IT'S EMBEDDED IN THE WALLS – MATERIALITY AND PEOPLE IN DISTRICT PSYCHIATRIC CENTRES

Inger Beate Larsen, PhD, Associate Professor, Department of Health, University of Agder, Norway.

"We shape our buildings; thereafter they shape us."

Winston Churchill (1874-1965)

Introduction

The physical presence, organization and location of any building no doubt have great influence on the people using them. This may even be a main consideration in the design and organization of a building. Buildings and spaces may exercise discipline, they can assert power and authority, or reflect on the status and circumstances of its users and inhabitants. In the same way people, tradition and the passage of time influences the materiality of any place. One could say that the experience and knowledge formed by this interaction between people and places becomes embedded or ingrained in the walls of these buildings. This "genius loci" – the spirit of the place - in the words of the architect philosopher Christian Norberg-Schulz (1980, 2000a, 2000b) – may have great importance for our perceptions and use of these buildings and their interaction with people.

This may be a particularly relevant approach when looking at buildings historically built as hospitals and asylums. These are buildings constructed especially for the care, welfare and healing of people, but at the same time they reflect ideas within medical thinking and political regimes of how healing could be accomplished. With a number of such buildings still in use as healthcare institutions we can ask if there are any general observations to be made on the impact of materiality and spirit of the place that are of importance to our understanding of these institutions today and the medical and caring practices connected with them?

In the following I will examine the impact the materiality of mental health institutions may have on patients and staff. The basis for the examination is fieldwork carried out

at district psychiatric centres (Distriktspsykiatriske sentra, DPS) in various parts of Norway (Larsen, 2009). These centres were originally built as tuberculosis institutions in the early 20th century and later converted to psychiatric institutions. The patients' and employees' experiences of being present in the physical and social space of these institutions will be examined, interpreted and reflected upon. This provides us with knowledge about the significance the institutions' materiality and inner life has on people, and how people influence the materiality.

Bjørkelid Tuberculosis Hospital, Voss, Norway ca 1930. In centre the resident MD Birger Lærum, together with manageress Ranveig Skjeldal and stud. med. Birger Lærum jr. Bjørkelid was built 1904 originally as a private villa, but was taken into use as a tuberculosis hospital, later as a district psychiatric centre. Architect unknown.

From tuberculosis hospital to psychiatric centre: The spirit, ambiguity and discipline of places.

In most European countries today mental health care is moving away from institutions and towards local communities. As a result, the treatment district psychiatric centres offer is limited to short term stays. Norwegian health policy furthermore stresses the user's perspective and the coping perspective as necessary preconditions for undergoing change. At the same time the need for specialist training based on a traditional medical approach is emphasized. On the one hand there is a wish for a transformation that requires changes in the understanding, recognition and treatment of persons with mental health problems. On the other hand there is a wish for further specialization and closer commitment to existing medical standards. This implies an ambiguity that on the one hand is distancing itself from the traditional belief that specialists know the patients' needs best, on the other hand maintaining the role and importance of the expert. The role of today's institutions for the mentally ill with this ambiguity present is thus an underlying issue in this discussion.

Bjørkeli District Psychiatric Centre. Extension by architects Tvilde and Mossige 1973. Photo by the author, 2004.

However my primary aim here is to contribute to developing knowledge about the reciprocity and interaction between materiality and people within mental health care. At the same time I will show that an institution does not exist independently of its history, including the health policies and knowledge that prevailed when the institutions were established.

The idea of the spirit of the place – genius loci – has been developed amongst others by the Norwegian architect Christian Norberg-Schulz (1980, 2000a, 2000b). He represents a phenomenological approach to the link between the importance of places and people's self-awareness. The French historian, philosopher and epistemologist Michel Foucault looks at different institutions' material, mental and social space as representational of what he calls the power- and knowledge relationship (1982a, 1982b, 1995, 1999). This relationship makes patients and employees both disciplined by others, and self-disciplined. Both Norberg-Schulz and Foucault examine in different ways the interaction between materiality and people, and provide a valuable basis for my own observations.

Gibostad Tuberculosis Hospital, Senja, Norway, built 1928. Architect Lilla G. Hansen. Later used as District Psychiatric Centre, closed 2006.

The Tuberculosis Hospital

Tuberculosis was the most serious epidemic disease affecting late 19th and early 20th century European society and was the cause of more deaths in industrialized countries than any other disease in that period. This resulted in a massive construction of institutions for the care and treatment of affected persons. This "sanatoria movement" began around 1880. Main therapeutic methods were exposure to open air and dry climate combined with quiet environments isolated from normal life. This influenced greatly on the location and design of these institutions. They were mostly located in remote areas, also dictated by the need for isolating affected patients from the general healthy population. The fresh, "oxygen-rich" air in forested or mountainous areas was considered particularly helpful. Special houses, porches, and cabins were built to allow easy access to the outdoors.

Christmas Seal Sanatorium in Koldingfjord, Denmark, architect Bernhard Ingemann. It was build 1911 for the money coming from the sale of Christmas Stickers. From 1911 to 1960 it functioned as a sanatorium for children with tuberculosis. After 1960 it was used as an institution for the mentally retarded. Closed 1983, reopened 1987 as a hotel. In the front we see the porches where patients were placed to recover in the fresh air from the nearby fjord, now being used as a bar and restaurant area. Photo by the author, 2006

Treatment against tuberculosis subsequently went into what can be described as a "surgical period", with massive "lung punctuation surgery" and similar chirurgical methods being developed for curing affected people. Tuberculosis was effectively eradicated as a health risk in Europe in the 1950-ties, traditionally seen as a result of the introduction of antibiotics and as a major achievement of modern medical science.[1] However improved nutrition and hygienic standards and the improved knowledge and efforts of housewives was probably also a major, but less glamorous and hardly recognized factor in the fight against the "White Plague" (Blom, 1998; Skogheim, 2000, 2001, 2003) In any event the substantial eradication of tuberculosis by the 1960-ties left massive buildings - and staff - redundant and alternative use had to be found.

Landeskogen Tuberculosis Sanatorium (1919) architect Kristian Hjalmar Biong – a typical example of the large sanatoria often built in remote locations, in this case in the Setesdal Valley in Southern Norway. Later converted to institution for the mental retarded (1969). Postcard ca 1930.

[1] Today tuberculosis is again present and developing in many West European countries, mainly due to new patterns of emigration during the last decades

My field work was limited to institutions with a past as smaller homes for the ill, in contrast to the massive sanatoriums known not only in Norway but in particular in Switzerland and the rest of Central Europe in the period (Of which Berghof, the sanatorium in Davos, used as the location for Thomas Mann's novel *The Magic Mountain* (1927) is the prime example). The smaller Norwegian institutions worked on the same diagnostic and therapeutic principles as the larger institutions, but they were more often designed to care for those considered incurable. The buildings were usually constructed in wood, as opposed to the imposing stone buildings of the sanatoria. They were often designed in a moderate "Swiss style", an architectural style fashionable at the time for private villas for the well-to-do, but also considered particularly well suited for those suffering from tuberculosis, with their high ceilings, light and open spaces and good circulation of fresh air. In addition they also resembled private wealthy homes – reflecting both the belief that a homely atmosphere would encourage healing but also the standards of those often wealthy female charity workers who established the institutions at the time.[2]

It is also of interest to note that several of these institutions were designed by the first female architect in Norway, Lilla Georgine Hansen (1872-1962) (Findal, 1996). This was again in line with the fact that the ideas of caring for the sick and poor and an ideology of social responsibility were associated with the female dominated charitable organizations which also often established and operated these institutions. It was thus probably not a coincidence that they also assigned a female architect to do design them.

[2] In Norway a charity organisation, Norske Kvinners Sanitetsforening (NKS), where only women were accepted as members, both built and operated a significant number of these institutions.

View from Gibostad Tuberculosis Home, Senja, Norway, later Gibostad District Psychiatric Centre. Photo by the author, 2004.

The District Psychiatric Centre

As the need for institutions for treatment of those suffering from tuberculosis declined, the buildings were gradually transformed to different uses. We enter into what can be called the "transformation period", mainly the 1970-ties. The institutions were still supposed to take care of long term patients, but the clientele gradually shifted to the mentally retarded or mentally ill. Some institutions during this period even catered for patients having both tuberculosis and psychiatric diagnosis, sometimes in the one and same person (Larsen, 2009).

In the beginning the buildings were used in their original state and continued with the same staff. Step by step most of these institutions were modernized and expanded, in line with their new use and changes in standards.

The location of these institutions was already fixed and could not be changed. The patients continued to be located in places isolated from "normal" society. On the other hand they had the benefits of the scenery and nature surrounding the old institutions, and they came to a place distinctly away from their everyday life and environment.

Vefsn District Psychiatric Centre, Mosjøen, Norway. Built as tuberculosis hospital in 1915, architect Enger. Photo by the author, 2004.

The extensions of the old institutions as a rule were done in a distinctly different style. Whilst the old buildings primarily were wooden structures, the new parts became dominated by concrete, bricks, steel and glass surfaces. The designs are heavily influenced by functionalist ideas: form follows function.[3] The ideal is square and clean surfaces, hygienic and easy to clean and maintain. Ornamentation is kept at a minimum. This applies to both interiors and exteriors. The contrast to the old, villa-style architecture is strong, creating an ambiguity which characterizes most of these now hybrid buildings with their traditional parts being "fused" with functionalist,

[3] The expression was first used by the American architect Louis H. Sullivan in his 1896 article "The tall office building artistically considered" (Sullivan 1896), discussing the tall office building which has inspired functionalist architect worldwide and initiated discussions about the tasks of architecture.

contrasting extensions. The ambiguity manifests itself in the homelike and friendly expression of the old parts and the efficient and seemingly hygienic expression of the modern parts.

Vefsn District Psychiatric Centre, Mosjøen, Norway. Behind the well kept old building we find the extensions designed by architect Nils Toft 1989. Photos by the author, 2004.

Materiality and people

The institutions described above, affected people's lived experiences to a considerable extent. In relation to the patients, institutions became places attracting them when they were ill. Location and materiality shielded and protected them from the outside world. Patients thought rest was an important part of their recovery process. Small rooms and homelike atmospheres contributed to relaxation and recovery. Conditions relating to consideration and caring comprise what encourages health.

In relation to the employees, on the other hand, institutions become places where they adjusted to a new and active treatment ideology. 'New' was interpreted as a further specialization within the medical perspective. The employees used the rooms as a way of distinguishing themselves from the patients. They worked towards disposing of the traditions from the era of tuberculosis. The employees' understanding of 'active treatment' easily came in conflict with the patients' need for rest in homelike atmospheres.

Another key issue is that the institutions represent an authoritarian understanding of mental problems as illnesses. This understanding of illness is related to the view of contagious illnesses in the early 20th century. This view seems to be ingrained in

today's institutions. Remote locations, guardrooms, and medicine dosage systems are important elements that support this view. This shows that the understanding, recognition and treatment of tuberculosis can be regarded as a general medical way of thinking that is still present in today's practice. Medicine as a discipline has great influence on patients, employees and the local community. This discipline protests against trends toward decentralisation, user perspectives and the coping perspective.

We can look further into these issues by examining in more detail some of the statements made by patients and staff during my field-work at these institutions:

1) *To get away to recover*

During my studies I met a number of patients who would explain that already prior to admission to the hospital they were in their minds "somewhere else". The hospital buildings, and their locations, were already parts of a "mental map" in the minds of these persons and clearly part of a wider context where getting away in itself was seen as an important part of the recovery process (Larsen, 2009, p 121). In fact, the institution as such and its location seemed to match the needs of the person, and their awareness of the place made it significant to them as patients. This in a way is in contrast with the general opinion and practice today of keeping the patient to the greatest extent possible in his own surroundings, being considered the best therapeutic approach within contemporary mental health care.

2) *To feel at home on the way home*

If the patient was going to recover and go back home, he was better off if feeling at home also during his treatment. The desires to get away were often matched with the expression of a desire for a "homely atmosphere" as opposed to what my informants considered as "hospital-like" surroundings: impersonal, large corridors, clean surfaces, etc. We see here clearly both the connection back to the values of the early smaller tuberculosis institutions and how the contrasts of these ideas with the characteristics of modern hospital architecture are apparent.

3) History in novelty

Furthermore, patients often expressed their wish to keep furniture, paintings etc. from the "homely" period of the institution's past and to include this in the more modern parts of the premises. This would create continuity and well being. Staff,[4] on the other hand, was not inclined to include the history into the novelty. Partly did it not match with their ideas of modern and efficient hospital management and therapeutic practices, partly they were afraid that continuing to use the symbols and expression of the "old" would contribute to define the patients as ill and restrict their recovery.

4) The obvious medication

As a result of a stronger and stronger medical driven regime the idea that medication was the key – or only - factor of recovery became deeply imbedded in the walls of the tuberculosis hospital. We know today that medication was only one of several factors leading to recovery and the decline of tuberculosis on the whole. A similar hope, and similarly questionable belief, that medication based therapy can heal mental diseases seems to have survived well into the new use of these buildings, and the whole physical organisation of the keeping and distribution of medicine – much similar to that of the age of the tuberculosis – supports this idea.

The spirit of places: A healing factor?

Institutions become places where patients can live when illness alienates them from their homes and local communities. To dwell in an institution becomes an important way of healing. However, it can be questioned whether patients are bound to the institutions because of their illness, and whether the institutions' role in a power-knowledge network traps them into an understanding of illness that may hinder recovery.

[4]This means staff on a high education level. Some of the staff members however agree with the patients. These were generally the ones on a lower educational level (hjelpepleiere).

Another significant factor is tradition. Ideas and practices surviving from the time of the tuberculosis institution, with the ideas of homeliness, proximity to nature etc., contribute to providing places, and thus people, with a more distinctive and enhanced identity that can result in patients more readily finding their own place back in society. Absence of tradition on the other hand can cause poor health. The history of tuberculosis may construct understandings of mental problems involving disciplined and self-disciplined strategies and techniques. The history of tuberculosis is ingrained in the walls of the institutions and may prevent new ways of understanding mental health.

If we look again to Norberg-Schulz, the spirit of the place will contribute to good health as it takes care of the continuity between the past and the present. When people are part of a context they are assisted by architecture and physical structures to establish their own presence and their own identity. Presence means being someone, which in itself is a contribution to better health.

Michael Foucault represents a different approach. We have to look at the institutions as manifestations of a disciplinating power-knowledge regime which forces the patients to consider themselves as being in need of the institution and its practices. If this is the case this regime may contribute to pressing the patient into a role and position where she or he appears as weaker and more careneeding than she or he actually is. According to Foucault this is all in the interest of society and the institution as parts of a greater power-knowledge regime.

In any event the above shows that understanding and awareness of the impact of the building, its location, context and history clearly is an essential part of developing sustainable healing practices in the treatment of people with mental problems.

Patients and staff in front of Gibostad Tuberculosis Hospital ca 1930.

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