Caring Architecture

Caring Architecture:

Institutions and Relational Practices

Edited by

Catharina Nord and Ebba Högström

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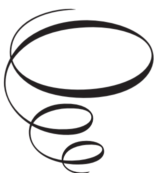

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COMMENTARY I

BETWEEN CARING AND ARCHITECTURE

GUNNAR OLSSON AND MARTIN GREN

MG: What is the first thing that pops up in your mind when you hear the expression “caring architecture”?

GO: That it is a falsity. Any architecture that is intentional is a way of forming other people, so I immediately sense an inevitable closeness between caring architecture and imprisoning architecture.

MG: So, architecture is about intentionally forming other people by physical structures?

GO: Yes, and you can have different intentions when you are forming the physical structures, but you are making a great mistake if you forget that the very point of building is to shape other people´s lives. It can be life in prison, in the caring home for the elderly, or in the living room where we now are sitting. How you do this forming obviously varies, but the fundamental idea is that by structuring spatial space you are simultaneously structuring people.

MG: Regardless of what kind of architecture we are talking about it is always intimately linked to relationships of power.

GO: Yes, architecture itself is very much steeped in power since its very essence is to form or delimit people´s behaviour. It is always about power-relations, about moving from physical infrastructure, like the concrete walls in front of you and me, into our malleable minds.

MG: In that sense, there is a straight line to be drawn from the architect to the politician.

GO: Well, there is no real modern politician who does not know that the very point of politics is to form people´s minds. A serious politician also knows that if you state that explicitly, then people will of course object, so instead they enter our minds indirectly by forming the physical environment in which we are living.

MG: As for the architects, can they do their forming in a caring way?
GO: Yes, of course.

MG: How would they, or we, know that the architecture is caring?
GO: I think it is a question of how you legitimate the interference. In the prison, you do so in one way, while in the madhouse, where the point is both to protect people from themselves and to form them in relation to others, you do it in another way. With the caring, it is very much the same. Thus, if you claim that you are building caring architecture you are inevitably legitimating your interference in other people´s life. You put yourself in a position where you claim to know what other people need. Not by building a prison to keep them contained but by caring for them, implicitly or explicitly claiming to know more about them from doing whatever we can. These people–those who are in that vulnerable situation–may literally sometimes not even know who they are.

MG: These people would then need a caring architecture that would help them find their way.
GO: Very much in the same way as a small child needs your care. And as a person who is now getting old, I realize that I may soon end up in that situation myself. I am convinced that most of us still want to have our freedoms and our lives. Some of these needs we may not even be aware of, but we certainly don´t want to be told what to do. In this caring situation, we want the architecture to be such that we are taken care of without knowing that we are taken care of. We do not want to trip on the threshold, and we would therefore like you to remove it. We would also not like you to put a black carpet in the middle of the room, for too many patients with dementia stepping on a black carpet is like stepping into a black hole. No one would like to be sucked into that abyss.

MG: The architecture, including the interior design, should take care of that.
GO: Yes, and we know this not only from experience but also from current brain research. For example, if we lose our memory we may need help to see the difference between the plate and the porridge. If they are of the same colour, we will not eat the porridge. Many old people are unfortunately senile and some of them are starving to death because they have lost their sense of taste; no wonder that they refuse to eat. Personally, I have long harboured the dream that fifty years from now someone will have invented an aid that will do to the sense of taste what your glasses do to your sight, and my hearing aids do to my bad hearing. Easier said than done, though, partly because the

senses are ordered according to the taboo of not getting too close looking at someone is socially acceptable, licking a stranger is not. One may also note that not too long ago bad hearing was taken as a sign of low intelligence.

MG: It seems that we are now moving from a caring architecture of thresholds, colours and spatial design, towards the human body itself. Certainly, that raises questions about the ethics of a caring architecture.

GO: Well, if we in our caring come too close to people we do so because we have crossed the forbidden line of the taboo. And that is precisely how it should be. Society, in this case operationalized as architecture, has no right to get into me. Yet that is exactly the ethical danger that any caring architecture must face.

MG: Caring architecture raises exo-somatic problems and opportunities in relation to the limits of the human body. How do you conceive of the limits of architecture itself?

GO: The limits of architecture are in the physical structure itself. When the architect designs a building so that I can enter it by a wheelchair, there is an interaction between a physical body and a physical entity. No one can object to that. As long as architecture stays on that level, as long as it tries to adjust physical structures to the caring of the human body, everything is fine.

MG: But that is not only what architecture does.

GO: No, because by designing and constructing physical structures you are deliberately influencing the possibilities for life and behaviour in that building. Once again, this means that architecture operates in the limit between body and mind, material things and social relations. Having norms and regulations for building so that the walls do not fall down is one thing, designing the geography of social interactions is quite another.

MG: And social interaction is what caring architecture designs.

GO: If you do not know where you are, the physical structure should be constructed in such a way that the loss does not matter, that it takes that problem away. Even if you are not able to find your way, you should be respected for who you are, even you may not even know what or where your mouth is. How do you design an environment for that type of situation, not only for the caretakers but for the caregivers as well?

MG: One of several ideological, political and ethical aspects of caring architecture is about who it is designed for, the caretaker or the caregiver?

GO: That is correct, and that raises the problem of who should decide. Obviously, the decisions operate on all levels, but when you have a caring

architecture it all comes closer and closer to the individual caretaker. Much of the debate now seems to be more about the caregivers than about the caretakers. The caretakers have relatively little power and it is often their children who feel the need to step in. To have your children take care of you may sometimes be necessary, but it is also a form of caring that is full of deep existential problems.

MG: And both the architecture and the caretaker may appear in many guises.

GO: Yes, and therefore it might be interesting to compare the architecture of care and the architecture of the zoo. Sometimes it seems that there is more concern about the architecture of the zoo than the architecture of the old people´s home. How do you preserve the integrity of these human beings? Indeed, I am occasionally feeling that there is more discussion about the rights of animals than about people who have lost their way. One should of course be very careful here, but there is a point to the point.

MG: Our conversation so far has brought up two crucially important issues.

GO: Yes, the first is about form and process, the relationship between the spatial form and what it does or is intended to do with human processes, the lives that are possible to live in that form. The other issue is an ethical problem that architects rarely confront: architecture is a hidden tool of power. The way you build–even where you place the electric sockets in the room–automatically determines the life that is possible to live in that spatial set-up. You construct a physical structure in order to change people´s minds. Very clear.

MG: So, there is always a politics that comes with and through architecture, in that it promotes human thought-and-action in certain ways. Some may be liberating; some may be confining.

GO: Yes of course, and that is how power always works. Also in architecture, it has a suppressive part and a good part. Power would not be power if it were not contradictory. The danger is that the goodness often gives way to the strictness of the power. For instance, it would be easy to build an escape-proof prison, but no prison-warden ever want to run a jail like that. It would in fact be the worst institution you can have, because what you must not do is to kill the prisoner's wish to escape. Likewise, you must not take away the caretaker´s idea that there is a life outside. To be precise, you must never build so that you kill the faculty of imagination, *the* faculty that makes us human. For example, we do not know what happens in the minds of people

with Alzheimer and dementia who by definition have lost their way. Have they also lost their way of imagining another form of life?

MG: In a way, there is the risk that the distance between imagination and the architecture would be reduced almost to zero.

GO: Yes, you might build a caring institution that is so caring that it becomes an escape-proof prison not merely of the body but of the mind as well.

MG: There is then important that caring architecture moves beyond architecture as physical construction.

GO: Yes. If you try to remove the physical foundation of architecture, it becomes more difficult but also much more interesting. Why? Well, because the interest turns precisely towards the relational realm that is located in-between the physical structure and the lives of human beings I have been talking about. Furthermore, one could, by alluding to Immanuel Kant, say that the architecture we know best is the building of the house of pure reason. It follows that we are tempted to use that logic also when we are considering the architecture of caring. And that is wrong.

MG: In other words, thinking architecture in terms of physical structure is not abstract enough?

GO: Of course, not. The way we find our way in the invisible world is by somehow imagining it *as if it were* visible.

MG: To the extent that architecture privileges a reason of physical structures as beings, it would be less well equipped to handle becomings and all the rest that is before or after, or in-between its physical architectonics. It follows that it may benefit from going from nouns to verbs, from architecture to architecturing, much as in the present book care has been turned to caring.

GO: Reflecting from the outside, I imagine that the authors are talking about architecture in that first sense and then expanding into a caring architecture. I do understand and applaud their attempt. However, in that very conception there might at the same time be a temptation to somehow transfer the mode of thought that is in the pure house of reason; since I know how to build a house so it does not tumble down, I too easily conclude that I also know how to build for caring. Humpty Dumpty sat on a wall…

MG: And caring architecture?

GO: Well, a real challenge for caring architecture means that it is not enough to construct a building that does not fall down. The real challenge is

instead to build so that the people who are cared for will not fall into the abyss. When the chips are down and the roulette spinning, who is taking it all?

MG: And on whose side is the caring architect when distributing the powers and agencies of caring architecturing?

GO: In my understanding, the architect would be in the infra-thin line of the *Saussurean Bar*. In that conception, caring architecturing is about the glue that at the same time holds us together and keeps us apart, that glue being at the same time both a noun and a verb. On the surface, it is about the physical structure and those who are living within it; deeper down it is about the relations between the architects who have designed the houses and those who are living in them. Once again, we are involved in the dialectics of form and process. In a sense, what I am saying is not merely true, but too true to be true.

MG: True or not, it is a nice way of pausing our conversation.

INTRODUCTION

CATHARINA NORD AND EBBA HÖGSTRÖM

Architecture and institutions

Architecture is hard and inert matter. Walls, roofs, and floors form buildings—by elements composed of solid materials: stone, glass and wood. These elements in turn form rooms, which are quantifiable in metres and square metres, their size defined according to hard, Euclidian spatial concepts, exact to the nearest millimetre. Buildings also have the capacity to restrict and delimit what people *do* within their boundaries; they distribute and direct subjects who, because they see buildings as constituting a self-evident frame for their everyday lives, are unaware of this direction. Thus, despite its apparent hardness, built space is also elusive: its ubiquitous presence and simultaneous absence work to conceal the magnitude and diversity of the influences it exerts over users. Although architecture comprises of tangible and solid matter, the small-scale spatialities this matter produces end up defying their own boundaries and transgressing their own physical content. By virtue of its partnership with those who populate it, whether human or non-human, architecture is therefore both non-tangible and fluid (Yaneva 2012, Dovey 2013, Till 2009).

Institutions constitute perhaps the most difficult of architectures. Their capacity to exert power over, and to forcibly affect, users, reveals their coercive quality as discursive architectural models and practices: institutional architecture in this sense can restrict ways of thinking and acting and privilege certain options over others (cf. Foucault 1977, Goffman 1961). Institutions are often "big things", both in the sense of being massive buildings in themselves and in their (international) proliferation as design models (Jacobs 2006). Hospitals, asylums, correctional facilities, national and political institutions and urban megaprojects are all ascribed particular capacities to impress, punish and govern citizens, and perhaps to care for their inmates (Dovey 2008, Markus 1993, Vale 2014). Although, it is sometimes difficult to link this caring and empathetic attitude to the austerity and rigidity of the architectural space of such institutions (Markus 1993, Åman 1976, Godfrey 1955).

It would of course be a serious mistake to assess the institutions of another time in accordance with the humanist values of the present. However, if older architectural models survive in the design of contemporary hospitals, facilities for the care of the aged, in psychiatric facilities, etc., can we then presume that the thoughts and practices that led to their production also survived in one way or another, by being embedded in architectural space? John Law argues that thought and matter—and architectural space constitutes both—are deeply entwined. He writes, “It is the generation of material effects that lies at the heart of the modernist project of self-reflexivity” (Law 1994, 139). Taking into account such effects, this book aims to open up new pathways for thinking about and discussing *institutional architectural space*. Borrowing from Law (1994), one point of departure for this work lies in our understanding of institutions as being iterated by the performance of matter, space, ideas and people through certain modes of “ordering”. Institutions and architecture are here seen as intimately intertwined in a manner that in fact bypasses the architectural object. This standpoint challenges a view, which positions the institution as a representation, a repeated model of architectural design and of certain discursive rationalities. Instead, we choose to address institutions as *performances*, to consider what they *do* rather than what they *mean* (Dovey 2013, Jacobs and Merriman 2011).

The architecture of institutions has changed dramatically in the last 50 years. The austere, impressive and strict institutional architecture of yesteryear has now been abandoned, giving way to other design models. The so-called “healing architecture” of newly designed hospitals endows spaces such as the lobby with a welcoming atmosphere, and places aesthetic emphasis on patient rooms where family members may even be able to stay overnight (Wagenaar 2006). Homes for the elderly have turned into assisted living facilities, in which older people no longer share their rooms with strangers and can socialise with fellow residents in ambitiously designed public areas with high-quality interior furnishings (Regnier 2002). Even the architecture of the most “hardcore” of all institutions—the prison—has been transformed in order to manifest humanist ideals such as respect for the individual and the humane treatment of inmates (Chantraine 2010, Fairweather and McConville 2000). Despite these shifts, changes in institutional architecture are far more complex than what is suggested at first glance. Far from a simple replacement of the old with the new, architectural design approaches are intertwined in intricate and often contradictory ways (Street 2012). The changes witnessed in institutional architectural design may in this sense be less profound than they seem, and in fact may simply reflect the greater influence exerted by culture rather than of any fundamental alteration in the way that we think about medical spaces. Thus, we encounter

a situation wherein new hospital designs may on the one hand reclaim medical and organisational ideas from the early 20th century, whilst at the same time integrating commercial environments in their structures (Adams 2007). The latter spaces (shopping malls, etc.) are often to some extent cut off from the rest of the hospital, with the primary aim of securing a patient base rather than making any real difference in relation to the wellbeing of the sickest and weakest (Sloane 1994). Like the healing architecture of the hospital, the "humane prison" can also be questioned with respect to contemporary societal needs for security and the consequent incarceration of "dangerous" inmates (Chantraine 2010). Similarly, the redesign of psychiatric hospitals, which have for several decades been the target for changes in size, location, timeframes and levels of control under labels such as *de*-, *trans*- and *re*institutionalisation (Parr 2008, Högström 2012), must also be considered as a complex layering rather than a replacement of old with new. The policy of deinstitutionalising mental healthcare has played out very different in different contexts, and has resulted in more or less successful community-based alternatives to asylum-based care, and this constitutes a further complexity, which must be taken into account (Gleeson and Kearns 2001).

Despite ambitions to create a new institutional architecture, the examples addressed in the chapters of this book—namely, a hospital (Björgvinsson and Sandin), a residential care home for teenagers (Severinsson), and assisted living (Nord, Andersson) and mental health facilities (Ross, McGeachan, Högström)—reinforce the on-going importance of older commitments to "reform" those admitted into institutional care. Thus, despite the isolation imposed on the individuals admitted into their care, the primary aim of such institutions is still to restore wellbeing, improve conduct and in most cases, rehabilitate individuals into the community of the healthy and the "normal". It is argued that the modern project was imbued by a preoccupation with the establishment of social order, embedded for instance in social engineering, with the aim of handling the ambiguous and the deviant (Bauman 1991). Traditionally, institutions were assigned the role in this context of "collecting and confining those who in one way or another could introduce chaos into the social order" (Markus 1993, 95). The chapters of this book reinforce the importance of this inheritance, describing facilities in which this commitment is still discernible, where "awkward" and sick people spend time severed from the community in order to become healthy and well-functioning citizens. Whilst the older institutional role of keeping up a given social order is therefore possible to trace in contemporary projects, the scholarly preoccupation with order has largely been eclipsed by an interest in the relationship between power and resistance in institutions, often building on the theoretical work of Michel Foucault (Dovey 2008, Allen 2003, Sharp et

al. 2000). Power thus appears in this anthology in its oppressive form but also in more obscure and opaque versions, as "manipulation" or even "seduction". Whilst acknowledging the importance of previous literature, we are not here primarily interested in tracing the social order as a product of the societal endeavour of institutions; rather, as we hinted at earlier, we adopt a view of space as an act of "ordering" as advocated by Law (1994) and by Hetherington (1997). As such, we contend—with Jacobs and Merriman (2011, 212, emphasis in orginal)—that "social order [i]s an outcome not of impervious, omnipotent, *out there* structures or systems, but *right here* coordinated (although not always rational) agreements and arrangements based in contingently formed skills and interpretations". Our interest takes us "right here", inside the walls of our institutions, with a focus on the everyday practices performed by architectural space and other matter in cooperation with the people who live and work in institutions for shorter or longer periods. Our aim is to elucidate how architectural space in institutions is involved in processes of complex ordering—the kind of ordering which destabilises order, as it were—thereby hopefully contributing a more detailed and nuanced image of what it is that is happening in institutional care today.

In this task, we also wish to emphasise the political implications of both institutions and of the concept of care. How a society treats their members in need of care—be they physically or mentally ill, old and frail, or young and deviant—mirrors the values of that society. Lawson (2007, 5) points out that the marginalisation of care in a time of individualism is a political act, which supports "the myth that our successes are achieved as autonomous individuals". In light of these comments, the criticism of institutions, which emerged in the 1960s and 1970s in line with discourses of "autonomy" in fact, appears to have largely constituted an act of stereotyping which has labelled the institution as being, above all, repressive (cf. Gleeson and Kearns 2001). Even if being "an autonomous individual" involved the recognition of justice and universal rights, care institutions were not seen to support such values under such a critique. To go "right here", inside the institutional walls, should be read as a desire to challenge these now out-dated stereotypes and to advance a more complex, multifaceted understanding of institutions as spatial, organisational, affective and political configurations where care, cure, control, agency, power, hopes and possibilities all merge.

Architectural geography and non-representational theory

This book sets out to show how people and spaces are able to negotiate, and often to challenge, the norms and patterns embedded in the intersection of architecture and institutions. A non-representational perspective allows the

emergent, flexible and mouldable practices in which institutional architecture is defied, contested and transformed to be brought into view (Anderson and Harrison 2010a, Thrift 2008). The label *non-representational theory* loosely gathers together theorists who stress relations and the contingent and emergent dimensions of the world (eg. DeLanda 2006, Latour 2005, Deleuze and Guattari 2004, Dewsbury et al. 2002, Barad 2007). In transforming the noun 'being' to the verb 'becoming' this set of theories make way within human geography and architectural research for concepts such as the *spacing* and the *practising* of architecture (Beyes and Steyaert 2011, Jacobs and Merriman 2011). Space as spacing "entails a move from representational strategies of extracting representations of the world to embodied apprehensions of the everyday performing of space, to different enactments of … geographies" (Beyes and Steyaert 2011, 47). Whilst we acknowledge that spaces are produced in the flow of everyday social life (Lefebvre 1991), we advocate that they must also be seen as being in themselves capable of production (Jacobs 2006). In developing these spatial concerns, non-representational theorists emphasise the distributed nature of agency, rejecting views which position human experience at the self-evident centre of all occurrences, ascribing agentic capacities instead to a far broader field which includes (dead) material, artefacts and even space itself (Wylie 2010, Bennett 2009). In this book, we aim to look beyond architecture and buildings as mere objects, and instead apply a relational spatial perspective, which positions architectural space as an actor and co-producer. Buildings, we argue, have agentic properties in that they do things to and with people. In this task, we sympathise with Jacobs and Merriman (2011, 211-212) wish to "animate architecture such that it is understood not simply as an accomplishment (or artefact) of human doing, but as an on-going process of holding together and, inevitably or even coincidentally, not holding together". Architecture is held together by practices embedded in space, and the chapters in this book address the many guises in which care practices are made manifest in and through architectural space. This "holding" is illustrated in situations wherein older institutions or architectural spaces that were originally built for another (completely different) function are literally held together by the introduction of new caring purposes. Taking inspiration from an architectural geography that profits a non-representational theoretical perspective, the studies of diverse institutional architectures and their holding capacities that are brought together in this book are, we believe, capable of "taking on board a conceptual awareness of the material, embodied, affective and minor configurations of space" (Beyes and Steyaert 2011, 56).

Inhabiting, designing, mattering and knowing—all notions raised by Jacobs and Merriman (2011)—constitute themes that appear and reappear throughout the book, in chapters which demonstrate (sometimes subtly and sometimes emphatically) the entwined, inseparable and co-constitutive relation of these processes in relation to one another. *Inhabiting* is an everyday practice; "[b]uildings inhabit our lives just as we inhabit them" (Jacobs and Merriman 2011, 214), and inhabitation occurs in the minor events and situations through which institutional care evolves, revolves and rebels. Notions of inhabitation are present in all the chapters of the book and this constitutes a key concept for the anthology as a whole. *Designing*—in terms of both the act itself, as well as the significance of representations in design and even the potential marginalisation of design ideas—also emerges as a recurring theme, with several chapters addressing designing as a major force in shaping the everyday, even to the point of overt manipulation. When it comes to notions of *Mattering,* both senses of the word resonate within the book. Matter (that is, the hard material stuff, the objects and the architectural elements) *matters* to what emerges from the "intra-actions" that produce institutional care (cf. Barad 2003). Closely connected to matters of concern are affects, emotions, values and attachments, which come about through the employment of tangible stuff in practice (Jacobs and Merriman 2011, 217). Finally, objects and physical spaces are also depicted here as mouldable shapeshifters, engaged in dynamic performances, which include numerous discursive positions. We adopt a pragmatic approach in relation to the concept of *Knowing*, which emerges through the work in this book as predominantly constituting a practice that is negotiated and developed in spatial performances and sometimes in utterances made by people. Jacobs and Merriman (2011, 219) emphasise the disciplinary differences between geographers and architects in matters relating to knowing, and building on that discussion, we seek to draw architecture and geography more closely together, since "buildings are a fundamental geographical setting" (Kraftl 2010, 403). Our aim includes participating in the research dialogue that Jacobs and Merriman wish to see between these two disciplines, thereby adding to knowledge about both and about the scientific crossroads where they meet, interact and entwine.

Caring architecture

A number of scholars have linked caring and therapeutic effects to space and architecture with the support of terms such as *geographies of care*, *landscapes of care* and *therapeutic landscapes* (Milligan and Wiles 2010, Conradson 2005, 2003, McCormack 2003). These concepts

encompass a wide range of caring spaces at scales that extend from the global to the local and that must be seen in the broader context of their political and ideological ambitions, their proliferation and distribution across private and public sectors, the form of care and the carers they support, and their ability to produce and reproduce gendered and (un)equal patterns of care. This research highlights the affective, emotional, material and spatial aspects of receiving and giving care (Milligan and Wiles 2010). Without entering an in-depth discussion of these particular concepts, we want to unearth the underlying premise presented by these scholars: that it is necessary to look at the complexity of caring situations; to take into account the relational aspects of care; and to see architectural space as an event, as something coming into being (Dewsbury 2000).

"[A]rchitecture is always a partial project, an unfinished project, by definition incomplete … You could even say that architecture is always a failure; it never accomplishes what it intends" (Lash et al. 2009, 10). Much of the literature addressing architecture for institutional care has normative connotations and is presented as recommendations, descriptions of best practice or guidelines (eg. Regnier 2002, Fairweather and McConville 2000, Wagenaar 2006). This approach to the architectural design of institutions, in which quality is often defined as a stable category ascribing certain values to both space and care, implies that a building is finished when it is completed, the point at which all endeavours are "accomplished". Such assumptions attempt to catch and imprison properties and situations that can neither be confined nor immobilised in this way. By applying a non-representational approach to care and architecture such as the one advocated through this book, we arrive at a different understanding of these captured moments, seeing them rather as parts of an on-going performance. Care is work that is repeated and tested many times until it reaches an acceptable quality. As such, it is *tinkering*, an unfinished practice involving the carer's affective, empathetic and improvising capacities in which good and bad become part of a continuous process (Mol, Moser, and Pols 2010). Caring qualities and architectural space are produced simultaneously, in the very moment in which care is carried out (Nord 2015). A further normative belief that must be dealt with is that of *person-centred care*, which the benchmark in debate surrounding care today is. The proponents of person-centred care stress that the individual patient's needs and wishes should be the leading determination and ethical core in every caring encounter (McCormack and McCance 2011). We argue that when this encounter is entwined in the contingency of place, matter and people, the category of absolute patient focus will be destabilised by unforeseen forces and incidents in the caring event. How then does person-

centred care appear in the context of spatio-material processes? Is person-centred care a relevant notion at all? To come to terms with such moral issues, we here focus on a form of care practice based on a "pre-personally emergent, but personally implicated affective space of ethical sensibility", which "shifts the burden of the ethical away from the effort to do justice to individual subjects, and towards a commitment to develop a *fidelity to the event*" (McCormack 2003, 496, 502 referring to Badiou 2002, italics in original). This does not rule out a person-centred care approach, but gives it an entirely new meaning by embracing the totality of the caring event. We contend, with McCormack (2003, 502), that "[t]his is in no way an anti-human position". Rather, it opens up the possibility that the individual body is something more than just that body involved in care-receiving, but rather enmeshed in emergent relations of caring "as that through which new spaces of thinking and moving may come into being" (502 referring to Dewsbury 2000).

The non-representational approach to care can contribute to destabilising the normative polarity in assessments of institutional quality and of ethical judgement. The comparison between institutional care and community-based care has often been framed in terms of a false opposition of "good" and "bad" (Gleeson and Kearns 2001), echoing the normative ethical standards on which this dichotomy is pinned. The chapters in this book aim to discuss the complexity and inconsistencies present in institutions, casting doubt on moral certitude and on the issue of what high quality architectural space is. Architecture is always incomplete (Lash et al. 2009, 10). It is this incompleteness that embodies architectural agency and allows it to act and to "'act otherwise' or lead to other possible futures" (Doucet and Cupers 2009, 1): either next minute, tomorrow or years into the future. Our hope is that the perspectives of non-representational theory will reveal institutional architecture and care "acting otherwise", providing pertinent examples of situations in which relational and transformative conditions emerge (or fail to emerge) as *caring architecture*.

Contributions

We hope this book will reveal a new dimension within the established topic of institutional architecture and institutional care. The themes explored within the different contributions interlink and overlap in a manner that illustrates the complex, diverse and sometimes even contradictory views possible in relation to institutional architecture and institutional care. Despite their differences, though, the contributions are united by a shared conception of architecture as a process of spacing rather than as an immobile object.

The anthology provides a series of examples of specific care features in relation to a series of specific architectural forms. The authors of the chapters—who come from the fields of architecture, design, geography and social work—together demonstrate the variety of ways in which care practices and care discourses make use of architecture and other materials in order to change and fluctuate, to stabilise and to capture new meanings by negotiations that take place in and with space. Each of the chapters highlights in a different manner how locations, buildings, rooms, regulations, policies or even organisational structures frame the way in which care is provided and how the experience of receiving care is perceived and performed. Readers will thus encounter not only a vast range of specific examples but also a multiplicity of theoretical perspectives, which reflect the range of positions that have given birth to non-representational theory itself (Thrift 2008). The work of important theorists like Henri Lefebvre, Gilles Deleuze and Felix Guattari, Bruno Latour and Michel Callon, and Karen Barad are thus repeatedly cited. In this way, we invite dialogue with a number of key scholars in this field.

In the first chapter, Erling Björgvinsson and Gunnar Sandin deal with hospitalised patients who are faced with a brutal reorientation of their normal spatial needs and preferences and are forced to adjust spatially to a new environment. The patients, Björgvinsson and Sandin reveal, soon start to rearrange their own spatial situation according to their personal needs and the site-specific circumstances, in ways which not only include replacing the institutional objects at hand with their private possessions, but also adjusting to the presence and needs of the staff and other patients. This chapter discusses the type of spatial manoeuvring and the norms that emerge when the patients negotiate and align with a hospital's culture.

In Chapter 2, Susanne Severinsson provides a *diffractive reading* of an art studio in order to examine the fluctuating and stabilising aspects of room and materiality in residential care for troubled young people. She explores, through various discursive lenses, what kinds of knowledge and subjectivities are produced in the art studio when they are looked upon as networks and translations of actants: as discourses, humans and materialities. The focus is on what is constituted or performed in emergent relations between teenagers, teachers, objects and material space captures both the stabilising social effects of materiality as well as its complexity and flow.

In Chapter 3, Catharina Nord explores three essential goals of caring—autonomy, privacy and dignity—by taking a closer looking at the historical, architectural roots of assisted living with the support of the Deleuzian/Guattarian concept *stratum*. Care is conceptualised in this chapter as *tinkering*, a practice that develops with the situation and that is largely an improvisation in order to find the best way of doing things. This way of

understanding care reveals the work done between set routines, opening the door to redefining the quality of care which emerges from an assemblage of diverse materials and actors, including architectural space.

Chapters 4 and 5 deal with the design of historical asylum space. In the fourth chapter, Kim Ross writes about the engineering of *affective atmospheres* within the interior of Scotland's 19th-century asylum spaces. With the aim of both controlling and curing, this act of planning and designing spaces to exert architectural influence over the asylum population was a highly politicised move by those in positions of authority. The moral, medical and hygienic dimensions of the discourse ultimately outline its institutional geography, and the profound influence it had on asylum layout and design, with the internal (and external) spaces of the asylum being engineered to affect the behaviour of the patients. Ross also brings to the fore the difficulties of using a non-representational theoretical perspective within historical research, suggesting a conceptual approach by looking at spaces as being *potentially* affective.

In the fifth chapter, Cheryl McGeachan acquaints us with the work of the Scottish psychiatrist Ronald David Laing who became internationally renowned for his work on humanist approaches to psychiatric care. Laing developed a strong reliance on the healing properties of asylum space and this chapter to reveals the differing ways in which Laing (re)configures psychiatric and therapeutic spaces through investigating *the Rumpus Room* experiment. McGeachan's specifically turns her attention to the complex interconnections between the spaces of care, the psychiatric encounter and the worlds of individuals experiencing mental ill(health) in which new subjectivities emerge.

Chapter 6 constitutes a discussion about the usability of architectural space in a changing and dynamic environment, specifically within the case of assisted living. Morgan Andersson presents *usability* as the result of normative design processes and the daily use of restricted common spaces for weak and elderly individuals. He argues that despite spatial limitations, the facility's usability is created in continual negotiations between the environment and users in the performance of spaces, artefacts and residents. Henri Lefebvre's three aspects of space are here used as a conceptual frame for discussing the tensions between conceived, perceived and lived space.

In the seventh chapter seven, Ebba Högström looks into the difficulties of translating specific spatial experiences into general design recommendations. The chapter revolves around organisation, design, experiences and representations of the *Saltsjöbaden Mental Health Centre (SMHC)*, which opened in 1975 as part of the decentralisation movement in Sweden. The design of the centre's premises was anchored in a discourse of

openness, equality and accessibility. However, the premises soon became a contested space, open to negotiation and conflicting rationalities. Consequently, when SMHC was used in guidelines for the “new psychiatry” by *SPRI*, a national institute for planning and rationalising health care, most of its relational potentialities were occluded.

With a little help from our colleagues

The book also includes commentary texts from experienced theorists from three relevant disciplinary fields, human geography, caring sciences and architecture. Gunnar Olsson and Martin Gren set out to contend the whole idea of caring architecture by their dialogue about the formative qualities on peoples’ behaviour and thinking of physical structures by which goodness and powers become blurred in dubious alliances. Chris Philo continues this theme by presenting the historical context of institutional care where no doubt coercion has been a central aspect. However, he also discusses the efforts from within the field itself to come to terms with inhuman ways of treating vulnerable patients by developing new spaces and caring practices. Ingunn Moser presents the relational embeddedness of care in material and spatial circumstances from which qualities, subjects and agencies arise. She also argues for stronger links between Science and Technology Studies and architecture that could form new fruitful constellations, ideas and issues. Albena Yaneva follows this line of thought by showing how the agentic qualities of architecture emerge from the contexts in which it is embedded. She concludes the book with a plea for a careful attention to architecture to enable it to care. We need to care for architecture.

COMMENTARY II

COVERTLY ENTANGLED LINES

CHRIS PHILO

Into the institutional field

> Pimbo's other exciting discovery was that of patients' behaviour in the new barber-shop. The shop, complete with strip lighting, chromium-plated hair rinsing equipment, shining new basins, large friendly mirrors, had taken the place of ward shaving and hair trim. A nice upholstered leather chair afforded new comfort, but it was the transformation which took place as the old demented man would take his seat. It seemed to Pimbo that the years had been rolled back. The patient would assume a new dignity, head held back, he would push out his cheek at the appropriate time to coincide with the razor. During the haircutting, heads would be turned obligingly when so required, and in general everything was done to assist the barber. (Unwin 1976, 32)

This passage comes from a "novel"–essentially a memoir–recounting the experiences of Pimbo, the nickname for Jack Freestone, himself evidently the stand-in for book's author, F.T. Unwin, from his days as a student psychiatric nurse in a British mental hospital of the late-1950s/early-1960s (Fig. CII:1). The passage encapsulates certain connections between material space and forms of care, arguably speaking directly to a theme of *caring architectures*, if here in the very specific circumstances of (re)designing a mental hospital "barber shop" for cutting the hair of male patients. More narrowly, what is intimated is a highly embodied instance in creating the "spatial politics of affect" (Thrift 2004), in that here ostensibly small alterations to the material spaces of the institution–a newly-fitted out "barber shop", with accoutrements akin to those of a modern barber shop on an everyday high street–foster an *affective atmosphere* (Anderson 2009) which tangibly infuses how the patients comport themselves. Heads held back and cheeks puffed out, as if with a rediscovery of some lost sense of pride in self and appearance, the patients "assume[d] a new dignity". Rather than the perfunctory shave-and-trim on the ward, the barest of caring acts

merely enacting hygienic control over the resident population, the patients were now allowed to visit this new site in the hospital, momentarily becoming something different, cared for humanly, even aesthetically, and with time taken on them as *more-than-just* patients. Similar results were reported for the equivalent "female shop", offering "[w]ash and set, perms and styling," and Pimbo "reckoned that a touch of the outside world had kindled the flame which once flickered before hospitalisation" (Unwin 1976, 32).

Unwin's recollections are of an intriguing period in post-WWII mental health reform, entailing dramatic shifts in the institutional geography of mental health care, as the earlier *asylum* system–dependent on set-apart institutions, massive built structures usually sited in splendid rustic isolation–was gradually being dismantled on the way to the more familiar *post-asylum* system of today (in most Western countries)–operated through overlapping networks of services and facilities, dispersed, sometimes fragmented, normally couched as *community*-based and *community*-facing (eg. Wolch and Philo 2000, Högström 2012, Parr 2008). For Pimbo, though, the old asylum-hospital remained his primary site of work and encounter for what he termed, intriguingly, his "being in the field" (Unwin 1976, 125): a "field" where he learned his trade from the spaces, patients and staff, and where he acquired, as per the title of his book, "dew on [his] feet" (145). Indeed, the book's events were set primarily within the orbit of Fulbourn Hospital, once the Cambridgeshire County Lunatic Asylum (opened in the 1860s), located a few miles into the countryside outside of Cambridge, premier city of British learning, and originally sealed in behind "forbidding walls"–albeit "the high stone wall which once surrounded the entire hospital [was] now long since a thing of the past" (7). As this remark suggests, however, the spaces of the old asylum-hospital were changing before Pimbo's eyes: the external walls had come down, as too the walls around the old exercise yard which had once "provid[ed] violent patients just enough space in which to burn their aggression" (18), and the doors had been unlocked ('"There are no locked doors now–it's observation that counts"': (8), quoting Tim, an experienced nurse). Indeed, "[t]hings were rapidly changing in the hospital, and Pimbo was seeing fresh faces walking casually around the grounds and corridors, faces that a few years ago were staring from top room windows, as though characters from a Victorian novel" (142). He particularly noted new ways in which patients started to inhabit the institution: "once never allowed to leave their wards", suddenly there they were "in the corridors" with a purpose, perhaps heading to and from the canteen to purchase food and drinks, no longer "mak[ing] a dash through a half-open door" but "walk[ing] contentedly along brightly painted corridors" (59-60). This was no longer a solely carceral