of it, you're having a bad day you focus on that little detail.

In this extract Carl's narrative is focused on his emotional responses to the skylight as a predominant architectural feature of the day area and the perceived qualities that this affords to the space. The account draws on wider public understandings about the vital properties of natural light and common perceptions of sunlight specifically as an enriching attribute for interior spaces, with the capacity to potentiate positive mood (G. W. Evans, 2003; Joseph, 2006; Ulrich et al., 2006, 2008). Carl's description of "daylight shining in" that "floods the room full of light" evokes a sense of openness and abundance, in which natural light pours in fluidly from the exterior to saturate the internal space. The imagery of reflectivity and brightness in the space also builds on wider understandings of associations between sparkling, polished surfaces and perceptions of cleanliness and newness. Through this imagery, Carl presents the bright, optimistic qualities afforded to the interior by daylight coming through the glazing, in stark contrast to his alternative perceptions of the skylight edge detail being "shabby", "shoddy" and "dirty".

Alongside his literal use of a camera lens to zoom in and out of the spaces discussed, Carl's reflection on how, "everything looks great until you look a bit deeper", also evokes the use of a metaphorical lens to shift between contrasting viewpoints in his appraisals of the overall institution. This motif of zooming between macro and micro perspectives recurs as a narrative device throughout the interview and is powerful in conveying Carl's sense of ambivalence towards the hospital environment. Spaces are positioned ambiguously as being neither completely one thing nor another, with the potential to be perceived both positively and negatively depending on the affective choice of lens and the specific spatial attributes that are brought into focus.

Throughout the interview Carl highlights how several other areas, including the telephone booth and the view from his bedroom window, all possess a sense of affective ambivalence that he underscores with a recurring metaphor of his relationship with the hospital environment being like a "double-edged sword". Carl thus implies that the spaces he inhabits can be appreciated positively for their affordances, such as creating connections to aspects of nature or to family and friends, whilst also being perceived simultaneously as unpleasant, unattractive or lacking in quality. Carl's concluding statement that, "if you're on a good day, you see the whole nice of it, you're having a bad day you focus on that little detail", also proposes an association between aesthetic perceptions of the ward environment and mood states. The narrative therefore implies that broader, more optimistic perspectives and impressions of the environment and the institution as a whole may be available when Carl is feeling good, whilst low mood may magnify or encourage an emphasis on the perceived flaws.

Carl's accounts of his ambivalence towards the hospital environment suggest that through his relationships with different spaces he finds himself continually caught in an 'in-between' position between affective states. Spaces are valued for facilitating an enjoyable sense of connection and opening up to the wider world, but at the same time they are also perceived as uncomfortable or constraining. Whilst the everyday environments Carl inhabits can be supportive and pleasurable on one hand, they are also typically troubling and disquieting on the other. The narrative thus suggests that Carl is suspended in an ongoing state of liminal affectivity (Stenner, 2013), perpetuated by his interpretations of the hospital environment's material and symbolic characteristics. Carl's experiences of the 'both/and' and 'neither/nor' qualities within spaces on the ward and the enduring ambivalence associated with his affective responses are therefore understood to generate unhelpful tensions that can contribute to his distress and limit perceptions of progression and psychological comfort.

Carl's metaphor of the bright, shining environment representing opportunities and "how good" he perceives the mental health service can be, alongside his positioning of an unkempt skylight detail as being "not refined" and "not right" implies that appreciation of material detail is also associated with wider perceptions of quality and integrity. The flaws perceived within this architectural detail can therefore also be understood to be speaking more broadly to Carl about the shortcomings and limitations of the overall institution. The narrative suggests that perceptions of aesthetic purity and refinement within physical surroundings can be gratifying and convey value, whilst details perceived as "shoddy" or "dirty" are symbolically associated with a sense of imperfection and lack of value or care. Correspondingly, through his appraisal of the skylight detail as lacking in quality or aesthetic consideration, Carl can also be seen to be receiving a wider message from the built environment about how patients might be valued or regarded by the institution. His accounts of defective or unclean aspects of the physical environment also present an image of aesthetic contagion that can be elaborated in reference to the sociologist Erving Goffman's (1961/1991) pioneering ethnographic research within psychiatric settings. Goffman argues that patients may experience a sense of "contaminative exposure" (p.31) in relation to the violation of boundaries between the self and the environment following admission to an institution. Physical forms of contamination might therefore be associated with the lack of privacy and constant scrutiny experienced by psychiatric patients in institutional settings, or with their exposure to unclean objects or dirty communal facilities. Drawing on Goffman's thinking, the awareness of environmental impurity described here by Carl and elsewhere in the interview, including when he describes how, "some of the corridors can smell of urine" can thus be interpreted as forms of contaminative exposure imposed by the built environment.

Within this extract, Carl's account of how his awareness of defects within the physical environment creates psychological discomfort accordingly highlights how negative perceptions of spaces and objects on the ward can be unhelpful and unsupportive to occupants' mental health. The description of a perceived environmental flaw as being something that, "just bugs you" suggests a sense of pervasive irritation that Carl does not have the option to resolve for himself and emphasises how inpatients typically experience very limited control over the ward environment (Csipke et al., 2016). Carl's account of his perceptions of the space playing on his mind while he is sitting within it positions the material environment as an actively intrusive force due to the psychological friction it can induce. Furthermore, the narrative also underscores how details within the physical environment are especially significant in secure settings, where patients have restricted access to varied visual or multisensorial landscapes and regularly spend long periods of unstructured time within the same spaces on a ward (Farnworth et al., 2004; O'Connell et al., 2010). In contrast to his experience of affective discomfort in relation to the imperfections identified within the built environment, Carl's appreciation of cloud-gazing as a "really relaxing" activity suggests there is a soothing quality and lack of friction within this natural scene that contributes to a positive affective state (S. Kaplan, 1995). Through the description of sitting on the day room floor to gaze up at the clouds, Carl presents an image of behaviour more commonly undertaken outdoors, whereby sitting or lying on the ground is typically associated with leisure activity or relaxation. Interpreting Carl's choice to sit on the floor in an internal space whilst looking up at the sky could suggest that having this perspective and connection to the ground provides an embodied association with the experience of relaxation in outdoor spaces and may assist his ability to relax in this setting (Berto, 2014).

Throughout the interview, Carl talks about ways in which he experiences a sense of physical and psychological discomfort within spaces on the ward, including a

lack of privacy. In the following extract, when reflecting on his perceptions of privacy in the hospital environment, Carl identifies his bedroom as one of the spaces that affords him the greatest sense of being private. However, he is also prompted to tell a story of feeling threatened and distressed within this space by an incident taking place outside his bedroom door.

Carl: Extract 2

R: […] Um, just thinking about the environment here, um, again and just thinking about the spaces, I was just wondering if there were any spaces here that you would sort of consider to be private at all?

C: Um, my room's probably one of the most private environments. It seems a bit daft, but sometimes if I'm in my room and I get really scared, like the other week when the door was being kicked in for a while, I kind of locked myself in my bathroom because it's one extra door (*laugh*) away from everyone and it's, I like that it's smaller. And for me I like, I do like smaller environments, I like, but not too small.

R: Mm.

C: So like, the phone room I find really small, but the bathroom here is just smaller than my room, with an extra layer of protection of another door.

R: Yeah, yeah.

C: But, I don't feel that many of the rooms are private in any degree, 'cause people are always popping in and out and not knowing what's going on and

R: Mm.

C: I'd rather just not be in here to talk to anyone privately.

R: Mm.

C: I know that at any moment someone could just ping that door open. But I know they're not gonna know anything, I know they're not gonna hear anything, in that moment, but there's always the potential.

R: Mm. Yeah. You mentioned about the size of the space,

C: Mm.

R: could you tell me a little bit more about, um, the sort of, the feelings that you get from those different sort of scales of environment?

C: For me, if the corri-, if

R: (*Coughs*).

C: usually like the corridors tend to be skinny and long, which makes me feel like it's a long, end-, never-ending journey, which, that, emotionally like how it can make me feel, but some of the day areas and communal areas almost need to

be a bit homely, a bit snugger, tend to be a bit too vast.

R: Mm.

C: But then I like the freedom in the courtyard's vast and open, feeling like you're not trapped in anymore. But um, the day area can almost feel like you've got an ant in a large dome. It's free to go wherever it wants within the parameters of the dome. But the courtyard feels different because it's outside. It's hard to explain.

Carl's account draws on widespread perceptions of doors as dynamic architectural features that are operated to facilitate connection or separation between spaces. Whilst doors may commonly be used to control levels of social interaction or privacy, Carl's narrative positioning of the doorways on the ward as sites of potential intrusion, both from patients and staff members, accentuates the limitations of his perceived control over the environment and the actions of others. Although the person outside his door cannot physically enter the bedroom, the account highlights how Carl is unable to control the sounds or vibrations transmitted into the space via the materiality of the door and his associated fear responses (Stansfeld & Matheson, 2003).

Carl's story of retreating to the bathroom emphasises the degree of his affective response and the significance of the situation as an undesired intrusion on his personal space. The narrative creates an image of the hospital as a series of nested spaces ranging from public to private and within this continuum, Carl perceives the en suite bathroom, as one of the smaller and most deeply nested rooms, to be one of the more private and in turn, one of the safest spaces. Closing the door to complete the bathroom volume as an enclosed room-within-a-room allows Carl to perceive reassurance from the "extra layer of protection" represented by the physicality of the door. Carl's account evokes imagery of doors as forms of physical and psychological defence, yet at the same time it positions doorways as points of vulnerability and potential exposure, depending on who has control of the door. When expressing concern that, "at any moment someone could just ping that door open", Carl presents an image of how power relations between staff and patients can be directly expressed through the

materiality of the ward. This comment also conveys a sense of his awareness towards potential threat within the ward environment which recurs throughout the interview.

Carl's account therefore highlights how intense affective experiences can be associated with doorways on the ward that signify physical and symbolic thresholds between different spheres of activity that occur either side. Doors can represent a border between different worlds, including the contrasting worlds of patients and staff activity or between environments and circles of activity that might be understood to be 'public' or 'private'. Whilst a closed door can create separation between different worlds, an open door can instantly bring two worlds together. Having control of a door can both enable or limit transition across a boundary and accordingly, the narrative implies that Carl's perceptions of having a lack of privacy within a secure psychiatric setting are associated with his experiences of lacking a sense of environmental control. It is also noteworthy that earlier in the interview the conversation with Carl was interrupted by a staff member opening the meeting room door to speak with him. At this point the interview recording was briefly paused, however, it is significant that he was not free from unpredictable intrusion even when participating in a research interview.

In his further reflections on associations between affective experiences and environmental scale, Carl's narrative imagery of a tiny ant moving within a big dome indirectly positions his own experiences of the day area as being like that of the ant. The dominant scale of the dome in his account also underscores his perceptions of the day room space as being "vast" and oversized. By positioning the restrictive dome as a metaphor for the building, Carl expresses his perceptions of power relationships between patients and the mental health system being symbolically embedded in the material structure of the hospital. Drawing on Foucault's (1975/1991) characterisation of psychiatric institutions as the embodiment of discipline and control over social deviancy, the power of the institution is understood to be being communicated to Carl

through the physicality, scale and proportions of the building. This symbolic link between environmental scale and perceptions of power is similarly expressed earlier in the interview in relation to Carl's awareness of the high walls around the courtyard. His account of experiencing the walls as dominant and overbearing highlights how the scale of the institutional architecture is able to position him and other patients as what he describes perceiving to be, "just a small part" of the overall healthcare system.

Such references to scale and proportion within the narrative suggest that an appropriate match of scale to function can contribute to perceptions of psychological comfort within spaces. The perceived oversizing and therefore non-domestic scaling of areas such as the day room and hospital corridors is positioned as a spatial attribute which contributes to the sense of unease that Carl experiences within those spaces. Whilst Carl's reflection that the communal areas should be "a bit snugger" evokes imagery of potential cosiness and a homely environment, the language also conveys his perceptions that the sizes of these spaces are not a comfortable fit and could be better tailored to suit the function and the users of the spaces.

This sense of congruence between scale and function contributing to perceptions of physical and psychological comfort within spaces is also conveyed through Carl's stories of his embodied experiences within smaller scale spaces on the ward. Whilst his account of the bathroom suggests that a sense of reassurance and protection can be afforded by small spaces, Carl's observation that some spaces can be "too small" presents an image of the relationships between scale, function and environmental conditions creating perceived thresholds of comfort within spaces. Carl references the telephone room as one of the smallest spaces encountered and earlier in the interview, his reflections on a photograph of that space further expound his sense of affective ambivalence in response to different spaces on the ward. Although Carl appreciates the room positively as a place to connect with friends and family, his account of its very small scale, combined with intrusive noise from the lounge and

conditions he perceives as “really hot and dirty”, convey his parallel experience of embodied discomfort within the space.

Whilst vastness is presented as a problematic attribute within some of the internal spaces, including the day area, it is a quality that Carl appreciates perceiving in the external courtyard. The glazing in the day area offers a sky view, yet Carl’s account presents the open-topped courtyard as able to afford a sense of liberation which is not available through the glazed internal skylight. Carl values the way in which the skylight in the day area creates connections between the ward interior and natural elements, including sunlight and clouds in the sky, yet the glazing also represents a symbolic overhead barrier that contributes to his perceptions of containment. Conversely, despite the high enclosing walls around the courtyard volume, there is no physical barrier within this outdoor space between Carl and the sky far above. By contrasting the image of the internal day area as an impenetrable dome with his perceptions of “freedom” and sense of not being “trapped” in the external courtyard, the account also implies that access to fresh air and direct sensory connections to nature are significant to Carl’s perceptions of psychological comfort.

In the following extract Carl further elaborates on his perceptions of environmental scale and atmosphere in relation to his embodied experiences within the communal day area.

Carl: Extract 3

C: […] It just never feels nice out there, it just feels eerie. Just too vast, too open, not home, not homely.

R: Mm. Could you say a little bit more about what features of it, um, might contribute to those, those feelings?

C: It’s a large space, where you’re constantly being watched from every angle, with the different rooms looking on, into, it’s almost like an atrium, it’s not almost like a room.

R: Mm.

C: Everything feeds off and you’ve, it’s, you’ve got people coming and going

in and out, which isn't good to just sit and watch something and concentrate on the TV or in a conversation. You're always worried about what's behind you if that door slammed and what's this, what's that.

Carl's account of the day area as "eerie", "open" and "vast" presents an image of a strange and discomforting environment and suggests that scale and atmosphere contribute to his perceptions of it as a "not homely" space. Carl's description of being "out there" in the day area, "with different rooms looking on", evokes a sense of exposure and being out on display in the space, which underscores his perceptions of being subject to continual surveillance, "from every angle". Through his account of the day area as a space in which, "everything feeds off", Carl presents an image of the environment as a busy thoroughfare without clearly defined boundaries. The narrative implies that the lack of clear spatial definition also contributes to Carl's perceptions of the day area as a liminal space without a clear identity. In contrast to his references to "home" and "homely", which prompt images of domestic living spaces, Carl's account of the day area as, "almost like an atrium" evokes imagery of public lobbies and large-scale corporate architecture. The narrative imagery therefore positions the day area as an unbounded space in which it is difficult for Carl to relax and where he remains vigilant towards potential threat from all around.

Carl reiterates an account of the day area's oversized scale elsewhere in the interview and the narrative implies that his perceptions of the space as "vast" and "not homely" are also associated with its poor acoustic qualities and a non-domestic arrangement of furniture. Carl perceives that the uncomfortable noise in the day area is associated with, "how far everything can be away from one another, the chair at one end of the room and a chair at the other" and his account implies that furniture spacing affects communication, such that his experience is, "almost like having to shout across". Noise issues are common in hospitals (Busch-Vishniac et al., 2005; Holmberg & Coon, 1999) and poor acoustics in these environments are typically aggravated by the

prevalence of smooth, sound-reflective surfaces that can cause different sounds to echo, overlap or produce long reverberation times (Joseph & Ulrich, 2007). Associations identified between noise sensitivity and mental distress (Stansfeld, 1992; Sutton & Nicholson, 2011) suggest that occupants' experiences of sound and the overall acoustic environment are especially pertinent to psychiatric settings. Ambient noise levels are a significant stressor and incorporating acoustic materials into the design of secure wards can control sound and mitigate levels of aggression that may occur amidst consistently high levels of noise and raised voices (Dvoskin et al., 2002; Hunt & Sine, 2017).

Large, open day areas, as described by Carl, are commonly connected to long echoic corridors, however, since highly reverberant spaces may exacerbate the perceptual distortions experienced by some patients (Karlin & Zeiss, 2006), acoustic control is a particular consideration in psychiatric settings. Clinicians involved in the design and development of medium secure psychiatric units have also suggested that facilities should ideally possess, "a comfortable, domestic scale and ambience" (Watson, 1998 p.524) to optimise the health and well-being of occupants. Watson highlights how the rationale for this is not limited to the creation of physically comfortable or pleasing spaces, but additionally it aims to induce perceptions of intimacy and mutual trust that are vital to therapeutic relationships yet may typically be lacking in patients' lives.

4.3 Wendy

Wendy is a mental health nurse and at the time of the interview she was working in a low secure ward environment. Wendy has previous experience working with patients in acute inpatient mental healthcare facilities and she notes that it had taken her time to adjust to working with a new patient group and adapt to working within a secure setting. Throughout the narrative Wendy presents herself as a conscientious, thoughtful and empathetic person who is concerned about the welfare of patients and colleagues with whom she works.

Wendy's stories position her in a busy, challenging and frequently stressful role of care and responsibility. Alongside duties relating to her own ward, she is at times also responsible for coordinating staffing and incident responses on other wards across the hospital site. Wendy's narrative conveys an underlying tone of stoicism and professionalism, yet it is also mixed with a sense of some frustration and concern in relation to staffing levels and her perceptions of how limited staff resources can affect the everyday experiences of patients and other members of staff.

The overall narrative implies that Wendy is very busy managing the different aspects of her role at work and that her time is generally in high demand. This is further emphasised at one point in the interview when it is necessary to pause the recording for a few minutes when a colleague knocked on the door to consult with her. Wendy's storylines focus around: (1) managing professional challenges and stress, (2) negotiating uncomfortable spaces, (3) managing her own and colleagues' emotions within her professional role, (4) having emotional responses to spaces and objects, (5) navigating boundaries and relationships with patients.

In the interview Wendy discussed photographs of: (a) walkie-talkie unit and bleep, (b) seclusion room intercom, (c) seclusion room door, (d) poster with list of items that are prohibited on the ward, (e) clinic room door, (f) poster on exit door noting that, "all staff and visitors must notify safety nurse when they are leaving the ward" and (g) door signage noting that, "only staff are to enter this room".

The following interpretation of Wendy's narrative focuses on the first, second and fifth intertwined storylines, through which Wendy articulates the complexity of her role, alongside ways in which she navigates her own emotions and relationships with other people in an all-consuming environment. Through these narratives, Wendy highlights similarities between the affective responses of staff and patients to spaces on the ward, whilst also emphasising how the unequal status of staff and patients within the institution contributes to significant contrast and disparity in their experiences of

space. In the following story, Wendy conveys a sense of the everyday challenges of her role and the embodied experiences of discomfort associated with working inside a secure ward environment for long periods of time.

Wendy: Extract 1

W: Um, just that I can feel quite, um, sometimes if I've been here for a long, if I've been here, kind of, quite often I don't get a break (*laughs*). Um, so and I do twelve-hour shifts, so it gets to a point in the day where I have to get out.
R: Mm.
W: I have to go and get some fresh air, because I can feel quite, um, what's the word I'm thinking of? Anxious, um, like I need fresh air.
R: Mm.
W: Because, because we're downstairs, we don't, we're not getting any natural sunlight or anything like that.
R: Mm.
W: Um and I feel like I need to get off, just for kind of five, ten minutes. Sometimes it can feel quite intoxicating in here.
R: Mm, mm.
W: Especially when, because, out in the office, it is like a goldfish bowl. You know, you, patients know exactly what you're doing, yes, I understand it needs to be like that so we can see what's going on, um, but staff can also, patients can also be very aware of what you're doing, um, also if there comes, patients will constantly count how many staff there are in the office. Because that will then determine to them, this is what they think, if they can go out on leave for a walk. They don't seem to take into consideration that actually my other nurse is doing medication, she's about to do medication, I've, I'm coordinating, my Healthcare support workers are busy doing safety checks. They're not interested in things like that, so they're constantly harassing you to go out.
R: Mm.
W: Um and sometimes you feel like, I've just gotta go out for five minutes, gotta go outside, need some fresh air and kind of and that, that usually works fine. Once I've been outside for five, five minutes I can come back in.
R: Yeah.
W: Um, but I'm always very grateful to leave at the end of the day (*laughs*).

Through highlighting the length of her shifts at work, Wendy's narrative positions her everyday lived experiences on the ward as typically intense and demanding. Wendy

emphasises a sense of commitment to her role through her account of frequently being too busy to take a break and her laugh following this statement suggests that the lack of break during a long shift might potentially surprise the researcher. Wendy describes feeling a sense of anxiety after spending a length of time within the ward environment and her use of the phrase, "it gets to a point in the day where I have to get out", evokes the sense of a regular and somewhat inevitable daily build-up of embodied distress that requires a form of release to allow her to go on working. By stressing her need for "fresh air" and highlighting the lack of sunlight in the "downstairs" space, Wendy presents an image of the ward as having gloomy, enclosed and semi-subterranean qualities, from which she feels compelled to emerge, as if coming up from below the surface for air and light. Wendy's perception of the "intoxicating" environment evokes the sense of a potent atmosphere accumulating inside the ward that can pervade and influence her state of being. In contrast, her appreciation of the fresh air outside when she is able to leave the ward for a short time, presents an image of restorative qualities being available within the outdoor environment (Hartig et al., 2014), that enable her to regain a sense of equilibrium before returning to the ward.

Wendy's perceptions of discomfort in the ward environment are further expressed by her description of challenges associated with working within the "goldfish bowl" setting created by the glazed nursing office. In this account, the glazing is positioned as being problematic since it visually connects staff and patients, yet simultaneously separates them by presenting a communicative barrier that offers up a misleading picture regarding staff availability. Wendy's account suggests that through its capacity to engender miscommunication and emphasise a staff-patient divide, the glazing can induce frustration and distress on all sides by exposing misalignments in the priorities and expectations of both groups. The glass is therefore positioned as being unhelpful to staff-patient relations and Wendy's comment that patients are, "not interested" in staff administrative duties inside the office further stresses a distinction

between the different 'worlds' of patients and staff. The sense of division created by the nursing station glazing is similarly emphasised through her use of the pronouns "they" and "them" in reference to patients.

Correspondingly, previous research has found that glazing around nursing stations can accentuate the differing status positions of patients and staff in psychiatric settings and convey messages to patients that staff are occupied and inaccessible (Reavey et al., 2019; Schweitzer et al., 2004). Power imbalances can thus be reinforced by the glazing, since patients must typically knock on the windows to attract attention, whilst staff are able to choose when to engage (Andes & Shattell, 2006). For some patients detained in secure psychiatric settings, the use of glass or acrylic screens around nursing stations may also be associated symbolically with prison environments or invoke perceptions of punishment (Shattell et al., 2015). Open nursing stations without glazing may therefore benefit patient-staff relations and help to improve communication within mental healthcare wards (Edwards & Hults, 1970; Shattell et al., 2015).

Patient participants in the present study and previous research (e.g. McGrath & Reavey, 2013; Riordan & Humphreys, 2007) have reported their perceptions of being under continual scrutiny from staff within psychiatric facilities. Wendy's account, however, suggests that she and staff colleagues may in turn feel self-conscious and closely watched by patients, particularly when working inside a glazed nursing station (Simonsen & Duff, 2021). Secure ward layouts are typically informed by 'panopticon' principles conceived by the philosopher Jeremy Bentham in the late 18th century, such that the central position of nursing stations on contemporary wards affords staff sightlines from a single point to observe patients in the common areas. Devised as a form of institutional surveillance, the panopticon design allowed a watcher in a central tower to observe multiple detainees at once, yet those being observed could not know if they were being watched or not. As highlighted by Wendy's experience, however, an

inversion of panopticon surveillance also occurs in modern psychiatric units, whereby staff within the nursing station are in turn exposed to observation by patients (Scanlon & Adlam, 2011). Wendy's repetition of the word "constantly" in relation to patients counting and "harassing" staff also contributes to an image of staff receiving unremitting and undesired attention from patients when at work in the nursing office.

Goffman's (1961/1991) examination of the social situation within psychiatric institutions can be drawn upon again here to provide theoretical elaboration on Wendy's perceptions of being uncomfortably visible within the nursing station. Following Goffman's thinking, Wendy can be understood to be subject to a form of "contaminative exposure" (p.31) that patients might typically experience under the constant gaze of others in psychiatric institutions, with limited opportunity for private activity. Whilst Wendy mentions elsewhere in the interview that nurses have access to an office space outside the ward, she suggests that the lack of private working space on the ward makes it difficult for staff to carry out administrative work without interruption. Similarly, previous research findings suggest that staff and patients may both benefit from the provision of 'offstage' areas on the ward to allow nurses to retreat or carry out administrative work (D. J. Brown, 2009). Improved positive nurse-patient interaction has also been found on wards where increased private space was made available for both groups (Tyson et al., 2002).

In addition to perceptions of mutual visibility on the ward, Wendy's narrative implies that patients and staff also share the common experience of wishing to spend time outside the ward environment. Wendy presents leaving the ward as a necessary strategy to manage her affective state, however, the account is also imbued with irony, since her distress is associated with perceptions of patients harassing staff due to the patients' own desire to leave the ward. Wendy's story emphasises how patients in secure settings commonly require one or more escorts in order to leave the ward, such that opportunities to access spaces outside the immediate ward environment are

closely linked to staffing levels and staff availability. Correspondingly, existing research examining experiences of psychiatric hospital admission has found that a lack of staff availability to provide escorted leave from the ward can induce distress and contribute to patients' perceptions of a lack of freedom in hospital (Gilburt et al., 2008).

Moments of laughter and humour feature throughout the interview and are typically used by Wendy to underscore the strength of feeling associated with her experiences. At the end of this story, Wendy's laugh emphasises her concluding comment that she, "is always very grateful to leave at the end of the day". Throughout the interview, Wendy's accounts highlight how similarities exist in staff and patient experiences of the ward environment, including perceptions of spaces as being uncomfortable or exposing and lacking connection to nature and the outside world. In line with experiences expressed by several patient participants, Wendy also articulates the strength of her need to spend time each day in the open air outside the confines of the hospital building. Whilst Wendy identifies key similarities in staff and patient experiences of space within the everyday environment, her concluding remark in this extract also emphasises the significant disparity in the relative liberties of staff and patients within secure settings and the positional contrast between both groups.

Alongside her accounts of how the material and spatial qualities of the ward can influence her own affective experiences, Wendy identifies further ways in which the environment might mediate everyday relationships between staff and patients. Within the following extract she elaborates on storylines of negotiating staff-patient interactions and explores how spatial experiences on and off the ward might be linked to her perceptions of creating therapeutic relationships with patients.

Wendy: Extract 2

W: Um, yeah. I mean, it, down here, yeah, it can be quite, um, difficult I think sometimes to kind of engage in a meaningful conversation, particularly with a patient, however, if you take them out for a walk and get them talking, within

the grounds, I think you get a whole different experience with the patient.

R: (*Coughs*). Mm.

W: Um, here, I think, you know obviously I think they feel very confined, um, but when we're out in the grounds, I think you can get a lot more from the patient.

R: Mm.

W: Um. So yeah, I think it, it does have an impact, yeah.

R: Yeah. Are there any reasons why you think that might be that you get that slightly different experience?

W: Freedom I suppose. Bit of freedom. You know, you're not constantly, you know, locking doors, um, opening doors, um, they're not, you know, I suppose, as well when they're out as well, they feel like they're a normal member of society, people wouldn't look at them and think they're a patient at [*name of hospital*]. They perhaps feel a little bit normal, more normal, so they're able to be a bit more themselves

R: Mm.

W: when they're out.

Wendy's description of being "down here" in her account of the ward reiterates her earlier positioning of the environment as a lower ground floor space with limited natural light and she contrasts perceptions of staff-patient relations inside the building with open air experiences in the hospital grounds above. Wendy's observation that being outside with a patient can provide "a whole different experience" suggests that she perceives a significant distinction in the kind of interaction possible in a natural outdoor setting, when compared with dynamics inside the enclosed ward environment. Whilst suggesting that patients may typically feel physically "confined" on the ward and perceive a sense of "freedom" when outside, Wendy's account also conveys a sense of emotional constraint and limitation indoors. Accordingly, alongside other participants across the data set, she perceives that patients may be more inclined to open up and confide in staff within more open and fluid outdoor spaces.

Wendy's perception of the value in spending time outdoors with patients also complements a body of existing research that highlights how people with mental health problems may experience multiple health benefits from walking outdoors (Doughty,

2013; Richardson et al., 2005) and engaging in physical exercise and social interaction within natural settings (Barton et al., 2012; Barton & Pretty, 2010; Mind, 2013). For people with lived experience of distress, the psychological benefits associated with being active in nature and participating in what is also termed, 'green exercise', may include improvements in mood and levels of self-esteem (Barton et al., 2012; Barton & Pretty, 2010). Recent decades have also seen increasing interest in the emerging area of therapeutic 'walk and talk' practice, involving counselling and psychotherapeutic activity undertaken in outdoor spaces (Doucette, 2004; Revell & McLeod, 2017).

Revell and McLeod (2017) explored therapists' perceptions of outdoor therapy and found that participants perceived a positive adjustment in traditional therapeutic relationship dynamics when walking side by side with clients in an outdoor setting. In contrast to sedentary office-based interaction, the participants' accounts suggest that the altered physicality of working outdoors can enable a range of beneficial processes, including a greater sense of equality between client and therapist and increased possibilities for non-verbal communication. The combination of physical movement and therapeutic work outdoors is therefore understood to be helpful in enabling clients to integrate mind-body activity and physical movement may also help clients to shift perceptions of feeling 'stuck' and generate alternative psychological perspectives. Research findings also indicate that therapeutic walk and talk practices can assist in the development of connections to nature that can support mental health (Jordan, 2014) and may contribute to improved individual perceptions of overall well-being and self-efficacy (Doucette, 2004).

Whilst Wendy refers to informal outdoor interactions with patients, her account implies that moving and talking together in an outdoor setting can be potentially therapeutic and associated with a shift in the relational dynamics between staff and patients. Through this extract and the earlier account of her own distress associated with spending prolonged periods of time on the ward, Wendy presents the

process of moving between spaces as a transformative experience that can facilitate a turning point between affective states. Wendy's observations can hence be understood to support previous research which suggests that movement through space, including the particular drive to move from enclosed internal spaces into the open air, can be a significant mediator of experiences of distress (McGrath & Reavey, 2015).

The narrative also indicates that staff-patient status positions are reinforced by power differences expressed through physical interactions with aspects of the built environment, such as doors and locks. Wendy's account thus emphasises how staff control over doors on the unit presents a hierarchy of access to space and highlights how perceptions of doors as symbolic and material barriers can serve as a continual reminder to patients of their status and lack of liberty (Muir-Cochrane et al., 2012; Reavey et al., 2021). Earlier in the interview, Wendy highlights how disparities in staff and patients' access to space are similarly reinforced through other material aspects the ward, including the 'staff only' notice on a door to the room where patients' cigarettes and vaping equipment are stored. When discussing a photograph of this room, that staff members typically go in and out of frequently during the course of the day, Wendy observes that,

> "Um, and it's just again, kind of, er, only staff are allowed, so it's kind of, the nurse patient divide, again, um, wh-, wh-, which can be quite, quite difficult on here. [**R:** Mm.] Um, kind of having to show your authority to patients, but then also we want them to tell us our deepest darkest secrets about thoughts and things and you, you try and build a relationship with somebody, um, but then you're kind of saying, oh actually no you can't come in here, you know, you're not allowed in here."

Wendy articulates a sense of discomfort experienced in her professional role, whereby she must navigate the paradox of attempting to establish both authoritarian and confidante relationships with patients. Wendy alludes to how perceptions of trust are essential for building therapeutic relationships, yet she is mindful that the sign on the door indicates a lack of trust. The door also marks a physical and symbolic boundary that underscores the differing status positions of staff and patients and divides their

circles of activity. Wendy's account thus highlights how the built environment conveys messages that can affect relational dynamics. By emphasising a sense of division, disparity and mistrust between staff and patients, the door and signage are therefore seen to be contributing to experiences of discomfort that are shared by both groups.

Figure 6
Wendy's photograph of door signage on the ward

In contrast to an image of power relations being embedded within the ward environment, Wendy presents the natural space outside the building as a more neutral territory that can mediate relational differences and create a sense of parity between patients, staff and the wider community. The account therefore implies that an absence of physical reminders of detention and control within the natural outdoor environment is significant to the change in staff-patient dynamics that Wendy perceives outside the ward. Her observations also reflect findings of previous research in secure psychiatric settings where support staff perceived a positive shift in relationships with patients in off-ward environments where staff were not continually locking and unlocking doors (K. Evans et al., 2012).

Goffman's (1961/1991) exploration of patient experiences within the asylum highlights how boundaries between typical spheres of life, such as sleep, work and leisure are removed when patients enter a psychiatric institution, meaning that everyday activity is commonly compressed into a single environment. Wendy's account, however, suggests that being active within the natural environment outside the ward might help patients to recreate a sense of spatial distinction between spheres of activity that enables a more typical representation of everyday life. This is underscored by her repetition of "normal" to describe how patients might feel when spending time outside the building when compared to their experiences on the inside. By implication, Wendy's narrative consequently conveys a sense of the ward as an unnatural environment, such that patients' experiences inside the building are non-representative of typical everyday life. The narrative thus presents a contrast between the external grounds, where perceptions of life outside the hospital are potentially more available to patients and the ward, which is positioned as a space where patients find it difficult to perceive a sense of ordinary life. Wendy's account implies that the secure ward environment is a contributing factor to detained psychiatric patients' perceptions of 'deviant' labelling (Coffey, 2012b), which in turn can be associated with experiences of being 'othered' by wider society (Tomlin et al., 2020).

Accordingly, movement from indoor to outdoor space is presented as a transitional process that can enable the possibility of an identity shift for patients – from the position of a detained psychiatric patient to what Wendy terms, "a normal member of society". The transformations associated with movement through space can thus be seen to be affording a shift away from the enduring conditions of a 'liminal hotspot' (Stenner et al., 2017) that may typically be experienced by detained patients in secure institutions. Wendy therefore suggests that patients may feel more at ease as individuals within normative off-ward spaces, where their status position is less reinforced by cues within the environment. Elsewhere in the interview Wendy also

notes that during her career she has at times felt, “a bit like a prison guard, not a mental health nurse”. Her account here, however, implies here that being outside, where she is not “locking doors”, can affect perceptions of her professional identity by reducing carceral associations to reinforce a role of care and underpin a more human-to-human relationship with patients that is more reciprocal and equitable.

4.4 Concluding comments

The narratives explored in this chapter have exemplified participants’ storylines about physical and psychological discomfort associated with experiences of spaces or objects within the hospital environment. Corresponding stories that conveyed patient and staff accounts of disquieting spatial experiences in these settings were also expressed more widely by both groups across the overall data set. Using liminality as a theoretical perspective through which to consider these experiences in process terms, the discomfort and unease expressed through the narratives has been conceptualised in the context of participants’ experiences of enduring liminality, or as a sense of being ‘stuck’ in a ‘liminal hotspot’ (Greco & Stenner, 2017; Stenner, 2013). The narratives thus highlight varied ways in which the occupants of secure settings can be seen to be uncomfortably suspended between different and typically contrasting ‘worlds’ or ‘forms-of-process’ when living or working in these environments (Stenner, 2017) and how spatial experiences might mediate transitions between worlds.

Participants expressed perceptions of their self-identity through the narratives (e.g. as detained patients or members of the wider society), or their differing positional status (e.g. as patients or members of staff). The stories explored here highlight how these self-positions can be mediated or sustained by the everyday spaces and objects encountered in secure settings. The barriers presented by physical features of the environment, including robust doors, locks and non-openable windows form symbolic reminders to patients about their lack of liberty, in addition to highlighting how staff are required to negotiate custodial responsibilities alongside their duties of care. For

some patients, the material and aesthetic attributes of architectural components and the utilitarian detailing of furniture items within the ward environment also present an unhelpful reminder of time spent in prison settings. Qualities of the built environment, including the material, aesthetic, atmospheric and acoustic attributes of spaces are thus argued to be reinforcing participants' perceptions of status or identity and defining the limits of their ability to transition between different and commonly conflicting self-positions. Correspondingly, symbolic cues perceived in the everyday environment, including the materiality, scale and proportion of spaces are seen to be conveying messages about power or control and the contrasting status and liberty of patients and staff. Such distinctions between staff and patients are thereby understood to be being continually expressed through their daily interactions with architectural components and the built environment.

The narratives examined in this chapter and across the data set frequently describe the hospital spaces as 'clinical' or lacking in domestic ambience and reflect how institutional concerns about safety and risk management are visibly expressed within the material environment. In the interest of reducing risk, the spaces and surfaces within secure settings are seen to have been pared back to a functional minimum and are hence portrayed through the narratives as lacking the layers of textural detail and 'warmth' typically associated with domestic interiors. In addition to spatial sparseness, however, the narratives convey how the visible and explicitly safety-derived detailing of architectural touchpoints, such as doors and joinery elements, expresses the prioritisation of physical safety over psychological comfort or aesthetics. Accordingly, narratives constructed around wider societal understandings of domesticity and expectations of comfort within residential spaces are used to highlight intractable tensions in the environment. Participants' stories draw particular attention to how the contrasting aesthetic, atmospheric, social and functional

characteristics of both 'home' and 'hospital' spaces are paradoxically combined within the same overall environment.

Participants' awareness of both carceral and clinical symbolism being built into the material fabric of the environment in this way emphasises how secure wards are positioned between the criminal justice and healthcare systems, whilst not being fully situated in either. Furthermore, the narratives illustrate how staff members can be seen to be negotiating a position of enduring liminality when navigating the conflicting professional identities associated with their contrasting custodial and caregiving responsibilities. Storylines concerned with the aesthetic or material attributes and upkeep of interior spaces, including the quality of architectural details, are also associated with patient participants' wider perceptions of value and care, or appraisals of how their own position might be regarded within the overall system.

Accounts of participants' affective experiences in over-scaled spaces illustrate how overbearing architectural features or volumes contribute to spatial expressions of institutional power. By reinforcing a sense of power inequality that can contribute to detained patients' perceptions of having limited agency or influence, these spatial experiences can be seen to be compounding a sense of patients being 'stuck' in their present circumstances. Such narratives also highlight how congruence between the scale or atmospheric tone and the function of spaces is significant to the levels or limits of physical and psychological comfort afforded by those environments. Spaces are thus perceived to be disconcerting or uncomfortable in instances when an environment's scale, proportions or ambient qualities are not well matched to its ostensible function. Storylines also convey how loud ambient noise in the environment, including slamming doors and shouting constitutes a form of psychosocial intrusion that is typically uncomfortable and unsettling. As a form of the 'contaminative exposure' observed in psychiatric institutions by Goffman (1961/1991), unwanted sound in secure settings is

also seen to be compounding patients' perceptions of lacking control and privacy in an environment where occupants have little or no private space.

Throughout the narratives, the physical settings and material elements that constitute the hospital spaces, including doors, walls and windows, are understood to be defining the limits of different spaces. This is unsurprising as these are boundary-making materials, however, these architectural features become significant within participants' stories when they are seen to have a role in shaping the boundaries between typically contrasting 'worlds' of activity. Participants' experiences of such boundaries are portrayed as being troublesome and discomforting when they present physical or symbolic barriers to communication between patients and staff or disconnect ward occupants from the valued and vitalising qualities of the natural world outside the hospital environment. The physical and symbolic attributes of restrictive internal ward environments are typically described by both patient and staff occupants as being increasingly constraining or distressing over time. Consequently, in addition to creating a valued physical connection to nature, the relative liberation of spending time in open-air spaces is understood to provide a welcome release from an uncomfortable build-up of affective 'pressure' contained within the secure boundaries of the built environment. Doors are presented as dynamic devices that can connect or separate contrasting worlds and commonly feature in storylines expressing participants' experiences of unease at the thresholds between 'public' and 'private' circles of activity, or between the differing status positions and activities of patients and staff.

In storylines explored here and across the data set, glass is specifically highlighted as a paradoxical material that can both connect and separate spaces simultaneously. Internal glazing is hence described as being able to generate discomforting ambiguity and influence communication by presenting misleading pictures to patients about staff intentions and availability. Furthermore, participants'

narratives highlight how the experience of being viewed through glass is typically unpleasant and exposing for patients and staff and contributes to the experience of psychological discomfort amongst both groups. By separating occupants from the multi-sensorial qualities of the natural world outside the hospital, or by 'offering up' inaccessible spaces, glazing may typically prompt frustration or remind patients about their status and lack of liberty.

Storylines conveying ambivalent attitudes towards the environment are seen to be helping participants make sense of their conflicting emotions when contrasting the positively perceived affordances of spaces with more challenging environmental attributes. Therefore, whilst particular spatial affordances (including features that facilitate social interaction or connections to people outside the hospital) are appreciated for being comforting or supportive, spaces can be simultaneously perceived to be uncomfortable, unpleasant and actively unhelpful in respect of their ambient or material qualities. The narratives convey how areas such as the communal lounge, which is portrayed as a thoroughfare that is insufficiently shaped to resemble a complete room, have a lack of spatial distinction that can result in the experience of troubling and ambiguous environments. By being open to other spaces all around, the day area thus has unbounded and indeterminate qualities which are perceived by occupants as exposing and uncomfortable. These 'both/and' and 'neither/nor' characteristics of the hospital environment can therefore be understood to be contributing to participants' perceptions of being suspended 'betwixt and between' in a liminal position between different worlds.

Chapter 5: Managing difficult experiences using objects and space

The first empirical analysis chapter explored patient and staff participants' stories that exemplified an overarching narrative concerning experiences of discomfort associated with spaces and objects in secure hospital environments. The analysis presented in this second empirical chapter explores a further set of stories that focus on participants' physical and psychosocial engagement with spaces and objects to negotiate difficult affective experiences and mediate discomfort experienced in the hospital environment. Tom and Patricia's accounts of their experiences as patients in medium secure settings will be explored in this chapter, alongside stories told by Ingrid, who is a staff member based on a medium secure ward.

The narratives contain participants' accounts of experiencing distress or troubling events in these settings and the ways in which patients and staff negotiate and manage difficult experiences day to day. The interpretation of the narratives focuses particularly on participants' accounts of how spaces and objects can mediate discomfort associated with spaces or objects encountered in the everyday environment and facilitate transition between affective states.

5.1 Tom

Tom is a young man and a patient on a medium secure ward. He has previously spent time in prison and describes leaving home at a young age before moving between different care home and hostel settings. Tom has not been permitted ground leave since his admission to the ward a few months before meeting, however, he talks about the enjoyment he experiences from spending time with other patients in the communal areas of the hospital building outside his own ward environment. Whilst Tom describes enjoying his own company, he also presents himself throughout the narrative as a sociable person with a cheerful sense of humour, who enjoys laughing with and being in the company of other people. Tom values the relationships he has formed in hospital

and his appreciation of perceiving a sense of community and mutual understanding between the patients on his ward repeats throughout the interview. Tom also keeps in touch with family and friends each day via the ward telephone booth and he expresses the importance to him of maintaining this regular contact alongside his appreciation of receiving monthly visits.

Throughout the narrative Tom positions himself as a person who enjoys having opportunities to contribute to the ward community and engage in meaningful activities. He also talks about experiencing a sense of pleasure and satisfaction through socialising and working alongside other patients, including time spent collaborating on creative initiatives designed to enhance and decorate the ward environment. Music has been a significant interest for Tom throughout his life and he describes how listening to music through headphones in his bedroom affords a valuable sense of retreat from the ward when needed and enables him to relax.

Although he refers to many challenges associated with being detained in a secure psychiatric unit, including his current lack of access to space outside the hospital building, Tom's overarching tone is determined and forward focused. Throughout the narrative he provides examples of using the less positive aspects of his experiences as incentives to enable him to remain focused on his goals and life beyond hospital. Tom is reflective about his past and present circumstances and he expresses a sense of pride in his perceptions of gaining new skills, including development in areas of his life that have previously been challenging, such as maintaining a tidy bedroom.

Tom's primary storylines focus around: (1) the significance of social connections and relationships and the spaces that facilitate these, (2) looking forward and using objects and space to motivate towards goals, (3) using spaces and objects as a form of distraction from difficult experiences, (4) valuing taking on responsibility and having a sense of contributing to the wider community, (5) negotiating relationships with staff

members and (6) perceiving connections between well-being and having a sense of control over the environment.

In the interview Tom discussed photographs of[10]: (a) a mural created by patients in the ward entrance corridor, (b) outline of his hand forming part of another collective patient mural installation, (c) a window on the ward containing a view of the grounds outside, (d) the on-site swimming pool, (e) belt worn by staff with radio and keys attached, (f) communal café courtyard located within the hospital building, (g) traffic light system associated with the airlock at the hospital's main entrance door, (h) dining room, (i) therapy kitchen, (j) telephone booth and (k) his bedroom.

The interpretation of Tom's narrative will focus on the first, second and third storylines, which intertwine throughout the interview and illustrate how psychosocial engagement with the environment is used to assist his transition between affective states. In the first extract, Tom's narrative is focused on his emotional responses to the windows on the ward and the views of the hospital grounds presented through them.

Tom: Extract 1

T: OK. So, the next photo is, um, of one of the windows on the ward.
R: Yeah.
T: Now the windows, um, just to give a brief description, they're probably like a foot by foot, panes of glass, with, um, you know sort of solid metal bars in between.
R: Mm.
T: Um, you know, they don't look prison-like, but, you know, I guess they illustrate that it is a medium secure and beyond the glass, is, is, I guess it shows what you could have had, sort of thing, you know, what I'm missing out on because, you know, due to the section I'm on I, I haven't got grounds leave yet so.
R: Mm.
T: I guess every time I see outside, it reminds me of the, you know, the life that I

[10] As Tom's images could not be printed beforehand, his photographs were reviewed on the camera screen during the interview. The digital files could not be transferred, however, prints of some of his photographs were later available.

had before I came into hospital and the, the freedom.

R: Mm.

T: And I guess you know, it's, it's, it reminds me that, you know, I don't have that, that choice to be able to just walk along that path that's in the photo and enjoy the, you know, the scenery and trees and the and things like that.

R: Mm, mm.

T: So, it's, it's quite, you know it's quite negative photo, but I guess, in certain senses it's what I want to work towards, it's an incentive.

R: Yeah, yeah. So you, you, when you're looking out, you're making a positive, um

T: From a negative.

R: Yeah.

T: Yeah, that's it.

R: Yeah, yeah.

T: You know while it doesn't feel great right now, you know, it's my, it's my, um, my drive, my incentive to work hard towards my goals and I guess, you know, stay on the right track.

R: Mm.

T: Because it's quite easy to sort of fall off sometimes and, you know, get dragged down by the negatives, but, you know, that's, it's quite important for me to stay on track and I think things like that help.

R: Yes, yeah, absolutely. And is there something about being outdoors as well that, um, is a, has, um, a positive, um, feeling

T: Yeah.

R: for you?

T: That's it. Yeah, definitely. I, I, before I came to, to hospital I used to be very much into my walking. Um, you know I got a lot fitter and I lost a lot of weight due to walking.

R: Mm.

T: I've just lost the camera again.

R: Don't worry, don't worry.

T: And um, you know, it, it's, it's quite a, it's been quite a big influence to me, so I guess, coming here and not being able to just freely go for a walk and clear my mind, is, is quite, quite a big change for me, but.

R: Mm. And how do you feel at times when you might want to go for a walk and clear your mind and you're not able?

T: It's, it's quite disheartening

R: Mm.

T: it is, you know, understandably, but, you know, I, I, understand why I'm here, for the reasons I'm here for and, you know, it's for me, you know, it's not for anybody else, it's to get me to where I want to be, to my, to my goal.

54. **R:** Mm, mm.
55. **T:** In my future. So you know it's just, ha-, being able to turn that round into
56. something positive is quite, quite important for me.
57. **R:** Yes, yeah.
58. **T:** It's quite hard to feel sometimes, but yeah.
59. **R:** Yeah, yeah.

Although Tom does not perceive the window design to be "prison-like", his description of "solid metal bars" located between small panes of glazing emphasises an image of robust window construction, which he perceives as a symbolic reminder of the medium secure context within which he is detained. In turn, the inaccessibility of the natural scenes and greenery framed by the windows presents Tom with a further reminder of his lack of liberty and his inability to leave the building due to the restrictions of his current section. Whilst everyday opportunities for walking outside might not be significant in other circumstances, Tom's characterisation of the hospital grounds as something that, "I'm missing out on" presents spending time within a natural outdoor setting as a longed-for activity and positions his lack of access to this external space as a poignant loss.

The view of the grounds therefore presents a continual reminder to Tom about his lack of "freedom" and his loss of access, not only to this external space, but also to the life he had before hospital and to the life that he hopes for beyond. The window represents a physical and symbolic barrier between confinement in hospital and relative liberation in life outside and the glazing is thus presented through the narrative as a material threshold between Tom's present circumstances and his past and future lives. Tom's wistful imagery of the window view representing what he "could have had" therefore not only expresses feelings of regret about his current circumstances, but also evokes a sense of grief associated with the loss of an alternative envisioned version of his life story.

Figure 7
Tom's photograph from a window on the ward towards the grounds

Tom positions the image of the window view, containing a path leading through the trees in the hospital grounds, as a "negative photo" that exemplifies what he has lost by being detained in hospital. Yet he also seeks to perceive the image positively by transforming it into an "incentive" that represents his ambitions and the future life he wishes to have. By visualising walking along the path through the grounds as a motivational image to aspire to and move forward towards, Tom is attempting to transform his affective experience from a negative state of loss to a position of optimism where he is focused instead on what there is to be gained. Interpreting these experiences as a liminal process (Stenner, 2017), Tom can be understood to be creating this imaginative imagery as a form of 'liminal affective technology' or 'symbolic resource' to self-generate liminal affective experience that enables him to move between affective states (Stenner, 2021; Stenner & Zittoun, 2020). That is to say that the aspirational images generated through Tom's imaginative processes are used to

assist with the production of emotional effects that can bring about psychological transformation.

Using imagination and visualisation to prompt such affective transformation can therefore also be interpreted as a process that is assisting Tom to alleviate the disconcerting experience of 'spontaneous' liminality (Stenner, 2017). In other words, this process of self-generating liminal affectivity can be understood to be helping Tom to mitigate the significant rupture in his everyday psychosocial experience brought about by hospital admission and experiences of psychological distress. Tom's depiction of walking outside to "clear my mind" implies that walking through open-air space is another previously used strategy to facilitate transition between affective states. Accordingly, Tom's use of this physical movement outdoors and integration of mind-body activity when walking can be interpreted as a further form of liminal affective technology that can facilitate psychosocial transformation. Tom hence feels dispirited by not being able to walk "freely" outside. His story suggests that, in addition to his loss of liberty, the loss of access to walking as a process for maintaining both his mental and physical health has been a significant adjustment following his admission to hospital.

Tom's storyline of staying "on the right track" extends the imagery of walking to express a sense of focus and purposeful movement forward in his life, however, it also conveys a moral tone, implying that other paths he might choose may not necessarily lead in the "right" direction. Tom's narrative imagery builds on wider cultural understandings of success and societal beliefs that dedication, focus and "hard work" are positive and respected qualities required to achieve a desired ambition. Through his account of having the potential to easily "fall off" the track and be "dragged down by the negatives", Tom presents an image of sinking into a low position, that is juxtaposed with the alternative uplifting imagery of him walking forwards towards his "goals" and the anticipated place he refers to as "my future". Tom's psychological processes are

presented as forces that have the potential to lower his mood and hinder progression, but which conversely, can also lift his spirits to support his onward "drive" forwards.

Tom's experiences can also be elaborated further in relation to Arthur Frank's (1995) book *The Wounded Storyteller*, in which Frank identifies 'restitution', 'chaos' and 'quest' narratives as three different narrative forms that individuals may typically create in response to experiencing challenges to health. Drawing on this thinking, Tom's overarching narrative can thus be interpreted as a form of 'quest' narrative, through which he is understood to be navigating his 'recovery' journey whilst focusing on the hopeful quest of pursuing his goals and imagined representations of his future self. Frank (1995) also describes a significant loss of health as being a loss of the, "destination and map" (p.1) that were used previously as a guide in that person's life. Correspondingly, it is suggested that producing narratives can have a therapeutic quality, such that telling stories might enable people experiencing a loss of health to recreate a 'map' to navigate their experiences and regain a sense of 'destination' in their lives.

Although Tom describes his journey as a difficult process that, "doesn't feel great right now", his telling of this story out loud can be understood as a self-motivating process that reinforces his intentions and underscores his commitment to the quest. Tom acknowledges that adjusting his affective state by attempts to transform difficult aspects of his experience into incentivising imagery is challenging and "quite hard to feel sometimes". However, his comment that, "it's not for anybody else, it's to get me to where I want to be, to my, to my goal", further reinforces his sense of destination and self-motivational discourse. Tom elaborates on this principal 'quest' narrative later in the interview when considering his thoughts about moving on from hospital. In this short reflection he is more explicit about the focus of his "goals" and the process of moving towards them when he notes that,

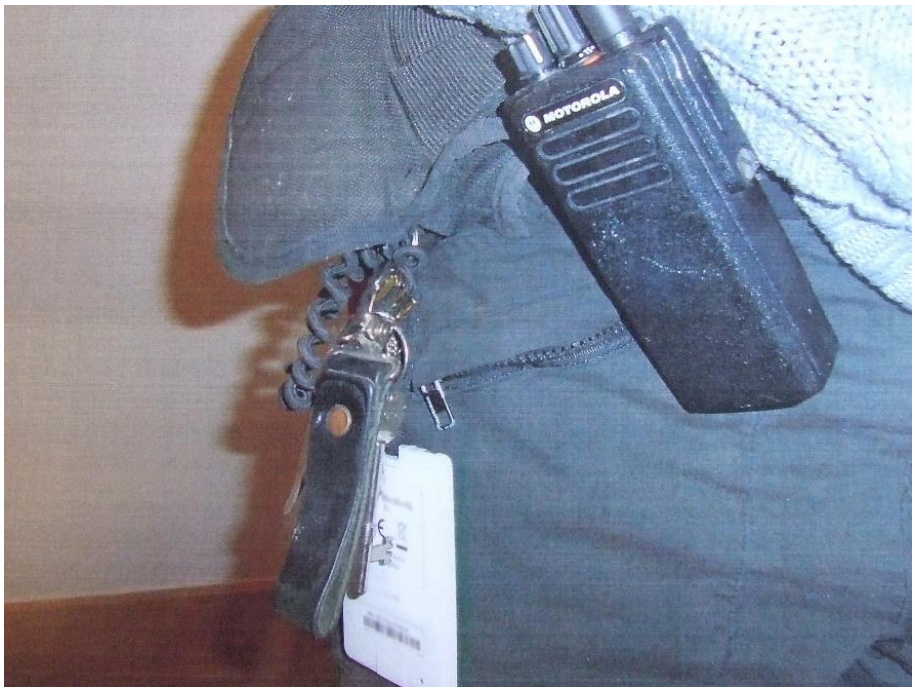
"I think, one the, one of the most important things for me to, to maintain my sight on, on

> my goals and, and where I, you know, the direction I wanna go is, painting quite a detailed picture of what I, I want my life to look like in the future, you know, from things to like how much sp-, time spent with friends and family, career, you know, my house and my, where I live [**R:** Mm.] you know, it's, it's moving on from here is quite an important thing for me and, and planning quite thoroughly is, is really helpful for me to maintain that, that goal."

In this account of "painting quite a detailed picture" of his future life, Tom highlights how imaginative processes are enabling him to envision and inhabit a comprehensive future space that represents his "goal" of an idealised life beyond hospital. Tom thus emphasises how using his imagination to produce motivational imagery constitutes a form of transformative technology that is helping him move away from difficult affective states and in turn, assist in managing the overarching experience of being detained in hospital. Through focusing on the specific details of his anticipated future life, Tom can accordingly be seen to be attempting to alleviate perceptions of being indefinitely suspended in an indeterminate zone situated between his life before and after hospital. Furthermore, by describing how detailed planning and visualisation of the future is helpful in enabling him to "maintain" his goals, Tom also highlights how these are ongoing and iterative process that he continually returns to for support and reassurance.

Elsewhere in the interview, Tom tells similar stories of everyday interactions with other poignant objects and spaces on the ward, including the radios and keys that are attached to staff belts and the 'airlock' double door security system at the entrance to the building. Keys and radios are used to control the hospital environment and Tom highlights how the presence of these objects strengthens his awareness of a lack of freedom within a medium secure setting, alongside providing an unhelpful reminder of his time spent previously in prison. However, as with the window view, he also describes his attempts to use imagination as a transformative device to generate alternative affective responses to the troubling objects or spaces he encounters within the everyday environment.

Figure 8
Tom's photograph of keys and radio on staff member's belt

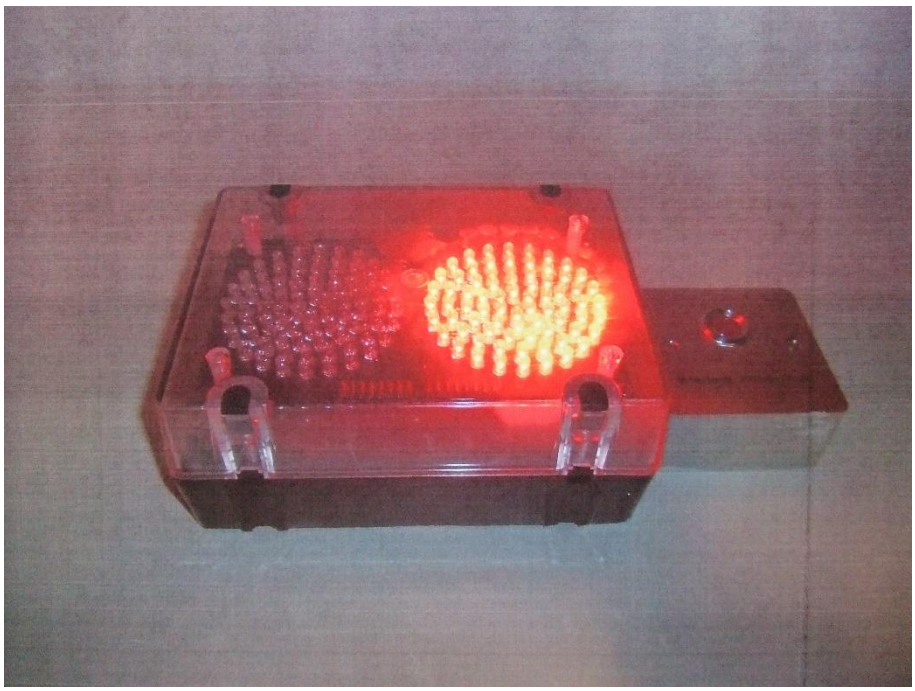


By transforming his perceptions of such spaces and objects into positive imagery that represents the envisioned future he is striving towards, Tom is seen to be transitioning from an anguished affective state to one that is more hopeful and supportive. Tom thus captures his attempts to generate alternative images when confronting these objects through his assertion that, "[…] one day we won't have to hear and look at the keys and radio and you know, it won't, it won't be a part of my life forever". Through the process of articulating this statement definitively to the researcher, Tom can also be understood to be reinforcing his own belief in its validity.

Tom further expands on the storyline of transforming troubling aspects of the environment into motivational imagery, when discussing his emotional responses to a photograph of the traffic light system associated with the 'airlock' doors at the main entrance to the building. The airlock forms a transitional zone between the internal and external environment and is a reminder to Tom of his detention in a secure institution and his inability to leave hospital or leave the building itself. Tom thus articulates

ambivalent feelings towards the airlock when describing it as a place where he is both happy to greet visitors on arrival and also sad to say goodbye to family and friends at the end of a visit.

Figure 9
Tom's photograph of the airlock traffic light system



Through this story, Tom describes the significance of the airlock as a threshold between his present life as a detained patient and his life both before and beyond hospital. In the following quote, Tom articulates how his imaginative processes are again employed to help transform difficult and distressing encounters with this part of the everyday environment into self-motivational imagery.

> "It, it's, you know, again, I guess it could be turned around in a positive way, one day it will be me walking out, you know, past the green light and, you know, whether it's just on grounds leave which is a more, you know, a closer goal, [**R:** Mm.] or leaving for good, you know, it's going, it's going to come around one day, so that's what I like to see it as. [**R:** Yeah.] You know, it will be me one day walking through there, you know."

When he visualises his future passage through the airlock to leave the building, Tom draws again on imagery of walking and forward movement to represent progression and his personal journey through life. By transforming the implied imagery of the airlock as a barrier into uplifting images of movement that represent his short-term and long-term goals, Tom can once more be seen to be using imagination as a process to stimulate affective transformation as a way of coping with his circumstances. Through the process of narrating this story to the researcher, Tom is again understood to be reinforcing his own belief in the realisation of his goals as a form of self-reassurance.

Throughout the interview Tom also recounts stories about how times spent socially with other patients, particularly in areas off the ward, can help mitigate difficult experiences associated with being detained in hospital. In the following extract Tom reflects on his embodied experiences in the swimming pool and his affective responses to this environment.

Tom: Extract 2

T: The next one is the swimming pool.
R: Mm.
T: This one's a positive one for me because I've always liked swimming. I I really enjoyed it and we have two weekly sessions. Um, so we go down there for an hour and it, it, it's, we often go down with 6 or 8 different patients and just have fun. It's our time to, you know we nearly, we nearly forget where we are, we nearly forget the situation that we're in. You know, it's an escape. If the ward's unsettled, we can just sort of have fun.
R: Mm.
T: Be ourselves. Be, I guess, be silly, you know we don't really get much opportunity to just have raw fun like that. You know, it, it is great.
R: Yeah, yeah.
T: It's good to go down and have like that social sort of setting where we all just enjoy ourselves is really nice.
R: Yes.
T: It's a very happy place the swimming pool for me.

R: Yes, yeah. And is there something, um, about being there with the, with other people that, um, contributes to that, that sense of en-, enjoyment

T: Yeah.

R: that you have in that space?

T: I mean you know, we're all in the same situation on this ward, so there's like, you know, quite a strong sense of you know, community and sense of belonging between us, um, you know, we all, we all understand each other's positions and we're all quite, you know, I guess, yeah, understanding towards each other, so you know being, having that, you know, mutual interest between everybody is is really nice, you know, in a different zone. Just, just, like I say, just coming away from the ward, you know, having that escape, that, we all enjoy it.

R: Mm, mm.

T: We do, so it's really nice having just, just to be with each other and be friends. It's lovely.

R: Mm. Yeah. And you mentioned being away from the ward, is that something that, um, you get in other, other spaces as well, that feeling of, um, almost escape from?

T: Yeah, that's it. You know, although the ward is generally quite a nice place to be, it's the same, you know, everybody has to have a like, you know, variation in their life and where they live and their environment and we don't get much of it, so opportunities like this where we have a solid hour where we can escape and you know, do something different is, is really nice and cherished.

In this story Tom positions the pool environment as a relaxing and enjoyable space that facilitates lively social interaction with other patients. By highlighting his long-standing enjoyment of swimming, Tom's narrative implies that spending time in the pool area also provides a sense of connection to his life before hospital and suggests that similar settings previously have typically been "happy" and enjoyable places. Tom's appreciation of the swimming activity as "our time" emphasises his perception of the regular pool sessions as a valued space and time for bonding socially as a group, where patients are able to enjoy each other's company, not only as peers, but also as "friends". His description of the environment as a "different zone" positions the physical location of the pool as a contrast to the ward context, but also evokes imagery of leisure activity

in the pool enabling an alternative social experience and the possibility of "escape" to another psychological space.

Although the swimming pool is situated inside the boundaries of the secure hospital building, Tom's narrative suggests that the pool is especially appreciated for being, "away from the ward" and as such, it affords perceptions of liberation, alongside a sense of retreat from the stresses of the ward. Through his account of valuing opportunities to experience "raw fun" and "be silly", Tom presents an image of untempered pleasure being afforded by spending time with others in the pool area, that he juxtaposes with a sense of the ward being at times a challenging and "unsettled" environment. Through describing the fun enjoyed by patients in this setting as "raw", Tom implies that this emotion is experienced in a natural and authentic state that contributes to its power. This image of authentic experience in turn suggests that patients may feel more natural and at ease together within this 'off-ward' space and thus more able to be light-hearted or experience pleasure there. The description of being silly similarly presents an image of how carefree play or childlike innocence might assist in patients' ability to gain respite from their everyday worries and concerns when socialising together in this space.

Accordingly, whilst the narrative implies that Tom associates being on the ward with a sense of restriction in an often volatile and stressful environment, he contrasts this with spending time in the swimming pool, which is positioned as a liberating, cheerful and almost unlimited space. In contrast to the confines of the ward, the absence of partitions in the pool area creates a large, open space. As a more generic and commonplace form of built environment, the pool setting also contains fewer physical cues, such as robust doors or locks and keys, to suggest that it is located within a secure unit. Correspondingly, Tom's repetition of "nearly" forgetting the realities of his personal circumstances and detention in a secure institution implies that spending time with other patients in the liberating pool environment can afford a closer

connection to typical life outside hospital than might generally be available on the ward. Tom's emphasis of "nearly", however, also highlights, that even when enjoying social activity in this more normative and less restricted space, he is not able to be fully transported away from his current situation. As a further illustration of these experiences, Tom talks later in the interview about how spending time and collaborating with patients in other 'off-ward' spaces, including the building's communal garden, can afford similar perceptions of escape and a sense of togetherness. He describes the shared garden accordingly as a "haven" that facilitates enjoyable social interaction and like the pool, the garden is expressed as a place where he can, "almost forget" that he is detained within a secure environment.

Tom's descriptions of appreciating his perceptions of a sense of "community", "belonging" and togetherness with other patients recur throughout the interview. His comments that as patients, "we all understand each other's positions" and "we're all in the same situation" draw on wider cultural understandings that shared experiences can create supportive bonds to connect individuals as groups. Tom's remarks also convey his appreciation of perceiving a sense of parity and a mutual lack of judgement between patients that he perceives to be particularly tangible in this setting. Detention in a secure environment, where patients can be understood to be 'suspended' in an indeterminate position between life before and life after hospital, is conveyed through the narrative as a shared and thereby equalising experience.

Tom's portrayal of his experiences can thus be interpreted in reference to Victor Turner's (1969/1996) specific use of the Latin term *communitas*, to define an unstructured state in which it is argued that individuals become equal through shared participation in a situation of liminal transition. Tom implies that his perception of *communitas* is especially pronounced during activity in the pool area, which by contrast to the ward itself, is positioned as an unstructured and less restrictive space. In this fluid environment where the typical 'rules' or limits of the ward are seen to be

broken down and temporarily suspended, the activity taking place in the swimming pool can be interpreted as an 'interstructural' situation (Turner, 1969/1996). Accordingly, activity in the pool is presented as a world-within-a-world, located between the restricted forms-of-process that comprise the ward environment and the more liberated spheres of activity associated with leisure spaces in the everyday world outside hospital (Stenner, 2017). Tom's perceptions of a strong sense of community and a mutual bond between patients specifically in the pool area suggests that the liminal fluidity of this specific environment also enables patients to have a greater awareness and enjoyment of equality and perceive a sense of *communitas*.

In contrast to the ward, where patients repeatedly encounter staff radios and keys and in which their movement through space is highly controlled and restricted, Tom presents an image of patients experiencing a smoother 'flow' through space within the pool environment. This picture of fluidity and a lack of friction is accentuated further by Tom's implied imagery of swimming and free movement through water as typical activity in a pool setting. Tom therefore suggests that the fluidity of this environment, where a collective identity as 'detained patients' can also be understood to have become melted down, is a contributing factor in enabling him and other patients to simply "be ourselves". Accordingly, Tom and the others can be seen to be enjoying the fluidity of this liminal situation, in which the temporary deconstruction of their collective patient identity enables closer connection to their individual identities and enhances the enjoyment of pleasure as "friends". Tom's narrative thus suggests that his enjoyment of spending time in the pool is linked to his appreciation of perceiving a simultaneous sense of community, liberation and retreat within this 'off-ward' space. By stressing how "we all just enjoy ourselves" when spending time there, Tom provides further evidence to the researcher to support his account of how swimming and social activity within this space can afford patients a mutual experience of pleasure.

Tom's appreciation of "variation" draws on wider public understanding that participating in varied activities and experiencing a variety of environments is expected in typical daily life and fundamental to health and well-being. Tom's remarks therefore emphasise how patients in secure settings have a restricted number of different spaces to inhabit and how patients' access to the environments that are available to them is generally controlled and limited. His comments also highlight how such access to space may be taken for granted by people in other circumstances, including the researcher, who is able to freely access multiple different spaces during the course of a typical day. Tom thus describes time spent in the pool as "cherished" and his references to time when describing the swimming sessions taking place twice weekly and for a "solid hour", presents an image of these as valued slots of time that form joyful highlights within his weekly routine. The image of activity being scheduled and divided up into hourly blocks that is evoked through the narrative also highlights how events, including visits from family and friends, are typically planned in advance. Reduced access to spontaneity and the impromptu activity associated with typical everyday home life may accordingly be contributing to patients' perceptions of an institutional environment and a lack of domesticity in secure settings.

5.2 Ingrid

Ingrid had been working as a healthcare assistant in a medium secure ward for several months at the time of meeting. She is enjoying the role and is also interested in working towards becoming a nurse. Throughout the narrative Ingrid presents herself as a caring and sociable person who enjoys spending time with patients and engaging together in different activities. She speaks about her commitment to nurturing therapeutic relationships and contributing to an overall sense of community amongst patients and staff on the ward.

Ingrid's narrative positions her within a very demanding environment and in a busy and varied role that she finds intense and challenging, but also enjoyable and

rewarding. Accounts of her work commonly refer to patient safety and Ingrid talks about different protocols and policies that staff and patients should follow to mitigate risk within the ward environment. The overall tone that underpins Ingrid's narrative is enthusiastic, optimistic and professional. However, she also highlights how staff resources are often limited and articulates her perceptions of how the daily experiences of patients and other staff members can be affected by staffing levels.

Ingrid is interested in how the ward environment is experienced by patients and staff and speaks about her appreciation of creative projects undertaken by patients to improve the appearance and ambience of the overall space with artwork. She also talks about her involvement with activities to help alleviate patients' experiences of boredom, particularly at weekends when sessions provided by the occupational therapy team are not typically scheduled.

Ingrid's storylines focus around: (1) appreciating efforts to improve the aesthetic environment and optimise space on the ward, (2) nurturing a sense of community amongst patients and staff, (3) valuing connections to external spaces and nature, (4) managing the intensity and challenges of the ward environment, (5) awareness of ward protocols and safety, (6) the impact of positive noise in the environment (e.g. the sound of patients talking and laughing together).

During the interview, Ingrid reflected on photographs of: (a) patient artwork and messages that form a 'welcome' collage on the ward entrance corridor wall, (b) wall artwork in entrance corridor, (c) paper fireplace attached to wall below the television unit, (d) decorations by patients on occupational therapy kitchen windows, (e) meeting room, (f) meeting room window decorations by patients, (g) occupational therapy room, (h) views through glazing to the external ward courtyard in the snow, (i) dining room and (j) exercise bike in quiet room.

The interpretation of Ingrid's narrative in the extracts that follow will focus on the third and fourth storylines, through which she highlights an awareness of the ward

as an intense and often stressful place where she typically works long shifts. In the following story, Ingrid reflects on her embodied experiences within this environment to consider how spatial interactions, both on and off the ward, might be associated with her affective experiences and perceptions of well-being at work.

Ingrid: Extract 1

R: […] So thinking about, about well-being, um
I: Yeah.
R: and um, your own well-being, um, are there any ways in, you think that, you think that your working environment might affect your sense of well-being at all?
I: (*Slight pause*) I think, er, not going outside is one, because I like to be outside, but then I always make sure that like what, if I do get my lunch break, I do go for an hour and half walk.
R: Mm.
I: I like to go outside and I think that's the one thing for me where it impacts because like, you don't leave the war-, the building, let a alone the ward a lot of the time
R: Mm.
I: especially if you don't get a break. Um, so I think that can be quite like negative on our own well-being.
R: Mm.
I: 'cause I like to be outside, because like you come to work, especially in winter now.
R: Mm.
I: you come to work in the dark, you leave in the dark, you don't go outside, you don't see what it's like outside, you kind of like, your days just disappear.
R: Mm.
I: But, yeah, I think that's, that's the one thing, but, if we can try and get outside in the courtyard at least that's something
R: Mm.
I: but sometimes, if there's, if we're really short on staff, you, if you don't get a break, the chances are no one's going outside 'cause there's not enough staff to have people outside, someone outside and people in the day area as well as people doing all the other various different things.
R: Mm.
I: Um so, yeah. I think that's probably the one thing (*laugh*).

R: Yeah. Yeah and, and i-, is, what is it about being outside that's?

I: I don't know, I like the fresh air.

R: Mm.

I: And it helps me like think through things. I don't, I find it's just a good ki-, way of coping with things, like say we've had like a really hard morning, doing lots of restraints or

R: Mm.

I: you know, or someone got assaulted or something like that, you know, it's a lot to like process.

R: Mm.

I: So for me like going for a walk outside, it really helps me like work my way through it mentally, like just walking, I find it really therapeutic for me.

R: Mm, mm.

I: It's something I find really useful.

R: Mm.

I: It's like not having, sometimes when you don't have that option and the ward has been that hectic and there's no staff in, it can be quite detrimental.

R: Mm.

I: Like it just plays on your mind more, but.

R: Yeah, yeah.

I: Yeah.

Whilst Ingrid highlights how she values spending time outdoors during breaks when on shift, her description of typically walking outside, "if I do get my lunch break", suggests the possibility of not having the break to be a common occurrence. Taking a lunch break is thus presented to the researcher as being more of an exception than a given, such that opportunities for staff to spend time outside during a shift are not guaranteed. Ingrid's position is reinforced by her repeated assertions that "I like to be outside" and "I like to go outside", which are presented in contrast to her account of experiencing days when she does not leave the building, or indeed the ward itself. Having a lack of sensory connection to the external environment during the day is presented as a problematic experience that is especially poignant during winter months when it is dark outside at both ends of a shift.

Through her narrative image of days that "just disappear", Ingrid conveys a sense of how the daytime cannot be fully appreciated when working inside the building and how a lack of access to external space affects her perceptions of time. Alongside this, the discomfort connected with not having access to the external environment is suggested to be further compounded by resourcing levels and their associated influence on the ability of staff to take breaks. Earlier in the interview, when discussing a photograph of the ward courtyard, Ingrid notes that her shifts are typically 12 hours long and mentions how she typically feels "energised" after spending time there during a shift.

Accordingly, Ingrid suggests here that access to the ward courtyard at least would be appreciated on the days when she is not able to leave the building. Her narrative implies, however, that when the ward is "really short on staff" and staff "don't get a break" then there are typically insufficient staff available to observe patients outside in the courtyard and also complete the other necessary duties on the ward. Ingrid summarises this situation and presents an image of the uncertainty associated with daily staffing levels through her observation that on these days, "the chances are no one's going outside". Her story therefore highlights similarities in the experiences of staff and patients and how staff availability affects the everyday activities of both groups. Correspondingly, staff resources are seen to be associated with, not only the availability of breaks for staff, but also with the daily experiences of patients and staff more broadly, including limits on access to outdoor space for both.

Figure 10
Ingrid's photograph of the ward courtyard taken on a snowy day

Following the researcher's question about what Ingrid appreciates when having opportunities to spend time outside, her initial response stating that she enjoys the "fresh air", positions the air quality of external space in contrast to the internal environmental conditions during a long shift. Ingrid's account also presents spending time walking outside as a valued activity that enables her to process the embodied experiences associated with troubling events taking place on the ward. When describing a "really hard morning" in which "lots of restraints" or assaults on staff might have taken place, Ingrid presents an image of an intense and demanding environment that she finds physically and emotionally challenging. Her depiction of aggression and the potential use of restrictive practice evokes imagery of an emotionally charged environment where staff and patients might experience distress

personally or observe other people's distress during their everyday interactions on the ward. Ingrid's comments about her affective responses to being involved in restraining patients also reflects existing research findings which suggest that implementing restrictive measures is typically a significantly distressing and dissatisfying experience for nursing staff (Duxbury & Whittington, 2005; Moran et al., 2009). Ingrid's account of walking outside as being a "therapeutic" activity therefore acknowledges her everyday encounters with some events on the ward to be difficult experiences that require processing. By describing how she might work her way through troubling experiences by walking outside, Ingrid presents an image of this step-by-step movement through space and simultaneous processing of her experiences as an integrated mind-body process.

Her account of frequently not having the "option" to walk outside also conveys Ingrid's perceptions of experiencing a loss of choice associated with the days where there are reduced levels of staff. This story thus implies that staff and patients might typically share common everyday experiences and frustrations on the ward, including having restricted access to outdoor space and having the desire to spend time walking outside the hospital building as a therapeutic process. Ingrid's positioning of situations where she cannot go outside as being "quite detrimental" accordingly highlights associations between staff mental health and the availability of sensory connections to outdoor spaces during a shift. In reference to experiencing distressing events, Ingrid's concluding comment that, "it just plays on your mind more" implies that without opportunities to walk outside and process such experiences, they can become 'stuck' and continue to play over in her thoughts.

In the next extract, which follows directly from the first, Ingrid is prompted by the researcher's questioning to reflect on her use of indoor spaces to manage discomforting experiences at times when it is not possible to leave the building or access outdoor spaces.

Ingrid: Extract 2

R: Are there places, are there places where you, you can go um, if you, you, if you if you don't have the opportunity to go outside, um?

I: Um sometimes you can like ask for like, like half, like ten minutes, twenty minutes, just to like, I'd go sit out, um, just as you come out of the ward, there's like some chairs there.

R: Mm.

I: And you just go and sit there for a little bit, some, it's like even though you're not out the building, you're still off the ward

R: Mm.

I: and you're like away from everything, 'cause if you sit in the office, you're gonna get asked questions, like people will be like, oh, could you do this, could you do that, could you do this?

R: Mm.

I: And you don't really ever get a chance to like, even if you took your lunch break at, in the office, you're not on your lunch break

R: Mm.

I: 'cause you're just, you'll just be running around, so yeah, so like just being able to like get off the ward in that little area is really nice.

R: Yeah. Yeah and that's something that you might do?

I: Yeah, I've done it a few times.

R: Yeah.

I: Like, on like when we hadn't had enough staff for like full breaks, just go for like ten minutes or something, just to get a bit of space (*laugh*). Go grab a cup of tea, sit down (*Sound of air blowing out 'phew' sound and laugh).*

R: Mm.

I: Relax as much as you can.

R: Mm. Yeah, yeah.

I: Yeah.

This account continues to present an image of staff being continually on the go in their duties at work and implies that perceiving a sense of disconnection and liberation from the intensity of the ward is necessary for taking a break and attempting to relax. Earlier Ingrid highlighted how she perceives open-air spaces outside the boundary of the hospital building to be optimal locations in which to walk and process her affective responses to difficult experiences at work. In instances when she is unable to go

outside the building, working in the open-air courtyard on the ward was also presented as an alternative way to appreciate being in an outdoor setting whilst on shift. Ingrid's account here suggests, however, that even when she is not able to be outside in the open, it is helpful for her to perceive a sense of being *outside* the ward. Although the seating area she describes is situated directly outside the ward entrance, Ingrid's repeated positioning of this space as "off the ward" conveys her appreciation of the physical and psychological separation afforded by the doors that enclose the ward.

Ingrid thus presents the ward as an enclosed and seemingly 'airtight' space, in terms of both physical and atmospheric containment and she implies that an intense affective atmosphere associated with occupants' experiences of distress and prolonged confinement can build up over time. Ingrid's request for a short break outside conveys how her responses to the uncomfortable atmospheric 'pressure' on the ward include the urge to temporarily escape the ward environment. By highlighting how she is able to "get a bit of space" when taking a short break in the seating area, Ingrid expresses a sense of release in being outside the ward boundary, despite still being contained inside the hospital within an indoor space. This image of release is further accentuated by the 'phew' sound that Ingrid makes in conclusion, which expresses a sense of relief and evokes a symbolic image of her breath being held and then released during momentary respite from the intensity of the ward. It is noteworthy that Ingrid does not mention the designated staff room in the building that is referenced by other staff participants in the data set. Her account of short breaks on days when it is not possible to take a full break or leave the building, however, implies that there may not be sufficient time to make a meaningful visit to the staff room at these times.

Ingrid's portrayal of the ward as a hectic and unremitting environment is further expressed in her account of unsuccessful attempts to take a lunch break in the nursing office. The imagery of staff being constantly interrupted whilst on a break in there conveys a sense of exposure and indirectly alludes to how staff are very visible in

the nursing office due to the surrounding glazing. By describing being "away from everything" when taking a short break in the seating area outside the ward, Ingrid thus underscores her perception of how attempting to take a proper break is incompatible with remaining inside this highly intense environment. The account of how Ingrid would typically "go grab a cup of tea" and "sit down" in the 'off-ward' space, presents an image of fleeting activity, but also conveys her appreciation of a sense of restoration there and respite from the ward. This imagery implies that perceptions of comfort are provided by the simple pleasures of drinking tea and having a seat. Ingrid therefore indirectly conveys how mundane activities, including drinking or sitting down might be difficult to achieve in a busy ward environment, where staff are typically on their feet and continually moving or "running around".

Ingrid's experiences accordingly illustrate how spaces and objects are used by staff as resources to manage experiences of physical and psychological discomfort in the ward environment and enable restorative transitions away from troubling affective states. A sense of restoration is thus understood to be generated by physical movement through space and particularly by movement across the boundaries that shape the contrasting atmospheres between intense and pressured spaces on the ward and more open or relaxing 'off-ward' spaces. Ingrid's accounts can also be seen to support research suggesting that break spaces are most likely to be used when located in close proximity to nurses' working areas and how providing access to outdoor spaces can significantly improve the perceived restorative quality of staff break areas (Nejati et al., 2016). Furthermore, at times when she is unable to leave the building, Ingrid's use of the space directly outside the ward, or the courtyard illustrates how hospital staff might improvise to create environments for breaks that can afford restoration and increase a sense of well-being (Pink et al., 2020).

5.3 Patricia

Patricia is a middle-aged woman who had been a patient on a medium secure ward for a number of years at the time of meeting. She describes making progress in her journey through mental healthcare services and her hopes for moving on to a low secure ward, before leaving hospital to live in a place of her own. Patricia mentions having a love of reading and in particular talks about how she enjoys spending time reading novels and newspapers. As she does not currently have permission to leave the building for ground leave, Patricia's time is largely spent indoors, however, she describes her enjoyment of spending time within natural settings when she previously had access to the hospital grounds. Patricia did not include external spaces in her photographs but mentions walking around the ward's outdoor courtyard at times for exercise and talks hopefully about the possibility of having unescorted leave when she moves on to a low secure ward. Patricia also highlights her appreciation of keeping close connections to her family and friends, including her enjoyment of having visitors, or keeping in regular contact using the telephone booth on the ward.

Throughout the narrative, Patricia repeatedly articulates her perceptions of the ward overall as a generally noisy, testing and sometimes frightening environment. However, although many aspects of life on the ward are presented as being very difficult, the narrative suggests that Patricia is resigned to her circumstances and implies that she perceives some of the daily challenges in the environment to be an almost inevitable part of patient experience. The overall narrative conveys a sense of understated fortitude in relation to her situation and Patricia's general tone throughout is hopeful and accepting. Patricia mentions that patients on the ward are typically empathetic towards each other and she expresses appreciation for the positive and supportive relationships that she has developed in hospital with other patients and members of staff.

Patricia's stories about her experiences are intertwined, but her main storylines focus around: (1) appreciation for spaces and objects that facilitate connection to other people and places, (2) awareness of associations between her personal possessions and perceptions of well-being, (3) affective responses to sound and the multi-sensory ward atmosphere and (4) enjoyment of spaces that afford connections to nature. Here the focus will be on the first, second and third storylines that Patricia returns to throughout the interview. These storylines have been selected to exemplify Patricia's affective responses to the ward environment and her ways of engaging with spaces and objects to mediate difficult and distressing psychosocial experiences.

Patricia discussed photographs of the following during the interview[11]: (a) dining room (b) communal day room, (c) laundry room, (d) telephone booth, (e) armchair in dayroom, (f) meeting room also used for arts and crafts activities and mindfulness sessions, (g) quiet room, (h) bedroom corridor, (i) her bedroom and (j) en suite shower room.

In the following extract, Patricia reflects on her emotional responses to the day area, which is presented as an often noisy and unpredictable environment.

Patricia: Extract 1

P: Yes. That's one of the chairs that we sit on for the day, which gets a bit uncomfortable, but it's a good place for me because I spend a lot of time reading the newspapers to keep up with what goes on in life and also, I've got some good thriller books that I read, so that's usually a happy sort of place.

R: Yes.

P: Um it's a bit of a chaotic space in that there's a lot going on,

R: Mm.

P: people are often shouting. It can feel a little bit scary if they're kicking off and,

R: Mm.

P: and worried that you'd get hurt, but I haven't ever been hurt so that's good.

[11] It was necessary to review Patricia's photographs on the camera screen during the interview because prints could not be produced with the equipment available on the ward. As the images could not be transferred digitally, they are not available for inclusion.

11. **R:** Mm. That's good. Do you tend to sit in the same place, or do you?
12. **P:** Yes, I do.
13. **R:** You do, yes.
14. **P:** Yes, I've got my own little place and I've got my things around me.

Patricia's reflection on the day room centres on the armchair where she typically sits and her description of being seated there "for the day", implies a sense of routine and that her daily activity within this area is typically sedentary. Although Patricia acknowledges the discomfort of sitting for long periods of time in her chair, she emphasises the positive attributes of the seat as a "good place" where she enjoys spending time reading newspapers and books. By highlighting to the researcher how reading the papers in that setting is valued for maintaining connections to events in wider "life" beyond her own, Patricia also indirectly alludes to her position as a detained patient, who does not currently have physical access to the world outside the hospital building. Patricia juxtaposes her perceptions of her chair as a "happy sort of place", where she enjoys reading, with a contrasting account of the day area, which is presented as a hectic and sometimes stressful environment where "there's a lot going on". Although Patricia presents tensions perceived within the environment matter-of-factly in this story, her description of the day room as a "chaotic space", where people are "often shouting" or "kicking off" and where she feels afraid for her own safety at times, presents an image of a volatile, noisy space imbued with potential aggression or threat.

Amidst imagery of a regularly unsettled atmospheric context, her chair is positioned as a discrete physical and psychological zone, which creates a personal territory within the communal lounge, that Patricia can perceive as "my own little place". By emphasising the space as being "my own", Patricia conveys an appreciation of perceiving a sense of ownership in this secure setting, where patients typically do not have access to their own furniture items and are generally restricted on the quantity or types of personal possessions they can have in hospital. Patricia's account

of sitting in her armchair also positions it as a more grounded and stable space, when contrasted with imagery of a turbulent surrounding environmental atmosphere. This sense of stability is further emphasised by the physicality of the chair itself, which in line with the style of lounge seating typically specified in secure psychiatric settings, is large, robust and heavily weighted to hinder movement.

Patricia's confirmation to the researcher that she typically sits in the same chair each day reinforces an image of routine within her daily life and positions the armchair as a familiar space. Patricia's account of sitting habitually in the same seat can therefore be understood to be appreciated for the sense of stability and familiarity it might afford, in contrast to the ever-changing atmosphere and dynamics of the surrounding lounge area. Patricia's remark that "I've got my things around me", evokes imagery of her individual zone within the lounge being extended by her possessions, such that greater perceptions of stability and protection can be afforded in this unpredictable environment by having these objects around her. By creating a personal territory using her chair and personal possessions, Patricia can be understood to be using objects and space to generate a helpful boundary between conflicting circles of activity that are occurring within the same environment. Patricia can accordingly be seen to be enabling a greater sense of normality and domesticity through her creation of a personal territory that constitutes a world situated within the wider, volatile world of the overall day area.

Although the ward is an ostensibly therapeutic environment and a place that Patricia currently considers to be home, her exposure to the distress and agitation of others in this setting is such that at times she is concerned about her own physical safety. The narrative of feeling at risk of potential harm in this environment therefore contrasts with wider societal understandings of hospitals typically representing safe and restorative places for the provision of care. When clarifying to the researcher that she has never actually been hurt there, Patricia's concluding remark stating, "so that's

good", implies gratitude alongside providing a sense of reassurance about this point, to both the researcher and to herself. The researcher, in turn, is seen to be affirming this statement by repeating Patricia's own words, "that's good" back to her.

The volatility of the environment in many UK psychiatric wards has been highlighted in previous studies (e.g. Jones et al., 2010; Quirk et al., 2004, 2006), where some patients have similarly reported perceptions of aggression and being at risk of violence from other patients when in hospital, or in some cases actually experiencing violent behaviour. Jones et al. (2010) found that whilst many patients felt a sense of safety or support from staff and other patients within inpatient psychiatric settings, any threats to their perceptions of security, including exposure to intimidation, aggression or bullying, prompted patients to feel unsafe and experience distress.

In the following extract, Patricia returns later in the interview to concerns about disruption, noise and perceptions of safety and describes an awareness of her affective responses to the overall ward atmosphere and the acoustic environment.

Patricia: Extract 2

R: […] Just thinking about sort of environments and your sort of sense of well-being are there any ways you might describe ways in which your environment affects how, how you are feeling?

P: Oh, I think it does when there is noise. I mean you can feel quite afraid when people are shouting and sound as if they are going to perhaps hurt somebody.

R: Mm.

P: Um, that can be very unsettling.

R: Mm.

P: Um and sometimes you just want to have peace, you want to be able to read in peace without the background noise and also to watch the telly. When you are trying to watch the telly in here it is very hard with background shouting and things like that.

R: Of course.

P: So, it does,

R: Yes, yes.

P: the environment does affect us quite a lot.

R: Yes and are there ways in which you try to deal with that sense of noise?

18. **P:** Well, I try to do the distress tolerance and switch off to it and take myself to a
19. nicer place and just try to let the whole thing wash over me without getting
20. involved.
21. **R:** Yes.
22. **P:** I never answer back to the people either, just ignore them.

Here Patricia reiterates how noise produced by others is a significant contributor to her own feelings of distress experienced in the ward environment. Intrusive sounds and the vicarious experience of other patients' distress and agitation are presented as environmental stressors that Patricia cannot readily escape within a space that is shared with a number of other patients and staff members. Patricia's portrayal of the aggressive shouting as "unsettling" conveys an image of how this unwanted noise can have a destabilising effect on both her own affective state and on the ambience of the space overall. The term "unsettling" recurs throughout the interview and is used by Patricia to describe her perceptions of disruptive events or troubling situations experienced on the ward that influence her affective state. By contrast, the words "peace" and "peaceful" also repeat frequently throughout the interview. Patricia's assertions that, "sometimes you just want to have peace", or "read in peace" illustrate here examples of her over-arching narrative focus on seeking tranquillity and calm within a chaotic and unpredictable environment.

Background sound, including noise from other patients is therefore positioned as an obstruction to Patricia's full enjoyment of leisure activities in the space, which typically include reading or watching television. Later in the interview, when reflecting on perceptions of her affective experiences within her everyday environment, Patricia also notes that,

> "[…] I am enjoying a book at the moment, so that takes me away from it, I feel in a different place [**R:** Yes] so that's good and sometimes I sleep in the lounge as well and that takes me somewhere different too (*laugh*), [**R:** Yes (*laugh*)] we're not supposed to (*laugh*)!"

This account positions both reading and dreaming as imaginative processes that allow Patricia to transition between affective states and enable her embodied experiences to be transported from the ward such that she can "feel in a different place". Patricia's use of her imagination when reading and engaging with television programmes, or when asleep dreaming, can thus be elaborated as a form of 'liminal affective technology' (Stenner, 2021; Stenner & Zittoun, 2020) that allows movement between worlds and enables her to experience a temporary sense of detachment from her current reality. In turn, these self-generated transitional processes of imagination can be understood to be helping Patricia manage the 'spontaneous' liminal experience of being in hospital or the experience psychological distress (Stenner, 2021). In other words, Patricia can be seen to be negotiating the discomfort of overarching and disruptive life transitions by using her imagination to generate liminal experiences that can facilitate transition between affective states. Patricia's story suggests, however, that background sounds on the ward, that may typically also convey distress, can disrupt her processes of affective transformation. Loud ambient noise is accordingly understood to be reducing the efficacy of her imaginative processes (e.g. those associated with reading or watching television), to facilitate transportation away from her current situation and enable supportive psychosocial connections to other places or people.

Patricia's appreciation of experiencing a sense of psychological detachment from the ward is also highlighted by her description of using the distress tolerance techniques she has learnt as a strategy to enable her to "switch off" from unwanted noise and take herself "to a nicer place". Alongside this, Patricia highlights later in the interview how she has learnt mindfulness meditation practices in hospital and uses these to take herself to a "safe place" psychologically, by focusing on her senses and embodied experiences. Throughout her overall narrative, Patricia's accounts repeatedly express how experiencing psychological safety as well as physical safety in hospital is significant to her overall sense of well-being. The predominant focus on

physical safety and risk mitigation in mental healthcare environments, however, is such that emotional or psychological safety is not seen to have the same parity of esteem (Veale et al., 2022). As Veale and colleagues argue, emotional safety is required for a person to maintain physical safety in psychiatric care and yet the prioritisation of physical safety in mental healthcare settings can result in higher levels of stress that may paradoxically increase physical risk.

Patricia's story also illustrates how patients might engage with liminal affective technologies (including mindfulness techniques) to negotiate their responses to witnessing other patients' distress and cope with the volatility of the ward environment. Through her concluding remark expressing how she avoids responding to provocation from other patients, Patricia also provides further testimony to the researcher of her desire to reduce stress by attempting to detach and disengage herself from an unsettled ward.

Whilst there is limited existing research examining occupants' experience of the acoustic environment in psychiatric inpatient settings, a body of evidence from studies in general hospitals suggests that excessive noise, or 'unwanted sound' can have significant detrimental effects on patients' physical and psychological health (Choiniere, 2010; Hsu et al., 2012; Ulrich et al., 2006). Westman and Walters' (1981) exploration of relationships between noise and stress also highlights how, in accordance with innate survival instincts, the meanings associated with sounds are key determinants of human responses, such that danger is signified by threatening sounds. Sounds can also take on specific meanings for individuals depending on their lived experiences and in secure psychiatric settings, where patients have commonly experienced difficult and distressing life events (Coid, 1992), perceptions of sound can be understood to be especially significant (S. D. Brown et al., 2019b).

As highlighted by Patricia's experiences, when sharing a hospital ward environment with a significant number of other people, patients also have minimal

control over ambient sound levels and have limited ability to avoid unwanted sound (Rice, 2003). Rice's (2003) ethnographic study of soundscapes in a general hospital explored how sounds are imposed on occupants and how limited sensory stimulation within the overall environment might contribute to heightened sensitivity to sound. Whilst sound interpretation enabled patients to navigate and understand routines in the environment, the study also found that it served as a continual reminder of their status as hospital patients. Although research exploring sound control in psychiatric settings is limited, seemingly simple interventions, such as the application of felt pads to furniture have been found to assist in reducing overall sound levels in mental healthcare environments (J. Brown et al., 2016). Furthermore, staff in Brown and colleagues' study perceived that the resulting decrease in noise contributed to a reduction in violent incidents observed on an older adult mental healthcare ward, as part of the overall effect of measures undertaken to reduce aggression in that environment.

Perceptions of sound and noise levels also contribute to staff experiences in hospital environments and a literature review undertaken by Ryherd et al. (2012) suggests that the effects of noise on hospital staff are generally negative. Sensory overload affects the central nervous system's capacity to process environmental stimuli and exposure to noise can diminish cognitive performance or induce psychophysiological stress responses, including activation of the sympathetic nervous system and raised blood pressure (Stansfeld & Matheson, 2003; Westman & Walters, 1981). Ryherd and colleagues' (2012) review findings accordingly imply that noise exposure can affect hospital staff members' health and levels of stress, in addition to their job satisfaction, performance and perceptions of the psychosocial environment at work. Anecdotally, in the present study, although interviews took place privately within closed rooms, loud noises, including slamming doors or distressed patients shouting were commonly heard in the background, including during the interview with

Patricia. In a few recordings, there were also instances where speech was momentarily inaudible due to the volume of the background noise.

Patricia also highlights her perception of noise and a sense of instability being prevalent in the bedroom corridor environment in the next extract when she reflects on her emotional responses to the bedroom corridor and her own bedroom space.

Patricia: Extract 3

P: That's the bedroom corridor which again can be quite noisy and a bit chaotic.
R: Mm.
P: And where we queue up in the morning in order to be let out, so that feels a bit strange (*laugh*).
R: Mm.
P: That's my bedroom, which at the moment hasn't got any of my possessions in so it's a bit sterile and a bit cold and obviously I do sleep there and relax there, but it doesn't feel very inviting right now.
R: No, how do you feel about um, not having your possessions?
P: Oh, no I don't like that at all. They are all under the bed and they are all higgledy piggledy and it's very unsettling.
R: Mm.
P: It's very hard to find outfits to wear. I can find my clothes, but I can't find outfits and it's very, very unsettling to do that.
R: Mm.
P: and I have to wear those very strange pyjamas, rip-proofs at night-time
R: Mm.
P: and again, that's rather uncomfortable and it feels a bit like a punishment, which of course, it is really.

Patricia's positioning of the bedroom corridor as "noisy" and "chaotic" echoes the earlier account of her perceptions of the day area and strengthens an image of the communal ward areas being loud spaces where unpredictable events might frequently take place. The imagery of patients queuing up there in the morning evokes a more carceral narrative and alludes to how power differences between staff and patients in secure settings are expressed and reinforced through spatial interactions and control of the environment. Whilst Patricia acknowledges that the experience of queuing there

can feel “a bit strange”, her short laugh following this also highlights a sense of understatement in this remark to the researcher. Patricia’s story of being in a “chaotic” environment whilst waiting “to be let out” is unfamiliar in a residential context and evokes imagery that might be more commonly associated with animals awaiting release from an enclosure or with the experience of detention in prison settings. Through this story, Patricia also highlights how patients may experience various layers of physical or procedural restriction that typically occur at the thresholds between different processes or spaces within the secure boundary of the ward itself.

Patricia describes how her bedroom has been cleared of all her belongings including her clothes. It is assumed that this is intended for her physical safety, however, Patricia interprets this as a form of “punishment” for misbehaving and as a removal of privileges, rather than an expression of care in light of her self-harm or suicide risk. Patricia’s depiction of the room without her possessions as “sterile”, “cold” and uninviting creates imagery of a stark, clinical and non-domestic space. Interpreting the meaning of “sterile” as literally being free from life, the narrative presents an image of the room, when stripped of Patricia’s belongings, as having also been stripped of any sense of her own life. As patients’ bedrooms on a ward are typically repeated with an identical layout and design, the removal of Patricia’s possessions can also be seen to be taking away the expression of her presence and individual identity from the space. Although the bedroom remains functional as a place to sleep and rest, in the absence of her belongings, the previously comforting qualities of the room as a supportive resource have been significantly diminished.

Patricia expresses how her distress is connected to being separated from her belongings and also by her feeling that these objects are disordered. Consistent with her earlier accounts of troubling experiences in the lounge, Patricia highlights again here her perceptions of “unsettling” embodied experiences. She articulates how these experiences are associated, not only with the loss of her possessions, but equally by her

awareness that they are in a state of disarray when locked away. When permitted access to her belongings, Patricia can find individual items of clothing, but a loss of choice can be inferred from her report of not being able to create outfits. In turn this can be interpreted as a loss of ability to express her identity fully using a selected ensemble of clothes. When considering her perceptions of disorder within the environment later in the interview, Patricia reiterates her experience of distress associated with her clothes being stowed "under the bed in a bit of a heap". She describes this experience as "very disheartening" and also asserts that "[…] I like my room ordered; I like to feel my things around me". This sense of the pleasure and reassurance gained from her belongings being associated not only with seeing them, but also with sensing their presence around her, resonates with Patricia's earlier comments about appreciating the feeling of having her things surrounding her in the day area.

Belk (1988) highlights the relationships between possessions and self-identity by building on William James' (1890, as cited in Belk, 1988) proposition that things which might be considered as 'mine', might also be perceived as 'me', to present a concept of the 'extended self'. Within the conceptual framework of the 'extended self', Belk argues that objects, people or places are all able to form part of an individual's sense of selfhood. In terms of forming an extension of the self, since clothes are worn directly on the body and are used to express a sense of identity, clothing can be interpreted as a form of possession with close links to selfhood. Patricia's account expresses her sense of both physical and psychological discomfort when sleeping in the rip-proof pyjamas and the requirement to wear these garments that have punitive characteristics is seen to contribute to her sense of being punished. Furthermore, her story evokes an image of the rip-proof pyjamas as a form of uniform (e.g. the standard issue clothing worn by prisoners) that in turn could be understood to be diminishing her sense of individuality. Her overall perceptions of having a lack of choice and control over her

everyday environment can thus be seen to be exacerbated by the removal of access to her belongings and her own clothing specifically. In the following extract, Patricia elaborates further on the affective significance of perceiving a sense of choice in her personal environment and having access to her possessions.

Patricia: Extract 4

R: […] Um, I was also, um, just thinking about, um, touching on it really thinking about your, your room, but um, wondering how important it is for you have choice when considering your personal environment?

P: Oh very much so. I like when I have got my own pictures around me, I put pictures in the wall of family and friends and oh, just have things like my books and toiletries, things personal to me, is important.

R: Yes.

P: And also to have my clothes organised so that I can feel on top of things.

R: Yes.

P: So yes, as it is at the minute, which is called a sterile room, it's really very unsettling.

R: It's absolutely sterile?

P: Yeah, it is sterile, that's what they call it. They clear everything out of it, all into the cupboards.

R: Mm.

P: But I'm hoping to get it back today (*laugh*).

R: Yes, yes. And are there any particular objects that you have, when, when those are, um, out in your room that you enjoy?

P: Oh yes, my photos.

R: Your photos.

P: My photos to remind me of everybody. They're the most important things to me.

When considering choice in her personal environment, Patricia's account of the significance of having her "own" pictures "around" her conveys a further sense of how personal possessions can be seen to represent an extension of her own selfhood and identity. The items she lists are "personal" to Patricia due to their psychosocial or physical closeness to her (e.g. as representations of family and friends, or as objects that she holds, such as books, or other items that come into contact with her body,

including toiletries and clothes). In contrast to her earlier account of the distress associated with her clothing being "higgledy-piggledy" and locked away under the bed, here Patricia clearly expresses her preference for experiencing a sense of order over disorder within her everyday environment. Patricia also underscores the psychological significance of being separated from her possessions in her account of this experience being "really very unsettling". The narrative accordingly implies there to be a direct relationship between the organisation and accessibility of her personal possessions and Patricia's own affective state. Whilst the experience of her clothes being unreachable and stored in disarray is described as distressing, in contrast, having an awareness of her clothing being orderly and organised enables Patricia to feel psychologically prepared and "on top of things". The removal and disordered storage of her belongings is thus seen to be having a disruptive and destabilising effect on Patricia by compromising her sense of agency and control over possessions that form part of her extended sense of self.

As an individual's most intimate belongings, including clothes, are typically stored in bedroom environments, the use of the term "sterile" to describe Patricia's room contrasts starkly with wider perceptions of bedrooms as highly personal and typically comfortable spaces in which to rest and relax. This description instead evokes imagery of an overtly clinical environment which surprises the researcher who queries if the space is "absolutely sterile". Patricia's clarification that the term is used by staff to describe the bedroom once her belongings have been stripped out thus presents an image of her possessions as a form of impurity or contamination within a spotless environment. This account also links back to Patricia's earlier description of her room as feeling "sterile", suggesting that her own experiences of the space may be reinforced by the term used by staff to refer to the room following the removal of her possessions.

Patricia's assertion that her photographs are the most important possession in her bedroom, however, highlights the significance of using these images to maintain

connections to family or friends and to events in the past. Her account of how the photographs "remind" her of everyone also evokes a sense that without them she might fear losing contact with people or forgetting them. Patricia's narrative highlights how there is a reassuring quality associated with having personal possessions in her room and being able to sense them around her. Whilst the removal of her access to these objects is reflective of predominant concerns about her physical safety, Patricia's account of being without her belongings suggests that this can also be destabilising and diminish her sense of psychological safety.

5.4 Concluding comments

The three narratives explored in this chapter have demonstrated how spaces and objects are used by patients and staff in secure settings to assist in navigating difficult emotions or facilitating transition between affective states. These accounts also provide illustrative examples of similar strategies expressed by participants across the overall data set. Drawing further on liminality as a theoretical framework through which to approach the interpretation of narratives, participants' accounts of managing difficult experiences have been considered in relation to processes used to self-produce liminal experience and assist transition between affective states (Stenner, 2020, 2021). Importantly, these self-generated, or 'devised' forms of liminal experience that can facilitate affective transformation (e.g. visualising future spaces), are also seen to be helping some participants mediate the raw or 'spontaneous' liminal experience associated with disturbance imposed by challenging and typically unforeseen circumstances (Stenner, 2017, 2021).

For patients, disruptions to their lives or challenges to their sense of selfhood could be understood to be associated with significant unplanned liminal transitions, including the experience of mental health crises or detention in hospital. Processes of self-producing liminal affective experience are accordingly seen to be helping some patient participants make sense of difficult or unfamiliar circumstances associated with

these significant transitions or ruptures within their lives. Staff participants' accounts similarly convey how processes of self-generating liminal experience to transition between affective states, such as physically moving between spaces, can help to mitigate unsettling experiences, or the sense of unease brought about by imposed occasions of spontaneous liminality. The narratives explored illustrate how incidents, for example, those involving the physical restraint of patients can disrupt staff members' routine flow of psychosocial experience. In circumstances such as these, members of staff are understood to be shifting from an enabling and caring role to an authoritarian or potentially punitively perceived position.

In order to produce 'devised' liminal experiences that enable affective transition, participants describe engaging with diverse forms of 'liminal affective technologies' or 'symbolic resources' (Stenner, 2017; Stenner & Zittoun, 2020). These experiences are typically used to enable transition from unsettling or distressing affective states to those that are more reassuring and supportive. Accordingly, patient accounts convey how imaginative processes can assist in creating a distraction from the difficult experiences associated with their current circumstances. These may include patients' unhelpful reflections about their individual situations when compared with ideal storylines about how their lives might have been envisaged previously. Imagination is thus seen to be engaged with for both supportive and motivational purposes and to assist in transforming experiences of troubling spaces and objects into comforting or incentivising imagery.

Such imaginative processes are also understood to offer a means for individuals to be psychologically transported to and from other places and across time. Spaces and objects are seen to facilitate participants' access to unlimited psychosocial connections between different people, places and events situated in past, present and future settings. Rich visual imagery to illustrate patient participants' future lives beyond hospital is accordingly constructed through detailed narrative accounts of the

envisaged spatial contexts in which these lives would be lived. Patient participants' processes of imagining and psychologically inhabiting future spaces are hence seen to provide a supportive and motivating sense of progressive transition from their current circumstances towards life beyond hospital.

Enacting physical movement through space via the use of visualisation is similarly understood to facilitate perceptions of forward progression that can enable participants to deviate from an unhelpful sense of being trapped between worlds or being suspended in an ongoing process of liminal transition. Actual physical movement through space and specifically, the transition between internal environments and external spaces is also seen to be mediating patient and staff experiences of psychological discomfort within the confines of restrictive indoor settings. This integration of mind-body activity produced by physical movement can therefore enable difficult or distressing experiences to be worked through by participants and processed by being 'walked through' during the transitional passage of moving through space.

Further examples of how liminal affective technologies are used to assist transition between emotional states are conveyed through participants' accounts of ordering and having control over space and objects, including personal possessions, using both physical and psychological processes. The narratives also highlight the significance of objects and personal possessions in helping to maintain and reinforce perceptions of self-identity. Objects and personal possessions are also seen to be helping participants create a sense of stability and construct a supportive 'world-within-a-world' that can provide a sense of protection from the often challenging and volatile ward environment.

Participants typically describe valuing positive social interaction and perceiving a shared sense of belonging or equality in the company of other people who are seen to be going through a passage of similar experiences. Correspondingly, spaces that are experienced as relatively less restricted than others are understood to afford

participants a greater sense of togetherness or equality and are accordingly seen to evoke a supportive sense of *communitas* as conceptualised by Turner (1969/1996). Experiences of transitional 'flow' between affective states or identity positions are thus portrayed as being smoother in less restricted spaces, where there are also typically fewer symbolic cues relating to power, status, risk or control perceived within the built environment. The narratives also highlight how spaces are appreciated and valued for their capacity to afford spontaneous and light-hearted social activity. Accordingly, it is noteworthy to contrast Tom's account of experiencing a sense of solidarity and *communitas* in 'off-ward' spaces that facilitate positive social interaction, with Patricia's attempts to disengage from other patients and her surroundings when she experiences the ward as unsettled and stressful.

Alongside this, narrative accounts of valued respite and relative liberation experienced when spending time in 'off-ward' spaces located beyond the physical threshold of the ward are frequently expressed and by patients and staff. Such experiences of movement through space are thus seen to symbolise a transition between the intensity of the world inside the ward and a contrasting world outside. In addition to actual physical movement, participants similarly describe using imaginative processes to psychologically inhabit less restrictive and more tranquil spaces. These imagined spaces are hence providing a sense of release from the challenges of the immediate ward surroundings and helping to generate feelings of safety or stability. Patient and staff participants' narratives here and throughout the data set particularly highlight the significance of external 'off-ward' spaces that can assist in maintaining a sense of the passing of time and providing valued access to the multi-sensorial aspects of nature, including natural light.

Chapter 6: Navigating relationships in secure spaces

The previous analytical chapters have explored participants' accounts that exemplify two overarching narratives expressed across the overall data set. Stories examined in the first analysis chapter illustrated how participants make sense of uncomfortable spaces within secure psychiatric environments, whilst narratives discussed in the second chapter focused on engagement with spaces and objects as strategies for coping with difficult affective experiences within those settings. The analysis presented in this chapter will focus on a third overarching narrative concerned with the stories told about how interpersonal relations between and amongst staff and patients might be associated with and be grounded within their everyday spatial experiences of the hospital environment.

The analysis draws on the narratives of four further participants, Mike, Nathan, Bradley and Estelle. Mike, Nathan and Estelle are members of staff working in medium and low secure ward environments and Bradley is a patient on a low secure ward. The stories explored here are concerned with participants' observations and experiences of interpersonal relationships and interactions amongst patients and staff within different spaces on the ward. Their accounts illustrate how perceptions of relational dynamics might be associated with everyday experiences of space and qualities of the environment within secure hospital settings.

6.1 Mike

Mike works on a medium secure ward and is an experienced occupational therapist and long-standing member of staff. He positions himself throughout the narrative as a creative and energetic person who is enthusiastic about his day-to-day work. Mike's account of his role suggests that he is especially passionate about initiatives developed with patients to visually enhance the hospital environment and facilitate creative expression. These projects include the creation of artworks and colourful murals in

some of the communal areas that patients have designed and produced during group sessions. Throughout the narrative Mike expresses his thoughts about how taking part in such activities might enrich patients' everyday experiences within the ward environment and enable the development of new skills. His stories imply that participation in collective projects, including painting and decorating, gardening, or cooking, can encourage increased communication and social interaction amongst patients who may have previously struggled to work in a team. Based on his own observations, Mike suggests that when patients feel invested in projects and take pride in the results, it can prompt overall improvements in the ward atmosphere, including potential reductions in incidents and levels of aggression.

Mike's overall tone is generally optimistic and throughout the narrative he expresses a strong sense of dedication to his role and appreciation of the time that he spends working with patients. He is also interested in how improvements might be made to the hospital environment and expresses disappointment in aspects of the ward design, including his perceptions of spaces often having bland and clinical qualities. His overall narrative is focused accordingly on the perceived benefits of functional or aesthetic adjustments to the environment, including the use of coloured paint on walls to enhance the ward and enable a degree of personalisation to spaces. He also talks about his belief in the therapeutic benefits to patients of spending time within outdoor spaces and feeling connected to the natural world. Whilst Mike has a busy and demanding role that is often challenging, his stories suggest that he gains much professional fulfilment from observing patients working together on projects and perceiving improvements in their self-confidence and mental health.

Mike's main storylines focus around: (1) how spending time in 'off ward' spaces might benefit patients, (2) how perceptions of space can promote or impede social activity, (3) aesthetics and symbolism within the physical ward environment, (4) the

benefits to patients of participating in collective and creative activities and (5) how spaces and objects mediate affective experience and distress.

In the interview Mike reflected on photographs of[12]: (a) on-site café courtyard, (b) dining room servery hatch, (c) mural artwork by patients on dining room wall, (d) patient lounge / day area, (e) bedroom corridor, (f) ward entrance corridor with welcome signage and mural artworks by patients and (g) therapy kitchen.

The following analysis will draw on all of these storylines to focus on Mike's perceptions of how staff and patient experiences of the hospital environment are connected to social interaction and relationships between and amongst both groups. In the following extract, Mike discusses a photograph of the communal lounge area on the ward and reflects on possible links between the design and ambience of the physical environment and the social interactions he observes and experiences in that space. Alongside his thoughts about how patients might make sense of their experiences there, Mike also talks about his own perceptions of the lounge area and experiences of spending time in the nursing office that is directly adjacent to it.

Mike: Extract 1

M: So that's the lounge.
R: Yeah.
M: Um, er, I just find it so depressing.
R: Yeah.
M: (*Laugh*) er, it's and I, the thing is I, I'm just constantly, when I'm stuck here, I was gonna do one in the office, but I didn't get the chance to do it on the, the office, you know it, it's like a goldfish bowl, sitting in there as well, it's very depressing, but just looking out on that, it's never really used a great deal.
R: Mm.
M: Um, it's just got furniture dotted around the outside, er, the TV stuck up there and it's just, I think it's just so open and um, it's just nothing about it that gives it any sense of, um, you know this is supposed to be their lounge, community, this is where they're supposed to maybe interact and instead everyone

[12] It was not possible for Mike's images to be printed or digitally transferred and his photographs were reviewed on the camera screen during the interview.

congregates down the corridor where they are not supposed to be, where staff are supposed to be observing and this is supposed to be a place where they're, they can socialise and actually enjoy each other's company and you know you got a few chairs there and there and it's just, doesn't work.

R: Mm.

M: I don't know if it's just too big, I don't know if we've got any clear plan on how to improve it and make it a better environment, you know, we get table tennis out here every now and then for the guys which is really good, but it just, for me, just is, doesn't work.

In juxtaposition to wider societal understandings of modern domestic living rooms as typically comfortable and potentially psychologically comforting spaces, Mike's candid opening account of the lounge as "so depressing" evokes the language of mental distress to position the environment as dispiriting and actively lowering mood. This imagery is further reinforced by the repetition of "depressing" within Mike's description of spending time in the glazed nursing office that directly overlooks the lounge. Whilst Mike's stories generally focus on his perceptions of how patients might experience the ward, the brief reference to the nursing office as a "goldfish bowl" alludes to his own personal experiences and a sense of exposure when working in there. Later in the interview, Mike also elaborates on the unease and discomfort he perceives in both environments when considering the relationship between the two spaces in the following reflections.

> **"**Um, I just, I just, I don't see it [*the lounge*] as being a sort of um, an area where I see much, much positivity, um, going on, um, you know, when, when you, normally in there you're in the office, you're normally ge-, the door's being banged on, um and I always, I seem to associate it really of just, where there's, um, where you're constantly being pressured for time. I'm on the computer, I'm looking out and it just, um, yeah, people, the only time people are in there is when they are waiting to go for their dinner, or um, waiting, or banging on the door for some, some, either medication or for, to go out for a session or, normally in a state of arousal, not in a pleasant, you know relaxed and sort of social mood."

Patient activity in the day area is presented here as being typically transient. Mike extends his earlier dispirited account of the lounge by positioning it as a space without, "much positivity" that patients would generally only choose to occupy whilst speaking with staff or waiting for other events to take place. Mike observes that patients in the lounge area are not typically socially engaged there and focus instead on staff activity in the nursing station and on attempts to attract staff attention. Mike's report of the office door being, "banged on" contributes to images of tension and undertones of aggression being expressed within the environment. This imagery supports his later observation that patients encountered there are regularly in a state of agitation and not typically in a, "relaxed and sort of social mood". Mike's narrative thus positions the door and glazing as an intensely affective threshold between the two adjacent, yet very different worlds and contrasting circles of activity that comprise the lounge and nursing office. Patients may typically express frustration or distress along one side of this division, whilst staff on the other side may feel exposed, harassed and "pressured for time". Mike's report of patients, "banging on the door" also makes an indirect reference to the incidence of loud noise within the ward environment that may heighten the affective atmosphere and disturb, distress or annoy patients and staff (S. D. Brown et al., 2019b; Hsu et al., 2012; Mazuch & Stephen, 2007; Ryherd et al., 2012).

Whilst the glazing physically separates the office and lounge, it simultaneously provides a visual connection between the two spaces that highlights the differences in their intended functions and environmental characteristics. When observed through the glazing, each area can therefore be seen as a backdrop to and visual extension of the other space. An incongruous visual adjacency is hence created between the lounge, which is provided ostensibly as a leisure space with a TV and armchairs and the office, comprising an active workplace with desks, phones and computer equipment. Furthermore, since patients are not allowed inside the nursing office, the narrative highlights how the glazing not only presents a direct view of an office environment

from a residential lounge, but also offers up a space to patients that they cannot access. Whilst staff can be seen speaking together inside glazed nursing offices, previous research findings indicate that patients' inability to hear such conversations due to the glass barriers can lead to speculation about what is being said and concern that they are being talked about (Simonsen & Duff, 2021).

An earlier study by Edwards and Hults (1970) examined patient and staff perceptions of the ward milieu before and after the removal of glazing around the nursing station in a psychiatric ward. Without the glazed window, fewer patients perceived that they were disturbing staff when visiting the nursing station and fewer patients were concerned about seeing staff laughing or talking there. After the glazing was removed, patients spent less time visiting the nursing station and staff spent more time interacting with patients outside it. Patients also expressed their view that removing the glazing had in turn removed perceptions that staff needed physical protection from patients, which had been associated with the presence of the robust glass window. Mike's account of looking out to monitor the lounge whilst working on the computer in the office, highlights how via the glazing he is connected simultaneously to two separate worlds and attempting to interact with both.

Mike's earlier observation that the lounge is "never really used a great deal", implies that patients choose not to spend time there, whereas by contrast, a lack of choice and sense of confinement is implied in his own description of being, "stuck here" within the office. Mike's narrative can therefore be seen to echo the findings of Shattell, Andes and Thomas (2008) who examined perceptions of the environment in acute psychiatric care and reported that staff felt confined and "caged-in" (p.242) by the enclosed nursing station and desired greater interaction with patients. In the same acute psychiatric environment, Southard et al. (2012) and Shattell et al. (2015) explored staff and patient experiences of the nursing station before and after removal of the existing glazed enclosure. Although Southard and colleagues (2012) found no

statistically significant difference in staff and patient experiences of the therapeutic milieu before and after the adjustments, their perceptions of this did not worsen without the glazing. There was also no increase of aggression towards staff by patients associated with the open station, as had been predicted by some staff members. Additionally, there was a reported decrease of 26% in the use of restraint or seclusion in the year following the removal of the enclosure. A qualitative study undertaken in the same context by Shattell and colleagues (2015) found that patients unanimously preferred the open station. Patients described experiencing a sense of freedom and togetherness, alongside increased perceptions of safety, including the sense that staff were able to respond to emergencies more rapidly. Both staff and patients viewed the glazed enclosure as being a barrier to staff-patient interaction. Whilst staff perceived that the enclosed station had contributed to patient frustration, they reported that the open station instead assisted with patient de-escalation.

Mike's overall evaluation of the communal lounge area is unenthusiastic and underpinned with a tone of disapproval. In the first extract, his depiction of armchairs being, "dotted around" and the TV being, "stuck up there" imply a sense of randomness that contributes to his critical appraisal of the space planning and furniture placement. Mike's depiction of the lounge illustrates that, in line with typical practice to mitigate risk on secure wards, the television is housed in a protective casing and mounted high up on the wall. By implication, Mike's narrative suggests that the high-level TV placement is awkward and unlike conventional ergonomic relationships between the television and seating in an average domestic living room. Mike's view of the lounge as being "just so open" is also presented in contrast to wider sociocultural understandings of living areas as being typically enclosed or semi-enclosed rooms, with a domestic scale and a convivially spaced arrangement of furniture.

Whilst living rooms in other residential contexts might typically be viewed as private spaces, his depiction of the lounge that is overlooked by and directly connected

to several other spaces on the ward, positions it more as a public thoroughfare than a private dwelling space. Mike's disappointment with the lounge and perception of how its openness and layout might influence behaviour are further expressed through his unequivocal and exasperated assertion that there's, "just nothing about it that gives it any sense" of being a social space. The day area is accordingly presented as lacking the necessary character and material qualities required to produce an inviting or social environment as stereotypically characterised by a residential living room. Whilst research findings recommend the provision of ample space in communal areas to enable patients to regulate social interaction (Ulrich et al., 2018), Mike's remarks also imply that the degree of congruence between the scale and function of an environment can affect occupants' perceptions of comfort. His account of the large space therefore evokes a sense of discordance between its domestic intentions as a lounge for relaxing in and its over-scaled proportions that can be understood to be more reflective of a public foyer or reception space for transient occupants.

The narrative indicates that the social relationships and interactions which may contribute to creating a sense of "community" on the ward are not readily enabled in the lounge and may be actively hindered by its spatial design and atmospheric attributes. Mike's observations about patient activity in the day area are consequently pertinent to existing research examining relationships between the physical design of psychiatric wards and levels of social interaction. Holahan and Saegert's (1973) investigation into relationships between the ward environment and patient behaviour compared an extensively remodelled psychiatric admissions ward with an identical ward that was left unchanged. Compared to the existing ward with drab finishes and worn furniture, patients socialised significantly more in the refurbished ward, where adjustments included fresh paint colours and the addition of comfortable new furniture to the day areas and bedrooms. There was no difference found in levels of non-social active behaviour between the wards, however, there was a significant decrease in

isolated passive behaviour observed within the remodelled ward. Group interaction was also encouraged by arranging new chairs and tables into small social groupings in one of the day areas.

In one of the earliest studies examining associations between furniture layouts and social behaviour in psychiatric settings, Sommer and Ross (1958) observed social interaction amongst patients before and after adjusting the day room furniture on a geriatric ward. Their study highlights how typical 'shoulder to shoulder' seating arrangements in day areas, that are similar to those observed here by Mike, can make conversation both physically and psychologically uncomfortable. Accordingly, the authors also warn that such layouts can lead to patients becoming, "observers" and "silent individuals sitting eternally in a waiting-room for a train that never comes" (p.128). By contrast, social interactions almost doubled when the furniture layout was changed and chairs were arranged around tables to create 'sociopetal' groupings (i.e. those which promote social interaction, as opposed to 'sociofugal' arrangements that minimise social contact). Several subsequent studies have similarly found that arranging comfortable furniture in small and flexible groupings facilitates social interaction in psychiatric settings (Jovanović et al., 2019). The use of moveable furniture also comprises one of the ten key design interventions identified in Roger Ulrich and colleagues' conceptual model for promoting reduced aggression in psychiatric facilities by reducing stress within the environment (Lundin, 2021; Ulrich et al., 2018). Within this model it is argued that using moveable furniture in communal areas increases patients' ability to regulate personal space and thus reduces stress levels, which in turn can contribute to reductions in levels of aggression.

Within the first extract, Mike's repetition of, "supposed to" in relation to patient and staff activity in the day area and bedroom corridor emphasises how the expected behaviour of both groups and their use of space is determined by ward policies and protocols. His account of patients challenging the 'rules' by gathering in the corridor

area where they, “are not supposed to be”, thereby alludes to a sense of patients’ collective resistance to authority through the occupation of space. Mike’s repeated assertion that it, “just doesn’t work” emphasises his exasperation with the space and awareness that adjustments are required to increase levels of comfort or sociability in the lounge area. This statement also underscores Mike’s belief that behaviour observed there is closely linked to the scale and layout of the lounge and its relationship to adjacent spaces on the ward, including the nursing office and bedroom corridor. By highlighting how sporadic standing-based activities such as table tennis have successfully provided a social focus to the space, Mike’s narrative reinforces his perception that the sparse and inflexible layout of heavy furniture in the lounge contributes to its typically non-social character. Through his description of the social activity associated with the table tennis equipment, this part of Mike’s narrative can also be seen to be bringing back the vitality and sense of purpose into the space in a way that is missing from the other parts of his account.

In the following extract, when discussing a photograph of the bedroom corridor, Mike reflects further about potential associations between the social interactions that he observes within both the corridor and lounge and the physical or atmospheric characteristics of these spaces.

Mike: Extract 2

M: So, er, bedroom corridor. Obviously, there’re no patients in there, but that for me it, er, tends to be a room, a, an area where there’s always conflict, always trouble, always pushing of boundaries and the environment, er, I just, I you look at it, the corridor and you always know that there’s, you know, patients shouldn’t be there, staff should be there observing, but, um, they’re always obst-, obstructing the, you know, very regularly obstructing the corridor and so you can’t see what’s going on down there and you know, the lounge is where they should be but they’re down there in that corridor, yeah, whenever I sort of see it you think, think sort of ah, yeah.

R: Mm. And why do you think, er, they tend to spend more time in the corridor?

M: It’s strange, because, um, we have a thing called a man cave, er, doo, doo, doo,

doo (*looking at image*), so this is, it would be just here (*pointing on image).*

R: Yeah.

M: And that's where there's like a little games room, and then so you have your staff who are supposed to be observing here and at the bottom and there's they're just there to observe, they're not supposed to really be socialising there, pa-, patients aren't supposed to be congregating there, supposed to be either in the lounge, games room or bedroom. Just bec- and um, because there's staff there patients tend to then automatically go there so they can interact and sort of talk to the um, staff and once one patient's there another one comes along, another one and then you know you've got staff who are supposed to be doing the observing and er, you've got 4 or 5 patients standing around and um, so I guess it's maybe that there's staff always there.

R: Mm.

M: But then they, it's just that maybe they feel comfortable and that there's a few few patients round there getting the chance to all have a bit of a social chat.

R: Mm.

M: Whereas again, you know, it's, it's more confined isn't it? You're actually able to talk near someone (*laugh*) and go to the lounge, it's, it's a big open space, it may be that if we had it set up as a, as an actual, you know, differently

R: Mm.

M: we might, it <u>might</u> help move those patients there, but if we've got a large room where there's just chairs are dotted around the outside wall, who'd want to go there?

R: Mm. Mm.

M: So maybe that's, maybe that's the way that we really need to, if we focus on improving the lounge, that will then stop the problems down the corridor.

Mike's earlier allusion to patients expressing a form of resistance to authority by gathering in the bedroom corridor is made more explicit here through his depiction of, "conflict", "trouble" and "pushing of boundaries" typically occurring in this area. The repetition of, "always" within Mike's observations of such activity also conveys his perception of friction being a constant and inevitable feature of the corridor area. His comments suggesting that patients, "shouldn't be there" and that staff are, "not supposed to really be socialising there" reinforce his earlier references to the expected behaviour of both groups being subject to the ward 'rules' and protocols. Mike's reiteration of, "supposed to" in relation to envisaged patient and staff activity in these

spaces, however, further emphasises his observation that opposite behaviours are generally taking place. By suggesting that staff, "should be there observing" and not be engaging with patients, Mike highlights his perception of tensions between the institutional expectations of social behaviour in that space and the reality of what might typically occur there. The narrative therefore draws attention to the ironic circumstances of patients not spending time socially in the lounge despite being "supposed to" and yet gathering in the corridor where they are not "supposed" to be. Mike's observation that patients move "automatically" to interact with staff in the corridor creates an image of an instinctive pull that draws patients towards the members of staff in there. It also highlights how, in contrast to the lounge area where staff may often be separated from patients by the nursing office glazing, there is no physical barrier between staff and patients in the corridor.

Although the narrative presents the corridor as being imbued with tension and conflict, it is simultaneously described as a sociable place where Mike speculates that patients might "feel comfortable" and wish to spend time in the company of other patients and staff. Staff are continually present in the corridor and hence might be perceived as being more available there than in the lounge, where patients might typically need to attract the attention of staff working inside the office. Accordingly, Mike's narrative account of patients being drawn to staff also suggests that patients may desire attention from and interaction with staff, more so than with each other. Perceptions of having a closer connection or more equal relationship with staff can therefore be seen to be facilitated in spaces where staff must leave the office and be available for contact with patients. Associated with this, a sense of safety might also be perceived by patients in the corridor due to the constant presence of staff at close hand in the event of an emergency.

In contrast to the large, open lounge area, the narrative suggests that the corridor encourages social activity by bringing people closer together in a contained

environment and that a sense of comfort might be gained from the proximity of other patients and staff. Mike's report of, "4 or 5 patients standing around" in the corridor presents an image of informality and spontaneous activity being appreciated by patients in an environment typically characterised by rules and routine. Standing casually in the corridor and "getting the chance to all have a bit of a social chat" is thus juxtaposed with patients choosing not to sit in what Mike perceives to be a rigid and unsociable arrangement of furniture in the lounge. Mike's description of the armchairs, "dotted around the outside wall" echoes the disapproving tone of his earlier reflections about the sparse and awkward furniture layout. His sense of frustration with the social affordances of the day area is captured in his rhetorical question to the researcher asking, "who'd want to go there?". Mike's thinking aloud about how setting up the space, "differently" might encourage greater use of the lounge alludes to its non-domestic attributes and an aspiration to create a more homely and inviting living space. His concluding comments in this extract hence underscore his perceptions of a connection between social interaction and the physical and atmospheric characteristics of spaces on the ward. Mike's suggestion that changes to the lounge might help resolve issues in the corridor proposes that the behaviours observed in both spaces are intrinsically linked and acknowledges a need for spatial adjustments to the ward to potentially influence social behaviour.

6.2 Nathan

Nathan is currently based on a low secure psychiatric ward and has been working as a health care assistant at the hospital for several years. Throughout this time Nathan has worked with patients in different settings, including medium secure and dementia friendly wards. In recent months Nathan's ward has moved to its current location from another building within the hospital. Nathan highlights differences in the design and layout of these two environments and his perceptions of how spatial characteristics of

the current ward, such as its integrated living and dining area can influence social behaviour and relationships amongst patients and staff.

Nathan's overall narrative conveys a sense of caution in relation to his work and an underlying tone of worry associated with his perceptions of risk and the harm that could potentially occur to patients or staff members in spaces on the ward. When reflecting about his emotional responses to everyday spaces, Nathan frequently highlights his perceptions of how aspects of the physical environment, or objects within it, such as cutlery or pool balls, could present risk to patients or staff members. Nathan's accounts of distressing events such as violent assaults from patients that he has experienced on previous wards, also highlight how past experiences can be active in the present to shape his perceptions of spaces and how these environments are experienced day to day.

Throughout the narrative Nathan refers to the professional relationships established between colleagues on the ward and he highlights the reliance upon close teamwork and diligence amongst staff members to make sure the environment remains as safe as possible. Although Nathan's overall tone is positive, he expresses frustration about staffing levels and how the frequent secondment of staff members to assist on other wards depletes staff resources on his own ward. As he works in a low secure setting where patients are typically at the point of moving on to community-based life beyond, Nathan expresses particular concern about the reduced availability of staff to support patients with regular daily activities outside the hospital.

Nathan's storylines are focused around: (1) being cautious and having concern about risk within the ward environment, (2) having a sense of responsibility for the well-being of others, (3) valuing positive relationships and teamwork with patients and staff colleagues, (4) how material and spatial attributes of the environment can affect social activity, (5) reflections on improving the ward design and aesthetics and (6) how staffing levels can influence everyday experiences for both patients and staff.

During the interview Nathan discussed photographs of: (a) ward clinic room, (b) small side room (also referred to as interview room or quiet room), (c) dining area half of the day room, (d) bedroom corridor, (e) nursing office (main area), (f) nursing office (back-office area).

The analysis will draw on the first five of these storylines and focus on Nathan's observations about links between the everyday spatial experiences of patients and staff on the ward and relationships between both groups. In the following extract, Nathan's reflections on his photograph of the communal lounge and dining area suggest that the physical and social milieu in this space can influence interpersonal relationships between patients and staff.

Nathan: Extract 1

N: Um and then obviously we've got, we've got the dining room side. Which is quite a social sort of area again. Um, where the guys just sit and chat

R: Mm.

N: and have a good laugh again.

R: Yeah and as a member of staff working in that, in that sort of space, um, how, how do you, how do you tend to feel when you're in this, in this area, um?

N: That's probably the room that we most, it's a difficult room 'cause you're really relaxed in there. Because it is that sort of social environment where people will sit and laugh and have a good joke, but it's also the area where probably like 70 percent, 80 percent of attacks on the staff happen, is within the communal area like a lounge or something like that.

R: Mm.

N: Um, previously, on a different ward it was, I was attacked in the lounge area, um by a patient so, you know, but to me, like, it's a lot more of a positive area, because I see a lot more sort of good happening in that, um, it's just like that one, maybe two instances before, that sort of drags it down a little bit.

R: Mm. Mm. Yeah, yeah. And, um, do you have any sort of thoughts about, about the overall space at all and the, the sort of feeling of the um, of the environment?

N: Um, I think space-wise, like it's, it's OK, I mean we've, we've made changes and and things since we've moved here, with like the telly and things like that, lowering it so it's actually easier to watch, um, the pool table, the ping pong

table, they're all changes that we've made, 'cause when we first moved in it was very clinical I mean, as you can see it's like white walls, it's like white carpet and and red carpet and that's about it and they try to make it look a little bit less clinical, there's posters, there's picture, big picture on the wall that probably costs a lot of money that actually, men don't want to sit and look at fields with lavender flowers and things like that, so I mean, to us it doesn't necessarily feel like it's massively appropriate for our kind of people that we work with, but we try and make it sort of (*yawns*) excuse me, fit to the best that we can.

R: Mm. Mm.

N: Um, but I think regardless, it's still, a lot of the guys still see it as like a fairly nice room to be in and it's like bright and (*slight pause*) cheerful.

R: Mm, mm. What sort of, could you give any examples of um, some of things you've, you've sort of you've done to make it more appropriate or, or, or fit, um?

N: Yeah, so the, the TV used to be up on the wall up here.

R: Mm.

N: Um and when you're sitting round, the chairs are quite low again because they're all like, um, heavy duty furniture, so the chair's quite low, they're difficult to move to move around and people weren't wanting to spend the time in, in the lounge area, um, because you're talking of looking up at a TV that's 12, 13 foot off the, off the floor, to stop people from being able to like yank it down and things like that and so it

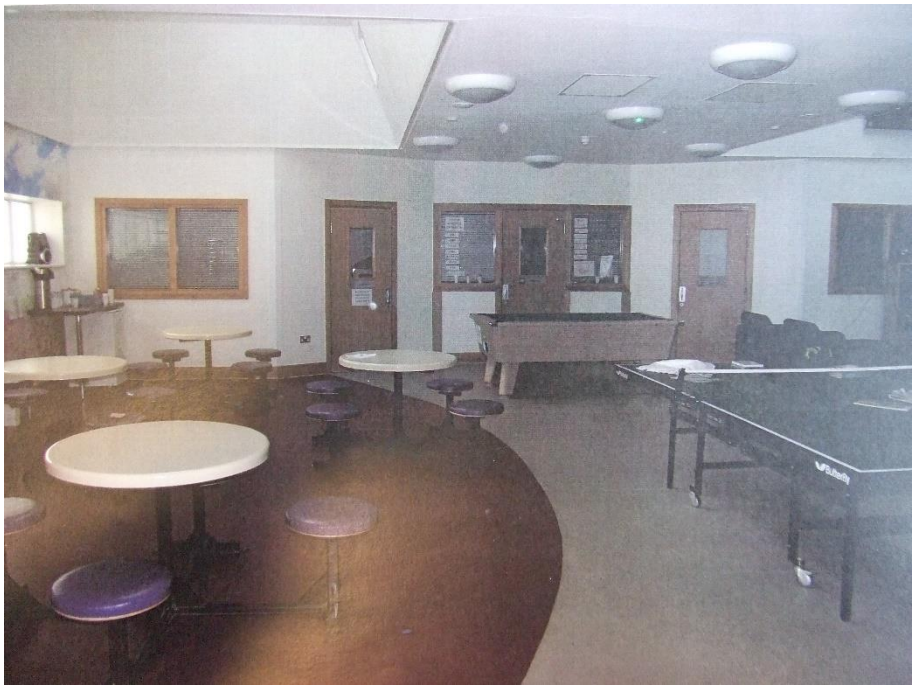
R: Mm.

N: it was a very anti-social space and we found that people were only coming coming together when it was dinner time and, and lunch time and things like that to sit at the dining tables, um, so we've got a new TV, we had to get all of like the wiring put in for it, but we got that and that's lowered and now we're actually finding that through most of the days and the evenings, like when we're here, we're putting films on and we're getting sort of like 6, 7 people watching films, I know like 6, 7 people doesn't sound like a lot but it's like, 70 percent of our ward will come out and sit and watch films or, or funny video clips and things like that.

Nathan's reflections on this space, which comprises a communal lounge with open plan dining area, present an image of frequent social interaction amongst patients and between staff and patients in this space. His descriptions of patients having a "good laugh" and a "good joke" together evoke a sense of informality and a typically amiable

and cheerful atmosphere. Nathan highlights his perception of paradoxical qualities within this space, however, by depicting it as both an enjoyable social environment where staff and patients can feel, "really relaxed", but also a place where staff must remain especially vigilant towards possible violence. The degree of potential risk within this environment is further emphasised to the researcher through Nathan's personal story of being assaulted in the day area on a previous ward. Recollections of difficult past experiences in similar settings are therefore understood to be present in his everyday experiences of spending time within the current lounge space.

Figure 11
Nathan's photograph of the communal lounge and dining area



Nathan talks about adjustments made to the ward that have aimed to address what he perceives to be the bland and "clinical" qualities of the design, including stark, white interior finishes. Alongside the addition of artwork to brighten up the space, attempts to soften the environment include the introduction of table tennis and pool tables to create a social focus of activity within the lounge. Elsewhere, Nathan also mentions how staff members who would, "historically sit in the office" now spend more time in

the lounge engaging with patients following the introduction of these communal games. The sociability afforded by the presence of the table tennis and pool tables is therefore understood to be promoting increased social interaction and influencing both patient and staff behaviour in this environment. As both these objects have a sizeable footprint and occupy three-dimensional space within the large volume of the day area, they can also be seen to be contributing to increased perceptions of closeness and a sense of conviviality amongst the people inhabiting that space. Furthermore, the addition of table tennis and pool tables has introduced forms of standing-based social activity to the lounge space, which create an alternative social dynamic when compared with more static seated interactions. Therefore, the fluidity of standing social encounters afforded in that space could also be argued to be encouraging the increased levels of informal and sociable interaction between patients and staff that Nathan observes there.

A largescale photographic artwork forms part of the adjustments made to brighten the day area, however, Nathan questions the suitability of the chosen imagery for the young male patient demographic on the ward. His comment suggesting that, "men don't want to sit and look at fields with lavender flowers and things like that" points to a disconnect between those specifying the artwork and their understandings of the individual patient groups who might inhabit that ward day to day. Elsewhere, Nathan also implies a sense of limited choice when referring to the ward artwork having been selected, "from a very bland catalogue of like generic, autumnal forestry scenes and things like that". Nathan's photograph of the space indicates that the image he refers to is applied to the wall of the day area as a large-scale mural. His speculation that this artwork, "probably costs a lot of money" also alludes to his impression of the mural as a well-intentioned, but not fully optimised investment for that space. Despite his assessment that the imagery is not well matched to the patient group, however,

Nathan observes that the overall day area, where some adjustments have been made to the environment, is generally perceived by patients as a "bright" and "cheerful" space.

Nathan's reflections on the nature-based content of the mural artwork can also be considered in reference to existing research exploring how different styles of art are experienced in healthcare settings (Nanda et al., 2008, 2011; Ulrich, 1991). A study by Nanda et al. (2011) undertaken in a psychiatric context examined patients' responses to different artworks displayed rotationally on the lounge walls within an assessment ward. A significant reduction in pro re nata (PRN) medicinal treatment for anxiety and agitation (i.e. medication dispensed as and when needed) was observed when artwork containing naturalistic landscape imagery was displayed, in comparison to an abstract image, or the control condition with no artwork. Earlier studies have also reported positive responses from patients to artwork containing natural images and negative reactions to surreal, abstract or ambiguous art, in both general hospital settings (Nanda et al., 2008) and psychiatric healthcare environments (Ulrich, 1991). Although research examining occupants' responses to artwork in mental healthcare settings is limited, the existing literature points towards potential psychological benefits of artwork containing nature-based imagery. Nathan's observations highlight, however, that artwork proposals should ideally be site-specific and be fully considered in relation to the intended environmental context, such that the content and imagery is tailored appropriately for the users of that space.

In a surprising contrast to its intended function as a communal lounge, where social interaction would typically be expected to take place, Nathan regards the day area before the adjustments as a, "very anti-social space". Based on his own observations, Nathan notes that patients did not typically spend time in the lounge previously and implies that the awkward relationship between the low seating and television positioned at high level was a contributing factor to this. By highlighting how the television has since been lowered to a more typical domestic height, Nathan argues

that this intervention has significantly influenced behaviour, such that patients now enjoy spending time there together, including watching films with other patients and staff. The adjustments made to the day area can accordingly be understood to have increased levels of perceived physical comfort in the space and in turn improved patients' perceptions of psychological comfort there. In the following quote, Nathan provides further elaboration on his thoughts about how patients might experience time spent sitting in that space and watching the television as a communal activity.

> "[…] Um, we watch like funny clips and stuff like that 'cause we, we tend to find that, um, like funny [*name of channel*] videos and things actually increases the morale of everyone, because everyone sits around and laughs and jokes. I think sometimes, think like the patients, a lot of the guys sort of think, you know like, I'm, I'm here, but if actually I've not just fallen face first into a muddy puddle and they have a good laugh and joke about it and I think it can put, sort of things into perspective a little bit, but we watch a lot of different types of films with them."

Nathan's account suggests that the collective experience of enjoying films and funny videos in this space can lift spirits and encourage a shift in patients' sometimes downcast thinking about their individual circumstances, towards a more hopeful state of mind. The shared social interactions in this space, including film watching and playing games together can consequently be interpreted as communal forms of 'liminal affective technology', that are drawn upon to enable transition between affective states (Stenner, 2021; Stenner & Zittoun, 2020). These processes of affective transformation can also be argued to be helping patients cope with the 'spontaneous', or unforeseen liminal experience of 'crisis' brought about by psychological distress and involuntary detention in hospital (Stenner, 2017). This liminal experience is enduring, however, and patients' experience of being detained in hospital can thus be interpreted as a 'liminal hotspot' (Stenner et al., 2017), in which they are 'suspended' indefinitely in an indeterminate position between their past and future lives. Furthermore, as Turner (1969/1996) argued, the shared 'interstructural' experience of a liminal situation can

be socially equalising for those going through a transitional experience together. Consequently, collective liminal experiences may also give rise to a sense of *communitas*, or an intense feeling of fellowship amongst participants.

A sense of *communitas* being experienced in the lounge is evoked through Nathan's narrative and additionally, he implies that a sense of solidarity is heightened by the social activities, such as playing pool with staff, which enhance participants' collective perceptions of equality. It could hence be argued that the experience of group social activity amongst patients (and between patients and staff) is contributing to increased perceptions of community spirit and cohesion within that space. Nathan's story also implies that having shared perceptions of being in a better position than unfortunate people experiencing comic mishaps in film clips can increase patients' sense of togetherness and prompt alternative perspectives towards their own circumstances. Moreover, social interaction and the joy of shared humour can also be argued to be diminishing staff-patient status distinctions and hence enabling a greater sense of parity, which in turn might enhance relationships between both groups.

In the following short extract Nathan later reflects further on how aspects of the current ward design might contribute to improvements in the quality of relationships that he observes and experiences there, when contrasted with staff-patient interaction in the previous ward environment.

Nathan: Extract 2

R: Sure. Um, just thinking about your relationships with other people, whether you feel there are any ways in which, um, they are affected by, by the environment that you work in?

N: Um (*slight pause*), no I think now that we're in the building that we are, I think the environment and the relationships

R: (*Coughs*). Excuse me.

N: with like the other patients in this environment are quite a lot better, mainly because obviously like a lot of boundaries have gone like, just stupid things like the dining room is now more like a lounge dining room, there's a lot of like our boundaries that might cause issues with our relationship with patients, like,

'no you can't leave the dining room because there's still cutlery', has gone, like naturally through the fact that there's no walls or doors

R: Mm.

N: um and a lot of the ward now is, it's a lot more like less restrictive, that we can take people into what would used to have been like a staff only area, like the servery to go and wash up and just through things like that I think the environment, the new environment we're in is helping relationships quite a lot more between us and patients and us and other members of staff.

When compared with the previous ward, Nathan suggests that the reduced number of internal partitions and doors between spaces inside the current ward environment has had a positive influence on the interpersonal relationships experienced and observed there. The narrative presents such physical divisions within the ward as symbolic barriers that contribute to tensions experienced between staff and patients in a secure setting. Nathan's story of patients not being permitted to leave the dining room in the previous ward until all the cutlery had been counted in presents an image of routine, rules and an institutional environment imbued with perceived risk. Power imbalances between staff and patients are therefore understood to be emphasised at such threshold points between different parts of the ward, where staff are required to enforce rules and control patients' access to space. In contrast, however, the narrative implies that the open plan dining and lounge area in the current ward layout affords a smoother flow between spaces and accordingly reduces friction between staff and patients.

Elsewhere, Nathan notes that the use and return of cutlery by patients is still closely monitored within the open plan dining area on the current ward, however, his account suggests that the absence of a division between the lounge and dining spaces affords decreased perceptions of restriction for patients. The sense of increased autonomy associated with this may in turn contribute to reduced environmental tension and improved staff-patient relationships. Furthermore, the reduced quantity of physical barriers within the current ward can be seen to be helping diminish the

disparity in staff-patient status that is emphasised by the presence of spaces that are visible to patients but only accessible to staff. By contrast, Nathan's report of some patients clearing up in the servery with staff at mealtimes creates an image of trust and teamwork within a shared environment. Collaborative activity between patients and staff within communal spaces on the ward could thus be interpreted as being helpful to fostering a more collegiate and equal atmosphere between both groups.

In contrast to his experiences in the lounge, Nathan reflects in the following extract on his emotional responses to working in a side room on the ward where the distinctions in staff-patient status and power relations are overtly expressed. The room is used for multiple purposes and Nathan talks specifically about his experience of its use as a space where staff must "search" patients for security reasons when they re-enter the ward after spending time outside the building.

Nathan: Extract 3

N: And for me again, it's probably, it's, it's the room that we bring our patients in when they first come, um, back on the ward after they've been off the wards, so, um, in there like your risks are around a patient's brought a weapon in or something that they shouldn't have brought in and that's the room that you'd find it, um, so obviously there's a lot of anxiety around like and when I search there's something on them that could hurt me or the other people that I'm here to, to look after, both staff and patients.

R: Mm.

N: Um, so that's probably where a lot of the anxiety comes from in that area, I mean it's used for a lot of positive sort of things as well, there's guys that make make models, like have sessions on model making and things in there and music sessions, so it's not just sort like a, a search room as such, it's used for sort of general purposes, but I think the, the searching of people in that room is what carries a (*slight pause*), like a bit of anxiety around what are they doing, what are they bringing in? Are they trying to hide something that they don't want us to find if I pat them down and I've touched their pocket, they've got something in there, how are they going to react?

R: Mm.

N: Um and it's just all sort of things like that.

R: Mm. Um, so typically, um, any patient who's been out of the ward during the

day, um, would, would, would come in here with staff

N: Yeah.

R: before entering the um, the main

N: Yeah.

R: area? Right, yeah. Yeah and do you think there's anything about the sort of, about that space, um, or um, you know, the, the, the sort of environmental conditions that um, affect your feelings when you're in there or, um?

N: Um, no I don't think there's anything like, specific, um, I think a lot of it is just around, um, again it's like fairly, it's not isolated area on the ward, like there's a lot of windows out on to the main corridor, so you can sort be seen by others, but it's off the main ward area, um (*slight pause*), like it's not, um, it's not like, pa-, people don't pass so frequently through like the course of 5, 10 minutes unlike the lounge or the bedroom corridor and things like that, so it is fairly sort of isolated.

R: Mm.

N: I think that with then with then what you're in that room trying to do, to search for things, just sort of heightens the anxiety around it a little bit.

R: Mm, mm. Sure. Um and in terms of the more positive, um, experiences, that, that take place in there, um, do you have any sort of reflections on um, how, that space might be, um, perceived by people using, using it?

N: Yeah, I mean I think see it, obviously like, large, the vast majority of our patients have never sort of brought anything in or attempted to bring anything in that they shouldn't have, one or two like you would expect one or two have tried, um, so I think, sort of, it is more of a positive room, er, like we go to the kitchen or something and there's a music session going on and we can hear them like singing and playing guitar and things like that, so it is quite a like relaxing room at times.

R: Mm.

N: Um and they make like models and paint and, and do things in there as well, sort of, um, with OT staff, or if they wanna go on the, the laptop, a ward laptop, then they go in there so it's, it does have a lot of positive uses, but I think the, like the sort of, not negative, but that one sort of use of the room, um, sort of outweighs it for me.

The side room described here sits within the secure demise of the overall ward and is located off the entrance corridor that is passed through to access the main ward area. Nathan's repeated account of experiencing, "anxiety" as an emotional response to this room underscores a heightened awareness of safety and the risks associated with his

role when working in this space. Nathan's concern is related not only to his own safety, however, as his description of, "other people that I'm here to, to look after" also conveys his sense of personal responsibility for ensuring the well-being of all his colleagues and the other patients on the ward. The narrative hence alludes to a link between Nathan's anxious state and his concern to be sure that 'contraband' items are intercepted, that is in turn associated with his sense of responsibility for the potentially serious consequences of something being missed. This image of possible danger and threat in the environment is underscored by Nathan's apprehension that a "weapon" might be brought onto the ward and his related concerns about potential physical harm to himself or others.

Figure 12
Nathan's photograph of the side room

The narrative accordingly conveys Nathan's typical state of unease in relation to searching patients and creates an image of him entering into the unknown within this room. A sense of unpredictability is further reinforced through his rhetorical questioning about patients' behaviour, including his concerns about, "what are they

doing, what are they bringing in?" and if challenged, "[…] how are they going to react?". These questions build up an impression of Nathan's disquiet about this aspect of his work and highlight the mistrust towards patients that is implicit in the process of searching by staff. In contrast, the physical intimacy that is implied through Nathan's account of having to, "pat them down" during the search process would require patients to put their trust in staff. This may be especially difficult, however, for patients in secure settings who have commonly experienced distressing life events, including violent discord between parental figures and physical or sexual abuse (Coid, 1992).

Nathan's wariness towards patients when searching thus highlights how a balance of trust between patients and staff can be disrupted by the activity in this space. Nathan also mentions that he is especially mindful when working with patients in this room, as he perceives it to be more isolated than other areas of the ward. Some of his anxiety about working in this space may therefore also be associated with the implied consequence that colleagues might take longer to respond in the event of an emergency there. Furthermore, Nathan's account suggests that the specific nature of the searching activity taking place and its unpredictable outcomes, including the potential to encounter "weapons", can intensify his concerns about safety and sense of isolation from the rest of the ward when working there. As illustrated by the following quote, Nathan also expresses concern elsewhere about physical safety when working alone with patients in other spaces on the ward, including the clinic room, which contains a number of objects that he perceives could potentially be used as weapons.

> "[…] obviously there are a lot of like dangerous and risk items in there, like needles, glass bottles and obviously, (*slight pause*) drugs, like cabinets and, and medication trollies with drugs in um and particularly, one of the guys that we're having to observe to take his medication in there is quite risky at the moment."

Nathan's role also includes responsibilities for monitoring patients' physical health, which take place here and he describes how he may also spend time in the clinic with patients who have self-harmed and therefore may be at a "crisis point in their life". The small scale of the environment where Nathan perceives that, "you could probably only fit like, sort of three staff" to assist with managing highly distressed patients if required, plus its relative isolation are all factors which contribute to his sense of anxiety when working there.

Nathan's story about the side room also highlights how this space is typically used for multiple functions. Therefore, in addition to being a room where staff undertake searches and patients experience being searched, it is also a place where both groups might spend time in therapeutic sessions, including music and craft activities. The multi-purpose functionality of the room accordingly highlights its ambiguity as a space that houses activities with both carceral and therapeutic connotations for patients and staff. Both groups might potentially experience distress or concern associated with the search processes in this room, but it is also a space where patients and staff may be involved in therapeutic sessions. Affective responses to the room may therefore be influenced by both the activity currently taking place within it, or by previous activities experienced there. Nathan captures his own ambivalence towards the space by describing his perception that it can also sometimes be a "relaxing room" and his appreciation of overhearing patients' music sessions taking place there at other times. For Nathan, however, his affective experiences and concerns linked to the security-related function of the room are understood to overshadow his appreciation of its more "positive" and therapeutic connotations. Through this story, Nathan also draws attention to a sense of paradox inherent in the work of staff members in secure settings, whose professional identities can be seen to be suspended within a role with both carceral and caring responsibilities.

When used for security checking purposes, the room represents a transitional zone and a symbolic threshold between the 'outside' world beyond the building and the 'inside' world of the main ward area. The narrative thus implies a sense of this space sitting betwixt and between these different worlds and representing a form of 'no-man's land' between the two. For patients, passage through this indeterminate space could also be interpreted as a liminal process of transition in which their perceptions of self-identity might shift from being members of the wider outside community, to re-assuming the status of detained patients in a secure setting. Nathan's concern about unknown items being brought onto the ward also presents an image of possible 'contamination' and a sense in which potentially harmful objects from the external world might enter and disrupt the sealed and closely controlled internal environment.

6.3 Bradley

Bradley is a patient in a low secure psychiatric ward and mentions that he has been detained in hospital for several years. He talks about having a need to get out, as he feels that his time to move on from the hospital is now long overdue. Bradley's narrative tone throughout is generally upbeat and he is optimistic about the future. He describes thinking ahead to independent living in the community following discharge from hospital and potentially moving in with his girlfriend.

Bradley describes the enjoyment and sense of freedom he experiences when taking part in activities within spaces off the ward. In particular, he enjoys the sessions that take place in a vocational skills centre located on the hospital site. His narrative implies that spending time in this environment has a different quality to being on the ward. He feels an increased sense of independence when working there and perceives that he is less overlooked by staff in this setting. He also appreciates the various skills gained, including achieving proficiency in wood working, through his regular sessions there. Bradley especially values the staff members at the centre, who he describes as

friendly, supportive and accommodating in terms of enabling him to work at a pace to suit his energy levels.

Bradley presents himself throughout the narrative as a down to earth and jovial person who enjoys social interaction and sharing a sense of humour with other patients and staff. He also appreciates the sense of connection and close bond with other patients that he feels is generated by living together in a communal environment.

Bradley's main storylines focus around: (1) how spaces affect social interaction and relationships with staff and other patients, (2) enjoyment of learning skills through activities and responsibilities, (3) how activities create a sense of focus and provide things to look forward to, (4) how his affective responses to environments are associated with the physical attributes of spaces and (5) the importance of having connections to nature and outside world.

Bradley reflected during the interview on photographs of the shrink-wrap machinery he uses during sessions in the vocational skills centre.

The analysis will draw on the first, third and fourth storylines to focus on Bradley's observations about connections between the physical layout and spatial affordances of the ward and the quality of social interaction between patients. In the following extract, following a question from the researcher, Bradley reflects on the overall ward environment and the communal day areas specifically.

Bradley: Extract 1

R: […] Um, and I wondered, you, um haven't included any of the, of the ward environment, I wondered was there a reason, um, for that, or do you have any, any thoughts about the, space here at all?

B: The ward is really good.

R: Yeah.

B: It's really (*slight pause*), I don't know how to put it. It's really service user friendly.

R: Mm.

B: There's a TV in the lounge, there's a pool table, there's a table tennis table and what I like about it is, the fact that dining area is part of the lounge so it's not a

separate room.

R: Yeah, yeah.

B: Yeah.

R: And, do you, how do think that impacts on how people, um, feel in the space,

B: People

R: having it open?

B: interact a lot better. Yeah. They interact.

R: Interact? Yeah. Yeah.

B: Because, for example, if you're in the dining area and there's someone in the lounge area, you can literally like call them over.

R: Yeah.

B: Instead of having to go round to their room or go to a separate room.

R: Yeah.

Whilst Bradley did not choose to take photographs of spaces on the ward, he expresses a general sense of satisfaction with the overall environment. His comments that the ward is "really good" and "really service user friendly" evoke positive imagery of a patient-centred environment and suggest that he perceives the design of spaces on the ward to be meeting patients' needs. To support his account of the ward as a "service user friendly" environment, Bradley lists various pieces of equipment (e.g. the television, pool table and table tennis table) that are on offer in the lounge to afford leisure activity and facilitate social interaction. Through this narrative, he draws on wider cultural understandings of playing games, or watching television with other people as typically sociable and entertaining pursuits. The affordance of positive social activity between patients is therefore understood to be a significant factor in Bradley's appraisal of the communal areas on the ward. He accordingly presents the list of available activities to the researcher as evidence of the ward being well-equipped and able to offer a variety of options for enjoyable pastimes that can promote social interaction.

Bradley's ward has recently moved from another low secure environment and his comments on, "what I like about it", in reference to the layout of the current ward are understood to be made in comparison to his experiences of the previous setting.

Bradley's account of the dining area being part of the patient lounge expresses his appreciation for the lack of division between the two spaces, whereby the social activities associated with each are combined into a single overall environment. His story also implies that the improvements in social interaction he has observed since moving to the current ward are linked to patients' embodied experiences in these more open and interconnected communal spaces. Improved social interaction amongst patients is therefore presented by Bradley as a beneficial attribute of the current ward. His observation that patients interact a lot "better" in this setting also presents an image of reduced friction in the environment and a sense that the spatial conditions are facilitating positive social interaction rather than working against it. Bradley's narrative thus implies that a greater sense of unity and esprit de corps is experienced by patients in this more integrated environment, where the flow of communication has been eased by increasing visual and acoustic connections and removing physical barriers. His account of the day area also evokes imagery of contemporary living and the common combining of dining and lounge areas in domestic open-plan settings to optimise living spaces and enhance a sense of connectivity. Whilst Bradley describes his appreciation for the layout of the communal areas within the current environment, later in the interview he also reflects on specific advantages he perceives in relation to aspects of the previous ward design.

> **"**It felt more homely [*the previous ward*]. [**R:** Mm.] Yeah. [**R:** Yeah. Can you, can you think, can you describe any ways in which it, it, you know, it, um, how it felt more homely?] We had an upstairs, downstairs. So, upstairs was your bedrooms, downstairs was the lounge area, dining area, stuff like that."

The removal of the boundary between the dining and living areas on the current ward is positively regarded by Bradley, yet here he also expresses a preference for having a clear spatial distinction between the sleeping and living areas. These comments again generate imagery associated with more conventional residential environments, in

which the living areas are often located on lower floors, with the bedrooms on upper floors. Following Goffman's (1961/1991) observations that the borders between typical spheres of life, including sleep and leisure are generally taken away from patients in psychiatric institutions, this account implies that the spatial separation between floors has a role in maintaining a distinction between different types of activity. The staircase accordingly represents a transitional passageway that creates a sense of separation between the contrastingly 'public' and 'private' spheres of life associated with the communal living areas and bedrooms respectively. Elsewhere in the interview Bradley also describes how in the absence of another place, he currently considers the hospital environment to be his home. The differentiation between the sleeping and living areas created by the staircase on the previous ward can hence be interpreted as contributing to a valued sense of domesticity that might be experienced in more typical residential environments. Similarly, the sense of contemporary open-plan living and togetherness implied in Bradley's account of the lounge-dining area on the current ward can be seen to be enhancing patients' perceptions of the environment, that are in turn improving experiences of social interaction.

It is noteworthy that some participants across the data set also comment on how the dining rooms on wards can typically be under-utilised between mealtimes. The incorporation of the lounge and dining areas as described by Bradley can consequently be seen to be optimising the space on the ward made available to patients for leisure activity. Bradley's account of being able to call across to patients, instead of "having" to go round to other rooms implies his awareness and appreciation of experiencing ease and efficiency within the current communal area layout. A sense of convenience in the environment may also be particularly significant for patients detained on secure wards, who frequently spend much of their time waiting for things to happen and whose ability to move freely through spaces is generally limited.

In the next story, Bradley provides further examples of ways in which he perceives that the material environment can shape the quality of social interaction and relationships between patients on the ward. Bradley contrasts his previous ward with the current environment to suggest that the spatial differences experienced in the latter can promote and enhance social bonding between patients.

Bradley: Extract 2

R: […] Um and in terms of sort of sharing the space here with other people, is that significant to your experiences here?

B: Yeah, everybody enjoys being in each other's company.

R: Right.

B: Yeah, I find that with this ward, that since we've been on this ward, the lads that are on it with me bonded really well.

R: Right, right.

B: Yeah.

R: Yeah. Do you, do you have any idea of why that, why that, why that was?

B: I would say it's because of the space, 'cause in (*name of previous ward*), when it was mealtimes, upstairs was open while the bedroom area was unlocked, no, was locked

R: Mm.

B: and but here it's unlocked. So instead of having, instead of thinking to yourself, right, 'I want to go to my room now',

R: Yeah.

B: we can go to our rooms any time.

R: Right. Yeah.

B: And, I reckon that has bigger impact because people don't want to be in their rooms all the time. 'Cause they're not forced to stay out of their room.

R: OK, so it's yeah.

B: Yeah.

R: They, they're wanting to spend more time.

B: Yeah.

R: Yeah, yeah, yeah. That's good. Yeah. So and are there any other sort of aspects about sharing, um, the space that, um, that's sort of, er, significant to you?

B: Yeah, we play pool, we play table tennis.

R: (*Coughs*). Excuse me.

B: Um, there's always somebody there to challenge. Which is good. (*Little laugh*).

R: Right. (*Little laugh*). A competitive challenge.

31. **B:** Yeah.
32. **R:** Yeah. (*Little laugh and slight pause*).
33. **B:** Friendly competitive challenge.
34. **R:** Of course! (*Laughs*).
35. **B:** (*Laughs*). Um, but there's no arguments, er and if two people have an
36. argument, then I leave them to it.
37. **R:** Mm.
38. **B:** I don't have any squabbles with anyone. I don't take anyone's side, it's up
39. to them if they want to deal with it.

When responding to the researcher's question about his experiences of sharing a communal environment, Bradley presents positive imagery of a typically harmonious environment and a sense of mutual appreciation amongst patients, whereby "everybody" enjoys spending time together. His account also indicates that the positive bonding he has observed amongst patients since moving wards is linked to their spatial experiences in the current environment. Whilst patients could not access the bedroom area freely throughout the day on his previous ward, Bradley highlights how they can now visit their rooms at any time. His account suggests that through experiencing a sense of choice and not being denied access to their bedrooms, patients paradoxically no longer have such a strong desire to be in them and consequently prefer to spend time socialising together in the lounge. Bradley's story also indicates how patients' spatial experiences in one area of the ward can be intrinsically linked to the social milieu or behaviour observed in other spaces.

Bradley's account of there being people available in the day area to challenge to a game of pool or table tennis evokes imagery of a convivial and typically populated environment. In addition to inviting recreational play amongst patients, these items of table-based leisure equipment may also be encouraging people to stand around watching or to dwell socially in the space. Whilst Bradley's narrative presents patients' interactions as typically good-humoured, his account suggests that experiencing a sense of "friendly" competition or challenge is significant to the enjoyment of playing

games and contributes to the pleasure of interacting socially with other people. Bradley thus indicates how the presence of this equipment in the day area is helping to build a sense of community spirit that is lacking in his account of patients previously preferring to spend time alone in their rooms rather than socialise together. Through this story Bradley emphasises the importance of experiencing a close bond or sense of fellowship with other patients and he evidences his perception of typically harmonious relationships amongst patients through his account of infrequent arguments. Elsewhere in the interview Bradley mentions that he has lived with some of the same patients for several years and through his account of avoiding disputes with other people, he presents himself to the researcher as being typically friendly and laid-back.

6.4 Estelle

Estelle is a mental health nurse who works on a low secure psychiatric ward. She has also had several years' experience working in the hospital on rehabilitation wards before moving to a low secure environment. Estelle's overall narrative portrays her as a thoughtful and empathetic person who is concerned about quality of care and patients' everyday experiences in hospital. For example, stories of her daily activities typically highlight staff-patient interactions and include reflections from her own perspective about how patients might feel frustrated or uncomfortable when detained within a secure environment. Estelle reflects throughout the interview on the ways that the ambient or physical qualities of the environment may be associated with how patients or staff might feel when inhabiting different spaces on the ward. She considers especially how the direct adjacency of some spaces to others might be experienced by patients as uncomfortable or exposing and describes attempts to afford patients and their visitors the greatest possible sense of privacy.

Estelle's accounts of relationships and interactions with patients on the ward convey an underlying tone of professionalism and compassion. She also highlights her belief in the importance of establishing a mutual sense of trust between patients and

staff and the value of building therapeutic relationships. Whilst Estelle acknowledges it can be very difficult at times when patients vent frustrations about their circumstances onto staff members, she describes her efforts to avoid feeling hurt or taking these situations personally.

The overall tone that underpins Estelle's narrative is positive and whilst positioning her role as demanding and often highly stressful, she describes her work as typically fulfilling and enjoyable. Estelle's reflections on her working life convey a sense of a collegiate environment where staff on the ward work closely together to form a mutually supportive team. She also highlights concerns, however, about how the regular reallocation of staff members to assist on other wards affects resourcing on her own ward that can impact adversely on the everyday experiences of patients and staff. Her comments highlight that reduced staffing levels on the ward can affect the availability of escorted leave and contribute to increased frustration in patients that may in turn be taken out on staff. Furthermore, Estelle observes that patients' expressions of frustration associated with limited staff resourcing can have significant consequences in terms of their progression through the system, including being moved back to medium secure settings.

Estelle's storylines focus around: (1) the role of the environment in efforts to improve experiences for patients, staff and visitors, (2) appreciation of positive relationships with patients and staff colleagues, (3) awareness of how spaces can facilitate or hinder social interaction amongst staff and patients, (4) how individuals' mood states can influence the overall ward ambience and affective atmosphere (5) how staff resources affect the everyday experiences of patients and staff, including patients' transition from low secure to community living.

Estelle reflected in the interview on the photographs she had taken of: (a) side room/quiet room, (b) kitchen/dining room servery hatch, (c) kitchen servery

equipment, (d) clinic room, (e) handover room, (f) activities kitchen, (g) dining table in activities kitchen.

The analysis draws on storylines one to four which contribute to Estelle's perceptions of how relationships between patients and staff and the affective experiences of both groups might be associated with spatial experiences or physical attributes of the environment. In the extract below, Estelle reflects on her perceptions of the servery adjacent to the ward dining area and the interactions between patients and staff in this area.

Estelle: Extract 1

E: OK, so this is the servery in the kitchen. Um (*slight pause*) that is, we have to give out the dinners now, um, which is a lot of work, er, it's quite challenging, 'cause we have to wash them up and and it's, you know, ten patients, it's, it's a lot, um, but at the same time, um, it's a chance to speak to patients and they all hang around the hatch and have a laugh and a joke, um, you know and I find that time is, it's nice because, you know, once you've given out the dinners, they're all sitting at the tables and you're standing at the hatch, you know and they just, yeah, banter and it's a nice time

R: Mm.

E: for interaction, good interactions. Um and that's why I took that picture 'cause, it is, you interact loads with staff and patients at that time, um, yeah.

R: Mm.

E: And and some of them, you know, they tell you, they'll be standing at the hatch start talking about anything that's bothering them, um, yeah.

R: Mm.

E: So it's not just about having a laugh, it's you know, they do open up at that time, 'cause, it's, it's an hour you know, just standing there and and talking.

R: Mm, mm.

E: So, I like that one.

R: Mm. Yeah, yeah. Shall we?

E: Yeah. (*Slight pause*) Yeah that was, sorry that was to, to prove that it was the kitchen.

R: Yeah.

E: But again

R: Yeah.

E: yeah, that's where we have our hot meals and dish them out to the patients and also staff are in the kitchen as well, again, it's a time where you're all interacting, you're all helping each other out, it's real-, like teamwork at that time, because we all know it's a lot of work, um, takes up to an hour, you know, with dishing out the food, washing, cleaning, everything.

R: Mm.

E: So you're all just helping each other, so again, in a stressful situation we will just come together and help each other. We have, er, a patient who comes in and cleans with us and um, then we have some that want to come and make their cheese toastie, so you know again, it's, it's like a big interaction for all of us, so that, it is quite a nice experience.

Estelle's initial reflections on her photo of the servery focus on the extent of work involved for staff in serving food to patients at mealtimes. Her description of how she and other staff members, "have to give out the dinners now" and "have to wash them up" presents these activities as both recent and required additions to their roles. Estelle also highlights the number of patients living on the ward as further evidence to the researcher about the amount of work entailed for staff within these additional duties. Whilst the narrative depicts this new aspect of her role as typically, "challenging" and "a lot of work" for staff, Estelle also conveys a sense of ambivalence by simultaneously positioning the associated interaction with patients and colleagues there as, "a nice time" and a rewarding experience. Alongside her expression of enjoyment in listening to patients' "banter" at the dining tables, Estelle's observation that patients will typically, "all hang round the hatch" to talk to staff contributes to an image of an informal and friendly atmosphere within that space. Patients can therefore be understood to be appreciating time spent with other patients there, but also to be enjoying having opportunities for social interaction with staff.

Figure 13
Estelle's photograph of the servery hatch (with the roller shutter down)

Figure 14
Estelle's photograph of the kitchen servery equipment

In contrast to some other areas of the ward, such as the nursing office, patients have immediate access to staff at the servery during mealtimes when staff are dedicated to an activity in which they are directly engaged with patients. The serving hatch also creates an opening between the servery and dining area to afford a direct physical connection between the two spaces and between staff and patients. The narrative therefore presents imagery of enjoyable social interaction and experiences of positive relationships between staff and patients. Experiencing the everyday domesticity of a space associated with serving food or washing up may also be a mediating factor in the positive social interactions between staff and patients described here. Furthermore, Estelle's depiction of patients, "standing at the hatch" and "standing there talking" implies that both the proximity to staff in that space and the informality of standing contribute to patients' ability to "open up" and confide in staff members who are also standing up in that space.

Estelle's description of the hour routinely allocated for serving and clearing up at mealtimes emphasises time-bound pressures for staff and she describes this hour as a period of intense activity. Despite portraying this activity in the servery as a "stressful situation", due to the volume of work required in a limited timescale, Estelle's account of mutual support and teamwork amongst colleagues working together presents an image of positive relationships and camaraderie in that space. Estelle's story also highlights how some patients also spend purposeful time in the servery on activities including helping to clear up after mealtimes or making "their cheese toastie". Instead of representing a 'staff-only' zone, the space can consequently be understood as an area of the ward that is shared by staff and patients. Estelle's description of the patient regularly cleaning up at mealtimes implies that a greater perception of parity with staff might be available to patients when working together there and a sense of satisfaction might be gained through contributing to the upkeep of the everyday environment. Through this story, Estelle also draws attention to the diversity of her own professional

role and how a variety of skills are required when working within different spaces on the ward during a typical day. Accordingly, within the following extract, Estelle describes the contrasting dynamics of nurse-patient interaction typically experienced when she is working in the clinic room on the ward.

Estelle: Extract 2

E: Clinic. Um, that is, I took that photo because they, again, that's another time where you're being, you, you know, it's personal, um, you have to get to know the patients and and it's that trust that you know, they don't want to be on medication, some of them don't feel they should be on medication and having to dish it out to, to them and having them put their trust in you, that you've given them the right dose, you're not trying to kill them, you're not trying to poison em, um, and again they open up, they can open up in that situation and also, you know, some of them will get chest pains and think they're dying or and then you take their blood pressure and you know, it's quite a personal experience, um, urine samples, you know all those sort of intimate moments that you share with the patient.

R: Mm.

E: And you know, so I took that photo because I just think it's, you know, a real personal room

R: Mm.

E: and

R: Mm.

E: they have to trust you in that moment so

R: Yeah, yeah.

E: and that's when you're, the nursing, caring side comes out when it's in that, in those moments.

R: Mm.

E: The clinic area.

R: Mm. Yeah, yeah.

E: And trust, real trust. Because they have to strip off and you know, you have to be so non-judgemental and not make them feel you know, horrible in any way so, um

R: Mm. Are there…?

E: that's very personal.

At the outset of her reflections on the photo of the clinic, Estelle's positioning of the room as a "personal" environment, presents an image of an intimate space on the ward

where she experiences a particular sense of closeness in her professional relationships with patients. Her photograph of this space also depicts an explicitly 'clinical' environment containing white metal medicine cabinets and medication trolley, alongside a pharmacy fridge and other pieces of medical equipment.

Figure 15
Estelle's photograph of the clinic room on the ward

In contrast to the sense of domesticity and parity between staff and patients evoked in Estelle's earlier account of working in the kitchen servery, the clinic is seen to be reinforcing unequal power dynamics in this space and the medicalisation of nurse-patient relationships. The compact footprint and scale of the room can also be seen to be enhancing the sense of intimacy that Estelle experiences when working here with patients. Her account highlights how the activities taking place in this space are personal and private to each patient and therefore contribute to her perceptions of the clinic as a "personal" space.

Accordingly, the narrative conveys how the degree of trust perceived in relationships between staff and patients is highly significant to the affective

experiences of both groups within that space. Estelle's narrative also points to the relational tensions that medication might produce between staff and patients, to whom medicine might be legally given without consent under the conditions of their section. In noting that some patients express resistance and concerns about taking psychiatric medication, Estelle's story alludes to how members of staff may be required to enforce compliance. Interestingly, however, this is framed more in terms of a trust issue for patients within Estelle's observation that, "patients have to trust you in that moment". Her report of, "having to dish it out", further emphasises patients' lack of choice and conveys a sense of her professional obligation to ensure that medication is correctly dispensed. This account is also presented in contrast to her earlier story of "dishing out" food to patients at the servery and these illustrations of her activities in both spaces allude to a sense of repetition and the regular daily routine of mealtimes and medication times within institutional settings. The contrasts between these duties and Estelle's associated interactions with patients when working in both spaces again highlight the diversity of her professional role. In conjunction with her reflections on serving meals, Estelle's account of the "nursing, caring side" of her work being dominant here therefore alludes to how staff must transition between diverse aspects of their roles and professional identities when working in different spaces on the ward.

Estelle's account of how patients must place "real trust" in staff underscores her perception of how staff-patient relations are especially important in this space where patients may not typically feel at ease. The narrative illustrates how creating a sense of comfort and reassurance within a trusting relationship is a significant factor in enabling patients to "open up" and confide in staff about their health concerns. Estelle's reflections also highlight the varied range of responsibilities for staff, who must also monitor patients' physical health and undertake medical tests and procedures in the clinic room. Through her description of patients having "chest pains" and being concerned about "dying", Estelle presents an image of patients seeking reassurance

from staff and experiencing intense affectivity within the clinic. The narrative frames these concerns as somewhat irrational, yet experiences of chest pains and heart issues are not uncommon in people taking psychiatric medicine (De Hert et al., 2012; Mackin, 2008). Accordingly, patients' experiences of acute vulnerability as implied here might also be brought about by the medication itself. Estelle's description of medical processes and patients having to "strip off" in the clinic presents an image of physical intimacy between patients and staff being experienced within that space. Her account of being "non-judgemental" towards patients and concern not to let patients who have removed clothing to feel, "horrible in any way" conveys her awareness about patients' perceptions of self-esteem and alludes to how body image may be a concern for some patients in psychiatric settings. Indeed, patients taking psychotropic medication may commonly experience side effects, including weight gain that can significantly diminish self-confidence and self-worth (Every-Palmer et al., 2018; Waite et al., 2022). It is noteworthy, however, that Estelle's reflections do not explicitly link psychiatric medication use with patients' concerns in relation to body image, or low self-esteem.

6.5 Concluding comments

The stories discussed within this chapter have demonstrated varied ways in which interpersonal relations in secure settings may be linked to staff and patients' everyday experiences of space in the hospital environment. The narratives accordingly illustrate how participants' spatial experiences can affect interactions between staff and patients and relationships amongst both groups.

Throughout the narratives explored, participants' stories have again highlighted the affective significance of architectural elements, such as walls, windows and doors that divide or contain the hospital spaces. Interpretations of the narratives position these commonplace features of the built environment as symbolic thresholds that typically occur at transitional points between different 'worlds' or forms-of-process (Stenner, 2017, 2021). Physical passage between such worlds is generally controlled by

staff and participants' stories reveal how relational tensions within the ward are often heightened along these material borders between contrasting circles of staff and patient activity. Reports of intense affectivity experienced or observed by both groups on either side of these thresholds, including feelings of stress and frustration, are common across the narratives. Accordingly, participant accounts reveal that patients and staff may both experience psychological and embodied discomfort within spaces on the ward, which can affect interpersonal relations and social interaction amongst and between both groups.

Participants here and throughout the data set frequently reflect on their responses to windows or glazed partitions within the everyday environment and the contradictory nature of glass as a paradoxical material that can both connect and separate people simultaneously. Accounts hence illustrate that the visual link created by windows between spaces that are otherwise physically and acoustically separate, can exacerbate feelings of frustration that may contribute to discord or conflict amongst patients and staff. Participants' stories particularly highlight the connections created by glazing between areas that have distinct aesthetic and functional identities, such as the nursing office and patient lounge. Although these spaces remain physically separated, the glass allows their incongruent visual identities to be combined into the misleading appearance of a single world that comprises both lounge and office.

This sense of duality and the ambiguous status of the visually combined, but functionally separate worlds of the patient lounge and nursing office can therefore be seen to be intensifying the psychological unease frequently experienced there by patients and staff. Mike's observations about the lounge's lack of success as a place where patients might wish to spend time socialising or relaxing also points to one of the overarching tensions apparent within secure psychiatric facilities, whereby for patients, the ward environment constitutes both 'hospital' and 'home'. The narratives also suggest that internal glazing might contribute to discomfort experienced in spaces

on the ward by creating the perception of an exposing glass vitrine that frames the positions of both 'observer' and 'observed' on either side.

Participants' narratives allude to how material aspects of the ward may be experienced as divisions that physically separate staff from patients and symbolically emphasise their differing status positions and liberties. Stories explored in this chapter highlight how patients may be drawn towards and feel more comfortable in spaces that enable direct access to staff members and offer opportunities for staff-patient social interaction. The removal of spatial barriers is hence described as enabling an improved sense of 'flow' within the environment, which can offset perceptions of restriction and reduce relational tension by combining spaces into integrated worlds or circles of staff and patient activity.

The narratives indicate that a reduction in the friction that commonly occurs at the meeting point between contrasting worlds can in turn improve relationships and communication amongst occupants of the ward. Participants' experiences thus indirectly suggest that where fewer material boundaries occur within spaces, there is also an associated reduction in the prevalence of symbolic features, such as doors and locks, which can serve as unhelpful reminders of the unequal distribution of power between patients and staff. Estelle's experiences of the servery hatch accordingly reveal how the open physical connection between patients and staff there encourages perceptions of parity and closeness that can enhance communication and positive relationships between both groups. The absence of glass in the servery window can be seen to be connecting the spaces and activities on either side into a combined world. Without the physicality of a glass sheet to see or be seen through, it can also be understood that occupants' perceptions of surveillance may be diminished there, which might in turn contribute to greater perceptions of psychological comfort in that space. In contrast to the expression of heightened tension along the borders between different worlds that are both connected and separated by glass, participants'

narratives imply that improved social relations are perceived within physically connected worlds or spaces where staff and patient circles of activity are combined.

The narratives also convey how the multi-sensorial aesthetics and environmental ambience of spaces on the ward can influence occupants' interpersonal relationships and behaviour in those environments. Within communal areas that are frequently described as bland and clinical, the lack of atmospheric warmth and colour is portrayed as discomforting and unconducive to promoting relaxation and social activity amongst patients and between patients and staff. The scale and layouts of spaces, including furniture arrangements are also seen to affect participants' perceived levels of comfort, that can in turn influence their experiences of conviviality or a sense of community in different parts of the ward. The layout of furniture and ergonomic arrangements within spaces can thus limit or promote social interaction and the narratives imply that smaller scale environments can bring people closer together socially, whereas over-scaled spaces might push people apart. The volume of overly large communal environments as described here, plus their architectural finishes and the sparsity of objects within them may also contribute to the creation of an unsettling acoustic environment that can compromise the enjoyment of, or potential for social interaction within spaces. Physically and psychologically uncomfortable environments are therefore seen to discourage social interaction and may typically be regarded as transitory spaces as opposed to being experienced as inviting places to dwell.

By contrast, the narratives indicate that standing-based social activity can create an informal and flexible atmosphere that may enable a sense of ease within spaces on the ward. The stories told highlight how informal interaction amongst patients and between staff and patients can occur when standing around in areas including the bedroom corridor, day areas and the dining room servery. In contrast to accounts of the sense of routine and restriction imposed by the ward, the narratives indicate that spontaneous social interaction can be experienced and appreciated by

patients and staff when standing in these spaces. Nathan, Bradley and Mike's accounts of standing-based social activities within day areas and Estelle's observations of patients and staff standing together informally around the servery hatch highlight how standing is typically associated with a more flexible social dynamic than seated interaction.

Accordingly, it is suggested that occupants may experience a sense of comfort in spaces where the nature of social interaction is fluid and informal. Conversely, standing-based activity can also be seen to be less relaxed and more alert than sitting, such that it is possible to move more quickly from a standing position than when seated. Correspondingly, this could imply an association between perceptions of safety and a sense of psychological comfort for both patients and staff when standing in this setting. Estelle's experiences at the servery hatch reveal how meaningful and important ad hoc conversations between patients and staff can also be prompted when standing informally or moving around in spaces together. Mike's account of impromptu social activity within the bedroom corridor presents an image of social dynamics like those which may occur in a domestic house party, where guests might typically prefer standing together socially in smaller spaces to sitting less flexibly in larger rooms. The narratives hence indicate that fluid social dynamics within spaces on the ward can improve perceptions of flow and flexibility within the environment that can contribute to reduced friction and relational tension. Significantly, however, whilst perceptions of physical and psychological safety were key to enabling patients and staff to be able to feel relaxed, participants' accounts also highlighted how spaces on the ward could be experienced paradoxically as simultaneously relaxed and dangerous.

Participants also talk about how group activities within spaces on the ward can afford collective social experiences for patients and staff. Group activity that contributes to a sense of equality between staff and patients is described as able to enhance perceptions of community and togetherness in the ward environment. Spaces

are appreciated for enabling collective social interaction and facilitating shared experiences between staff and patients, including the simple pleasure of laughter, that can create a sense of parity and enhance relationships between both groups. Bradley's reflections on the communal areas of his ward suggest how the availability of leisure equipment (including table tennis and pool tables) actively encourages enjoyable social interaction and facilitates a sense of community on the ward.

Participants' stories suggest that movement through different spaces within the ward, or physical transitions between the hospital building and the world 'beyond' its boundaries may be associated with shifts in perceptions of self-concept or status positions for both patients and staff. For patients, physical transition between the different worlds within and beyond the building may be associated with shifting perceptions of self-identity and transition between the position of a detained patient in a secure institutional environment and a member of the wider community. Nathan's reflections about the process of searching patients within the side room accordingly position this space as a liminal zone which patients must navigate when physically and symbolically transitioning between the wider world outside the hospital and the inside world of the ward. The description of this in-between space thus implies a sense of distinction between these internal and external circles of activity and presents an image of institutional attempts to avoid 'contaminating' objects from the outside world entering the 'sterile' inside world of the ward.

Participants' observations reveal how relational tensions may exist within transitional or ambiguous spaces where the structures of different worlds can be seen to have been broken down. Nathan's account of his unease when searching patients in the side room, illustrates how activities within spaces that represent a transitional threshold between contrasting worlds, or identity positions, may be uncomfortable for both patients and staff. Stories such as this also point to inherent contradictions within the professional identity of staff in secure psychiatric settings who undertake a role

that has both caring and carceral responsibilities. Participants' accounts suggest that interactions taking place within different spatial and social contexts, both on and off the ward, may require staff to move between contrasting self-positions in their relationships with patients. This might include transitioning between an authoritarian role and more equitable 'peer-like' relations with patients when collaborating together or interacting informally in some spaces on the ward.

The nurse-patient relationship is a primary therapeutic tool within mental healthcare and a sense of trust is essential to building positive relationships between patients and staff (Gilburt et al., 2008). Participants describe complex negotiations around mutual trust and the narratives highlight how patients must engage in activities that require their trust in staff, yet staff members must also interact with patients on duties which convey a lack of trust. Nathan's account of socialising in the lounge with patients, despite his past experience of being attacked by a patient, illustrates how this is also the case from a staff perspective, whereby trust is required in a climate where there is mistrust. Participants' experiences of activities in spaces where perceptions of trust are at stake are thus described as being highly affective. The narratives also convey how spaces on the ward can be perceived contradictorily by staff as environments that are simultaneously both relaxed and dangerous.

The stories imply that awareness of risk and potential physical harm influences perceptions of the environment and the physical adjacency of spaces can contribute to staff concerns about safety and being isolated from colleagues' support in the event of an emergency. Mutual trust and a sense of teamwork amongst staff members are understood to be relied upon heavily to mitigate risk and help maintain safety within the ward environment. Teamwork experienced between patients and staff is also valued and can be afforded within spaces on the ward where both groups are able to collaborate on activities with a sense of equality. Spaces that afforded greater perceptions of equality and connectivity between patients and staff were therefore

understood to be assisting with building up a sense of trust between both groups that was perceived to be vital to the development of positive therapeutic relations (Gilburt et al., 2008).

Chapter 7: Discussion and conclusions

In the context of limited empirical exploration regarding the everyday experiences of patients and staff within the environments of secure psychiatric care, this thesis provides a close examination of staff and patients' lived experience, in its embodied and affective sense. Participants' experiences have been interpreted through a theoretical framework that integrates a psychosocial process account of experience with narrative psychology and the transdisciplinary concept of liminality. The primary research aim was to explore how participants make sense of their experiences in secure psychiatric settings through photographs and narratives and examine the role of space and environments in mediating affective experience. Through investigating how staff and patients inhabit the organisational spaces of institutional care, the research has also sought to examine how secure mental healthcare facilities can afford supposedly 'private' spaces inside their own 'public' spaces.

This visual-qualitative study employed semi-structured interviewing with 19 participants, in conjunction with participant-produced photographs, to invite patients and staff to talk about their everyday experiences of spaces in secure mental healthcare settings and the feelings or emotions associated with these environments. Together with the researcher, each participant constructed narratives around the spaces and objects presented in the photographs and offered reflections about their experiences in response to questions raised during the interview. The study aimed to ground patient and staff recollections of lived experiences in these material contexts, by focusing on images of physical spaces or objects within the everyday environment. Accordingly, it was envisaged that this approach would assist participants in recalling and reflecting on their embodied and affective experiences within specific physical settings, or recounting events that had taken place within them. Through this combination of visual images and narratives, staff and patients produced detailed and nuanced

accounts of the material, atmospheric and psychosocial characteristics of diverse spaces and of their own lived experiences within the hospital environment.

As discussed in the introductory chapter, there is renewed and increasing research interest in the intersection between architecture, design and health outcomes or lived experiences within healthcare environments. Accordingly, theories including those of 'therapeutic landscapes' (Gesler, 1992, 1993, 2005) and 'supportive design' (Ulrich, 1991), drawn respectively from geography and environmental psychology, alongside work in social psychology and architecture, have framed an expanding body of literature exploring connections between the physical, symbolic, social and atmospheric characteristics of mental healthcare environments and occupants' experiences (see Connellan et al., 2013; Curtis et al., 2007; Donald et al., 2015; Kanyeredzi et al., 2019; McGrath & Reavey, 2019; Mclaughlan et al., 2021; Reavey et al., 2019; Wood et al., 2013b). The thesis has correspondingly discussed varied ways in which spaces and objects mediated participants' lived experience and interpersonal relationships in secure psychiatric settings, through an exploration of how patients and staff made sense of their affective responses to the environment using narratives and photographs.

7.1 Summary of findings

It has been argued that the narratives explored within the thesis demonstrate an ongoing interplay between experience and space (McGrath & Reavey, 2019), such that the affective experiences of staff and patients in secure psychiatric settings are understood to be spatially distributed throughout the everyday environment. The findings presented in the three preceding empirical chapters have also drawn attention to similarities and differences in how patients and staff experience the everyday environment as co-occupants of secure mental healthcare spaces. Whilst the empirical chapters have been organised around examples of participants' stories that were felt best able to address the research questions, many of the storylines overlap within the

narratives explored in the analysis and across the overall data set. Alongside the narrative-based approach used to interpret the data, the concept of liminality has also provided a transdisciplinary perspective for exploring participants' accounts of their lived experiences within the framework of a relational process ontology (S. D. Brown & Stenner, 2009; Stenner, 2017).

In Chapter Four, patient and staff accounts of discomforting experiences in the hospital environment were interpreted in relation to the unease of being caught in a 'liminal hotspot' located between different 'worlds' or circles of activity (Greco & Stenner, 2017; Stenner, 2013). Participants were accordingly understood to be suspended in a variety of liminal zones situated between the contrasting 'forms-of-process' associated with: (a) patients' lives before and after hospital admission, (b) patient and staff status positions or spheres of activity, (c) the 'custodial' and 'caregiving' responsibilities of staff, (d) being 'inside' and 'outside' the hospital, (e) 'public' and 'private' spaces and (f) 'hospital' and 'home' environments.

Within Chapter Five, varied physical and psychosocial processes involving space as described by patients and staff were interpreted as forms of 'liminal affective technologies' (Stenner, 2017; Stenner & Zittoun, 2020) that were engaged with as means to self-produce liminal experiences that could enable transition between affective states. Such transitions typically involved movement away from distressing or difficult affective states towards preferred alternative states that provided reassurance and support. The technologies employed by patients and staff were associated with: (a) imaginative processes, (b) physical and psychological movement through space, (c) physical and psychological ordering of spaces and objects, (d) social interaction and (e) inhabiting spaces outside the ward.

The narratives examined in Chapter Six explored the role of spaces and objects in mediating interpersonal relationships and social interaction amongst patients and staff. Exploring participants' stories in process terms, the symbolic or material

divisions experienced by participants within the environment, or spatial features of the ward, were interpreted as thresholds situated at points of transition between contrasting 'worlds' or 'forms-of-process' (Stenner, 2017, 2021). Accordingly, participants' narratives highlighted a spatial relationship between interpersonal dynamics and the convergence of differing spheres of activity within the ward, whereby environmental and relational tensions were typically expressed at the meeting points between contrasting worlds. Participants' narratives included accounts of heightened affectivity experienced at the transitional thresholds situated between: (a) patient and staff spheres of activity, (b) contrasting patient self-identity positions, (c) different staff self-identity positions, (d) 'domestic' and 'clinical' perceptions of spaces and (e) worlds 'inside' and 'outside' the hospital.

7.2 Key insights

The introductory chapter explored a series of inherent tensions associated with secure mental healthcare facilities, including the paradoxical functionality of these settings as simultaneously restrictive places of carceral containment and therapeutic spaces to facilitate 'recovery' and rehabilitation. Participants' stories have illustrated ways in which these conflicting priorities are manifest environmentally and experienced by staff and patients through everyday interaction with the institutional spaces of secure psychiatric care. Key insights drawn from the analysis presented in the empirical chapters will be explored in the following sections and the implications of the research will then also be discussed.

7.2.1 The discomfort of feeling 'stuck'

One of the primary functions of secure psychiatric facilities is to support patients' journeys of 'recovery' and assist their preparation for reintegration into wider communities and the institution can itself be conceptualised in terms of a transitional or transformative process (McGrath, Mighetto, et al., 2021). Yet in these environments

patients are typically detained for indefinite periods and can be seen to be caught in an ongoing liminal transition between their past and future lives. S.D. Brown and Reavey (2015) have referred to this state of suspension in terms of 'presenteeism', whereby through containment in a secure psychiatric setting, patients' previous lives and future aspirations may become displaced or disconnected through a predominant organisational focus on matters of the present. In the current study, the concept of liminality has similarly provided a perspective through which to interpret participants' stories of experiencing physical and psychological discomfort within the hospital environment, in the terms of unease associated with being caught in an 'in-between' or indeterminate state.

Due to patients' typically prolonged length of stay in hospital, secure psychiatric facilities also represent a 'home' environment (Brunt & Rask, 2005). However, as McKellar (2015) points out, whilst research findings imply a preference amongst patients and staff for familiar, deinstitutionalised and humane environments, psychiatric ward interiors generally reflect the dominant medical model of mental healthcare, giving rise to stark, clinical environments. Correspondingly, in the present research, participants' stories commonly conveyed a sense of the hospital wards as uncomfortable spaces, positioned awkwardly between conflicting aesthetic, functional and organisational priorities. Inherent tensions between operational concerns about safety or security on one hand and the provision of a therapeutic context on the other were revealed through interaction with the hospital environment and were seen to heighten participants' sense of discomfort or ambivalence towards spaces on the ward.

Loose furniture or joinery and architectural components, including door sets and windows comprise core components of interior spaces and the explicitly robust or safety/security-driven design and utilitarian detailing of these elements contributed to participants' experiences of a clinical or punitive ambience. These physical features of the environment were understood to be communicating directly with patients and

reinforcing unhelpful self-identity positions associated with 'deviancy' or 'abnormality', that were constraining and thus potentially limiting processes of transition or 'recovery'. Material or spatial attributes of the environment similarly 'spoke' to staff members and emphasised conflicts between carceral and caring responsibilities within their professional role that were frequently troubling and implicated in the dynamics of establishing or maintaining therapeutic staff-patient relationships. By contrast, spending time in more familiar or normative interior environments and outdoor spaces was found to reduce experiences of discomfort and enable transition between identity positions. Increased experiences of comfort were thus seen to enable patients to perceive a reduced sense of 'abnormality' and to optimise the caring role of staff, whilst promoting a sense of trust between both groups.

The physicality of the hospital architecture presented a material and symbolic boundary between the contrasting worlds and circles of activity inside and outside the institution. Experiencing connections between indoor and outdoor spaces and having direct access to the open air was seen to have a fundamental role in reducing the discomfort of an enclosed, restrictive environment for both patients and staff. Architectural features that connected patients visually to the outside world whilst simultaneously removing their connectivity to the multi-sensorial qualities of nature were seen to be both limiting the therapeutic potential of the environment and actively creating discomfort or distress. The scale and proportions of the hospital architecture and internal spaces were also frequently referenced and for some participants, the typically large scale of the physical environment was associated with experiences of affective discomfort. Features of the built environment, such as high courtyard walls or long corridors, were experienced as overbearing and embodying a sense of institutional dominance that was unhelpfully juxtaposed with patients' own experiences of having little power or control. Experiences of poor acoustic quality associated with the layout, scale and materiality of spaces were similarly described as

contributing to experiences of unease in the environment. Large, open day areas without clearly defined boundaries were unconducive to the affordance of comfort and were described as lacking a clear sense of spatial identity.

Spaces were seen to be incongruent with a residential context and correspondingly, it is argued that creating familiar environments which are reflective of 'normal life' is more significant to longer stay secure psychiatric contexts than traditional hospital settings for short term recovery (Olausson et al., 2021). Olausson and colleagues also draw on reflections from Malone (2003) to highlight how through hospital admission, individuals are displaced from the social contexts that shape identity, typically at times of acute vulnerability, to enter into an unfamiliar environment as a patient. Admission to a psychiatric hospital is accordingly a typically disruptive experience, which may in itself be frightening or confusing (Chevalier et al., 2018; Fenton et al., 2014; Riordan & Humphreys, 2007) and for some people may also be potentially traumatising (Murphy et al., 2017). Being disconnected from the familiarity and comfort of more 'normatively' designed everyday environments that exist outside secure institutions can also be seen to be compounding patients' experiences of restriction, or sense of being held in an awkwardly indeterminate position between worlds.

7.2.2 Creating comfort and becoming 'unstuck'

Participants described how ways of coping with discomforting everyday experiences in the hospital environment frequently included engaging physically and psychologically with spaces or objects to help facilitate affective transition, typically between troubled and more comfortable states of being. To gain a sense of respite from difficult circumstances, including stressful experiences associated with being on the ward itself, participants engaged physically with spaces and objects, or used imaginative processes to help create and inhabit psychologically safe or reassuring environments. These

processes were also seen to be helping patients and staff establish a sense of stability or be more grounded within disruptive or volatile situations, for example, at times when the ward was experienced as 'unsettled' by both groups. The varied processes used by participants to help mediate discomfort or distress by providing reassurance or a sense of stability, were interpreted through the data analysis as self-generated liminal experiences that were employed to assist affective transformation. Physical and psychological engagement with spaces and objects to facilitate affective transformation was also seen to be helping patients and staff mitigate the unsettling effects of experiencing imposed circumstances or events. For patients such events were seen to include the disruption of being detained in a secure hospital and the experience of acute mental distress. For staff these circumstances typically related to troubling aspects of their professional role, including involvement in restrictive practice and seclusion, or experiences of being physically assaulted at work.

Engagement with liminal affective processes involving space and objects in the environment was seen to be enabling patients and staff to move through difficult experiences and regain a sense of control over events taking places in their lives. Such processes were consequently understood to be helping patients and staff become 'unstuck' from a sense of unease or paralysis, by allowing them to move forward and to cope or be able to 'go on'. Experiencing a sense of progression by avoiding being caught in a position of discomfort was consequently seen to be significant in relation to experiences of well-being for both groups. For patients this sense of forward movement beyond their current circumstances could also be seen to be connected to 'recovery' and rehabilitation in a broader sense. Processes of psychologically planning or visualising and inhabiting alternative environments, including past or imagined future home spaces, were accordingly referred to as comforting or motivating and potentially healing experiences. Similarly, a sense of comfort was gained by patients

through physically arranging or organising and their bedroom space and from engaging with personal objects within it.

Within the empirical analysis chapters and across the data set, staff and patients also spoke frequently about their appreciation for spending time in spaces that were located off the ward, including outdoor areas. These settings were seen to facilitate a sense of respite from the intensity of the ward environment for both groups and were described as affording a more equal relational dynamic between patients and staff. The narratives also implied that the degree of physical distance from the ward was less significant than the experience of being spatially removed and separated from the ward environment. Staff typically observed that having an increased sense of freedom, comfort or privacy in spaces outside the ward could also help patients to confide in and 'open up' to staff, which was felt to be important therapeutically. Contrastingly, the narratives conveyed a sense of patients being more reticent and more constrained or held back in their emotional expression and ability to put their trust in staff within the restrictive or less private spaces of the ward.

Patient participant comments about being able to just "be ourselves" in areas such as the swimming pool, were echoed in staff narratives which suggested that patients were typically more at ease and able to express their individual personality more fully in areas off the ward. This was especially the case in spaces, such as kitchens or outdoor areas, that were experienced as more naturalistic and normative, or having a greater semblance of domesticity, with fewer aesthetic or procedural reminders of the secure context. Spending time in such spaces, typically when engaging in enjoyable and meaningful activity, including work, was seen to be enabling patients to get closer to the core of their own self-identity as individual people and be less influenced and constricted by labels such as 'offender' or 'patient'.

These findings can also be considered in relation to McQueen and Turner's (2012) study exploring views about work activity amongst people using forensic

mental health services in secure facilities and community settings. The theme of 'normalising my life', as identified by the authors, represented positive experiences of working and participants' observations implied that employment, including voluntary work, helped develop an independent sense of self that was important in building confidence or self-worth. A systematic review and narrative synthesis of qualitative research examining meanings of recovery for patients in secure psychiatric settings by Clarke et al. (2016) similarly found that experiences of 'connectedness' and 'a sense of self' were two prevalent facilitators of 'recovery' across the literature. Correspondingly, the findings of the current study suggest that spending time on meaningful activity in spaces containing fewer overt signifiers of security or risk management can helpfully contribute to rehabilitation processes by enabling patients to develop a more 'normalised' or familiar sense of selfhood.

Processes associated with movement through and within the secure environment were also relevant to participants' experiences of accessing spaces off the ward, including areas outside the hospital. The narratives implied that being outside the building, in natural settings or walking in open space was helpful in enabling transition between affective states for both patients and staff. Due to length of time required to leave or re-enter the building, however, staff were seen to forgo opportunities to access external space during shifts due to the limited time available on their breaks. Access to outdoor space for both groups was also mediated by the limitations of staff resources.

The narratives indicated how inpatient psychiatric settings can typically be intense and often volatile, or unsettling environments in which both patients and staff may feel concerned about their own safety or the safety of other people (Lundin, 2021; Mind, 2004, 2011; Quirk et al., 2004; Quirk & Lelliott, 2001). Staff and patient stories illustrated how experiences of physical and psychological safety for both groups are mediated by the material and atmospheric attributes of the hospital environment.

However, the removal of patients' personal possessions due to concerns about physical safety risk, can diminish patients' experiences of psychological and physical comfort at times when it may be most needed and illustrates how physical safety may typically be prioritised over emotional safety within these environments (Veale et al., 2022).

7.2.3 Integrating worlds

The stories explored in the analysis chapters and across the data set have highlighted varied ways in which staff and patient experiences of being in the physical environments of secure psychiatric services are closely intertwined with relational experience or social interaction in those spaces. The material or symbolic boundaries experienced by participants in the everyday environment were interpreted through the analysis as thresholds situated between contrasting 'worlds' or spheres of staff and patient activity. Environmental tensions were especially evident at the interface between different worlds and were revealed through staff and patient accounts of intense affective discomfort. These experiences of discomfort or distress were in turn seen to adversely influence communication processes and interpersonal relationships amongst both groups, often through prompting expressions of frustration. Spaces where the occupants of one world felt scrutinised by 'observers' located within another visually connected, but physically separate world were also associated with experiences of unease amongst patients and staff. By contrast, environments in which staff and patient activity was more fully integrated in the same physical space, were seen to enhance experiences of comfort that contributed to improved relations and communication between or amongst both groups.

Physical and symbolic thresholds in the environment were also seen to emphasise positional distinctions between patients and staff, including their differing experiences of status or power within the institution. Yet, in more integrated spaces, with fewer tangible divisions, participants reported a greater sense of parity between

staff and patients that could enhance social interaction and contribute to an increased sense of community. Spaces where a greater sense of equality was experienced between patients and staff in turn assisted in enhancing a sense of trust between both groups that is recognised as an essential aspect of positive therapeutic relationships (Gilburt et al., 2008). Participants' stories also suggested that a sense of congruence between the scale or proportion and the function of spaces is significant to experiences of physical and psychological comfort, or discomfort within the hospital environment. Correspondingly, the extent of social interaction in spaces on the ward was seen to be associated with the environments' active role in affording comfort and in bringing people together or conversely pushing them apart.

An increasing body of literature is focused on patient 'recovery' in secure psychiatric care (Clarke et al., 2016; Drennan et al., 2014; Livingston et al., 2012; McKeown et al., 2016; A. I. F. Simpson & Penney, 2011) and it is recognised that positive relationships experienced by patients in secure psychiatric settings, including therapeutic relationships with staff, are supportive to 'recovery' processes (Mezey et al., 2010). Correspondingly, having a sense of being respected, well-regarded and understood in therapeutic relationships with staff is significant to patient satisfaction in relation to secure mental healthcare services (Bressington et al., 2011; MacInnes et al., 2014). The quality of therapeutic relationships between staff and patients has hence been identified as a key determinant of satisfaction for patients detained within secure psychiatric settings (Coffey, 2006). Research findings also suggest that positive social environments and staff-patient interaction, alongside increased patient activity (i.e. engaging in social or therapeutic activity, rather than spending time alone) can improve clinical outcomes for patients in inpatient mental healthcare settings (Collins et al., 1985; Sharac et al., 2010). Sharac and colleagues' (2010) literature review examining staff and patient interaction and activity in psychiatric wards highlights, however, that nurses typically spend up to only half of their time engaging with

patients and a significant amount of patients' time is spent alone. Participants in Molin and colleagues' (2016) study exploring patients' experiences of everyday life and interactions in psychiatric wards emphasised the importance of familiar relationships with staff and the experience of ordinary social interactions together, such as sharing informal conversations and laughter (see also Reavey, Poole, et al., 2017). In the current study, participants' accounts similarly illustrated how patients valued spending time with staff members and generally wanted to interact together socially.

Participants' stories highlighted that although staff are not resident on the ward, the hospital constitutes a form of communal living because patients and staff continually co-occupy the same environment. The narratives illustrated, however, that an uneven distribution of everyday activity or duties within the environment emphasised the positional differences between patients and staff that diminished experiences of togetherness. Both groups suggested that for patients, having responsibility for the care or upkeep of spaces can promote perceptions of greater autonomy and provide a valued sense of having a more typical domestic life. Experiencing a sense of homeliness in the environment was linked to social interaction and the quality of relational experiences in spaces. Small spatial moves including re-positioning the height of the television unit or introducing games equipment, such as table tennis or pool tables, were seen to bring a sense of domesticity and conviviality to spaces that encouraged greater social interaction. Accordingly, these modest adjustments to the physical environment contributed to participants' accounts of closer relationships and improved interaction between and amongst patients and staff, alongside an increased sense of community and camaraderie. Positive interpersonal relationships were also experienced in spaces that brought patients and staff together in everyday domestic activity and mundane tasks, such as clearing and washing up after a meal.

Correspondingly, Marshall and Adams' (2018) study examining staff relationships with patients in secure psychiatric settings, found that staff members shared a holistic view of 'recovery' that recognised the value of positive relationships and the need to create a sense of home within the institution. Staff acknowledged how patients typically viewed the hospital as their home due to length of stay and suggested that therapeutic relationships could be improved by creating more homely environments. Staff members' suggestions on how to improve relationships included incorporating small home-like touches to the ward milieu, in terms of physical changes, but also through homely actions or gestures, such as enabling staff to sit down and share a meal or have a coffee with patients. Nurse participants in Martin and Street's (2003) study of therapeutic relationships in forensic psychiatric nursing similarly observed that factors contributing to building positive nurse-patient relationships included sitting down informally with patients, or taking part in shared activities, such as sport, or going for a walk outside. Papoulias and colleagues' (2014) systematic review exploring the therapeutic potential of psychiatric ward design also found that home-like environments and the availability of private or semi-private spaces were associated with increased social interaction and improvements in patient well-being. Furthermore, studies examining modifications to enhance the ward environment have found significant reductions in the use of seclusion and restraint following minor physical adjustments, such as rearranging furniture to facilitate social interaction, replacing old furniture and introducing warm paint colours (Borckardt et al., 2011; Taxis, 2002).

7.3 Implications

The participants' stories explored in this study have illustrated diverse ways in which the inherent tensions between operational priorities within secure psychiatric settings are manifest in and mediated by the physical, social and symbolic environment. The

narratives have particularly highlighted ways in which tensions between safety and security requirements and the creation of an ostensibly therapeutic environment become apparent through participants' spatial interactions and affective experiences in relation to spaces and objects in the hospital.

In light of multiple legal, clinical and architectural considerations, designing and planning secure psychiatric facilities is a complex task (Seppänen et al., 2018). In recognition of the risk-related challenges associated with secure settings, a guiding principle in the design and development of forensic mental healthcare services is concerned with optimising physical, procedural and relational security (Department of Health, 2011a; Kennedy, 2002; Seppänen et al., 2018). Physical security is concerned with the material integrity of the secure environment, whilst procedural security relates to the effective implementation of robust operational policies regarding safety and risk management. Relational security has been defined as, "the knowledge and understanding staff have of a patient and of the environment, and of the translation of that information into appropriate responses and care" (Department of Health, 2011a p.10) and according to Kennedy (2002), it has utmost significance in maintaining therapeutic progress for patients. It is consequently argued that the therapeutic and safety, or security concerns of the environment in secure services should not be viewed in isolation, or as polarised ends of a spectrum, but instead be regarded and addressed as integrated concepts (Department of Health, 2011a; Seppänen et al., 2018). Correspondingly, A.I.F. Simpson and Penney (2011) point out that in order to align with a recovery paradigm within forensic mental healthcare, it is necessary to view, "[…] treatment and security as requirements of one another, rather than dichotomous goals" (p.304). The therapeutic alliance between staff and patients is hence understood to form a common ground between effective security and successful treatment in secure psychiatric services (A. I. F. Simpson & Penney, 2018). However, the creation of relational security is contingent on the physical environment (Seppänen et al., 2018)

and environmental design can also be regarded as an important therapeutic interface between security and treatment as integrated priorities.

Within the present research, the environmental tensions revealed through participants' affective experiences in secure psychiatric settings have been conceptualised in process terms. Experiences interpreted as forms of enduring liminality, or the sense of being stuck between 'worlds', were typically characterised by paradox and described as discomforting for both patients and staff. This sense of discomfort was frequently associated with participants' simultaneous experience of contradictory 'worlds' within the same physical environment. Within these hybrid spaces, there was generally a sense of imbalance. As an example, concerns regarding security, risk management and physical safety, were seen to dominate over comfort, familiarity and emotional safety in terms of the messaging conveyed to occupants through details in the environment (Veale et al., 2022).

As discussed earlier, however, an enduring indeterminate state may also give rise to novelty, through what Greco and Stenner (2017) have termed 'pattern shift', involving attempts to redefine paradoxical contradiction by embracing both 'worlds'. In secure services, pattern shift may then be brought about through design innovation and creativity to enable greater integration of staff and patient worlds, or the worlds 'outside' and 'inside' the hospital, alongside increased congruence between therapeutic and security or safety-driven requirements. Patients and staff talked about experiences of discomfort within the everyday environment, yet participants' stories also revealed diverse ways in which a sense of comfort could be created through engagement with spaces or objects, both physically and psychologically. Engaging with design as a creative process or technology to facilitate innovation could assist in addressing discomfort, whilst also helping to optimise the aspects of the environment that provide comfort or are vitalising, reassuring and supportive.

As discussed in the introductory chapter, the notion of 'designing in' comfort or familiarity into mental healthcare environments is not new. It represented a fundamental principle in 19th century asylum design, whereby environments were specifically designed to be cheerful, comfortable and homely as a means to offer a supportive surrogate family to patients (Boult, 2017). Through careful attention to detail at all scales, the built environment was understood to play an active role in rehabilitation, such that design was not regarded as neutral, but instead seen to have the capacity to either enhance or detract from the process of healing (Edginton, 1997, 2003). This philosophy and approach towards the creation of a therapeutic environment also attempted to provide a sense of familiarity in order to remove distinctions between the worlds 'outside' and 'inside' the institution (Edginton, 2003).

Despite more recent renewed recognition of the environment's role in mental healthcare and increased awareness of widespread preferences for familiar and non-clinical spaces, the design language of inpatient psychiatric care is typically lacking a congruent identity and remains situated within a medical design typology (McKellar, 2015). The findings of the current research can be seen to support the argument for creating familiar and non-sterile spaces as a key objective in mental healthcare design (Karlin & Zeiss, 2006; Shepley et al., 2016). However, it could also be argued that enabling 'pattern shift' in this context requires innovation and collaborative design thinking. This might include a shift in perspective from a position of attempting to make clinical or carceral environments more familiar or homely, to the creation of familiar and comfortable environments in which physical safety and security requirements are unobtrusively integrated. This would also involve raising aesthetic aspirations in relation to the overall built environment, including the design of interior products or architectural fixtures that contribute significantly to the clinical or carceral tone of spaces and 'speak' to occupants.

A similar point is made in relation to 'building in' emotional well-being into carceral spaces by Jewkes et al. (2019), who highlight that recent initiatives to provide trauma-informed care and practice in UK women's prisons are compromised by environments with, "hostile architecture, overt security paraphernalia, and dilapidated fixtures and fittings" (p.1). Such inherent and explicit aspects of the built environment are accordingly argued to be antithetical to trauma-informed approaches and may then trigger, exacerbate, or contribute to symptoms of trauma. A holistic and revolutionary approach is consequently called for, in which trauma-informed design is built into the environment, "from the ground up" (Jewkes et al., 2019 p.7). The authors also question if carceral settings could be designed for healing, by incorporating trauma-sensitive design principles and innovation from ground-breaking healthcare environments, such as the Maggie's centres for cancer support.

As non-residential sites located beside regional hospitals, each Maggie's centre is a unique space with a domestic architectural scale designed to optimise the therapeutic potential of the environment (D. Martin & Roe, 2022). Hopeful atmospheres and environments are accordingly manifest through high-quality architecture, connectedness to light and nature, alongside careful attention to detail and materiality, to create comfortable, non-clinical spaces that offset the anxieties which typically accompany cancer treatment (Butterfield & Martin, 2016; D. Martin et al., 2019). Whilst Jewkes et al. (2019) point out the challenge of reproducing the bespoke qualities of Maggie's centres in mainstream healthcare settings, the philosophy and design principles that underpin these environments are nonetheless aspirational.

Within the context of mental healthcare spaces, pioneering work by the Madlove collective blends research with creative practice to bring together people with diverse backgrounds and different mental health experiences in a project to re-envision psychiatric environments as 'designer asylums' by creating positive spaces to

experience mental distress (Zorwaska, 2019). This ongoing work integrates diverse perspectives, including experts by experience, non-experts, artists, designers, academics or mental health professionals and illustrates the importance of collaborative approaches, whilst demonstrating the need for creativity and innovation in approaches to mental healthcare design.

The *Design with People in Mind* booklet series published in the UK by the Design in Mental Health Network has also contributed to the sharing of key research evidence relating to environments and mental health across the literature, including nursing, psychiatry, psychology, architecture and design (Reavey et al., 2021; Reavey, Harding, et al., 2017; Reavey & Harding, 2018, 2019). By presenting summaries of key evidence in an accessible format, these publications aim to share research findings with diverse stakeholders, with the hope of benefiting those who design, live or work in mental healthcare environments.

The narratives explored within the current study have suggested that affording increased comfort to occupants by diminishing environmental contradictions and tensions has implications for both patient and staff well-being, in addition to the relationships between and amongst patients and staff. For patients, the reduction of environmental friction to promote greater ease and experiences of comfort in the everyday environment may then also have wider consequences for 'recovery' and rehabilitation.

7.4 Reflections on the research process

Reflections on the overall research process will be outlined in the following section, including thoughts about my experiences as a novice researcher undertaking this visual-qualitative study in the context of low and medium secure mental healthcare environments. This includes an awareness of my active role in the research and the influence of my own assumptions, lived experiences and personal characteristics on

the approach to the research, including the study design and the processes of collecting, interpreting and presenting the data.

The reflexive process recognises a distinction between, 'personal' and 'epistemological' reflexivity, as two reflexive modes that respectively acknowledge the researcher's role in shaping the research, as an individual person and through the theoretical and methodological approach to the research (Willig, 2013). Personal reflexivity, as outlined by Willig (2013), is concerned with the influence of individual characteristics on the research process, which may include the researcher's own values, beliefs, experiences, age, gender, or social identity. As discussed in the methodology and analysis chapters, my own personal characteristics and those of the participants, plus our social interaction together were accordingly understood to have a bearing on how the narratives were co-produced in the interviews and the content of the stories told (Silver, 2013).

Willig (2013) also details how epistemological reflexivity is concerned with the researcher's theoretical assumptions about the world and the production of knowledge. Epistemological reflexivity thus includes exploring the ways in which the study design or approaches to analysis contribute to how the data analysis is developed and presented. Correspondingly, in the context of narrative inquiry, Wong and Breheny (2018) point out how different analyses will be produced by different researchers as a result of their individual influence on the research at each stage of the process. This might include the questions that are asked during the interview, or the researcher's responses to participants' stories and the process of identifying and selecting the narratives that are felt best able to address the research questions. Reflexive processes recognise the researcher's own motivations or investments in the subject matter, although these can be viewed not as 'biases' to be removed from the research, but instead as conditions that frame the research process and have a part in shaping the findings (Willig, 2013).

Having a background as a practitioner within the discipline of design and architecture informed my interest in exploring experiences of everyday spatial interaction in secure mental healthcare environments. This perspective can also be seen to have played a part in shaping the overall study and my involvement throughout the research process. As an example, the inclusion of photography and visual research methods in the study design reflects the visual orientation and focus on creative expression within design practice. My interest in design and the built environment may have also influenced the interviews in terms of the emphasis given to certain topics, or the questions asked in response to participants' reflections on their photographs.

Reflexivity is also concerned with issues of ethics and undertaking the research in secure psychiatric environments presented a range of ethical considerations as discussed in Chapter Three, alongside practical considerations, including access and communication (Spiers et al., 2005). Consistent with the specific research focus on exploring experiences of the environment in secure psychiatric facilities, particular reflexive consideration is given to the research context and the experience of undertaking the study in these settings. These reflections recognise the significance of the active role played by the research environment itself in mediating the conduct of the study, including the process of data collection.

7.4.1 Research in secure settings

Following the initial contact made with patients during community meetings on the wards, it was necessary for the intervening liaison about meetings with patient participants to take place via staff members. Communication processes were consequently more removed with patient participants than staff members, with whom it was possible to liaise directly and increase a sense of rapport. Due to the nature of the secure environment, it was necessary for interviews with patients to be undertaken on the wards, typically in meeting rooms or side rooms and not within other areas of

the hospital. The participants' narratives highlighted, however, that patients might also typically spend time in these spaces for other meetings, including mental health tribunal panels and consultations or therapy sessions with psychiatrists and psychologists. Recollections of potentially difficult past experiences or events taking place there previously may have been significant in terms of how participants experienced those spaces during the interviews and the extent to which they felt at ease within them. Whilst some of the interviews with staff members took place in meeting rooms within office areas located elsewhere in the hospital building, the majority were also undertaken within side rooms or meeting spaces on each ward. This proximity to the ward and having an awareness of everyday ward activity taking place in the background may have influenced some staff members' ability to feel removed from their typical duties and responsibilities whilst participating in the interview. As an observable example of this, on one occasion it was necessary to pause the interview with a staff participant when they had to leave the room quickly to assist colleagues in responding to an incident on the ward.

Several interviews with staff and patients were also interrupted briefly by other members of staff knocking on the door, or simply entering the room. As highlighted in some participants' accounts, perceptions of privacy and potential intrusion within the environment may have played a mediating role in the degree to which people felt comfortable and able to talk freely about their experiences during the interview. From my own perspective, the experience of the interviews being disrupted in this way on several occasions was distracting and slightly unsettling in an unfamiliar environment where I was typically not fully at ease. It also revealed a sense of how functionality might typically be prioritised over privacy within the environment. It was necessary to relocate to another space partway through an interview on a couple of occasions, as the original room was subsequently required for other purposes. Despite the disruption, however, I found that there were also benefits to moving rooms twice

during the interview with one participant, as we spent time together inside several of the rooms discussed, rather than looking only at photographs of these spaces.

The typically difficult acoustic characteristics of the hospital environment, as discussed within some participants' narratives, were also significant to the experience of conducting the research and background noises from other parts of each ward were typically perceptible during the interviews. In some cases, the volume of individual sounds, such as doors slamming or people shouting, was so great that one or two words were rendered inaudible in some of the interview recordings. Instances of loud background noise during the interviews were therefore a distraction and potentially unsettling to participants, as they were at times to me as a researcher and a visitor to the ward. Noise disturbance is especially material to the interview context within psychiatric healthcare environments where people experiencing distress may commonly have a heightened sensitivity to sound (Stansfeld, 1992; Sutton & Nicholson, 2011) and some people may experience intrusive thoughts or voices. When visiting the wards, it was troubling to hear expressions of other people's distress or frustration, such as shouting and the adverse influence of these sounds on my own affective state was compounded by their volume and reverberation in the environment.

In the individual meetings with patient participants, it was typically necessary to wear a personal safety alarm which occasionally made unexpected beeping noises during the interviews. These sounds were disconcerting and implied that something might be amiss elsewhere in the ward. Although the beeping did not cause a significant disruption to the interviews, these sounds made the alarm's existence more visible in the research environment. In line with participants' comments about the symbolic significance of keys or radios worn by staff, the physical and audible presence of the safety alarm could be similarly understood to be unhelpfully emphasising positional differences between me as the researcher and patient participants. Correspondingly, as only the researcher wore a safety alarm during the interviews, this object may have

reinforced patients' discernment of having an 'offender' identity, or a sense of being feared or perceived as 'dangerous' by others (Jacob et al., 2009). I was consequently conscious of wearing the personal safety alarm in the meetings with patients and slightly unnerved by thoughts that I might inadvertently set it off. Alongside the CCTV cameras in the rooms used for the interviews, the alarm could also be seen to be accentuating wider discourses about safety, security and risk mitigation that underpin the management of secure psychiatric environments (Kennedy, 2002).

For reasons of patient protection, it is generally prohibited for cameras to be brought onto secure wards and a digital camera belonging to the multi-disciplinary team on each ward was typically made available for use in the study. In cases where a ward camera was not available, specific permission was obtained from the research setting to allow a camera to be taken onto the ward for research purposes. Each ward had different systems or limitations associated with printing or making participants' photographs available for use in the research and it was not possible to print out the images on some wards due to the equipment available there. In these instances, it was necessary to review participants' photographs on the camera screen rather than laying out prints on a table. Consequently, it was less easy for participants to visually cross-refer between photographs in these cases and the images were typically talked through in a more linear way. This also meant that participants often moved through the set of images more quickly.

The smaller size of images when compared with prints also meant that some details were not so readily appreciated when reviewing on a camera screen and it was less easy for both participant and researcher to have a clear view of each photograph simultaneously. Alongside this, in several instances where participants' photographs were taken using ward equipment, it was not possible for the digital images to be shared, so only paper prints, which were typically black and white, could be retained where available. As a result, not all participants' photographs could be reviewed again

for reference during the transcription and analysis processes. Additionally, this meant that some participants' photographs were not available for inclusion in the thesis and a few of those that have been included have a low image quality as it was necessary to reproduce them from paper prints.

The narratives revealed how participants frequently perceived a lack of control over the hospital environment and similarly, reflecting on the physical and acoustic intrusions in many of the interviews highlighted my own limited control as researcher over the spaces where these took place. The characteristics of the research context were thus typically contrasting with what might be considered 'ideal' conditions for undertaking qualitative research interviews, such as affording a peaceful environment with minimal distractions, for the benefit of both the participants and researcher. Additionally, I was mindful that the need for staff members to be aware that a patient was taking part in the study may have further affected patients' sense of privacy in relation to the research process in a way that did not apply to staff participants.

By regularly visiting wards and undertaking interviews there I observed general activity that provided valuable additional insights into the everyday experiences of patients and staff. Several of my own experiences as a visitor to the wards were parallel to those expressed in participants' narratives, including perceiving a lack of control over the environment as described above. Despite being at liberty to leave, I also experienced a sense of restriction and containment when visiting the wards. To exit the building, it was necessary for a staff member with key fob to escort me through the hospital to the main airlock, typically via a number of corridors and several sets of internal doors. Spending time visiting the wards enabled me to absorb a sense of the atmosphere and enhanced my understanding of how each of these slightly different environments operated. However, I was also conscious of not wishing to intrude in those spaces and typically felt a desire to have less visibility as a visitor to the ward. This was especially so within glazed nursing stations, where I felt

uncomfortable observing events through the glazing and experienced similar feelings of exposure in these spaces to those expressed by some of the staff participants. The experience of being in secure environments and undertaking research in this context was intense and quite difficult at times, in both practical and emotional terms. Participants' accounts of their experiences were often moving. In contrast to patients' experiences of detention, I was also mindful of my own experiences and relative freedom as a person living independently in the community. I was aware of researcher responsibility in relation to participants and conscious of ethical considerations or dilemmas, for example in writing about participants' lives, or how stories are interpreted in the analysis (Josselson, 2011). Throughout the project, it was important for my own well-being to have opportunities in supervisory meetings to discuss the research, including ethical considerations, at each stage.

7.5 Future directions and concluding comments

The aim of this thesis was to explore the role of space and objects in mediating the affective experiences of patients and staff within secure psychiatric settings and to understand how participants make sense of their experiences in these environments using narrative and photographs. Notwithstanding the logistical challenges already discussed, the use of photo-production as a visual method was a strength of the research and helped facilitate the generation of rich and spatially grounded narratives regarding participants' everyday experiences in secure mental healthcare settings. Accordingly, the study has afforded a close examination of secure psychiatric environments and afforded increased visibility to these very particular healthcare spaces that are not widely or easily accessed. It was envisaged that photo-production might be perceived as a creative and enjoyable activity and several participants remarked anecdotally that they had enjoyed taking the photographs and the process of choosing what to feature in the images. As the participants were based on six wards

located within a range of buildings across the hospital site, it was also possible to explore the experiences of staff and patients in several medium and low secure environments with varying layouts and designs. Whilst the overall sample size was determined by the availability of individuals volunteering to participate, the composition reflected an almost equal split between staff and patients, women and men and low and medium secure environments, which provided balance to the study.

People who use mental health services are becoming progressively more involved in the design and conduct of research within mental health settings, however, involvement is more limited in forensic mental healthcare environments (MacInnes et al., 2011). This may reflect a variety of reasons, including significant practical, access and communication issues involved in collaborating with patients in secure facilities, alongside the additional time and resources required to engage with people using forensic mental health services (Faulkner, 2007; Spiers et al., 2005; Völlm et al., 2017). These issues present challenges to research in secure psychiatric settings, however, collaborative studies can empower people who may typically be marginalised and enable the exploration and prioritisation of issues that are beyond clinical parameters. Whilst collaboration with experts by experience in secure settings would have similarly enhanced the design and development of the current research, a limitation of the study was that this was not achievable within the overall programme and available resources. Future co-produced research would be valuable to explore patient and staff perspectives and increase understanding about how the design of secure psychiatric spaces might optimise the therapeutic potential of the environment. The Experience-based Co-design (EBCD) approach has been widely used in UK general healthcare as a framework for participatory action research in which patients and staff work together to share experiences of healthcare environments to help expose and prioritise areas of focus for service improvement (Bate & Robert, 2007; The Point of Care Foundation, 2016). Although its use to inform potential change within mental healthcare services is

relatively new, adapted forms of EBCD have also been developed to suit the complexities and ethical considerations of working with 'vulnerable' populations in mental healthcare contexts (Isobel et al., 2021; Larkin et al., 2015).

As mentioned in Chapter One, a second parallel study to explore the lived experiences of people using forensic mental health services and staff in high-support accommodation within the community was also developed and pursued originally as part of the current research project. The proposed study aimed to examine experiences of space within high-support housing settings and explore how the material, social or atmospheric features of such environments might mediate lived experience, including patients' experiences of transition between inpatient psychiatric settings and the community. For people discharged from secure hospital wards into high-support accommodation settings in the community, the latter represent a transitional zone between relative restriction and isolation experienced within secure inpatient environments and greater social re-integration into the wider community (Cherner et al., 2014). Consistent with secure inpatient settings, high-support housing facilities for people who use forensic mental health services similarly intersect the mental healthcare and criminal justice systems. Forms of surveillance and restriction are likewise apparent in this form of community-based shared accommodation, where the environment typically includes 24-hour staffing, CCTV monitoring, door access control and signing-in processes for visitors. Patients who have been detained in secure psychiatric facilities may typically be conditionally discharged into the community and failure to comply with prescribed conditions, such as engaging with mental health services or taking prescribed medication, may result in being recalled to hospital (Latham & Willliams, 2020).

There is, however, limited existing research exploring how supported accommodation settings in the community for people with mental health difficulties are experienced by occupants (Bengtsson-Tops et al., 2014; Krotofil et al., 2018), or

examining the efficacy of service provision (Chilvers et al., 2006; Killaspy et al., 2016; McPherson et al., 2018). Further empirical study would therefore usefully expand knowledge and understanding of how the environments that constitute high-support housing in the UK are experienced by people who use forensic mental health services and staff in those settings. Whilst the separate study proposed to address this could not be progressed within the current research programme, undertaking this research in the future would valuably build on findings from the present exploration of patient and staff lived experiences within secure inpatient facilities. Future research conducted in high-support accommodation could assist in increasing empirical understanding about how occupants make sense of their experiences within this form of residential setting, including the experience of transition between secure inpatient environments and the community (Coffey, 2012b).

Further study in this context could also help expand knowledge of how the concept of 'recovery' might be perceived by people who use forensic mental health services and staff respectively as a personal and organisational goal, in addition to furthering understandings of associations between 'recovery' and spatial experience (Borg et al., 2005; Borg & Davidson, 2008; Mezey et al., 2010; Milbourn et al., 2014). The discrimination perceived through labelling as both 'offender' and 'psychiatric patient' has been identified by patients in secure settings as an impeding factor in 'recovery', specifically in the context of discharge from hospital and independent community living (Mezey et al., 2010). Studies have also highlighted how housing quality and appropriateness of living conditions can be associated with social integration and community adjustment for people discharged from inpatient psychiatric settings (Baker & Douglas, 1990; Dorvil et al., 2005). The restrictions that may be imposed under conditions associated with hospital discharge can also limit the extent of social inclusion and choice that people who use forensic mental health services may experience in the community (Mezey & Eastman, 2009).

People who use mental health services in the community may typically prefer to live alone or with family (R. Warren & Bell, 2000), however, as with inpatient settings, people living in supported accommodation are not able to choose their co-residents. For people with severe and enduring mental health difficulties, improved perceptions of quality of life may also be associated with housing stability (Kyle & Dunn, 2008), or living in private accommodation as opposed to hostels or boarding houses (Browne & Courtney, 2004; Tanzman, 1993). Consequently, perceptions of housing and domestic space are pertinent to the 'recovery' experiences of people using forensic mental health services, who are typically marginalised and may commonly experience social exclusion or discrimination in relation to their mental health needs or offences (Adshead, 2000; Menditto, 2002; West et al., 2014; Williams et al., 2011). Reasons for this include widespread stereotyping and media portrayals of people with mental health difficulties as 'dangerous' or 'violent', alongside overlapping stereotypes about offenders (Perlin, 2008; West et al., 2014). It is envisaged that future research examining occupants' experiences of high-support housing settings could increase understandings of the environment's role as a material resource and how the design of spaces for supported living may be implicated in processes of rehabilitation (Chesters et al., 2005; Johnston et al., 2022).

In summary, this thesis has been undertaken in the context of limited research exploring patients' perspectives about the everyday experience of secure mental healthcare services (Coffey, 2006). Alongside this, studies examining the relationships between the built environment in psychiatric settings and patient outcomes are under-represented within the literature (Liddicoat et al., 2020; Papoulias et al., 2014). Simonsen et al. (2022) also highlight that whilst the concept of 'healing architecture' has developed over recent years in relation to the spatial organisation of healthcare environments (see Frandsen et al., 2012; Lawson, 2010), there is at present no agreed definition and knowledge of how healing architecture can shape clinical and patient

outcomes is limited. There is also currently only a limited transdisciplinary evidence base informing the design of secure psychiatric facilities (Mclaughlan et al., 2021). Correspondingly, Shepley and Watson (2013) found that only 2% of 269 articles reviewed in an exploration of collaborative research relating to healthcare design represented collaborations between designers and healthcare professionals.

The present research has aimed to integrate the expert experience and knowledge of patients and staff in order to increase empirical understandings of how the everyday environment might mediate occupants' lived experiences in low and medium secure facilities. By exploring the narratives of staff and patients as co-occupants of secure psychiatric environments, it has also been possible to identify important similarities and differences in the lived experiences of both groups within these settings. The analysis of participants' stories highlights how spaces and objects within secure environments can be experienced by patients and staff members as supportive or challenging and sometimes both simultaneously. Increased understanding of how everyday spaces are experienced by staff, patients and people who use forensic mental healthcare services may help inform the development of service provision. Furthermore, research findings could assist in mitigating issues associated with the commonly conflicting expectations and priorities of patients and staff in relation to the environment in psychiatric settings (Curtis et al., 2013; Papoulias et al., 2014; Veale et al., 2022).

The stories explored in this study have drawn attention to the active role of the built environment in shaping occupants' everyday experiences in secure mental healthcare facilities. The data analysis highlights how the spatial and sensorial characteristics of the environment are interwoven with staff and patients' embodied psychosocial experiences in these settings. Participants' narratives point to the affective significance of detail within the environment, including the aesthetic and haptic qualities of architectural finishes or touchpoints such as fixtures and fittings, in

addition to the social and atmospheric attributes of spaces. Accordingly, the smaller scale details of spaces, including joinery elements, furniture and sanitaryware, are understood to be just as salient to occupants as the larger scale architectural aspects, such as the walls or volumes that form the overall environment. Because the internal spaces in secure psychiatric facilities are typically sparse, the architectural components and products that comprise the interior can be seen to have increased prominence in these settings than in more familiar, or less minimally furnished environments that have a more layered or textured ambience. Furthermore, the findings highlight the significance of imposed exposure to the environment's physical and atmospheric qualities, in these restrictive settings where staff typically work long shifts and patients spend long periods of unstructured time within a very limited number of spaces.

Correspondingly, throughout the data set, the environmental context was seen to be closely associated with staff and patients' experiences of both physical and psychological comfort and conversely, with their experiences of discomfort and distress. The narratives accordingly suggest that design and spatial planning opportunities to help mitigate experiences of discomfort could include paying careful attention to acoustics and materiality, alongside creating environments with a clear functional identity and a congruent match between the scale and function of the space. The findings additionally point to a significant need for aspirational and creative approaches to de-institutionalising the appearance and experiential qualities of the furniture and fittings typically produced for psychiatric settings, that were found to 'speak' unhelpfully to occupants through their form, detailing or materiality. The stories told by patients and staff also highlight varied ways in which the design of the environment mediates communication processes and social relationships within the institution. Both the spatial arrangement and the physical composition of the built environment are described as having the capacity to block or enable the spatial and communicative 'flows', that are in turn linked to the fluidity and quality of relationships

or social interaction between and amongst patients and staff. Participants' narratives suggest that material barriers such as glazed nursing station enclosures can impede such flows, whilst a greater sense of ease or improvements in occupants' relational experiences might be promoted in spaces where physical or symbolic barriers are diminished.

Whilst the insights gained contribute to the literature concerned with psychosocial studies of health and space, the study demonstrates a need for ongoing empirical examination of the complex relationships between the spatial, affective and relational dimensions of patient and staff experiences within secure mental healthcare environments. There is also a need for transdisciplinary collaborations as an important means to accelerate spatially informed and novel research regarding space and place in relation to health and care (Roxberg et al., 2020). Collaborative research and practice exploring the experiences of staff, patients and people who interact with mental healthcare services will continue to expand understandings of the interplay between health, space and environmental design.

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Appendices

Appendix A: Service user participant information sheet (page 1 of 2)

London South Bank
University

Service User Participant Information Sheet (Study One - Group One and Group Two)

Public and private space within forensic mental health accommodation

You are being invited to take part in a research study. This study will contribute to my PhD studies in Psychology at London South Bank University. Taking part is entirely up to you and before you decide it is important for you to understand why the research is being done and what it will involve. This sheet explains the purpose of the study and provides information about what would be involved in taking part. I will read through this sheet with you and will answer any questions you may have. Please ask if anything is unclear.

This research aims to explore the everyday experiences of service users and staff in forensic mental health residential settings and I would be very interested to hear your thoughts about the place where you live. The study is looking to explore the ways in which your personal environment might affect or reflect how you feel day to day. The research will include other service users living here and in supported housing in the community. Members of staff who work here and in supported housing in the community will also be asked to participate. In total, approximately 30 people will be included in the study. The study is open to people over the age of 18 and research will be taking place here during the coming weeks.

Do I have to take part?
No, you are under no obligation and if you do not wish to participate it will have no impact on your current care.

What's involved?
You are being invited to take part in a study exploring the everyday experiences of forensic mental health service users and staff in residential environments. You are being invited to participate as you have personal experience of living here and I am interested in hearing about your experience. If you decide to participate, your care team will be made aware that you are taking part in a research project. If you'd like to take part, you will be asked to produce up to ten photos of the place where you currently live. These should reflect your typical everyday experiences and should capture the range of feelings you may hold towards the places, spaces or objects which you encounter in daily life. You should avoid taking photos of other people and photos including other people who could be recognised will be deleted. A digital camera will be provided for use in this study and I will print your images before we meet for an interview at a convenient time for you.

When we meet I will ask you to talk about the photos and I will ask you some questions in an interview which may last about 45 minutes. It is not anticipated that you will be at any disadvantage from participating. I will not ask you any direct questions about your mental health or why you live here. Some questions may invite you to reflect on personal and possibly sensitive subjects, however you can decline to answer any questions raised and you may also ask to stop the interview at any time. Afterwards I will also give you a short debrief about the study. Should anything arise during the research to cause you to feel concerned or upset, contact details for independent support organisations that you could contact for information or to speak with someone in confidence are provided at the end of this sheet. You should also speak with the staff where you live or your care coordinator if you feel affected by the research.

There's no financial benefit, but you might find it interesting to contribute your experiences to research which aims to expand knowledge of the experience of forensic mental health accommodation, or to have the opportunity to discuss this topic with a receptive listener. At any point until completion of the PhD thesis, if you wish to withdraw entirely from the

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Appendix A: Service user participant information sheet (page 2 of 2)

research you may do so without giving a reason and your care will not be affected. You may also request that any answers given in the interview are removed from the transcribed data or request that any images supplied are deleted or are not reproduced in publications of the research.

Confidentiality & data protection
Interviews will be recorded and transcribed before being studied as part of a research project. Only the researcher will listen to the recording of the interview. All information provided will be treated confidentially, with the exception that you disclose a serious or previously unknown crime, or suggest that future harm to others or self-harm may occur. Such disclosures will be reported to your care team. All data will be kept confidential and anonymous in any future publication of the research and all names will be changed to ensure anonymity. Any other identifying details including place names will also be changed or omitted and any reference to you will be coded.

Any data collected will be kept in a locked filing cabinet and any electronic data will be stored on a password protected computer in an environment which is locked when not occupied. Data collected will be destroyed 10 years after the project is complete. The anonymised interview transcript may be shared with other researchers to optimise the use of good quality research data and to ensure peer scrutiny.

Consent process
Please take time to decide if you would like to participate in the research. If you decide to take part I will ask you to provide written consent using a consent form which I will read through with you. You will be given a copy of the signed consent form and participant information sheet to take away and a copy of these will also be retained in your personal file.

Research ethics
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Greater Manchester East Research Ethics Committee.

Thank you for your interest and for considering taking part in the research.

Researcher
Katharine Harding
Division of Psychology,
London South Bank University
103 Borough Road, London SE1 0AA

Research supervisor
Professor Paula Reavey
Division of Psychology,
London South Bank University
103 Borough Road, London SE1 0AA

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting Professor Nicola Thomas whose contact details are noted below.
Email: nicola.thomas@lsbu.ac.uk **Tel:** 020 7815 8045

Support organisations
Samaritans website: www.samaritans.org.uk **Tel:** 116 123
Provides support to all experiencing difficulties or crisis.
Mind website: www.mind.org.uk **Tel:** 0300 123 3393
Provides support to all experiencing mental health problems or distress.

Version 3: 06.04.17

Appendix B: Staff participant information sheet (page 1 of 2)

London South Bank
University

Staff Participant Information Sheet (Study One and Study Two)

Public and private space within forensic mental health accommodation

You are being invited to take part in a research study. This study will contribute to my PhD studies in Psychology at London South Bank University. Taking part is entirely up to you and before you decide it is important for you to understand why the research is being done and what it will involve. This sheet explains the purpose of the study and provides information about what would be involved in taking part. I will read through this sheet with you and will answer any questions you may have. Please ask if anything is unclear.

This research aims to explore the everyday experiences of service users and staff in forensic mental health residential settings and I would be very interested to hear your thoughts about the place where you work. The study is looking to explore the ways in which your personal environment might affect or reflect how you feel day to day. The research will include other staff working in forensic mental health inpatient settings and supported housing in the community. Service users who live in these settings will also be asked to participate. In total, approximately 30 people will be included in the study. The study is open to people over the age of 18 and research will be taking place here during the coming weeks.

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No, you are under no obligation to participate.

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You are being invited to take part in a study exploring the everyday experiences of forensic mental health service users and staff in residential environments. You are being invited to participate as you have personal experience of working in these environments and I am interested in hearing about your experience. If you'd like to take part, you will be asked to produce up to ten photos of the place where you currently work. These should reflect your typical everyday experiences and should capture the range of feelings you may hold towards the places, spaces or objects which you encounter in daily life. You should avoid taking photos of other people and photos including other people who could be recognised will be deleted. A digital camera will be provided for use in this study and I will print your images before we meet for an interview at a convenient time for you.

When we meet I will ask you to talk about the photos and I will ask you some questions in an interview which may last about 45 minutes. It is not anticipated that you will be at any disadvantage from participating. Some questions may invite you to reflect on personal and possibly sensitive subjects, however you can decline to answer any questions raised and you may also ask to stop the interview at any time. Afterwards I will also give you a short debrief about the study. Should anything arise during the research to cause you to feel concerned or upset, contact details for independent support organisations that you could contact for information or to speak with someone in confidence are provided at the end of this sheet.

There's no financial benefit, but you might find it interesting to contribute your experiences to research which aims to expand knowledge of the experience of forensic mental health accommodation, or to have the opportunity to discuss this topic with a receptive listener. At any point until completion of the PhD thesis, if you wish to withdraw entirely from the research you may do so without giving a reason. You may also request that any answers given in the interview are removed from the transcribed data or request that any images supplied are deleted or are not reproduced in publications of the research.

Version 3: 06.04.17

Appendix B: Staff participant information sheet (page 2 of 2)

Confidentiality & data protection
Interviews will be recorded and transcribed before being studied as part of a research project. Only the researcher will listen to the recording of the interview. All information provided will be treated confidentially, with the exception that you disclose a serious or previously unknown crime, or suggest that future harm to others or self-harm may occur. All data will be kept confidential and anonymous in any future publication of the research and all names will be changed to ensure anonymity. Any other identifying details including place names will also be changed or omitted and any reference to you will be coded.

Any data collected will be kept in a locked filing cabinet and any electronic data will be stored on a password protected computer in an environment which is locked when not occupied. Data collected will be destroyed 10 years after the project is complete. The anonymised interview transcript may be shared with other researchers to optimise the use of good quality research data and to ensure peer scrutiny.

Consent process
Please take time to decide if you would like to participate in the research. If you decide to take part I will ask you to provide written consent using a consent form which I will read through with you. You will be given a copy of the signed consent form and participant information sheet to take away.

Research ethics
All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Greater Manchester East Research Ethics Committee.

Thank you for your interest and for considering taking part in the research.

Researcher
Katharine Harding
Division of Psychology,
London South Bank University
103 Borough Road, London SE1 0AA

Research supervisor
Professor Paula Reavey
Division of Psychology,
London South Bank University
103 Borough Road, London SE1 0AA

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting Professor Nicola Thomas whose contact details are noted below.
Email: nicola.thomas@lsbu.ac.uk **Tel:** 020 7815 8045

Support organisations
Samaritans website: www.samaritans.org.uk **Tel:** 116 123
Provides support to all experiencing difficulties or crisis.
Mind website: www.mind.org.uk **Tel:** 0300 123 3393
Provides support to all experiencing mental health problems or distress.

Version 3: 06.04.17

Appendix C: Consent form

London South Bank
University

Service User and Staff Consent Form (Study One and Study Two)

Public and private space within forensic mental health accommodation

Name of Researcher: Katharine Harding

	Please initial box
1. I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I may refuse to answer any questions and I am free to withdraw at any time before the research is published, without giving any reason, without my medical care or legal rights being affected.	☐
3. I have been informed about what the data collected will be used for, to whom it may be disclosed and for how long it will be retained.	☐
4. I agree for the interview to be recorded digitally and transcribed.	☐
5. I agree to having anonymised direct quotations from my interview used in any publications or presentations of this research.	☐
6. I understand that the interview being carried out is confidential, unless I disclose a serious or previously unknown crime or indicate that harm may occur to myself or others.	☐
7. I agree that the photographs or images which I supply may be reproduced and included in any publications or presentations of this research.	☐
8. I agree to take part in the above study.	☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

When completed: 1 copy for participant; 1 copy for researcher site file; 1 (original) to be kept in medical notes

Version 2: 14.03.16

Appendix D: Service user interview schedule (Study one - group one)

Service User Interview Schedule (Study One - Group One)

Public and private space within forensic mental health accommodation

Introduction

- Could you begin by telling me a little bit about yourself? You can include any information that you'd like. *(If the participant's age is not mentioned, ask if they would mind sharing).*
- Looking at the set of images which you've produced, could you take me through them individually and tell me about each one? It would be interesting to hear about why you chose to make each image and any feelings you hold about them.

The interviews will be led primarily by the participant and will focus on the photographs produced as a means by which to elicit rich narratives from each service user around their experiences of space and place. The indicative list below is a prompt for the researcher from which certain questions may be drawn and threaded into the course of the dialogue as and when appropriate. This approach is supported by the research supervisor's previous experience of interviews with mental health service users and acknowledges that for reasons including medication, some participants may have limited capacity to maintain concentration.

Home

- Could you describe what you would consider to be a definition of home?
- Could you describe whether you experience any sense of enjoyment or pleasure in the physical qualities of the place where you are living or from any of the objects within it?
- How important is choice to you in considering the details of your personal environment?

Well-being

- Could you describe any ways in which your personal environment affects your well-being?
- At times when you might have experienced distress, could you describe any ways in which thinking about other places where you have lived, or places in the community has been reassuring?
- Are there any ways in which you feel that an awareness of order or disorder within the place where you live has been relevant to your experiences of well-being?

Transition

- How do you feel in your personal environment at the moment?
- Could you tell me about any expectations or concerns you have in thinking about where you might live in the future?
- Could you tell me about past experiences of moving between places you've lived before?

Privacy

- Could you describe any spaces here which you consider to be private?
- How important is privacy to your sense of well-being and for what reasons?
- Could you describe whether there are ways in which your relationships with other people are affected by the place where you live?
- Are there ways in which sharing the place where you live with other people is significant to your experience of home?

Conclusion

Finally, could you tell me something about why you were interested in taking part in this type of research and how did you find the interview?

Version 1: 25.01.16

Appendix E: Service user interview schedule (Study one - Group two)

Service User Interview Schedule (Study One - Group Two)

Public and private space within forensic mental health accommodation

Introduction

- Could you begin by telling me a little bit about yourself? You can include any information that you'd like. *(If the participant's age is not mentioned, ask if they would mind sharing).*
- Looking at the set of images which you've produced, could you take me through them individually and tell me about each one? It would be interesting to hear about why you chose to make each image and any feelings you hold about them.

The interviews will be led primarily by the participant and will focus on the photographs produced as a means by which to elicit rich narratives from each service user around their experiences of space and place. The indicative list below is a prompt for the researcher from which certain questions may be drawn and threaded into the course of the dialogue as and when appropriate. This approach is supported by the research supervisor's previous experience of interviews with mental health service users and acknowledges that for reasons including medication, some participants may have limited capacity to maintain concentration.

Home

- Could you describe what you would consider to be a definition of home?
- Could you describe whether you experience any sense of enjoyment or pleasure in the physical qualities of the place where you are living or from any of the objects within it?
- How important is choice to you in considering the details of your personal environment?

Well-being

- Could you describe any ways in which your personal environment affects your well-being?
- At times when you might have experienced distress, could you describe any ways in which thinking about other places where you have lived, or places in the community has been reassuring?
- Are there any ways in which you feel that an awareness of order or disorder within the place where you live has been relevant to your experiences of well-being?

Transition

- How do you feel in your personal environment at the moment?
- Could you tell me about any expectations or concerns you have in thinking about where you might live in the future?
- Could you tell me about past experiences of moving between places you've lived before?

Privacy

- Could you describe any spaces here which you consider to be private?
- How important is privacy to your sense of well-being and for what reasons?
- Could you describe whether there are ways in which your relationships with other people are affected by the place where you live?
- Are there ways in which sharing the place where you live with other people is significant to your experience of home?

Conclusion

Finally, could you tell me something about why you were interested in taking part in this type of research and how did you find the interview?

Version 1: 25.01.16

Appendix F: Staff interview schedule

Staff Interview Schedule (Study One and Study Two)

Public and private space within forensic mental health accommodation

Introduction

- Could you begin by telling me a little bit about yourself? You can include any information that you'd like. *(If the participant's age is not mentioned, ask if they would mind sharing).*
- Looking at the set of images which you've produced, could you take me through them individually and tell me about each one? It would be interesting to hear about why you chose to make each image and any feelings you hold about them.

The interviews will be led primarily by the participant and will focus on the photographs produced as a means by which to elicit rich narratives from each member of staff around their experiences of space and place at work. The indicative list below contains questions which may be threaded into the course of the dialogue as and when appropriate.

Workplace

- Could you describe whether you experience any sense of enjoyment or pleasure in the physical qualities of the place where you work or from any of the objects within it?
- How important is a sense of choice to you in considering the details of your work environment?

Well-being

- Could you describe any ways in which your working environment affects your well-being?
- Are there any ways in which you feel that an awareness of order or disorder within the place where you work has been relevant to your experiences of well-being?

Privacy

- Could you describe any spaces here which you consider to be private?
- How important do you think privacy is to the experience of well-being here and for what reasons?
- Could you describe any ways in which you feel that your relationships with other people are affected by the place where you work?

Transition

- Could you describe any ways in which you feel that spaces within the housing project/inpatient setting and in the local community might assist or hinder service users' experience of transition e.g. transition between different secure inpatient settings, transition between inpatient settings and the community, or transition between high support and lower support accommodation in the community?

Conclusion

- Finally, could you tell me something about why you were interested in taking part in this type of research and how did you find the interview?

Version 1: 25.01.16

Appendix G: Service user participant debrief

London South Bank
University

Service User Participant Debrief (Study One and Study Two)

Public and private space within forensic mental health accommodation

Thank you for taking the time to be interviewed for this research and I hope you may have found it interesting to take part. As mentioned in the information sheet, I am studying Psychology at London South Bank University. The interview and images you have provided will contribute to my PhD research project and possible future academic publications or conference presentations.

The interview will be transcribed and analysed in the context of previous research in this area. The current study aims to provide further understanding of the everyday experiences of UK forensic mental health service users and staff within inpatient and community residential settings. The research may potentially inform the management and development of services and increase understanding of how residential environments may affect the experience of well-being and the recovery process.

All the information you have provided will be made anonymous to ensure complete confidentiality. Some sections of the anonymised interview transcript may be quoted directly within publications of the research. If you wish to withdraw entirely from the research you may do so without giving a reason, at any point until completion of the PhD project, however, after that time, it would be impossible for the researcher to comply. Should you wish to withdraw from the research, your care will not be affected. You may also request that any answers given in the interview are removed from the transcribed data or request that any images supplied are deleted or are not reproduced in publications of the research.

Because the material discussed was personal to you, you may have started thinking about subjects or feelings which came up in the interview. Should anything arise during the research to cause you to feel concerned or upset, contact details for independent support organisations that you could contact for information or to speak with someone in confidence are provided at the end of this sheet. You should also speak with the staff where you live or your care coordinator if you feel affected by the research.

Thank you again for your participation in this research.

Researcher
Katharine Harding
Division of Psychology,
London South Bank University
103 Borough Road, London SE1 0AA

Research supervisor
Professor Paula Reavey
Division of Psychology,
London South Bank University
103 Borough Road, London SE1 0AA

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting Professor Nicola Thomas whose contact details are noted below.
Email: nicola.thomas@lsbu.ac.uk **Tel:** 020 7815 8045

Support organisations
Samaritans website: www.samaritans.org.uk **Tel:** 116 123
Provides support to all experiencing difficulties or crisis.
Mind website: www.mind.org.uk **Tel:** 0300 123 3393
Provides support to all experiencing mental health problems or distress.

Version 3: 06.04.17

Appendix H: Staff participant debrief

London South Bank
University

Staff Participant Debrief (Study One and Study Two)

Public and private space within forensic mental health accommodation

Thank you for taking the time to be interviewed for this research and I hope you may have found it interesting to take part. As mentioned in the information sheet, I am studying Psychology at London South Bank University. The interview and images you have provided will contribute to my PhD research project and possible future academic publications or conference presentations.

The interview will be transcribed and analysed in the context of previous research in this area. The current study aims to provide further understanding of the everyday experiences of UK forensic mental health service users and staff within inpatient and community residential settings. The research may potentially inform the management and development of services and increase understanding of how residential environments may affect the experience of well-being and the recovery process.

All the information you have provided will be made anonymous to ensure complete confidentiality. Some sections of the anonymised interview transcript may be quoted directly within publications of the research. If you wish to withdraw entirely from the research you may do so without giving a reason, at any point until completion of the PhD thesis, however, after that time, it would be impossible for the researcher to comply. You may also request that any answers given in the interview are removed from the transcribed data or request that any images supplied are deleted or are not reproduced in publications of the research.

Because the material discussed was personal to you, you may have started thinking about subjects or feelings which came up in the interview. Should anything arise during the research to cause you to feel concerned or upset, contact details for independent support organisations that you could contact for information or to speak with someone in confidence are provided at the end of this sheet.

Thank you again for your participation in this research.

Researcher
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If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting Professor Nicola Thomas whose contact details are noted below.
Email: nicola.thomas@lsbu.ac.uk **Tel:** 020 7815 8045

Support organisations
Samaritans website: www.samaritans.org.uk **Tel:** 116 123
Provides support to all experiencing difficulties or crisis.
Mind website: www.mind.org.uk **Tel:** 0300 123 3393
Provides support to all experiencing mental health problems or distress.

Version 3: 06.04.17

Appendix I: Transcription conventions

Adapted from Coffey (2012b)

[??]	Inaudible word or section of speech.
(*Laughs*)	Description of participant or researcher action or body language during interview (e.g. laughter).
<u>Underlined</u>	Underlined text denotes the speaker's emphasis on a word or part of a word.
Um	Sounds uttered by the researcher or participants during the course of speech transcribed phonetically (e.g. 'Um' or 'err').
[…]	Omission of part of the transcript.
[*Name of ward*]	Text in square brackets indicates information omitted from the transcript, or a note adding clarification to the meaning or context of speech.
Wor-	Hyphen appended to an incomplete word indicates a cut-off word or sound.
R:	Denotes researcher and other letters are used to indicate the first letter of the pseudonym for each participant.

Appendix J: Alice

Alice was a patient in a low secure environment at the time of the interview. Alice mentions being quite young when she was first admitted to hospital and prior to moving to her current ward, she also received care in another low secure environment. Alice is close to her family and whilst she has not been able to go back to the family home since being admitted to hospital, she is excited because her first home visit is due to take place soon. Alice's family live a significant distance away from the hospital and she expresses appreciation for the regular visits that she receives from her parents, despite the long distances that they need to travel.

Alice describes her enjoyment of cooking and baking. With staff support she shops for ingredients and uses the patient kitchen to cook meals and bake on a regular basis. Alice talks enthusiastically about her fondness for animals and how she values having the opportunity to spend time with therapeutic dogs that sometimes visit the ward. Alongside listening to music on the radio, Alice enjoys socialising in small groups and through the narrative she positions herself as a person who cherishes moments of fun enjoyed with other people. Although she describes having had a very difficult journey to this point, Alice brings humour into the stories she tells about the challenging times and events she has experienced. Her overall narrative has an underlying tone of positivity and she is enthusiastic about life beyond hospital, including her plans for studying towards a future career.

Alice's main storylines focus around: (1) links between space and her emotions, (2) enjoyment of spaces that facilitate social interaction, (3) enjoyment of outdoor spaces, (4) associations between spaces, possessions and selfhood, (5) negotiating relationships on the ward and (6) visualising future spaces.

In the interview Alice reflected on photographs of: (a) her bedroom, (b) quiet room, (c) visitors' room, (d) patient kitchen, (e) day area, (f) ward corridor, (g) crafts room, (h) patient lockers, (i) meeting room and (j) day area mural.

Appendix K: Darren

Darren is a patient on a medium secure psychiatric ward and he mentions having also spent time in prison previously. He is reserved when speaking and the overall tone of his narrative is quite flat throughout. Darren describes having had no belongings at the time of his admission to hospital and how he appreciates having since acquired some possessions, including a stereo. Although aspects of the ward design remind Darren of prison, he perceives the hospital to be a less institutional setting overall. In contrast to prison, he talks about how having his own bedroom key affords a valued sense of having freedom to come and go within the ward environment.

Darren describes his enjoyment of socialising with other patients during activities including cooking sessions in the therapy kitchen, or gardening in the hospital café courtyard. He also mentions how spending time in outdoor spaces, such as the café courtyard or a smoking point on the perimeter of the grounds is especially valued and offers a form of distraction from his current situation. Woodworking sessions in the off-ward workshop are described as enjoyable and able to provide an escape from boredom. The narrative also conveys a sense of Darren's pride in particular items that he has handcrafted and the skills gained in the workshop.

Darren's main storylines focus around: (1) spaces that provide a retreat and sense of sanctuary, (2) how possessions and objects are linked to self-identity and a sense of personal investment, (3) having an awareness of carceral symbolism within the physical environment, (4) appreciation of spaces that facilitate social interaction, (5) using space as a distraction or form of escape and (6) enjoyment of outdoor spaces and spaces outside the hospital building.

Darren talked about photographs taken of: (a) his bedroom, (b) bedroom corridor, (c) therapy kitchen, (d) off-ward communal café courtyard, (e) off-ward woodworking workshop, (f) door to medication room, (g) dining room servery hatch and (h) dining room.

Appendix L: Felicity

Felicity is a trainee occupational therapist working on a medium secure ward. She is enthusiastic about her role and her overall narrative tone is positive. Felicity describes experiencing a sense of enjoyment in observing patients gain confidence and skills through participation in therapeutic activities. She expresses appreciation for the items created by patients, particularly the artworks displayed on walls throughout the ward.

Felicity's accounts convey her sense of how the scale, temperature, atmosphere and appearance of the everyday ward environment can affect the quality of therapeutic relationships when working with patients in groups or individually. She especially values the non-institutional attributes of the therapy kitchen and perceives this space on the ward to have the homely appearance and realistic functionality of a typical domestic kitchen. Felicity highlights how the informal and impromptu conversations with patients that arise during individual cooking sessions in this space provide useful opportunities for patients to confide in staff about their worries or concerns. She also believes that patients benefit from spending time in spaces that are outside the ward itself, including the craft room. Felicity observes that 'off-ward' areas are an important resource for patients and feels that these spaces are particularly valued by people who don't have ground leave or access to the community.

Felicity's main storylines focus around: (1) appreciation for patient artwork, (2) therapeutic benefits of home-like and non-institutional spaces, (3) associations between spatial attributes and staff-patient relationships, (4) the importance of maintaining staff-patient boundaries and (5) how the scale or atmospheric conditions of spaces affect therapeutic work (6) benefits of off-ward spaces for patients and staff.

During the interview Felicity presented photographs of: (a) ward entrance with patients' handmade welcome signage above the door, (b) therapy kitchen, (c) small group room including patients' artwork on the walls, (d) off-ward therapy room for arts and crafts projects.

Appendix M: Gavin

Gavin is a trainee occupational therapist on a medium secure ward. It is his first experience of working in a mental healthcare environment and he speaks positively about his overall experiences in this setting. The tone of his narrative is upbeat and he expresses appreciation for the strong sense of teamwork and lack of hierarchy he perceives amongst colleagues within the multi-disciplinary team.

In his reflections about the hospital spaces, Gavin remarks on the large overall scale and proportions of the building and his sense that a spacious environment is important for patients, especially for people who are not able to leave the ward. Whilst noting that generous spaces can benefit patient and staff safety in medium secure settings, he also perceives that some parts of the hospital environment are overly large or disproportionate in relation to their function and some spaces have poor acoustics.

Gavin highlights the physical and psychological health benefits of spending time in outdoor spaces and feels it is positive that patients have access to external spaces via the dedicated courtyard and garden on the ward. He generally stays inside the building during his breaks, however, due to the effort of entering or leaving the building via the security airlock and the time that this takes.

Gavin's main storylines focus around: (1) appreciating positive relationships with colleagues and patients, (2) the proportions and scale of the building and interior spaces (3), having awareness of carceral symbolism within the built environment, (4) how sense of openness in the environment is linked to staff and patient experiences (5) the benefits of off-ward spaces for patient and staff well-being and (6) associations between the layout of spaces on the ward and relationships between and amongst patients and staff.

Gavin discussed photographs taken of: (a) café inside the hospital building, (b) dining room including food servery hatch, (c) ward courtyard, (d) patient lounge/ day area.

Appendix N: Jo

Jo is a clinical nurse leader on a low secure ward. She has worked with the same patients in an older building previously and notes how it took her time to adjust to the increased number of doors and locks in the current environment when compared with the previous ward. Whilst she perceives the original ward to have been a less carceral environment overall, Jo highlights how it was harder to monitor patient safety there due to the ward layout which presented a number of blind spots.

Jo appreciates the current ward for its spacious attributes, including large bedrooms, generous day areas and an outdoor garden. Throughout the interview she empathises with patients' experiences and reflects on how people might feel in spaces on the ward, including the lounge, which she feels to be like a waiting room with perimeter seating and the television positioned at high level. Jo highlights the value of having 'off-ward' spaces in which staff can take short breaks from the stresses of the ward. Accordingly, she notes that staff, patients and visitors typically enjoy spending time in a side room, which affords a sense of privacy and separation from the main ward. Jo's narrative indicates that she is dedicated to improving patient experiences and she comments on the importance of consulting with nurses when new hospital spaces are designed, as nursing staff will spend each day on the ward.

Jo's main storylines focus around: (1) how the generosity of space on the ward benefits patients, (2) the influence of aesthetics on mood, (3) comparisons between the current ward environment and an older ward, (4) ways in which the ward layout affects safety and risk management, (5) attempting to optimise patient privacy, (6) negotiating uncomfortable spaces, (7) benefits of off-ward spaces for patients, staff and visitors, (8) ward rules and safety protocols (9) and creating a home-like environment.

Jo reflected on the following photographs in the interview: (a) larger patient day area, (b) smaller patient day area, (c) ward courtyard garden, (d) seclusion room, (e) patient bedroom corridor and (f) circulation area outside the nursing office.

Appendix O: Karen

Karen is a healthcare assistant based on a low secure ward. She is a long-standing member of staff and has worked previously in both medium and low secure environments. Karen's accounts indicate that she is dedicated to her role and she is particularly enthusiastic about helping patients to prepare for independent living. Whilst she alludes to her perception that healthcare assistants' perspectives are not especially influential within the overall institution, she describes feeling valued by being invited to share her experiences in the research.

Karen's narrative conveys a strong sense of camaraderie amongst staff and she notes how all colleagues in the building support each other as a team when responding to incidents. She refers frequently to risk and safety and highlights how environmental features, including the use of electronic fobs instead of keys enable staff to respond quickly. Karen often works outside the ward and feels that patients typically confide in staff more in 'off-ward' spaces, particularly outdoor spaces, or places in the community.

Karen's main storylines focus around: (1) awareness of risk and ward safety, (2) how spatial experiences influence staff-patient relationships, (3) the importance of connections to nature and outdoor spaces, (4) having emotional responses to spaces and objects, (5) how physical features of the environment help staff and patients, (6) optimising spaces and resources in the environment to benefit patients and (7) perceptions of her professional role.

Karen discussed the following photographs: (a) CCTV monitors above seclusion room door, (b) seclusion room door, (c) seclusion room door hatch, (d) seclusion room interior, (e) extra care suite courtyard, (f) digital panel to alert staff to emergencies on other wards, (g) doors to unused kitchen in the building, (h) panel to enable staff to open locked doors inside the building using an electronic fob, (i) unused IT suite within the building, (j) sports hall within the building, (k) glass wall in off-ward circulation area, (l) fire extinguishers inside secure cabinets.

Appendix P: Sal

Sal is currently a patient in a medium secure ward environment. He has been detained in hospital for several years and mentions that he has also previously spent time in prison. Sal describes having been on a very difficult journey and talks about how he is excited to be moving on imminently to a low secure setting.

The overall tone of Sal's narrative is optimistic about the future and his eventual discharge into the community. Although he is looking forward to moving to a low secure ward in another hospital, he hasn't yet seen the place he'll be moving to and is waiting for confirmation on the timing. Sal describes how he will miss the current ward and his close friends but feels that he has been there too long and become too settled. A sense of him having been detained for several years within institutional environments is also conveyed through his very detailed accounts of the ward rules and protocols which recur throughout the interview.

Sal presents himself as a sociable person and he expresses his enjoyment of spending time with other patients in off-ward spaces, including playing football, cooking and gardening in the hospital courtyard garden or an allotment in the grounds.

Sal's main storylines focus around: (1) moving forward and looking ahead to his life beyond hospital, (2) the importance of social interaction and engaging in meaningful activities, (3) the enjoyment and satisfaction of perceiving a sense of choice and independence, (4) how spaces and activities can enable psychosocial transportation away from his current circumstances, (5) being aware of and respecting rules and routines on the ward and (6) the importance of experiencing a clean and tidy everyday environment.

In the interview Sal reflected on photographs of: (a) ward entrance corridor mural, (b) therapy kitchen, (c) off-ward communal café courtyard, (d) off-ward communal café, (e) dining room, (f) dining room servery hatch and (g) bedroom corridor.

Appendix Q: Vicky

Vicky is an assistant psychologist and currently working with patients on a medium secure ward. Through the narrative she presents herself as being dedicated to her role and she is enthusiastic about working therapeutically with patients. Vicky describes her experience of the nursing station as like being in a goldfish bowl and she is concerned that patients can become distressed or perceive that their needs are not being met when staff are busy on other tasks there. Managing her own stress can be difficult in a medium secure environment and she appreciates having access to an office area off the ward which affords a sense of respite from the ward when required and a space to complete administrative work without interruption.

Vicky is also mindful of how the ward environment is experienced by patients. She suggests that the atmospheric qualities of meeting rooms, including light levels, temperature and affordance of privacy are significant to patient experiences of participating in therapeutic sessions in those spaces. Vicky highlights how patients benefit from spending time in outdoor spaces and she uses the ward courtyard for mindfulness sessions, in addition to providing mindful walks in the hospital grounds for patients with ground leave. Whilst she went outside regularly during her breaks when based in a smaller building, in her current workplace Vicky now finds it easier to stay indoors due to the scale of the building and time needed to go through the airlocks.

Vicky's main storylines focus around: (1) the clinical qualities of the overall environment, (2) how the scale, layout or atmospheric attributes of spaces affect therapeutic work, (3) the value of off-ward spaces for staff and patients and (4) the therapeutic benefits of green spaces and spending time outdoors.

Vicky reflected on the following photographs in the interview: (a) her desk in an off-ward office area, (b) large meeting room on the ward, (c) smaller meeting room on the ward, (d) small office within the nursing station, (e) main nursing station area.

Appendix R: Sample participant storyline summary

Wendy: Main storylines
(1) Managing professional challenges and stress - Feeling stressed by aspects of her professional role e.g. - Sharing responsibility for several wards' staff + patients, plus her own, when holding bleep. - Adjusting to working in a setting with wards split across several separate buildings. - Dealing with the stress of coordinating staffing when limited staff resources are available. - Managing patients' expectations on her own ward when staff are seconded to other wards.
(2) Negotiating uncomfortable spaces - Experiencing affective discomfort in spaces on the ward e.g. - Feeling exposed when working within the glazed nursing office. - Having awareness of the ward atmosphere building up and becoming uncomfortably potent. - Feeling a need to 'escape' from the enclosed ward to 'reset' during a long shift. - Being disconnected from nature and natural light within the ward environment. - Managing conflicting emotions associated with use of the seclusion room.
(3) Managing her own and colleagues' emotions within her professional role - Managing her own emotions to maintain calm amongst colleagues during ward incidents. - Concealing emotions to maintain a professional position amongst colleagues + patients. - Managing emotions to express authority to patients e.g. during aggressive incidents. - Having a 'prison guard' feeling associated with seclusion use affects nursing self-identity.
(4) Having emotional responses to spaces and objects - Experiencing anxiety associated with certain objects on the ward e.g. - The bleep equipment prompts a sense of unease in anticipation of challenging events. - Clinic and medical equipment are reminder of a previous experience of patient emergency. - Metal detector wand that can pick up contraband / weapons that might constitute a threat.
(5) Navigating boundaries and relationships with patients - Role involves building patient relationships, but environment reinforces power differences. - Awareness of power being expressed through physical environment + patient interactions. - Needing to maintain professional boundaries and not become complacent amongst patients. - Patient relationships involve both caring nursing and authoritarian 'policing' roles.