

The Atmosphere of the Ward: Attunements and attachments of everyday life for patients on a medium-secure forensic psychiatric unit

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Abstract

The climate or atmosphere of a ward in secure psychiatric care is typically studied by examining the relationship between social and environmental factors. However the experiences of patients are irreducible to a set of discrete dimensions or factors. Drawing on recent work in affect theory and architectural studies, we argue for an approach to atmosphere that places it 'in between' persons and space, as a 'spatially extended quality of feeling' (cf. Böhme, 2017a) of which patients are intimately aware. The paper discusses empirical material drawn from a broader study of inpatient medium-secure forensic care in a large hospital in the South of England. We show how the process of becoming attuned to the fluctuations and shifts in the atmosphere of the ward is a critical aspect of everyday life for patients. Attunement cuts across existing notions of power and resistance in these settings. We also demonstrate how attachments to a range of objects, some created by patients, can either expand or punctualize attunement, enabling change in the overall atmosphere. We conclude by speculating on how we might rethink spaces of recovery on an ethospheric basis.

Keywords: Affect Theory; Ward Atmosphere Scale; Service User Perspectives; Ethosphere; Foucault; Design in Mental Health

Introduction

Two of the research team enter a ward on the medium secure unit. We have been through a number of security checks and several locked doors to arrive at the ward to conduct our interviews on this very hot summer's day. The ward is a fairly calm space, with large windows, high ceilings and glaring white walls. Before we move through the air-locked space onto the ward, the member of staff who accompanies us stops suddenly, with a sharp movement of the hand. "Wait there, please". She moves into the ward to discuss something with another member of staff. We wait in the airlock, anxious about what is going on. The atmosphere is tense. The staff

member returns and explains there is a patient lying on the floor near the doorway. She instructs us to enter the ward, and to not pay any attention to the woman who appears to be sleeping. Why doesn't she just sleep on her bed in her bedroom? Nobody asks: we are told to move slowly round her. The member of staff jokes that the woman just needs a little rest - nothing to worry about. We walk round the woman, confused by this whole episode. When we return to exit the ward later on, the woman has gone.

This extract is taken from the research diary maintained as part of a study of a large medium-secure forensic psychiatric unit in the UK. The note captures the confusion of the researchers as they are escorted into a locked ward. The physical environment appears to be relatively pleasant – lots of light and colour, plenty of space. But something feels very wrong. The researchers take their cues from the staff members, who are clearly engaged in rapidly making sense of what is happening. We are told not to worry, just follow the lead and do not engage directly with the patient. We comply with this request and proceed with scheduled appointments that we have made on the ward. Nothing further is mentioned about this patient. We don't see her again.

There is a very long and rich tradition of research on the environments in which health care is provided. The effects of light, temperature and noise on the health and wellbeing of patients are well established (Shatell & Andes, 2006; Reavey & Harding, 2017) and are reflected in the design of modern hospital spaces. The physical environments of hospitals also have strong symbolic dimensions, which embed broader ideological conceptions of the place of the patient in the health care system (Brown et al, 2015). For example, many newly built or redesigned hospital spaces in the UK use multi-purpose 'lounge' environments rather than 'waiting rooms', typically aligned with retail opportunities, which emphasise that the patient (and their families and carers) are consumers of health services who exercise 'choices' (see O'Doherty, 2017 on 'loungeification'). But arguably as important is the social environment or milieu through which care is enacted. A hospital is constituted out of a complex ordering of social relations, some of whom perform established medical hierarchies (i.e. consultants, nurses, patients), others of which have more ambiguous and contested purposes (e.g. the presence of social workers, managers, human resource professionals – and researchers).

Foucault's work continues to provide the key point of reference for understanding the ordering of social relations in hospital space. A social relation of any kind is fundamental a relation of power, which affords specific capacities to act, informed by the discursive structure of the knowledges in play. In principle, patients can do whatever they like, but they do not typically do so because the trajectories of their health and well-being are mapped out for them by clinical expertise in such a way that their actions are made to hang heavy with the consequences that are rendered as direct outcomes of their 'choices'. As Foucault (1976) demonstrated so clearly many years ago, medical power comes from the patient giving herself or himself over to the gaze of the doctor rather than through compulsion.

There remains one notable exception. Mental health care continues to involve the provision of care irrespective of the wishes of the service user. In the UK, this takes the form of either the use of a section of the Mental Health Act to detain a person in a psychiatric hospital until such time as they are declared to present a reduced risk to themselves and others ('sectioning'), or community treatment orders (CTOs) which require service users to adhere to a specific course of treatment (usually psychoactive medication) whilst remaining in the community. Many psychiatric hospital wards are locked and patients may be medicated against their will or detained in isolation in 'seclusion rooms' if they do not follow the instructions of ward staff.

This apparent disjunction is noted by Foucault. His 1973 College de France lecture course on Psychiatric Power offers the following summary:

Cooper has said 'At the heart of our problem is violence' and Basaglia: 'The typical feature of these institutions (school, factory, hospital) is a clear-cut separation between those who hold power and those who do not'. All the great reforms, not just of psychiatric practice but also of psychiatric thought, revolve around this power relation: they are so many attempts to shift it, conceal it, eliminate it, or nullify it. Fundamentally, the whole of modern psychiatry is permeated by antipsychiatry, if by that we understand everything that calls into question the role of the psychiatrist previously given responsibility for producing the truth of the illness in the hospital space. (Foucault, 2006: 341-342)

Invoking the names of the renowned anti-psychiatrists, David Cooper and Franco Basaglia, Foucault presents modern psychiatry as locked into a struggle with a rival will-to-truth which contest one another at every turn. Whilst this depiction of psychiatry is very much of its time, the lines of force it draws remain live, although many would characterise the contemporary struggle as between a heavily biologised version of psychiatry and psychosocially informed approaches to mental health (Cromby et al, 2013). The place of lived experiences of mental health within this struggle remains fraught, with those who identify as 'experts by experience' concerned that their voices may be co-opted by psychiatry in so-called 'co-production' or 'patient public involvement' approaches, and some equally troubled with what it means to step outside of the language of disorder altogether, and the implications for access to health and social welfare support.

But there are risks in using Foucauldian notions of psychiatric power as a driving force for analysis. Take the opening example, of the patient laying on the floor. Where would we locate power here? Is it situated in the overall architecture of the ward itself? Or in the practices that are enacted within it? Doubtless in one sense it is in both places, but this does not get us very far in understanding what is happening at this moment to the woman on the floor. We see no coercion, no attempt to inculcate the patient into the truth seeking practice of psychiatry – she 'just needs a little rest'. Perhaps then, we may see this instead as an act of resistance, a deliberate pushing back against the ordering of the ward. But again, there is not much by way of evidence to support this. And indeed coding her actions analytically as 'resistance' might be seen as reproducing the failure to engage with her own lived experience that service users have so eloquently critiqued.

We want to argue that to understand the specific modes of ordering relations on a secure psychiatric ward, we need to suspend initial recourse to notions of power and resistance. Wards can be places where power is visibly exercised and resisted in turn. In our experience, seclusion, and less punitive, but no less coercive measures such as 'de-escalation' (where patients are encouraged to take 'time out' coupled with PRN drug prescription - i.e. additional doses of medication given to address escalating behaviour) are common occurrences. But they can also be complex relational spaces, where it can be difficult to initially tell staff and patients apart (staff do not wear uniforms, but dress in the same tracksuit and loose casualwear worn by patients). They can also be places of great

excitement and energy – in one of our most recent studies part of our recorded interview data became unusable because of the sound of a patient’s landmark birthday being raucously celebrated with 50 collectively and chaotically sung verses of ‘Happy Birthday to you’. Much of time they are places of grinding boredom, where staff are unable to meet the needs of patients as they retreat to the nurses station to complete administrative work, and patients wander, restless and uncomfortable as a consequence of their medication, from watching television to laying down on their own in their bedroom. A ward can be all of these things in the course of a single day, and many other things besides.

It is the felt texture of the psychiatric ward as a lived space that concerns us here. The feel of the ward – the rhythms and sensations disclosed to daily life that are experienced at an intimate level – is continuously subject to change. Feelings are here not so much emotional responses to the environment, but rather an affective atmosphere that seems to envelop and attach itself to the persons who live and work on the ward. That atmosphere fluctuates, passing from phases of volatility and threat, through periods of calm, to odd moments when there is a shared, but near unspeakable sense that something unusual is about to happen. The atmosphere is also not bounded by the physical space of the ward itself. As Quirk et al (2006) show in their study of three psychiatric hospitals in greater London, psychiatric units tend to be ‘permeable’. Patients at different stages in their recovery may leave for community visits. Staff rotation can be high. Visitors arrive at the unit either in the flesh or virtually through telephone and Skype calls. Things also land in the ward through highly circuitous routes – music, clothing, photographs, cigarettes, drugs, pornography – carrying with them traces of the relations that have marked their journey. The atmosphere blends together currents from remote places and times.

In this paper we show how patients become intimately attuned to the atmosphere of the ward through attaching themselves to range of objects – including other people – through which their experiences become articulated. We argue that atmosphere is irreducible to a set of discrete dimensions or factors, but this makes it nonetheless tangible and critical to how daily life is lived on a psychiatric ward. In the following sections we begin by discussing how ward climate and atmosphere is typically conceptualised and assessed, and describe its limitations. We then draw upon recent work in human geography, architecture and anthropology to offer an alternative approach to atmosphere that focuses on the ‘in

between' character of affect. This approach is then used to read empirical material from a study of a large medium-secure forensic psychiatric unit. We conclude by speculating on how we might rethink spaces of recovery on an ethospheric basis.

Evaluating the Ward Climate

The best-known tools commonly used to evaluate the social climate or atmosphere of psychiatric settings are the Essen Climate Evaluation Schema (EssenCES) (Schalast et al, 2008) and the Ward Atmosphere Scale (WAS) (Wenk & Moos, 1972). Both of these tools take the form of questionnaires used with either patients or staff which pose a series of questions that are meant to elicit a subjective position on a number of underlying scales or factors. The psychometric properties of the tools are well established. As Tonkin notes, along with a small number of other instruments, there is published test data covering '50 years, 11 countries, and three continents, including a range of populations within prisons and forensic psychiatric hospitals', with a total of 59,070 participants (2016: 1394). It goes without saying that this is an impressive amount of data.

The tools tend to measure roughly the same underlying dimensions (although the specific constructs differ slightly). EssenCES identifies 'therapeutic hold' (i.e. the extent to which therapeutic intervention is felt to meet the needs of patients), 'patient's cohesion' (i.e. whether there is mutual support amongst patients) and 'experienced safety' (i.e. perceived levels of threat, aggression and violence). A 'good' climate is one which is felt to be safe, mutually supportive, and offering meaningful therapies. The WAS has a similar three factor structure – 'relationships', 'personal growth', 'system maintenance' – but breaks these down into 10 sub-scales to include issues such as 'involvement' (under relationships), 'personal problem orientation' (under personal growth) and 'order and organization' (under system maintenance). Again, these dimensions seem to have strong face validity. Wards are felt to be more positive when it is possible for the patient to focus on their journey through recovery in a supportive peer environment that is well structured and controlled by staff.

However, as with any psychometric instrument, there are abundant issues with these tools. As a self-report questionnaire, there are various factors that might bias responses. Patients on secure psychiatric wards are typically very concerned about how 'risky' they are deemed by staff. Being 'stepped down' in terms of risk assessment is important because it is a

marker of progressing towards the end of detention. There is then something at stake for patients in how they complete the questionnaire – Tonkin (2016) reports that studies where patient anonymity was not offered give different results to those where anonymity was guaranteed. There are also differences in how staff and patients respond to both scales. In a study of a large high security forensic psychiatric institution in the Netherlands, de Vries et al (2016) found that staff tended to rate therapeutic hold higher than patients, whereas patients were more concerned with cohesion and safety. Moreover, the characteristics of individual patients had statistical importance. Friis (1986) claimed that there was evidence that different patients diagnoses also affected results.

At a conceptual level, there is a broader issue with the nature of climate or atmosphere as a construct. Social climate has been defined as the “the interaction of aspects of the material, social and emotional conditions of a ward, which may – over time – influence the mood, behaviour and self-concept of the persons involved” (Milsom et al, 2014: 87). This definition reflects a classical psychological distinction between person and environment. On the one side is the sociomaterial environment (which confusingly also includes an affective element), on the other, is the person with their subjective mood, actions and sense of self. The explicit theory-in-use here is that the outside, environmental factors get inside the person through some unspecified mechanism.

Both sides of this distinction are problematic. Whilst Schallast et al (2008) and Moos (1989) argue that social climate is distinct from the organizational culture and physical design of the ward, it is difficult to conceive of how they are not intrinsically bound up with ‘material, social and emotional conditions’ which impact upon patients. A patient’s bedroom on a psychiatric ward, for example, is carefully and minutely designed to reduce the risk of self-harm (e.g. ensuring removal of ligature points, sharp edges, breakable objects and surfaces) and to ensure that staff can maintain surveillance of the patient through door viewers or internal cameras at any moment. The physical design is encoded with the dominant organizational discourses of managing risk to self and others, which is clearly meaningful to patients. A bedroom ‘speaks’ to the patient, and what it says is: you are the kind of person who is likely to self-harm, you are a risk, you cannot be trusted, I am taking away your ability to hurt yourself. In this way, the configuration of psychiatric hospital space directly embodies broader sociocultural debates around mental health. Bedroom doors, for

example, are constructed to different design specifications across Europe, with the overwhelming concern in the UK being to reduce the possibility of the patient barricading themselves within their room (solved by having doors open out of rather than into the bedroom). Doors are then highly culturally specific – they ‘do not travel well’ (Clive Stone, personal communication) across settings.

On the other side, the idea that the person possesses their mood and exercises control over their behaviour in such a way that it is meaningful to say that it is ‘influenced’ by the conditions of the ward, does not sit well with contemporary psychological thinking. Capacities to act in some way or other sit within a relational nexus (see Stenner, 2018; Brown & Stenner, 2009). Violence or aggression, for example, are not spontaneous outbursts, but are actions that occur within a chain of reciprocal shifts amongst forces. Feelings are similarly not so much personal properties as ways in which persons are engaged with the world around them. Mood is in the spaces as much as it can be said to be in the person.

In this sense, there is an odd tautology involved in defining climate or atmosphere as the interaction between two existing terms, since neither is conceptually separate from the other to begin with. But that does not mean that these terms are of no use. Rather what is required is a way of rethinking them on the basis of a prior indivisibility. That it is to say, that rather than dismiss atmosphere as unhelpful to understanding the feeling of the ward, we want to put it right at the centre of analysis.

Affective Atmospheres

The notion of atmosphere has been reworked within the range of approaches to feeling and emotion collectively known as ‘affect theory’ (Anderson, 2014; McCormack, 2018; Gregg & Seigworth, 2010). Whilst this diverse area has little by way of a common theoretical foundation, it emphasises that feeling and emotion do not arise within the person, but are instead constituted through the resonances of bodies with one another. An atmosphere then names the in-between space of feelings that occurs between bodies. As Tonino Griffero has it:

[A]tmospheres are feelings poured out into space. They are modes of a corporeal pre-dualistic communication that at times is supersubjective and superobjective – the

calm before the storm, the fever of the limelight, the numinous, the wind etc – and at times is more dependent on the subject, or condensed into (or anchored to) preferential objects. In any case, they are quasi-things whose ecstasies are expressive characters of qualities and whose extraneousness to thingly dimension and to the predicative structure often lead to misleading projectivist explanations. (Griffero, 2014: 108-109)

What Griffero attempts to do here is to overcome a dualistic positioning of atmospheres at every turn, whilst simultaneously keeping feelings close to the persons who articulate them. So whilst feelings may be poured out into space, there is no suggestion that there is necessarily an agent who does the work of pouring. Atmospheres are in-between – they are ‘quasi-things’ that appear to have their own existence whilst also being dependent on the relations out of which they are constituted. Consider for example, the common experience of walking into a crowded room and feeling the atmosphere change. What is happening is a complex ‘dance of agency’ (cf. Pickering, 1995), involving conversations, proximities and intimacies between bodies, undulations in sound and vision, the gathering of all this together within the physical boundaries of the space. But the atmosphere nevertheless feels as though it is irreducible to all of this, as though it was a thing in itself.

The peculiarly there and non-there character of atmosphere is marked by Griffero’s use of the term ‘ecstasy’, which is derived from *ek-statis* – a being outside of oneself. Our feelings are both within and outside us. The atmosphere is part of our own actions, but it is also attached to us, like a fog in which we are enmeshed. In a similar fashion to Griffero, Gernot Böhme refers to ecstatic qualities when he defines atmospheres as ‘spatially extended quality of feeling’ (2017a: 15). What is extended, for Böhme, are the potentials of arrangements between things that infuse or ‘tincture’ the experience of space. For example, the main door that serves as entranceway to the psychiatric ward described in our initial example is excessively heavy, in order to meet both fire safety and security standards. It opens slowly, and if allowed, closes with a large banging sound. The solidity of the door, its presence as marking the limit of the ward, along with the sounds it makes, particularly at night, radiate throughout the ward. The qualities of the door colour the experience of being in the space, lending a sense of being in detention.

The sense that atmospheres envelop a space can be recalled in the etymology of the term – *atmos*=exhalation/vapour; *spharia*=globe/sphere. Anderson (2014) argues that atmospheres do a work of bounding, constituting very particular spatio-temporal rhythms:

Atmospheres are a kind of indeterminate affective excess through which intensive space-times are created and come to envelop specific bodies; sites, objects, people, and so on, all may be atmospheric or may feel and be moved by atmospheres. (2014: 160)

This is an important contrast with the usual idea of a ward atmosphere as something like a long-term stable ‘climate’. As Anderson describes it, an atmosphere is changeable, volatile and in part indeterminate. We are aware that something is about to happen – in the same way that we can feel the imminent arrive of rain – but not necessarily what is coming. Atmospheres are then, to a certain degree, excessive. They cannot be reduced to component factors, instead forming a complex array of feelings.

Indeterminacy does not imply that we cannot find our way within an atmosphere. Böhme (2017b) uses the phrase ‘tuned space’ to refer to the constellation of feelings within an atmosphere. He points to staged atmospheres such as set designs or advertising campaigns, where there is a deliberate attempt to constitutes feeling through a multi-modal combination of elements. This is akin to the collective musical tuning of an orchestra or the drilled mutual orientation of a dance company. But the term can also be applied to ‘tunings’ which have emerged without a clear driving agency, through the gradual autopoietic resonances of a setting. Whilst psychiatric hospital wards are closely designed to detailed specifications, the atmospheres which emerge within them come from the perdurational process of becoming as the space is transformed in practice – bits and pieces are shifted around, bodies settle in particular rhythms, clusters of feeling begin the settle into place.

If space is tuned, then entering into a space requires that the person to find a way of resonating with the space, of becoming *attuned* to the atmosphere (or ‘response-able’ in Joanna Latimer’s (2018) terms). Stewart (2011) refers to this as the ‘commonplace labor of becoming sentient to world’s work, bodies, rhythms, and ways of being in noise and light’ (2011: 445). She offers the following literary example:

It was September, the low season, but the place was filling up, and he leaned back against the bar with his ginger ale and scanned the club for pockets, those dark human spaces in the room where something has just changed: above the music a man lets out an appreciative yell when before he was quiet; one of the dancers out on the floor laughs a little too hard or steps back too fast; a chair leg scrapes the carpet – something Lonnie can't hear, just feels, a shift of objects in the space there, this change of air, a pocket of possible trouble (Dubus, cited in Stewart, 2011: 446)

In this excerpt from Andre Dubus' *House of Sand and Fog*, Lonnie, a bouncer in a strip club, looks out over the crowded room, alert for signs of trouble. This is a space to which he is highly attuned. Lonnie can feel things in their emergence, the initial ripples of what is to come, before there is a clear signal. This is a practiced sensibility for finding his way through the relational possibilities of the atmosphere. Stewart uses the slightly gnostic phrase 'getting into things' as a way of characterising attunement. One has to know not necessarily what is happening, but how one could 'get into it' – feel the rhythms and forms of emergence that the atmosphere brings about. In a similar vein, Shapiro (2015) describes attunement as 'somatic modes of attention' (p. 373) and forms of 'bodily reasoning' (p. 378) through which chemically sensitive persons train themselves to become aware of their environment. Calvillo (2018) speaks of an 'attuned sensing' as a practice that emerges through bodily engagement with air toxicity (see also Calvillo & Garnett, 2019). In all cases, attunement is an intimate, embodied practice of engaging with the environment in ways that are highly sensitive to minute atmospheric changes.

However, the attunement of the body is often further refined and expanded through an attachment to something beyond itself. As Moreu & López (2019) show in their study of junk, we may feel through things, through the relational possibilities that are offered up by intimacy with another body, whether that be human or non-human. Attachments work by coupling rhythms with one another, creating pockets of ordered space-time within the atmosphere. In Antoine Hennion's work (2015; 2017) attachments between bodies and objects become a central focus of analysis. Hennion argues that 'the attachment is what gets experienced' (2017: 114). What this means is that the relation of attachment is itself the basis of experience, rather than the consequence of the action of one body upon another. Moreover, Hennion draws on the unique resonance of the French term *Éprouver*,

which can be translated as both 'to try' and 'to feel'. Experience then has an experimental character, an effort at placing oneself within a relation in order to open oneself up to a feeling. Attachments, for Hennion, are characterised by an intimacy between those things that are being attached, such the qualities that are immanent within bodies and object circulate and become articulated through the relation.

In summary, rather than approach atmosphere as the influence of social and environmental factors on patients and staff, we can treat the entangled space of feelings on the ward as the primary medium to be investigated. The atmosphere envelops the space and the persons who dwell within it, and establishes the relational possibilities for being and acting together. Orienting to that space through processes of attunement, including those that arise from intimate attachments to aspects of the space become critical. In what follows, we now turn to exploring how patients develop an intimate sensitivity to the particular atmosphere of a forensic psychiatric unit, and how this sensitivity is deployed to manage daily life in detention.

Entering the Atmosphere

Sharphill is a large, purpose built medium-secure unit comprised of six wards (four male and one female wards, along with an acute ward). All of the patients within the unit are on a forensic care pathway, meaning that they are detained under Sections 37 and 41 of the UK Mental Health Act, which determines that care should be provided in a hospital rather than prison setting. The majority of patients at Sharphill have either been transferred from the prison estate or have been 'stepped down' from high-secure care in one of the three major units in the UK (i.e. Broadmoor, Rampton, Ashworth). As such, most patients have prior experience of living in a secure setting, which can in some cases be for over ten years or more. Nevertheless, being transferred to Sharphill can be an overwhelming experience for many patients, particularly if they arrive during episodes when they are highly distressed. Here Cynthia talks about how she experienced admission to the unit:

Interviewer: How do you feel your mental health is in this ward?

Cynthia: I don't like it here, it's depressing. Well, [prior hospital] is not too bad. But here it's not like that, they close my cell doors, they close my mind, my eyes and all these things ... an animal. I don't like it.

What is described here is a visceral reaction to the setting that leaves Cynthia feeling like ‘an animal’. The features of the space itself, with the locked doors and individual bedrooms are felt as directly impinging on her sense of self. She is being ‘closed down’ by the environment. Tellingly, Cynthia refers to her bedroom on the ward as a ‘cell’, eliding the difference between hospital and prison space. The comparison between the two spaces has a measure of ambiguity for most patients. Joshua, for instance, described the external space of the ward in the following terms:

Joshua: So, with the high fences and all that, it's sort of like a prison. Well, it's worse than prison. The fences are higher and there's more doors

The issue here is that Sharphill is indeed ‘sort of like a prison’, since it has mandatory high walls and fences, along with heavy airlock doors that bang repeatedly when opened and closed both day and night. Whilst ward staff do not wear uniforms, they carry large bunches of keys and are obliged to perform regular round the clock monitoring of patients, particularly when they are alone in their bedrooms. Whilst much has been done in the design of the built environment to reduce the carceral look of Sharphill (e.g. painting fences green so they blend into the surrounding greenery), it still feels like a prison to many patients:

Christopher: Um, in terms of the design of the wards, like, it looks like a – like a prison, like you can't come out of. And the doors are double locked. I came to the assumption one day, it was just a thought, like I was living in hell, you know, because there's so many doors, so many – so many, um, keys that the nurses carry around that they have to open and then it's like, um, you get the sense that am I imprisoned here forever, for life?

In formal terms, Sharphill is not a prison, it is a hospital, a place of care and recovery rather than punishment and rehabilitation. Much as patients use the idea of incarceration as the model to understand life on the unit, there are significant differences. Whilst a prison sentence carries a specified term, there is no similar tariff applied to detainment under section 37/41. Discharge is a matter of clinical judgment, further ratified by the Government Home Office. A prison sentence also has a definite temporal structure in relation to past

offending behaviour and future rehabilitation. Patients on a forensic care pathway also have a prior 'index offence', but the care provided in places like Sharphill is not meant to address that offence directly. It seeks instead to stabilise the patient's mental health condition so that either a return to prison or discharge to a low security setting (e.g. hostel, supported housing) becomes possible. In fact, the relationship to the past is often a highly problematic for patients on forensic pathways (see Reavey et al, 2019), who may be unable, sometimes for legal reasons, to return to their previous homes and communities. The future is equally uncertain. The object of recovery is not the overcoming of past events, but rather the capacity to self-manage one's own mental health for the rest of one's life whilst carrying the burden of past acts and experiences (which for many patients can involve being victims of violence and abuse as well as being a perpetrator).

An ambivalent relationship to the past and the future on the part of patients complicates the process of attuning to the particular atmosphere of a medium-secure ward. Patients are typically encouraged not to 'dwell' on the past, since this is considered to be antithetical to recovery. But equally, since the purpose of care in this setting is to move patients further along in the system, rather than discharge directly into the community, there is little by way of focus on the wider future. The concern is primarily with managing feeling and conduct in the present. In this sense, patients find themselves entangled in the everyday relations of the ward atmosphere without a strong sense of how this relates to the temporal arc of the passage through forensic care. When past and future are rendered problematic, meaning has to be found in the minutiae of the everyday. Kathleen Stewart's (2011) phrase 'getting into things' – which is a rendering of Heidegger's (1962) notion of 'entangled absorption' in matters at hand – provides an apt description of this process of narrowing existential horizons down to the immediate. Take, the following commentary by Derek on a photograph he has taken of his bedding:

Derek: I like the pattern on the duvet cover ... all the lines were pointing kind of out towards the window, but there was also like the bars, there were like bars on the – on the – the pattern on the bed sheets and there was – there was, you know, there's linear sort of pattern which kind of mirrored a little bit of what's going on – with the bars and the windows. But it was also like – for me it was also a directional, so it was like beyond what was the bars on the windows.

At one level this is a description of the functional nature of the setting – cheap and plain materials with little aesthetic character, which mirror the bar that obscures the view from his bedroom window. But the more the description runs on, the more Derek ‘gets into’ or ‘feels his way into’ the objects around him, a sense of logic of detainment being encoded into all aspects of the space becomes apparent. The pattern of the bedding repeats the enclosure of the bars on the window. And yet, there is something else which starts to emerge, a sense that the pattern, the lines, is also pointing somewhere, to an outside that cannot be properly articulated, but is nevertheless felt as lying beyond the space of detention. Derek may not be able to engage with past and future, but from ‘entangled absorption’ in the present he can begin to sense affects that offer an anticipation of a space and time outside of the unit.

The process of feeling the specific affects that emerge from absorption into matters at hand can also be referred to as attunement. Derek is highly tuned into the details of the space around him. We might gloss this as a ‘high-definition’ experience of ward, as in the following:

Derek: I was watching – there's a whole – there's a whole range of life here. There's a whole community here and – and – and there are ladybirds. There are bumble bees. There are little butterflies that come. So if you observe this closely enough, you will see that there is another community within this community ... And so for me, when I'm sitting here, sometimes it reminded me of the things that we take for granted. I mean most of the smallest things and the little things and the things, but when I'm sitting here, I'm – I'm constantly reminded that there is another life that goes on and it is continual and it's – you know, it's quite vibrant and colourful ... if you pay enough – pay close enough attention you'll see that there's another world that – that goes on and it goes on behind that – that boundary

Becoming attuned in this way involves a multi-modal experience of the space where another ‘world’ appears to emerge that offers possibilities beyond the immediate routines of the ward. This attunement might be seen as a generative process of creating a ‘world within a world’. Yet conversely, we can also see attunement as a denial or refusal to engage with the actuality of detainment. By escaping into the community of bees, Derek is ‘tuning out’ the human community of forensic patients, nurses, clinicians and social workers with whom he currently dwells. More importantly, the meaning and significance of his

detainment is lost. In Heideggerian terms, the 'angst' or 'dread' that opens up a relation to a life beyond the unit is warded off by this vivid perceptual attunement to worlds within worlds. Seeing 'more' in the present involves a temporal and existential contraction. At the same time, we can recognise this form of attunement as a survival strategy for getting through an unspecified period of detention. For patients such as Derek, the ward may offer one of the first experiences they have had of relative safety and security in their lives – there may be good reasons for wishing to entangle themselves ever further into the minutiae of the present rather than engage with the difficulties and distress of the life trajectory that has led them to this place.

Tincturing the atmosphere

As part of the research process, patients on the unit took photographs of spaces and objects that held importance for them (see afterword). These photographs formed the basis for interviews where the emotional significance of what was depicted became clear. To use Hennion's term, the scenes were typically based around specific kinds of attachments. For example, Sue had produced a photograph of a loaf of bread that she had made during a supervised cookery session (see fig 1). Initially it seemed that this attachment was pleasurable, that it was an exercise in taking a small measure of control over dietary intake, and an opening up to the sensual pleasures of cooking at eating. But it became apparent that, due to staffing issues, supervised cooking occurred very rarely on this ward. The attachment was then also marked with frustration and disappointment, the sense of the ordinary pleasures of living that are lost during the course of detention. In this way, attachments involve both intimacy and feeling, along with ambivalence and reversibility. This is legible in the image itself – note the central framing of the bread, placed carefully on the rack to cool, yet set in a kitchen space that is otherwise bare and clearly little used.

(Insert Fig.1 with caption: Fig 1. Photograph of a loaf of bread taken by Sue)

Shapiro (2015) describes how chemically sensitive persons act as in a manner akin to 'human Geiger counters' in their capacity to apprehend the environment. In the case of Sharpill, it is the attachments rather than bodies alone that serve as sensors for the unfolding affects of the unit. The attachment to the bread becomes a way of acutely experiencing the tensions between care, security and economic efficiency that dominate

forensic psychiatric care. But attachments can also be a way of intervening in the atmosphere, a means of adjusting or transforming the affects that circulate. James is well known within the unit for his artistic experiments. He has produced a number of large canvas paintings, some of which are on public display on wards and in a visitor space in the broader hospital setting. Here he discusses one the larger works he has created:

James: I did a picture on the wall, a big one, a sheet on the wall, with – it's got blue and it's got, er, one and only unique human being with a distinct role to play in the universe. And that took me two weeks to do.

Int: Oh, was that you?

J: Yeah, I stuck it up there, sort of wow factor. When people come in, they always remark on that, and it's – it gives the right impression of the ward, that it's not dull and boring and clinical, white walls, there is some colour. And also it's a statement which isn't overtly religious. It's a statement which is there to encourage people, which is what people need. It's each of them saying, you're a unique person, you have a role to play.

I: So is that message for the patients?

J: Patients and the staff.

(Insert Fig.2 with caption: Fig. 2 Photograph of an artwork taken by James)

The picture is hung prominently above James' bed (see fig. 2). It depicts an outline of a solitary figure against a blue background. James contrasts this colour scheme with the 'clinical white walls' of the ward. Blue is typically associated with movement – clouds moving across the sky, the churning of waves. Here it contrasts with the fixity and containment of the clinical setting. The painting captures a sense of vitality, a feeling of being alive, which is all too often absent in psychiatric care (see Brown & Reavey, 2019). This is reinforced by the figure, which James describes as offering a symbol of uniqueness, of individuation in the midst of detainment. James explicitly positions the picture as an effort at reconfiguring social relations through offering a message of destining and individuated trajectories to both 'patients and the staff'.

If the attachment to the bread in the last example acted like an atmospheric sensor, then the attachment to the picture serves as an atmospheric transducer. The qualities of vitality and individuation that are immanent to the James' work are fed into the space. As Böhme (2017a) puts it, the qualities 'tincture' the atmosphere in a manner akin to a watercolour paint dipped into a glass of water. What James calls 'the wow factor' is this transductive movement of transforming the ward atmosphere by way of the attachment. Staff and patients alike participate in the affective transduction of these qualities through their engagement with the picture. This can also be seen in a different way in another of James' works, a fireplace that he has constructed out of cardboard (see fig. 3). The fireplace is mobile, and James regularly positions it in different places within his bedroom (see discussion in Tucker et al, 2019). However, unlike the painting, this particular work does not appear to be deployed to shape the atmosphere of the ward as a whole. James describes the fireplace as creating a 'homely feeling' in his bedroom. Rather than tincturing the whole space, the attachment fireplace seems to perform an 'auto-affective' function of insulating his bedroom from the unit, of creating an micro-atmosphere, a small sliver of enclosed space-time, within the hospital space.

(insert Fig. 3 with caption: Fig. 3 – a photograph of James' fireplace)

The tincturing of atmosphere can produce complex and ambivalent experiences. It is the norm in most secure and locked wards to have a common area with a television at its centre. Here Vincent describes the atmosphere around the television. It has been observed that in the majority of inpatient psychiatric care, patients are left for long periods of time watching cable television networks (Lawrence, 2005). Sharphill is no exception:

Vincent: The day area. We sit down, there's a TV, flat screen TV in there. We can put it on the music channel, music videos. Beyoncé and Jay-Z and all of the music what's going on, videos, it's them singing it. Or you can watch the news. I've been watching the news, I've been watching programmes about flying, everyone can fly – and all different things you can do, just sitting there watching telly.

In our experience, on male wards the television is usually tuned to music channels, such as MTV Base, or alternatively to sports or news channels. Conflicts tend to occur between patients over which channel to watch, particularly around televised events (e.g. football tournaments, Eurovision etc). The wards at Sharphill were deliberately designed to create maximum open communal space. This means that conflicts around the television can rapidly transform the entire atmosphere of the unit. It also makes it possible for individual patients to exercise control over the greater part of the soundscape of the unit by taking control of the television, as one patient reportedly did by insisting that the Al-Jazeera news network be on at all times. When, as Vincent describes, music television is being watched, particular kinds of intimate experiences seem to be afforded. We have observed heavily medicated patients position themselves as close as possible to the television, presumably because the bass sounds of the music provide a pleasurable form of resonance. It is also the case that the music videos played on channels such as MTV Base feature young dancers adopting sexually charged poses. The communal experience that Vincent describes is partly oriented around these images. Sexuality is a highly problematic issue on forensic pathways (see Brown et al, 2014). A show of affection or actual intimacy between patients is completely proscribed, and sexuality itself is ruled out as an inappropriate topic for either general or clinical conversations. Watching music videos is one of the few occasions where a shared experience of sexuality – albeit unspoken and unspeakable – can be engaged in. Victoria Knight (2016) has argued that within the prison estate, televisions are used as a device to make the hardship of long-term detention more tolerable, thus normalising questionable practices such as restriction to the prison cell. Whilst the use of televisions at Sharphill operates differently, we can see a similar balancing of affects, where a small release from the culture of denying physical intimacy is allowed.

Punctualizing the atmosphere

By definition, an atmosphere forms an enclosure, a 'sphere' of envelopment (McCormack, 2018). However, as we have seen, it is possible that denser pockets of other enveloping feelings might emerge within the overall atmosphere. Atmospheres are not totalising, nor are they necessarily highly bounded. Whilst the atmosphere at Sharphill becomes tangible from the moment one enters the building, what visitors, staff and patients bring with them are affective traces from elsewhere. The atmosphere is pulling in feelings from a wide range

of sources. To use Andy Pickering's (1995) term, it is akin a mangle that presses affects into close proximity with one another – a shout that comes from outside the gates, an anxiety passed on from the evening TV news, anger and violence emanating by a patient recently transferred from prison. Here is James talking about what he brings back when he allowed leave to walk in the hospital grounds:

James: I like, um, wooden things, like woodwork. I collect things in the ground and make other things. If I see it lying around and I think it can be used I'll use it.

Int: So was that, was that something that you did before? Or is it something you've started doing since you've been here?

James: Um, I just picked up things and found out I could do it really.

Int: Great, so, um, why do you like doing that kind of thing? What do you get out of it?

James: It keeps me occupied. Stops me thinking about the past. And I used it initially to concentrate my ideas into doing things creative instead of self-harming.

The pieces of wood that James finds outside the walls of the unit travel back with him and end up as parts of the attachments he produces with his art works. These are objects that come from outside the clinical environment, that have qualities that can be used to make something different happen. But this is not their only purpose. As James describes, the practice of looking for 'found objects' also does a work of holding him into the atmosphere without allowing his existential horizons to extend into the potentially troubling region of the past. This kind of entangled absorption creates a foothold, a definite perspective on the unfolding atmosphere that provides focus and attention.

Following Munro (2004), we will call this process 'punctualizing'. For Munro, drawing on Heidegger, punctualizing is a showing or disclosure of identity that is made in response to a 'demand' or 'summons' made by others. But objects can also issue their own 'solicitations', as Kurt Lewin claimed in pointing to the *Aufforderungscharakter* ('invitation character') issued by aspects of the material world (a concept subsequently taken up and developed by JJ Gibson (2015) as 'affordances'). Pieces of wood lying on the ground 'invite' or 'solicit' the act of being picked up and explored. This summons requires an interruption in existing activity, a re-direction of focus. In the course of that act, we become indexically disposed towards the world through a very specific medium. Punctualizing is then a specific form of

attachment that demands focus and locates us, even if momentarily, in a particular temporal and spatial orientation to the atmosphere in which we are enveloped. Take the following example, where Vincent is describing an armchair positioned centrally in the ward, where he will typically be found at many points during the day:

Vincent: Well that armchair is next to the pool table. And people usually sit there. You sit there and watch people, watch each other play. So I take a turn and I get up and play pool and someone else sits there. When I finish, he gets up and goes and plays pool and then I sit down. It depends if I win. The winner stays on.

Int: Oh. So when you're sitting in this—

Vincent: Well you can sit down and watch the TV or – cause it's there – you can see who comes in and comes everything from outside and inside and down the corridor. Then they go in the office or they go in there, or it it's a doctor or a nurse or whoever.

The wards at Sharphill are constructed around a 'cruciform' design, where four spokes of the ward meet at a central area. The armchair is positioned within the central area, from where it is possible to survey the majority of the ward area. Vincent describes using the chair as place to rest whilst waiting to play pool. But it becomes clear that this is not the only activity that goes on around the chair. From here it is possible to watch people entering the ward and to observe what they do. In fact, we learnt that Vincent is well known for occupying the chair, which he has re-positioned to secure an optimal vantage point on the ward. Given that one of the major issues in secure psychiatric care is patient boredom, arising from the relative lack of structured activities, it appears that Vincent has arrived at a novel attachment where he can 'people watch' from the very centre of things, without needing to be involved. The passage of staff and patients entering and exiting provides a temporal rhythm that adds structure to his day. He has found a way to 'parasitise' the surveillance practices that are designed-in to the ward structure, and in so doing extracted pleasure from its functioning. Vincent occupies the position of being 'all seeing', but has no obligations towards what he sees other than his own visually mediated enjoyment.

Surveillance is a reversible process at Sharp Hill. Whilst staff monitor patients, patients in turn monitor staff and each other, creating a double layering of watching and being watched (Halford & Leonard, 2006). Each bedroom has an embedded door viewer or 'peephole' so that staff can monitor patients whilst they are in their individual rooms (in some cases, monitoring may involve staff physically entering the bedroom at regular intervals round the clock). It is also not unusual for patients to use the peepholes to observe their peers. Responding to the possibility of being observed can become a routine concern for many patients, such as Leon:

Leon: The staff are fine. They – the staff will leave – the staff here will leave you – on all the wards in here the staff will leave you alone, but it's just, it's like external stuff like maybe stuff you can hear, like through the window or through the door, you know. And, and you can't see the person ... I know that behind the curtain there's a peephole but I normally block it up. And they complain about that, saying you're not allowed to. But I don't like being like – feeling like I'm being looked at, it's not my – I normally block up my peephole, yeah.

Being watched by an unidentified person or hearing indistinguishable sounds or disembodied voices creates a creepy discomfort and confusion that can exacerbate worry and fear in patients (see Brown et al 2015). Donald et al (2015) found that acute psychiatric hospitals can also be perceived by inpatients as 'confused', 'confusing', 'weird' spaces, 'somewhere between a hospital and a home without being neither'. This is worse still if such sounds evoke difficult memories of past abuse or situations where patients have experienced loss of control (Garfield et al, 2013). Addressing surveillance and intrusive noises, whether it be through blocking the peephole, as Leon does, or by other measures such as learning to distinguish the sources of sounds, forms a backdrop to daily life. The intrusions act as summons that regularly punctualize the hours. Patients hook themselves into the atmosphere through their response to these summons, in that they become focused on either repelling or reframing the intrusions. The practice as a whole can be seen as a form of 'territorialising', in Deleuze & Guattari's (1988) sense of the term. It is a way of marking out a personal space within the atmosphere, creating a habitable existential area within the 'unhomely' nature of the unit as a whole.

The tension between the 'homely' and the 'unhomely' can manifest as sudden changes in the atmosphere. Staff speak of ward atmospheres in general terms as being 'settled' or 'unsettled'. The former means that relations between patients and staff are well established, and that there is little sense of tension or of visible displays of aggression on the ward. But changes in staffing, ward practices, or the admission of a new patients can destabilise this atmosphere. When patients do become agitated or aggressive, staff are trained in a range of techniques to manage escalating behaviour. This usually begins with 'talking down' a patient, offering a PRN medication, or a 'time out' in a dedicated 'de-escalation room'. If this fails, then patients may be physically restrained and placed in 'seclusion'. From a patient perspective, escalating behaviour usually follows an incident where a patient feels that their requests have been ignored or their need not met. Here Leon describes how these incidents have arisen for him:

Leon: [W]hen I break the door down I'd come out and start cursing people, well, not cursing, just saying to the staff, 'Look, can you sort this out for me, I feel as though this is happening, that is happening.' They're saying 'It's all in your head, it's all in your head.' And I say to her, 'Okay, can I have a cup of tea?' They will say, 'No, it's not time.' You know, so if you're ever distressed, say you're openly distressed, yeah, and you are trying to explain yourself and nobody knows what you're talking about, and all you want is a cup of tea, to go over and try and collect your thoughts ... But no, they will say, 'No, it's not time.' And 'If I do it for you, I've got to do it for them' and this and that. And it's very confusing. And that happened here when I first came here, they, they tried to. But the difference here is they changed the rules.

Leon admits to behaving aggressively, but claims that this has been caused by staff refusing to amend their own work schedule to accommodate his particular needs (although this has now changed, he adds). Here we can see a clash between two aspects of the ward. Staff manage Leon's distress by appealing to clinical reasoning – he should recognize that there is no reason to feel the way he does, that it is a part of his mental health issues. Leon instead seeks to domesticate his feelings by bringing them within the 'homely' practices with which he is familiar. If he could just have a cup of tea and sit down to gather his thoughts, he feels that he could gain control over his distress. But the personal space here conflicts with ward

practice, with a resulting escalation in behaviour on Leon's part. On this basis, a settled atmosphere appears to be one that can allow the temporary expansion of a territorialized personal space when it confronts an intrusion. It is the restriction of this space that destabilizes the atmosphere as a whole.

Conclusion: The Ethosphere of the Ward

Forensic psychiatric care clearly involves issues of power – the relative power to detain, to compel patients to adhere to medication, and to define mental health as a medical condition that requires self-management by the person in perpetuity. However, using power as an analytic to describe the complex spaces of medium-secure care is problematic. We run the risk of overlooking the myriad, subtle ways in which relations within the space are enacted to create an unfolding, highly changeable atmosphere that envelops patients and staff alike. Within this atmosphere there are moments and incidents where power is nakedly exercised – such as the use of restraint and seclusion – but there are many more moments where it is not clear what is about to happen, what the mood is that permeates the space, what the very purpose is of the unit and the care it provides.

We share the widespread concerns about the use of detention and the politics of secure psychiatric care (see Cromby et al, 2013). It is acknowledged even within policy circles that inpatient care for mental health, despite being a 'last resort', often fails to meet the needs of patients and does not adequately support recovery (NHS England, 2016). We have also seen that forensic psychiatric care is typically provided by low-paid, over-worked staff, who have to enact practices that sometimes conflict with the stated logics of the institution (see White et al, 2012), and received by patients who come from some of the most deprived socio-economic conditions in the country, who have traumatic life experiences, as well as having committed offences that clearly need to be seriously addressed. This is not a space that makes for easy moral or political judgments.

If medium-secure care is to continue to exist, then it seems critical that we understand how it is actually experienced by those who provide and receive it, and that we think carefully about the design of the spaces where it is enacted. An obstacle here is the deeply embedded assumption that the material and social environment influences the person to facilitate particular kinds of behaviour. But if an atmosphere is indivisible, if it is as much 'in'

the person as it is 'in' the socio-material milieu, then this kind of quasi-causal analysis breaks down. Better then to start with the atmosphere itself, with the entangled relations that are experienced as moods as feelings that emanate throughout the space and seem to inhere in everything that happens there.

Our analysis has tried to capture this intimate, felt texture of the atmosphere of the ward. We have paid particular attention to the ways that patients become attuned to the atmosphere, how they feel exposed to the variations and resonances of atmospheric fluxes. Here attachments to the mundane features of the space become important – relationships to doors, chairs, food, paintings – because these act as the means to focus feeling and concern in narrow ways that make the ambivalence of past and future more manageable. Patients 'get into' the atmosphere in ways that make it more tolerable and potentially homely through these subtle acts of positioning themselves in relation to objects and others. 'Punctualizing' and 'territorializing' relationships can help to navigate open-ended detention in a space that is potentially threatening and confusing.

The analytic of atmosphere might also allow for a different way of posing questions of power and responsibility. In his classic analysis of village life in Bali, Gregory Bateson (1968; 1973) develops a notion of 'ethos' as 'the expression of a culturally standardized system of organization of the instincts and emotions of the individuals' (1973: 81). Drawing on a modified version of Game Theory, Bateson argues that Balinese culture aims towards a maximization of intensities in relations as a means of achieving stability (here we find one of the sources of the notion of 'plateau' in Deleuze and Guattari's 1988 work). Everything is in motion, but this ongoing variation in forces aims at achieving social balance or 'continual non-progressive change' (Bateson, 1973: 98).

Whether or not Bateson has grasped the processes of Balinese culture appropriately, the idea that cultural values are enacted through the entanglement of persons within a system or ordering feelings and affects is highly productive. If we use this idea to turn around on the concept of atmosphere, we may say that the work of orienting to and acting to transform an atmosphere is, simultaneously, an ethical work of enacting and contesting values. We speculatively offer the portmanteau term 'ethosphere' as shorthand for the relationship between atmosphere and ethics that we have begin to explore here. For

example, the work that James does with his paintings, or that Leon does in blocking the peephole, can be seen not so much as acts of resistance, but as participation in a struggle to establish collective moods within the unit that articulate common values in relation to care. Our point is that politics of daily life on the unit are better understood as played out around intimate attachments to loaves of bread or cups of teas than they are in relation to the ostensive logic of detention. If we wish to want to begin to improve these spaces, then this this might be a good place to start.

Methodological Afterword

The material which forms the basis of this paper was collected as part of a broader project conducted in a large, purpose built medium-secure forensic mental health unit in a city in the South of England. The overall aim of the study was to explore the relationship between the built environment and patient experiences of detention. The research was based around interviews with 40 staff and patients, along with observations recorded during fieldwork. We use the term ‘patient’ rather than ‘mental health service user’ because this is technically correct rather than because of a position on the clinical status of mental health. The interviews with patients used a ‘photo-production’ methodology, where patients were initially asked to produce a series of photographs of places around the unit that has particular importance or interest for them. These photographs formed the basis of the interview. The data was analysed using a ‘thematic decomposition’ technique that we have described in other places (Reavey et al, 2019; Tucker et al, 2019). All names and identifiers are pseudonyms.

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