Placing Therapeutic Landscape as theoretical development in *Health & Place*

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In a paper first aired at the 1990 International Medical Geography Symposium in Norwich, Wilbert Gesler introduced the idea of therapeutic landscape. In a series of subsequent case studies, including in this journal (Gesler, 1996), Gesler indicated how landscape ideas drawn from humanist and structuralist influences in the 'new' cultural geography (e.g., sense of place, symbolism, hegemony and territoriality) can deepen interpretation of the therapeutic reputation of certain places. Most work drawing on the concept has been located within health geography with therapeutic landscape described as perhaps the one theoretical development that the sub-discipline can truly claim as its own (Kearns and Moon, 2002).

Our survey of issues of *Health & Place* since its inception in 1995 revealed 119 papers that included the concept in their title, abstract and/or keywords. In this review, we consider how authors have invoked therapeutic landscape in their work and map out its hallmarks as a maturing theoretical construct. We focus particularly on the published record in this journal as well as including remarks offered by Gesler himself in the course of an email exchange (Kearns and Milligan, 2017). These sources allow us to critically reflect on the evolution of the idea and its significance over the last quarter century. We question whether scholarship drawing on these ideas is indeed advancing a theoretical agenda or rather constitutes a more disparate collection of work that finds therapeutic landscape a convenient 'umbrella' under which to justify research in the idiographic tradition.

Thematic patterns of therapeutic landscape scholarship in *Health & Place*

Gesler's early papers examined specific sites as case studies that were generative of, and had reputations for, enhancing wellbeing (e.g., Gesler, 1996). These papers sought to examine whether "*the various environments – physical, social, and symbolic – envisioned in theory actually be found on the ground or, for the geographer, in specific places?"* (Gesler pers. comm, 2017). Gesler himself never anticipated the breadth of scholarship his framework would spawn, adding:

> *The biggest surprise to me, is that the idea developed at all beyond my original papers. The second surprise is the variety of places and situations health geographers and others took the idea to – everyday situations such as care in the home, the marginalized, the disabled, summer camps, parks, green and blue spaces, non-Western settings, literature, and so on*.

Papers published in *Health & Place* framed by therapeutic landscape ideas can be grouped according to a number of themes: spaces of care; mobilising the concept; therapeutic landscapes beyond the Anglo-American world; and everyday spaces and populations.

Spaces of care

Just as Gesler examined places of health-seeking pilgrimage, so too many of those working with his concept in *Health & Place* have focused on specific contemporary destinations for health care. Others have examined the spaces of home and hospital. Watson et al (2007), for instance, considered experiences of labour, finding that health professionals too often approach care sites as already that area constituted rather than being relationally constructed (see also Water et al's (2018) examination of paediatric outpatients' departments as therapeutic places). Oster et al (2011) use the concept to examine what makes these spaces therapeutic for women. The authors highlight that these spaces are not intrinsically therapeutic, but rather are experienced differently by different people. This view echoes Conadson's (2005) contention that there is a fundamental relationality at stake in people's experiences of therapeutic landscapes. (This relationality is also observed in a psychiatric setting by Curtis et al (2009) who conclude that 'history matters', with some aspects of the hospital provoking traumatic recollections while the same features invoke nostalgia for others).

In a more specific evocation of the benefits of natural environments, Grose (2011) used a therapeutic landscape framework to examine children's preventoria (isolation institutions for tuberculosis prevention) established in the early 20th century. These sites were underpinned by the rationale of 'escaping the city' and regimes of therapy based on the curative potential of 'fresh air', an idea that has prevailed in the tradition of children's health camps (Kearns and Collins, 2000). This coding of the 'natural' as therapeutic is a theme that has continued to be pursued since case studies such as Gesler's work on Bath (1998). Day (2007), for instance, examined public experiences of air quality, arguing that central London is regarded as emphatically non-therapeutic, while less urbanised London locations associated with better air were more 'natural' and therapeutic. Yet, for both Wakefield and McMullan (2005) and Milligan and Bingley (2007) there is an ambivalence: the possibility of places being simultaneously therapeutic and harmful or 'scary'. These authors challenge assumptions that natural landscapes are necessarily therapeutic, highlighting their contested and contingent nature where health-denying and health-affirming places may co-exist. In doing so they point to the social, cultural and embodied contexts that can contribute to people's complex relationships with nature.

The implied binary between therapeutic and non-therapeutic places according to the degree of 'nature' experienced reaches back into the history of urban planning/public health. It finds more recent echo in Windhorst and Williams' (2015) investigation of

students' preferences for natural environments; they found more affinity for familiar 'natural places' at-a-distance from both the built and social campus environment. Findlay et al (2015) identify a dearth of studies involving older people and assert the importance of understanding embodied ability levels, a gap also addressed by Coleman and Kearns (2015).

In general, a point of divergence seems to be whether 'nature' is a necessary element in order for a landscape to be deemed 'therapeutic'. Some authors emphasise the fundamentally therapeutic qualities of natural elements (Day,2007; Finlay et al. 2015; Grose, 2011; Serbulea & Payyappallimana, 2012; Thomas, 2015; Volker and Kistemann, 2015; Wang et al. 2018; Windhorst & Williams, 2015). Others, however, stress the therapeutic valences of non-natural elements (e.g., Bornoli et al., 2018; Masuda and Crabtree, 2010; Piet et al.,2017; Shortt et al.,2017). More recently, authors have picked up on ideas posited by Volker and Kistemann (2015) that seek to take a more subtle approach to understanding the salutogenetic and therapeutic relationships between people and different types of natural landscapes. Here writers distinguish between blue spaces (lakes, the sea, open water etc.); green spaces (e.g. woodland, parks and the countryside) and yellow spaces (desert) (see for example, Lengen, 2015; Finlay et al, 2015; Wang et al., 2018, respectively).

Mobilising the concept

A minority of papers emphasise movement as opposed to, at least implicitly, regarding landscapes as perceptually and materially static. Invoking the 'mobilities turn' in the social sciences (Hannam et al, 2006) Gatrell (2013) argues that attention should be paid to the therapeutic qualities of moving between places. Gatrell's work focusses on walking to propose 'therapeutic mobilities' which incorporates three dimensions: activity, connection and context. Working in a similar vein, Doughty (2013) addresses the lack of attention to embodiment and movement in therapeutic landscapes work, with a particular concern for the sociality within walking practice and its restorative potential. To her, the social spaces created are experienced as restorative and walking *together* offers a mobile therapeutic landscape. Similarly, Bornioli et al (2018) identify the significance of non-natural features in the course of walking through therapeutic landscapes.

Therapeutic landscapes can also be local, mobilising and activity-rich. To incorporate the movement-in-place occurring in a community garden, for instance, Pitt (2014) engages the concept of 'flow' which she sees as the state in 'time passes quickly and one ceases to feel separate from task or world' (p 85).' Elsewhere, community gardens have been examined as a therapeutic third place allowing not only physical activity, but also social interaction and spiritual solace (Marsh et al, 2017; Thomas, 2015).

Beyond the Anglo-American World

There are few examples of the application of therapeutic landscape ideas in non-Western settings. An early and innovative exception was Clare Madge's (1998) analysis of the health care system of the Jola people of The Gambia. Her documentation of indigenous medical beliefs and practices focused on the role of herbal medicine and, in particular, the linkages between indigenous medicine and biomedicine. A later and well-cited application was Wilson's (2003) engagement with First Nations experience in Ontario in which the author critiques the lack of attention to the spiritual dimension as well as the focus on the exceptional in therapeutic landscape framings. Wendt and Gone (2012) update this interest, coining the term 'urban-indigenous therapeutic landscapes' for colonised experiences. Beyond North America, MacKian (2008) addressed critiques of therapeutic landscape as overly 'Western' by examining constructions of health and place in media constructions in Uganda. In one of the more novel developments, Wang et al (2018) examine 'sand therapy' in China to explore how painful embodied experiences and cultural beliefs are assembled to produce therapeutic experiences in the 'yellow' space of the desert. The authors engage with Conradson's (2005) relational notion of landscape, arguing that these experiences cannot be understood as intrinsically therapeutic. Rather they should be interpreted as such through a particular cultural lens. Also in China, Zhou and Carey (2016) considered doctor-patient conflicts and how the organisation of rooms and decorations can contribute to the hospital being a therapeutic landscape and positively shaping doctor-patient relationships.

Returning to Gesler

In our exchange, Gesler was clear that his choice of case studies was strategic

> *I decided to look for places for which there was a lot of information… in order to try and prove the utility of therapeutic landscapes. That is mainly why I chose … Epidauros, Bath, and Lourdes. I realise now that I was trying to write a 'thick description' of these places….I would claim that when you apply the framework, you are attempting to be comprehensive, to examine everything that you possibly can that is out there*

Here we see him indicating that, while the intersection of physical, social and symbolic spaces are key to his ideas, the focus of his case study sites is less about reputational uniqueness and more about the availability of information about these places. Hence, although it might be easy to critique some subsequent work for moving beyond the unique to the everyday, the key is the extent to which this work contemporaneously engages with the social, physical *and* symbolic within these landscapes. To him:

> *If you say you are going to use therapeutic landscape as an analytical framework, then you should employ all three environments. Use it all or not at all. To leave out one or more is the heresy of incompleteness.*

This suggests that employing therapeutic landscape in a research setting requires an exploration of the social, the physical and the symbolic. Further, researchers should strive for completeness; an accounting of all those physical objects that make up that landscape and well as the relationship between these 'things' and the social, symbolic and cognitive. What Gesler is inferring, is a need to be alert to both human and non-human interrelations. Hence there are incipient connections to assemblage thinking (see Foley, 2011).

Gesler further commented that:

> *What surprises me… is the robustness of (the idea) over time. The reason for this might be that it somehow combines both theory and method: the method is backed by theory and the theory is put into practice by the method.*

Emphasising the importance of a 'thick description' means that therapeutic landscape inherently lends itself to qualitative approaches. While traditional interview, focus group and archival approaches are still much in evidence, there is also a clear move toward enhancing 'thick description' through an engagement with more innovative methodologies. Examples published within *Health & Place* include Doughty's (2013) use of 'go along' interviews, combined with GPS, to explore the embodied and mobile production of therapeutic landscape. Milligan and Bingley (2007) use psychotherapeutic methods that include sand-play and visual model-making to explore the impact of childhood woodland experiences on the therapeutic engagement with nature in young adults. Rose and Lonsdale (2016) use Participatory Action Research and the arts to explore how re-imagined landscapes through painting might enhance wellbeing in later life; while McKian (2008) and Zhou and Grady (2016) respectively, use textual and discourse analysis to explore firstly, media influences on therapeutic landscapes as they empower women in Uganda; and secondly, how (combined with visual and observational data) different modes of meaning are constituted through language, embodied interaction and the physical environment in doctor-patient relationships in Eastern China. Other papers incorporate a range of visual and participatory techniques, observation, mapping, diaries, and visual novellas to explore the impact of therapeutic landscapes amongst a wide range of topics including: migrant refugees (Sampson and Gifford, 2010); medication and the development of therapeutic spaces of care in the home (Hodgetts et al, 2011); and the barriers and facilitators to everyday access to local natural spaces for local community members (Hansen-Ketchum et al, 2011). We have also seen the use of photovoice (eg Windhorst & Williams, 2015; Shortt et al, 2017), photo elicitation (Coleman & Kearns, 2016), and autobiographical narration (Lengen 2015).

New Directions

Distinct from the methodological innovation referred to above, there are a number of ways in which the therapeutic landscape framework has been extended rather than simply deployed in the pages of *Health & Place*. Drawing on psychoanalytic theory, for instance, Rose (2012) argues for it to incorporate not only physical spaces but also 'landscapes of the mind'. Lengen (2015)'s work is relevant here, considering place as an idea potentially accessed through visualised perceptions among psychiatric clients. This 'imaginary 'reach' is also evident in Tonnellier and Curtis' (2005) use of therapeutic landscape ideas to interpret links between health and place in Balzac's 'The Country Doctor'.

Foley (2011) offers another new direction, examining Irish holy wells to suggest a 'therapeutic assemblage'. Drawing on the perfomative turn in geography, Foley identifies material, metaphoric and inhabited dimensions of lived, experiential dimensions of health in space. This builds on Conradson's (2005) view of relationality and emphasises connections between inner meanings and outer contexts. Foley's (2015) later work on swimming was further novel in its mobilizing of therapeutic landscape ideas into 'blue' spaces (Volker and Kistemann, 2015), drawing on non-representational theories (NRT) and using the idea of immersion. Connecting with Conradson's (2005) thinking, Foley avoids claiming intrinsic qualities of watery spaces, but rather sees swimming as a therapeutic encounter experienced differently by different people.

A fundamental distinction is between papers that appear to see landscapes as inherently therapeutic (Nagim & Williams (2018), Glover & Parry (2009), Marsh et al. (2017), Moore et al. (2013); Volker & Kistemann (2015), and those that regard them as relational. With respect to the latter, two authors warrant particular mention. First, through a case study of a respite centre in southern England, David Conradson (2005) argues for fundamentally relational dimensions of the self-landscape encounter. These dimensions transcend landscape qualities themselves and instead involve people's interactions with that landscape, leading him to argue that the term 'therapeutic' is more accurately ascribed to people's experiences rather than the landscape itself. Gesler, himself, sees this as a novel contribution and "*unexpected simply because I would never have thought of it. It has made a very welcome impact."*

In a pair of subsequent papers, Cameron Duff (2011, 2012) builds on Conradson's critique by proposing the notion of enabling 'places'. Engaging with Latour's actor-network theory, Duff argues that healthy places, or 'enabling places', are constructed in a series of enabling encounters, networks and associations. Duff (2011) contends that while the character of enabling places is well established, their distinctive therapeutic qualities and the means of their development are less well understood. Therapeutic properties of place are relational achievements – produced by the unique convergence of enabling resources in place, whether these be material, affective or social. Duff argues that this focus on relationality of place is the primary innovation

associated with ‘enabling places’. The key contribution of these papers is the theorised demonstration that participants actively construct enabling places.

Conclusion

In this commentary, we have surveyed how authors have invoked therapeutic landscape ideas in papers in *Health & Place* in an attempt to map out its hallmarks as a maturing theoretical construct. We have augmented our review with selective comments from Gesler himself. What is of note in reflecting on how this construct has been applied and evolved within *Health & Place* is the breadth of disciplinary influences upon those engaging with the concept. Moving well beyond its original location within medical geography (Gesler, 1992), authors are now drawn from within the arts (Rose 2012); health sciences (Burgess Watson, 2007; Brewster, 2014); management (Duff, 2011; Wang et al, 2018); nursing (Moore, 2013); public health (Volker and Kistemann, 2015); psychology Oster, 2011; Wendt, 2012); and politics (Sampson, 2010) to name but a few.

In summary, work invoking therapeutic landscape has been diverse and collectively diffuse. Gesler himself is unsurprised:

> *What emerges from the three environments [physical, ecological, symbolic] can be very complex. There are many human and non-human actors involved in the three environments (thinking of Actor-Network Theory here) and they all interact with each other. This complexity can be teased out in so many different situations that now that I reflect on it, the variety of directions TL has taken should not be so surprising.*

At times, and on re-reading, some papers perhaps use the concept a little too glibly. Certainly some scholarship has drifted a good distance from Gesler’s (1992) goal of engagement with the tripartite elements of physical, social and symbolic environments.

On the positive side of the ledger owever, we see therapeutic landscape as having offered three key contributions. *First,* it has been a theoretical pivot facilitating methodological experimentation and diversification. It has maintained an importance for ‘thick description’ and fostered an openness to methodological innovation and experimentation. *Second,* it has allowed a return of the idiographic tradition in health geography, offering us a window into the generative potential of particular places for wellbeing. In this respect uptake of the framework in health geography has mirrored the surge of interest in humanistic geography in the parent discipline in the late 1970s, and its granting of permission for case studies, emphasis on localized experience and validating of the sensing of landscapes (see e.g. Gorman, 2017). *Third,* therapeutic landscape has been a platform from which deeper theorising has occurred; by way of example, without this scholarship there may have been less of a platform from which

to consider the potential of Latourian or Deleuzian thought in health geography. Through Duff's (2011) 'enabling places' idea, for instance, we see a questioning of the expansiveness of 'landscape' and return to place (paradoxically, perhaps, advanced by a non-geographer) as a foundational construct in human geography and one of the core concerns in the journal's name.

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