AN EXPLORATION OF THE MEANINGS OF SPACE AND PLACE IN ACUTE PSYCHIATRIC CARE

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Abstract:
Spatial human experiences such as confinement and freedom are important to acute psychiatric care. The physical space that inpatient psychiatric/mental health nurses and acute psychiatric patients share influences human relationships. The purpose of this paper is to explore the meanings of space and place in acute psychiatric settings, to discuss how these meanings affect human relationships, nurses' work environment and patients' perception of care, and to present how the design and use of nursing stations affects therapeutic relationships. We hope to encourage dialogue and research that will help clarify the meaning of space and place in acute care psychiatric units, and make for healthier work environments for nurses and healing care environments for patients.

Factors that influence the distribution of control between psychiatric/mental health nurses and acute psychiatric patients include the physical space they share. Halford and Leonard (2003) suggest that, "Not only do people make spaces, but spaces may be used to make people" (p. 202). That is, people operate from a framework that is in part created from the space they occupy. Space can be described as open, free, ineffable, and taken-for-granted (Tuan, 1977). Place comes from space—once space is known and has personal, human meaning attached to it, it becomes place (Tuan, 1977). Phenomenologically speaking, "place" exists only as it is referenced by people (Samuels, 1978). According to Liaschenko (1994), places "organize social space and, therefore, social relations and power, practices, resources, and knowledge" (p. 19). Acute care psychiatric units are an example of such a space. The purpose of this paper is to explore the meanings of space and place in acute psychiatric settings, to discuss how these meanings affect human relationships, nurses' work environment, and patients' perception of care, and to present how the design and use of nursing stations affects therapeutic relationships.

Hospitalization of any type involves relinquishing a certain amount of control, creating a power imbalance because nurses and doctors have knowledge and expertise that patients do not (Haug & Lavin, 1981). Individuals enter hospitals to achieve a level of health that they could not achieve alone. In conjunction with very personal and private nursing care (e.g., related to bodily functions or the expression of intense emotional feelings), patients are at risk of losing dignity. In a study of hospitalized patients' perceptions of dignity, Matiti and Trory (2004) found that "patients had two alternative points of view about being admitted to hospital. On the one hand they saw the need for treatment of their illness, and on the other hand they feared the loss of

dignity in the process. They realised they had to submit, but at the same time they were worried by it" (p. 740). Lack of privacy is inherent in hospitalization. Private boundaries are muted in the communal space of the hospital, and patients have little room to call their own. Although some aspects of hospitalization may be intrinsically humiliating (like being naked in the presence of an unfamiliar adult), it is expected that measures will be taken to reduce to a minimum the amount of embarrassment the patient may feel (like closing the door if a patient is to be undressed to increase privacy).

Nurses and patients both benefit from having their own space. Nurse-only space and patient-only space have been found to be highly beneficial to each group's respective experiences (Halford & Leonard, 2003; Thomas, Shattell, & Martin, 2002). A separate nurse-only room described by Halford and Leonard allows nurses to express themselves with decorations and casual conversation that has nothing to do with their roles as professional nurses. Nurses "deeply enjoyed" their designated space because it allowed them to escape briefly from the "ceaseless gaze" of the unit environment (Halford & Leonard). Similarly, Thomas, Shattell, and Martin found that a smoking room unofficially reserved for patients in a psychiatric unit was described by patients as "the best place on this floor" and "very therapeutic." The patient's smoking room, which was also enjoyed by patients who did not smoke, was an "inner sanctuary" where patients could speak freely, away from the "watchful eyes" of nurses. The enjoyment of these places by nurses and patients seems to stem from a desire for isolation and distance where each group cannot be visualized by the other (for patients it is the "watchful eyes" of the nurses, and for nurses, it is the "ceaseless gaze" of the unit). Both nurses and patients seemed to recognize the need for places to call their own, perhaps to relieve the pressures of role performance when in the presence of the other.

SPACE AND CONTROL IN ACUTE PSYCHIATRIC CARE
Spatial human experiences such as confinement and freedom are important in acute psychiatric care. Goffman's (1961) description of the "total institution" included many aspects of the meaning of space and place in the lives of patients in "asylums." Asylums are places where the "encompassing or total character is symbolized by the barrier to social intercourse with the outside and to departure that is often built right into the physical plant, such as locked doors, high walls, [and] barbed wire" (Goffman, 1961, p. 4). Paradoxically, the confinement of the locked space does not always translate into feelings of confinement for those hospitalized there. In a recent study of acute care psychiatric units, Shattell (2002) found that patients experienced freedom while in the locked unit but experienced confinement by the "freedom" of the outside world. That is, patients were often afraid to leave the safety of their space and place (acute care units), because in the outside world they felt restricted by their "self-destructive impulses" (Shattell, 2002).

Although patients may express perceptions of freedom, their mobility and control is limited within the space of acute care psychiatric units. Psychiatric patients have little control over space, and the space they occupy is constantly being invaded by health care staff and other patients. "Staff have the right to enter and… make themselves at home in patient space, but not vice versa" (McMahon, 1994, p. 365). Patients have no real claim to privacy in psychiatric units. Even if patients have a private room, this space can be entered for routine observations and for

unannounced meetings by nurses, doctors, and other health care staff. These invasions of privacy are necessary, primarily for the safety of the patient in the psychiatric unit.

Nurses' control over space in a typical acute care psychiatric unit is undeniably greater than that of patients. Nursing stations are off limits to patients, and various physical barriers are used to prevent patient entry. Some nursing stations have locked doors and Plexiglas walls. Although closed nursing stations are prevalent, it should be pointed out that not all psychiatric nursing stations are tightly enclosed. However, even more physically open nursing stations often have strict policies regarding access to them. For instance, in more "open" nursing stations, there may be brightly colored tape (e.g., red, blue, or yellow) on the floor of the doorway, clearly delineating the beginning of the patient-free zone known as the nursing station.

Nurses' stations in psychiatric units are themselves within a larger locked space, a place where nurses and other health care staff are the only persons with access to the outside world. Presence on psychiatric units is optional for nurses: They can leave whenever they choose. Even within the unit, nurses can withdraw to a private area (if one is provided) when the environment becomes too stressful (Rossberg & Friis, 2004). Patients, however, are required to remain on the unit until they are deemed fit to leave.

Studies that address the effects of these differences in access to and control of space in psychiatric units are scant; however, some connections have been made. The fact that nursing stations often have locked doors and Plexiglas walls has the clear effect of cutting off patients' access to nurses. Nursing stations in these acute psychiatric units thus demonstrate the "powerful and pervasive" link between hospital design and behavior described by Schweitzer (2004). If a patient wants to speak with or receive care from a nurse who is inside this fortress, the patient must first breach the physical barrier that separates them. In some units, this means knocking on a door; in others it involves tapping on a little window, and in still others, waving the arms in front of the Plexiglas to get a nurse's attention. As one patient said in a study by Cleary and Edwards (1999), "Sometimes you just get totally ignored but sometimes they're saying 'excuse me, wait a minute'" (p. 474). A patient in Jackson and Stevenson's (2000) study of why persons with mental illness need psychiatric nurses said this of the nursing station: "They sit in the office [nursing station] and the patients are outside and whether going through distress or whatever, you knock on the door and say, 'Can I see somebody?' 'You can just wait. You'll be all right. Just go have a cup of tea.' That is what I have found on the wards" (p. 385). In contrast, psychiatric patients are generally expected to interrupt what they are doing if a nurse requests their attention. Nurses thus have the power to decide when to engage in contact with patients, but patients often do not have a choice.

ARGUMENTS PRO AND CON REGARDING PATIENTS' ACCESS TO THE NURSES' STATION
Arguments for restricting patients' access to the nursing station are numerous. Psychiatric patients, unlike hospitalized medical-surgical patients, are prone to problems with boundaries. A physical barrier may not be needed to separate nurses and patients in medical-surgical units, but in acute care psychiatric units, this may be the only way to guarantee that nurses will not be frequently interrupted while performing duties that do not involve direct patient contact. Additionally, confidentiality—on the surface at least—is a compelling argument for "walling-

off" patients from the nursing station. For example, nursing stations often have white boards containing vital patient information needed by members of the health care team. Information that is needed for caregivers is not appropriate for all patients. The confidential information exchange that occurs within the nursing station is crucial to the command center's smooth oversight of acute psychiatric care units.

Sometimes a simple unit redesign can have a profound impact on human relationships. Positive nurse-patient interactions increased dramatically after a psychiatric unit was redesigned to include more private areas for nurses (Tyson, Lambert, & Beattie, 2002). Interestingly, Tyson, Lambert, and Beattie's (2002)findings were thought to at least partially reflect the way the nursing station was used by patients. Before the redesign, patients would "pace up and down near the door and pop into the office to ask to go out" (Tyson, Lambert, & Beattie, p. 100), and these frequent "intrusions" into the nurses' "territory" appeared to negatively affect nurses' reactions to patients overall (Tyson, Lambert, & Beattie). This study clearly shows the benefit, for both nurses and patients, of nurses having a separate, private space of their own. Nurses became more satisfied with their work environment. They became more receptive to patients' needs, and patients received an improved quality of care.

A counterargument to the view that physical barriers should prevent patients from breaching the walls of nursing stations is that patients are in acute care psychiatric units to gain support, to learn how to control negative impulses, and to make socially appropriate decisions. As Shrivastava, Kumar, and Jacobson (1999) noted, "The hospital … should be designed in such a way as not only to serve as a temporary home, but its environment should aid recovery" (p. 121). When patients are fenced off physically, they are not given the chance to exercise self-control, demonstrate an understanding of boundaries, or exhibit knowledge of social norms. The presence of the nursing station wall subtly reinforces the idea, in both patients' and nurses' minds, that psychiatric patients cannot or will not respect the nursing station as a work area, and will not restrain themselves from interrupting nurses' work there. According to Malone (2003), "Power, as Foucault shows us, not only conceals itself, but conceals through spatial forms that reinforce power relations" (p. 2318). This sort of physical constraint renders patients' attempts at mental restraint irrelevant because the opportunity to exercise said attempts has been removed.

The enclosed nursing station may make the performance of health care workers' clerical work easier, temporarily, but it has the potential to harm patients' abilities to act in responsible, mature ways in the future. Acute care psychiatric units, according to Goffman (1961), function as "forcing houses for changing persons" (p. 12); however, "if the inmate's [patient's] stay is long, what has been called 'disculturation' may occur—that is, an 'untraining' which renders him temporarily incapable of managing certain features of daily life on the outside, if and when he gets back to it" (p. 12). As Osmond suggested, the environment that meets the needs of the mentally ill, among other things, "maintains the social skills which the patient possesses, restores lost or damaged social skills … (and) encourages and reinforces the acquisition of good social skills" (cited in Izumi, 1968, p. 44). Trusting patients' abilities to respect nurses' boundaries may be an important aspect in achieving these goals.

IMPLICATIONS

Ultimately, patients are the reason why hospitals exist, and the focus should be on their treatment and care. Clerical duties performed by nurses and other health care workers are a byproduct of patient care, though this fact is often overlooked by those overburdened by paperwork. Paperwork and documentation have been shown to take up to 13-28% of nurses' work time (Institute of Medicine, 2004; Pabst, Scherubel, & Minnick, 1996; Smelzer, Hines, Beebe, & Keller, 1996; Upenieks, 1998; Urden & Roode, 1997; the remaining time theoretically is used for direct patient care activities and communication with other health care members. However, studies in acute psychiatric settings suggest that the amount of time nurses spend providing therapeutic care is relatively small (Ryrie, Agunbiade, Brannock, Maris-Shaw, 1998; Whittington & McLaughlin, 2000. While building relationships is an intervention that is intended to foster healing, Thomas, Martin, and Shattell (2004) found that psychiatric nurses had few meaningful interactions with patients because of interpersonal barriers (e.g., an impoverished view of personal efficacy) and organizational barriers (e.g., short lengths of hospitalization and high patient acuity). It seems reasonable to suggest that physical barriers (like a Plexiglas wall) between one and the subject of one's work could also diminish the amount of time one spends doing that work. In addition, perception of what nursing as a job entails may affect the performance of one's duties. A patient's mental health status is clearly within the realm of any nursing work, but the mental health of patients can be overshadowed easily by more concrete, well-defined duties such as documentation. A tendency to focus on managerial, technical, and clerical duties may be especially difficult to overcome for psychiatric nurses. In acute care settings, psychiatric nurses' duties tend to be more vague and usually without clear measurements of success or failure.

Psychiatric nurses do not perform procedures on patients; psychiatric nurses work through problems *with* patients. It may be difficult for nurses to choose the uncertain outcome of performing psychiatric interventions with patients. However, it is imperative that, if the choice exists, nurses do not retreat into the nursing station, but face the sometimes difficult task of interacting with acutely mentally ill persons. Perhaps Pieranunzi's (1997) advice to go "beyond the 'patientness' of the person to the person" (p. 160) may be difficult to follow, considering the structure of contemporary psychiatric units. However, by being aware of the spatial barriers that a nursing station creates, we can begin to question how these barriers affect the healing potential of nurse-patient relationships.

Research on the meaning of place for both nurses and patients in acute care psychiatric units is sparse. As explored in this paper, there are many areas that are open for further inquiry. For example, how do psychiatric nurses view the nursing station? How does a completely enclosed nursing station impact the development of therapeutic relationships? How is the quality of care affected by nurses' use of the nursing station? How do patients view nursing space and patient space? Is a more open space plan beneficial to patients? Does an open space plan impact nurses negatively? Do nurses retreat to the comfort of the nursing station out of fear from physical and/or emotional harm? Does interpersonal interaction with acutely ill psychiatric patients cause vicarious traumatization in acute care psychiatric nurses?

CONCLUSION
In this paper, we have explored how the meaning of the nursing station can affect relationships between nurses and patients. It is possible that on acute psychiatric units the nursing station is a

metaphor for nurses' existential dilemma to distance themselves yet relate to patients. The space and place of the nursing station may alienate psychiatric nurses from patients, as it may patients from nurses. According to Samuels (1978), "Human reality is charged with spatial relations and a history of man is a geography of men in search of their places, articulating their alienation and their concern for relationship" (p. 35). Through this beginning exploration, we hope to encourage dialogue and research that will help clarify the meaning of space and place in acute care psychiatric units, and make for healthier work environments for nurses and healing care environments for patients.

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