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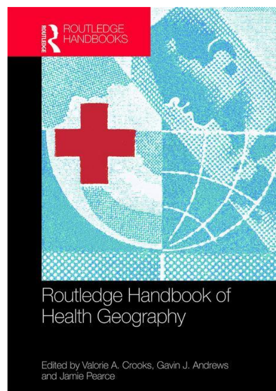

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17

THERAPEUTIC LANDSCAPES

From exceptional sites of healing to everyday assemblages of well-being

Jessica M. Finlay

The concept of therapeutic landscapes represents a valuable application to assess the relationship between health and place in a wide variety of spaces. Gesler (1993) first introduced the concept to geographers as places with "an enduring reputation for achieving physical, mental, and spiritual healing" (p. 171). By incorporating theory from cultural and human geography (e.g., sense of place, symbolic landscapes), Gesler argued that scholars could examine sites of healing in health geography. He built upon humanistic geography's attention to individuals' and groups' attitudes and feelings toward the environments they inhabit, suggesting that intimate personal and emotional relationships between self and place could impact one's health and well-being. Initial applications of therapeutic landscapes tended to focus on extraordinary destinations, such as pilgrimage sites (Gesler, 1996); parks and wildernesses (Palka, 1999); and hot springs, baths and spas (Gesler, 1998). Subsequent scholarship critiqued that, while important, these exceptional spaces are generally encountered over short time periods and are not intended to foster long-term healing (English, Wilson and Keller-Olaman, 2008). Williams' (1999) volume expanded the concept from extraordinary locations to everyday places associated with the maintenance of health and wellness. Indeed, scholars broadened exploration to nontraditional and mundane pursuits of well-being, such as home settings (Williams, 2002), children's summer camps (Kearns and Collins, 2000), collective gardening programs (Milligan, Gatrell and Bingley, 2004) and yoga studios (Hoyez, 2007). In the last 15 years, the concept has evolved considerably to critically study complex relationships between health and place.

Sites of study

Scholars tend to focus on three main types of therapeutic landscapes: physical environments, symbolic environments and social environments.

Physical environments

This area of scholarship constitutes classic therapeutic environments that many people associate with healing and health. These sites literally promote well-being through natural landscape (e.g., scenic beauty, hot springs) and constructed design (e.g., spas, hospitals). Gesler (1993) first investigated the healing reputation of the Asclepian sanctuary at Epidauros, Greece. The site was famous throughout the ancient world for its dream healings; it was known for its appealing temple buildings, gentle waters and beautiful landscape. The

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climate, water quality and scenic environment produced a strong sense of place and reputation for healing efficacy. It provided visitors with a sense of refuge and security. Stemming from Gesler's original attention to sites of healing, a robust area of focus for therapeutic landscapes is modern institutional settings, such as health centers, hospitals and clinics. Scholars investigate the role of location, architecture, design and organization (e.g., room comfort, available technology) in local healing processes (Smyth, 2005). Curtis and colleagues (2007), for example, assessed the hospital design of a mental-health inpatient unit. Staff and service users described which aspects of the hospital – including cleanliness, the location of nursing stations, food quality, air conditioning, windows and natural light and gardens – were beneficial or detrimental to patient well-being. The role of nature constitutes a second primary focus area for therapeutic landscapes, which stems from Western ideology that people can attain physical, mental and social healing by spending time outdoors in natural spaces. Finlay and colleagues (2015), for example, investigated how green and blue spaces affect older adult health and well-being. They found that landscape elements including parks, gardens, street greenery, lakes and the ocean influenced participants' physical, mental and social health. Therapeutic effects resulted from direct physical engagement (i.e., being physically present in the landscape), as well as mental engagement (i.e., through retreat and restoration). Natural and built physical environments are thus relatively easy to grasp, because they are tangible, comprising what we can see, hear, smell, taste and feel.

Symbolic environments

When connecting physical environments to healing and well-being, we must consider how they are perceived and what they might mean. A courtyard fountain on hospital grounds, for example, may symbolize tranquility and rejuvenation and have implications for healing in addition to treatment received inside hospital walls. Many objects around us have meaning because they symbolize something important (Gesler, 2003). A doctor's white coat, for example, traditionally signifies medical knowledge and authority. High-tech equipment in modern hospitals symbolizes scientific advancement and the power of biomedicine. Particular localities express cultural values, social behavior and individual actions embedded in that place. Western hospitals and clinics are generally understood as powerful sites of healing, treatment and biomedical care. Symbolic environments thus arise from individual meanings and collective interpretations of place. This type of therapeutic landscape often provides support, care and healing outside of, or in parallel to, traditional biomedicine. Examples are spas, yoga studios, tai chi locations and gardens. Buzinde and Yarnal (2012) applied the framework of therapeutic landscapes to understand medical-tourism sites as curative spaces combining modern and alternative forms of medicine with travel and leisure. Under this phenomenon, wealthy Westerners travel to nations such as Thailand, India and Mexico to receive health care and enjoy touristic activities. These sites link symbolic expectations of leisure travel (e.g., fun, relaxation, a reprieve from life's everyday strains) to medical interventions (e.g., surgery, organ transplants, plastic surgery, dental care). Physical and abstract symbols, myths, stories, spiritualism and language are also important to this area of work. Healing sessions often involve symbolic language or actions to transform an individual from sickness to health. For example: the language of patient-healer interactions, the room color in a hospital or a shaman's stories recounted during a therapeutic session all affect healing (Gesler, 2003). This work emphasizes how individuals attribute personal meanings, values and emotions to spaces to perceive them as therapeutic. These perceptions may differ widely.

Social environments

Healing is a social activity that involves interactions with many different people in varying roles (Gesler, 2003). Physicians and healers, for example, with the power to diagnose ills and prescribe treatments, play a pivotal role in our well-being. Interpersonal therapeutic environments generally include kinship groups and

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networks of care supplied by family, friends, health professionals, community members and other agents of support (Smyth, 2005). This body of literature therefore concentrates on therapeutic landscapes in relation to others: institutional, home and community-based spaces that facilitate interpersonal interaction. Everyday public spaces, and their implications for well-being, feature across this literature. Milligan and colleagues (2004), for example, investigated older people's experiences of communal gardens. They found that communal gardening created inclusionary spaces to combat social isolation and promote the development of social networks. By enhancing quality of life and emotional well-being through socialization, the communal-garden allotments constituted a therapeutic landscape. Social relationships are an essential component of many therapeutic landscapes.

Fuzzy boundaries

The three environments described above are convenient categorizations; in practice, therapeutic landscapes transcend boundaries. In the previous example (Milligan, Gatrell and Bingley, 2004), participants derived health benefits from gardening activities and physically engaging with the space. The gardens symbolized the relaxation, peace and tranquility of nature. They also facilitated social interaction and positive connections with neighbors and passing members of the local community. Extraordinary locations also combine multiple therapeutic experiences and types of environments, such as in Palka's (1999) analysis of visitors to Denali National Park. Tourist experiences included direct engagement with nature (the physical environment), as well as individual expectations of self-exploration, restoration and renewal (the symbolic environment). The next section will consider how the substance and relative importance of these three categories vary greatly by time, place and individual (Baer and Gesler, 2004). We will see that no therapeutic landscape is perfectly healthy.

Potentially therapeutic: a contested and relational approach

Spaces are not intrinsically therapeutic, but they can promote healing and well-being depending on how people view and interact with them. In other words, no space can guarantee a positive health experience for everyone. What may be therapeutic for one person may even be harmful to another. Baer and Gesler (2004) advocated for applying the therapeutic-landscape concept to difficult and contestable examples with potentially "less positive shades of meaning" (p. 406). They used the fictional example of J.D. Salinger's *The Catcher in the Rye* to call attention to ambivalent spaces that are not completely positive and may even be destructive. A real-life example of this is the beach, which many consider a therapeutic landscape for relaxation, reflection, socialization and exercise. However, others may find the beach unhealthy given sun-exposure risk (Collins and Kearns, 2007) or a past negative experience. Public parks can also be perceived as pleasant and inviting, or conversely threatening and dangerous, depending on the individual. Perception, circumstance and embodied identity (including gender, race/ethnicity, mobility level and self-confidence) filter people's experiences of potentially therapeutic landscapes (Finlay et al., 2015).

Therapeutic landscapes are thus disputed, rather than a site of mutual consensus. In an effort to recognize diverse and complex spatial relationships, Conradson (2005) observed that "individuals clearly experience even scenic environments in quite different ways, in terms ranging from enjoyment through to ambivalence and even anxiety" (p. 338). He conceptualized therapeutic landscape *experiences* in a manner that is attentive to the relational dimensions of encounters between self and landscape: a complex set of transactions between people and their broader socio-environmental settings. What may be therapeutic must be filtered through individual context and broader socioeconomic conditions.

Foley (2011, 2014) built on the notion of therapeutic landscapes as fluid relational outcomes to understand these spaces as negotiable, conditional and undetermined. Foley examined holy wells and baths as therapeutic assemblages encompassing material, metaphoric and inhabited dimensions. The *material* of Irish

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holy wells incorporated tangible bricks, water, visitors' physical bodies and documented and experienced cures (an embodied therapeutic experience). *Metaphors* encapsulated the wells' cultural reputations as long-standing sites of spiritual healing and beliefs. *Inhabitation* referred to rituals, prayers and daily enactments performed at holy wells: the lived, experiential and performative dimensions of health in place (Foley, 2011). Foley applied notions of embodiment, performance and non-representational theory to critically think through material and immaterial relationships at play between people and objects in spaces of health.

Diverse pursuits of health

Geographic applications of therapeutic landscapes are applied to diverse populations and locations. Distinct populations and experiences under consideration include pregnancy and childbirth (Oster et al., 2011), women (MacKian, 2008), older people (Milligan, Gatrell and Bingley, 2004; Finlay et al., 2015), immigrants and refugees (Sampson and Gifford, 2010) and medical tourists (Buzinde and Yarnal, 2012). Literature focuses on the mentally ill, self-help groups (Laws, 2009) and drug-treatment programs (Love, Wilton and Deverteuil, 2012). Studies highlight inequalities, gendered assumptions and uneven power relationships in the production and navigation of therapeutic landscapes. They demonstrate that health is negotiated at multiple overlapping scales and involves much more than the absence or presence of illness and injury. This holistic approach to health involves broad notions such as safety, social inclusion, financial security, intellectual stimulation, empowerment and cultural self-determination.

A small but growing body of literature attends to the intertwining of land, family and community in Indigenous peoples' experiences of therapeutic landscape. Wilson (2003), for example, explored culturally specific dimensions in the context of everyday lives of Anishinabek. Alaazi and colleagues (2015) investigated therapeutic landscapes of the home through Indigenous peoples' experiences of a housing intervention. This research broadens understanding of First Nations peoples and the cultural significance of linking health and place in non-Eurocentric populations. Further non-Western scholarship includes traditional medicine in Africa. Bignante (2015), for example, explored the patient-healer relationship and its role in producing well-being in northern Senegal. The study demonstrated specificities and embeddedness within local belief and value systems of patients and healers outside of the Western biomedical model.

Bodies are increasingly recognized by the literature as central terrains of health and illness. Two studies of breast-cancer survivors (English, Wilson and Keller-Olaman, 2008; Liamputtong and Suwankhong, 2015), for example, depicted the body as a landscape that requires adjustment and recovery. Women worked on their bodies (e.g., through diet and exercise) to heal themselves both physically and mentally. The findings demonstrate complexities of healing bound up in physical, psychological and emotional aspects at the intimate scale of the body. Elsewhere, Doughty (2013) worked on the embodied production of therapeutic landscapes by walking with participants to explore the affective potency of shared movement. In this example, shared movement produced supportive social spaces and therapeutic bodywork in the pursuit of well-being.

Extending beyond physical sites, therapeutic landscapes also encompass spaces of the mind. Gastaldo and colleagues (2004), for example, narrated their experiences as four Canadian immigrants. They interpreted migration through individualized mental strategies that each author uses to enhance his or her mental health and further his or her well-being in times of change. Rose (2012) applied a psychoanalytic approach to work out psychological therapeutic landscapes. People conceptualize landscape encounters to mirror their own feelings and emotions. For example: we know that dark storm clouds are not really angry, and we know that browned leaves and withered flowers are not sad. But we interpret them in this way in order to represent and manage our own affective states. Some individuals use visualization strategies to cope with change and stress, thus creating therapeutic landscapes in their minds.

We can see that therapeutic landscapes represent a constructive metaphor to investigate complex relationships between health and physical, psychological and social spaces. The concept broadens the scope of health geography and meaningfully connects to broader fields of social, cultural and emotional geography.

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Nuanced understandings of health as embodied and emplaced inform scholarship in health geography and beyond. Therapeutic landscapes are beginning to be recognized in outside disciplines such as nursing (Gilmour, 2006), landscape and urban planning (Jiang, 2014) and kinesiology (Van Ingen, 2004). The concept connects well to other health-related disciplines, including environmental psychology, sociology, medical anthropology and public health.

Future progress

Scholarship addresses increasingly broad relational experiences of health and well-being, including gendered, aged, cultural, emotional and multiscalar navigations of therapeutic landscapes. Despite growing appreciation for interpersonal approaches, our understanding of culture and race/ethnicity remains under-theorized. Research remains closely tied to white, Eurocentric contexts and experiences (notable exceptions include the Indigenous and African scholarship mentioned previously). Arguably, then, the concept of therapeutic landscapes could focus more on sociocultural intersections of identity, such as overlapping experiences of gender, age, race, income and socioeconomic status. Scholars could also do more to interrogate power relations and stereotypes that influence therapeutic experiences. This may lead to compelling areas of inquiry, such as how the clinical gaze and hierarchical power relations filter doctor-patient health-care experiences in marginalized communities. Scholarship to date has not sufficiently explored relational dynamics and individual agency contributing to the construction, navigation and maintenance of therapeutic landscapes.

Regionally, therapeutic-landscape scholarship is dominated by scholars from Commonwealth countries (e.g., the United Kingdom, Canada, Australia, New Zealand). American geographers have yet to consistently grapple with this topic, and US contexts remain understudied. Given unique sociopolitical complexities and health-care contexts, this area is ripe for investigation. Further geographic limitations include limited existing perspectives from the Global South. Research to date focuses primarily on Western sites. Patient-healer negotiations outside of the Western biomedical context, for example, remain under-theorized. This area of inquiry has potential to demonstrate how physical and emotional wellness are mediated by not only other people and place, but also sociocultural vectors (e.g., herbs, sacred objects, holy scriptures, massages, purifying baths, incense, music, sounds) (Bignante, 2015). Scholarship needs to attend to mediating non-Western elements and incorporate a broader understanding of well-being that simultaneously embraces the practical and the spiritual, cosmic and religious. A postcolonial lens could also critically unpack core/periphery relations through health access and provision, unveiling structural relations of power (Buzinde and Yarnal, 2012). For example, we can consider Hoyez's (2007) example of yogic therapeutic landscapes through the filters of global production and uneven reproduction. A minority of yogis have visited Indian sites in person, yet the majority utilize a mental practice of such sites and attempt to practice Indian reproductions in Western settings. Yoga is thus an example of re-appropriating place through therapeutic practice, with complicated implications for neocolonialism of the Global South.

Therapeutic landscapes still tend to focus on clear sites of healing and relatively straightforward health maintenance. Scholars need to pay more attention to ambivalent and stigmatized landscapes that contribute to wellness in less obvious ways. Medical anthropologist Mokos (2017), for example, studied beneficial dimensions of river-bottom homeless encampments. Camps tend to be grouped with other unmanaged sites of decline and despair that homeless people inhabit. These sites were never intended for health maintenance or human occupation, yet homeless people inhabit these untherapeutic landscapes. Mokos (2017) grapples with complexities of exclusion, systematic violence, and stigma, helping readers understand river-bottom camps as therapeutic landscapes for inhabitants. They can provide care through belonging, access to nature, privacy and social benefits. Embracing the intricacies of therapeutic landscapes generates opportunities for more just ways of promoting health.

Literature on therapeutic landscapes continues to advance from intrinsic values of place to incorporate complexities of power, individuality, agency and intersection. One promising area of future scholarship

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encompasses performative aspects and embodied encounters. Evans (2014), for example, attended to the therapeutic dimensions of ambient music. As people listen to and feel with therapeutic soundscapes, their embodied encounter can transform the listener's awareness and emotions: "this shift in self-awareness, disposition, or liveliness ('therapeutic') emerges as the body becomes *affected* within a particular network of relations with other objects ('landscape')" (p. 175). The body thus acquires new capacities, empowering an individual to act and feel well. This example of ambient music dissolves boundaries between the individual and environment, relating to Foley's (2011) fluid and performative notion of assemblage. We can extend consideration of the body in space and movement ranging from the mundane (e.g., cooking, caregiving, bathing) to the extraordinary (e.g., pilgrimage, refugee movement). Therapeutic experiences are always relational, embodied, multisensory and fluid.

Broader investigation of therapeutic landscapes will pose methodological challenges and opportunities for advancement. The concept is one of the few frameworks developed exclusively by qualitative health geographers. We can expect integration with quantitative approaches, such as spatial analysis, virtual technology and more precise measurement of therapeutic sites. Emerging methods applied across geography and beyond, such as the mobile interview (Finlay and Bowman, 2017), can broaden therapeutic inquiry *in place*. Longitudinal studies can capture shifting relationships and life-course circumstances that influence the relative importance of therapeutic landscapes over time. Temporality, personal history and remembrance are important elements of future consideration. For example: how does one's past exposure to particular landscapes and cultural practices influence current use? Comparative practices across more diverse settings could further investigate the individualized and often ambiguous role of therapeutic landscapes.

Gorman (2016) called for multispecies ethnographies of therapeutic spaces to highlight the way in which different human and non-human beings engage with place. He stated a need for expanded more-than-human actants, artifacts and technologies to infiltrate therapeutic-landscapes scholarship. This line of inquiry could extend the notion of intersubjectivity to how we share therapeutic spaces and practices with other beings and objects. Given the rapid rise in technology, we need to integrate the role of mechanized tools and robots in care spaces. Emerging technologies, such as voice-activated cellphones, robotic dolls for Alzheimer's patients and self-driving cars provide new opportunities for care. With widespread technological changes, our health and wellness demands also shift. Multidimensional understandings of wellness in place need to include the role of technology filtering through our everyday lives.

Armed with a better understanding of the factors influencing person-place health relations, academic research on therapeutic landscapes can ideally facilitate broader well-being. Williams (2017) called for using the concept as a tool to mobilize positive change. As inequalities in access to health and wellness grow, therapeutic-landscapes scholarship can vocalize and draw critical attention to vulnerable populations and marginalized spaces. Individuals and contexts could include impoverished neighborhoods, public-health epidemics, incarcerated individuals, displaced refugees and victims of violence. Therapeutic landscapes are always in part a political project (MacKian, 2008). Only by further exploring the intricacies of everyday marginalized peoples and contexts can we hope to develop an understanding of more effective and empowering policy strategies. To advance a more just and inclusive form of scholarship, we must continually ask: what is therapeutic, and for whom?

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