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Spaces for smoking in a psychiatric hospital: Social capital, resistance to control, and significance for 'therapeutic landscapes'

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ABSTRACT

This paper reports on research framed by theories of therapeutic landscapes and the ways that the social, physical and symbolic dimensions of landscapes relate to wellbeing and healing. We focus especially on the question of how attributes of therapeutic landscapes are constructed in different ways according to the variable perspectives of individuals and groups. Through an ethnographic case study in a psychiatric hospital in the North of England we explore the perceived significance for wellbeing of 'smoking spaces' (where tobacco smoking is practiced in ways that may, or may not be officially sanctioned). We interpret our findings in light of literature on how smoking spaces are linked to the socio-geographical power relations that determine how smoking is organised within the hospital and how this is understood by different groups using the hospital building. We draw on qualitative research findings from discussion groups, observations, and interviews with patients, carers and staff. These focused on their views about the building design and setting of the new psychiatric hospital in relation to their wellbeing, and issues relating to smoking spaces emerged as important for many participants. Creating and managing smoking spaces as a public health measure in psychiatric hospitals is shown to be a controversial issue involving conflicting aims for health and wellbeing of patients and staff. Our findings indicate that although from a physical health perspective, smoking is detrimental, the spaces in which patients and staff smoke have social and psychological significance, providing a forum for the creation of social capital and resistance to institutional control. While the findings relate to one case study setting, the paper illustrates issues of wider relevance and contributes to an international literature concerning the tensions between perceived psychological and psychosocial benefits of smoking vs. physical harm that smoking is likely to cause. We consider the implications for hospital design and the model of care.

Introduction

This paper reports on research framed by theories of therapeutic landscapes and the ways that the social, physical and symbolic dimensions of landscapes relate to wellbeing and healing. We focus especially on the question of how attributes of therapeutic landscapes are constructed in different ways according to the variable perspectives of individuals and groups. Through an ethnographic case study in a psychiatric hospital in the North of England we explore the perceived significance for wellbeing of 'smoking spaces' (spaces in and around the hospital where tobacco smoking is practiced in ways that may, or may not be officially sanctioned).

Spaces for smoking in hospitals are controversial, since there are clinical arguments for preventing smoking to protect physical health. However, as we discuss below, smoking spaces are also perceived to be significant for the psycho-social wellbeing of patients and staff and, for those who smoke, are seen to contribute to the 'therapeutic landscape' of the hospital. As we discuss below this raises interesting questions about the social and symbolic construction of what constitutes a 'therapeutic landscape'.

The theoretical basis for this study draws substantially on the therapeutic landscape literature developed within the field of health geography and beyond (e.g., the anthropology of health) over the past two decades (Curtis, 2010; Gesler, 1992, 2003;

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Williams, 1999, 2007). Briefly put, the therapeutic landscape concept proposes that health situations in places can be considered as consisting of three interconnected environments: (a) natural and built physical environments; (b) social environments, including social relationships; and (c) symbolic environments, which emphasise the importance of meaning (Curtis, 2010). Studies of hospital design have a decades-old history of a focus on how to make physical environments therapeutic (e.g., Canter & Canter, 1979; Philo, 2004; Ulrich, 1984). However, a study of an inpatient mental health unit in East London (Curtis, Gesler, Fabian, Francis, & Priebe, 2007; Curtis, Gesler, Priebe, & Francis, 2008; Gesler, Bell, Curtis, Hubbard, & Francis, 2004) found that contemporary assessments of the designs of health care buildings by the UK National Health Service (NHS), and studies of hospital design in general, tended to neglect social and symbolic landscapes. Of particular importance to this study are the ideas that social dimensions of therapeutic landscapes may include the formation of social capital within health care settings and symbolic dimensions may include the development of opposing feelings of stigma and empowerment.

As work on therapeutic landscapes evolved, the field of study widened and deepened, and it was soon recognized that therapeutic landscapes are complex and contested (Geores & Gesler, 1999). Indeed, not only do different features of physical, social, and symbolic environments have either positive or negative impacts on different participants in health care settings (Wakefield & McMullan, 2005), but human interactions and 'relational dynamics' within potentially therapeutic spaces (Conradson, 2005, 2007). The enactments and performances that are carried out 'in and with place', such as socialising behaviours or exclusions of certain groups (Foley, 2011, p. 476–477), may influence and shape therapeutic outcomes. Collins and Kearns (2007) focused on the tensions between enjoyable sunbathing and risks from ultraviolet radiation, highlighting how the New Public Health Agenda and related health promotion discourses emphasise the health risks associated with activities that may also be deemed to be pleasurable. These discourses may be effective as a means of influencing behavioural change, but may inadvertently lead to a disrupted sense of wellbeing.

In terms of our study on smoking spaces within the psychiatric inpatient facility the initial landmark, which has served to shape smoking within the context of institutions was the 2006 Health Act. In 2006 the Health Act in Britain specified that almost all enclosed public spaces, including vehicles and work spaces, were to be "smoke free", though exemptions were made for "*any premises where a person has his home, or is living whether permanently or temporarily (including hotels, care homes, and prisons and other places where a person may be detained)*" (Health Act, 2006, chap. 28). Mental health facilities were only granted temporary exemption for a year, after which time all indoor smoking areas were to be 'removed' (Ratschen, Britton, & McNeill, 2008). Some of the high-security forensic psychiatric inpatient facilities in England (e.g., Rampton Hospital in Nottinghamshire) responded by banning smoking altogether (Cormac et al., 2010). However, implementation of such complete smoking bans and smoke-free policies in psychiatric facilities are acknowledged to be challenging, and open to debate (Ratschen, Britton, & McNeill, 2009; see also Haller, McNeil, & Binder, 1996; Lawn & Pols, 2005; Wye et al., 2010). Some psychiatric hospitals, such as the one where we conducted our research, have chosen, rather than instigating a complete ban on smoking, to regulate smoking among patients and only allow it in certain outdoor spaces, while staff members are required not to smoke at work. In this paper we explore some of the reasons for such a compromise and the implications for the design and use of the hospital as a therapeutic landscape.

Rates of smoking among people with mental illness are often higher than those found in the general population (Ballbe et al., 2011; Esterberg & Compton, 2005; Goff, Henderson, & Amico, 1992; Lawn, Pols, & Barber, 2002; Olivier, Lubman & Fraser, 2007; see also HDA, 2004). This may be partly because smoking has certain perceived social and psychological benefits, seen by those who smoke to outweigh the physical health risks (Hirshbein, 2010). For example, smoking may be used as a form of relaxation, which alleviates stress. It may be seen as a psychological support and facilitator for social interaction with other smokers, helping to alleviate the isolation that often accompanies mental illness. Exercising the choice to smoke may seem to provide a sense of empowerment in an aspect of one's life, which may be important for relatively disempowered groups (Kagan, Kigli-Shemesh, Tabak, Abramowitz, & Margolin, 2004; Lawn et al., 2002). Thus, according to Richie, Amos and Martin (2010) "*[c]ultural and social contexts are important in shaping smoking behaviours*" (p. 461). It has also been suggested that nicotine is seen as a form of self-medication, which may "alleviate some side effects associated with anti-psychotic medication" (HDA, 2004, p. 5). There may also be a lack of advice and support given to people with mental health problems who may want to give up smoking (Department of Health, 2011, p. 20), and there is some discussion as to whether smoking may in itself be one of the possible trigger factors of psychological ill health (Boden, Fergusson, & Horwood, 2010; Pasco et al., 2008). Even though the practice of cigarette smoking may in fact be unhelpful for their psychological as well as physical state, smoking cessation may therefore be more difficult for some of those experiencing mental health problems.

In a psychiatric hospital setting, smoking may "play a central role in social interactions on the ward", and staff may seek to control patient's access to smoking as a mechanism of social control as well as a health protection measure (Olivier et al., 2007, p. 572; Skorpen, Anderssen, Oye, & Bjelland, 2008). In a study undertaken in a psychiatric setting in Norway, Skorpen et al. (2008) describe the "smoking room as [the] patients' sanctuary" and a place for "resistance" (p. 728), which enables patients to retain a certain amount of control over their identity and their dignity in what would otherwise be a powerless situation.

These arguments are also supported by socio-geographical literature which shows how smoking behaviour is related to social geographies of power, resistance and social capital, which we elaborate on in the following sections of this paper before moving on to discuss our methods and findings.

Spaces of power and control: regulation of smoking spaces

There are a number of ways in which power and control operate through the regulation of smoking spaces. One of these is through the visible signs and floor markings, which are used to territorially demarcate the areas of public space in which smoking is either allowed or prohibited (Colgrove, Bayer, & Bachynski, 2011; Poland, 2000, 2006). In places where there is no such demarcation, the situation can be ambiguous, and under these circumstances, smokers are required to determine and monitor the applicability of smoking regulations (Poland, 1998, p. 216), an act that requires a clear understanding of the socio-geographical context. For example, in England smoking is now no longer allowed in enclosed public spaces or public transport. The formal legal sanctions, which enforce compliance to the regulations may include fines for smoking in a space that has been designated as 'smoke-free' (see: Health Act, 2006, chap. 28).

Emphasis is also continually placed on the benefits of smoke-free environments (Bell, Salmon, Bowers, Bell, & McCullough, 2010; Colgrove et al., 2011), and social sanctions may consist of