‘Let there be light’ or life in the dark? Vital geographies of mental healthcare

Ebba Högström a, Chris Philo b, *

a Blekinge Institute of Technology, Spatial Planning Karlskrona, SE 371 79, Sweden
b University of Glasgow, School of Geographical and Earth Sciences, Glasgow, Lanarkshire, G12 8QQ, UK

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ABSTRACT

This paper explores the relations between light and dark/white and black disclosed in a study of Gartnavel Royal Hospital in Glasgow, Scotland, where an old Victorian lunatic asylum remains, if becoming ruined, on the same site as a modern mental healthcare campus. In-depth interview work recovering the ‘spatial stories’ of patients and staff, past and present, reveals a complex mixture of positive and negative memories and interpretations prompted by both the ‘darkened spaces’ of Old Gartnavel and the livelihood associated with both sets of spaces. These findings are framed by (a) a reading of Badiou’s short monograph on Black (Badiou, 2017) and (b) an engagement with light and dark studies, both of which suggest a rebalancing of the normal valuations whereby dark/black is cast as the realm of death, everything that deadens and threatens life, whereas light/white is cast as that of life, liveliness and vitality. The scholarship here speaks to work on vitalist health geographies, agreeing that vital health-worlds can surface almost anywhere, but reminding that the fragility of such worlds can always be threatened by too much over-ordering.

1. Introduction: Focus, concepts, literatures

This paper is about an old lunatic asylum that has survived into the present, now an increasingly ruined ‘big house’ on a hill surrounded by a modern mental health campus. Its original motto, ‘Let There Be Light Again’, suggested the ambition of its nineteenth-century founders to deploy the technology of an asylum – including its site in environmentally pleasant surroundings replacing the darkened, polluted interior of an early-industrial city – in order to ‘de-cloud’ the minds of its mentally unwell residents. There was a genuine will to soothe the damaged psychological states of these individuals, even as wider social fears about their difference and unpredictability fuelled the call for distant satellite spaces, wards, clinics and support facilities; or that many ended up closing, to be replaced by entirely new suites of provisions elsewhere.

In this case, a medley of such spaces trailed around the hill on which the original establishment still stands, culminating in the opening of a state-of-the-art inpatient facility, just below the old asylum buildings on the same site. This new facility has repeatedly been praised as ‘full of light’, hence faithful to the institution’s founding motto.

There is merit in the narrative just written – from darkness to light, from cruel to humane treatments – in both the particular case identified and more generally. But there are caveats to be voiced, familiar in the critical circles of radical psychiatry, anti-psychiatry and psychiatric history (Foucault, 1965, 2006), wherein progressivist accounts of an ever-improving medical-professional response to the problematic of ‘madness’ must be seriously questioned. The motivation of our paper is to provide another lens on this narrative, then, centralising the problematic of light and dark through the ‘spatial stories’ told by people associated with the asylum-mental health campus that features in our opening paragraph.

Substantively, we contribute to the subfield of geographical inquiries on ‘space, place and mental health’ (Curtis, 2010), particularly ones studying sites receiving people with mental health problems – the ‘mentally ill’ or ‘the mad’, to use other designations – and for sites variously confining, sheltering and treating them. These sites have
varied dramatically by place and period in purpose, scale and bound-
edness, but an outline recounting tells of a transition from ‘asylum ge-
ographies’ to ‘post-asylum geographies’ (Hogstrom, 2012, 2018, Philo, 1997, 2000; also Parr, 2008; Rosenberg, 2009): from the remote asylum or mental hospital, largely sealed-off from the wider world, to that plethora of more widely dispersed ‘deinstitutional’ or ‘care in the com-
munity’ provisions mentioned above. The asylum has not entirely dis-
appeared, however, since a need (if disputed) remains for some people to receive psychiatric inpatient treatment – to treat acute conditions over short periods but also to care longer-term for ‘chronic’ patients – meaning that there is still geographical work to be done on what Curtis et al. (2009) have termed ‘the rebirth of the clinic.’ A key reference-point is research by Curtis and colleagues on two new-ish English psychiatric inpatient facilities (Curtis et al., 2007, 2009, 2013; Wood et al., 2013, 2015; also Gessler et al., 2004), both of which replaced older hospitals, asking – in what they term ‘post-occupation evaluation’ – how patients and staff have responded to the different geographies afforded by the older and newer provisions. Matters of light and dark, as elements of institutional fabric and design, pepper these papers, while their broader perspective as the prime framing of our inquiry here, echoing prior and staff have responded to the different geographies afforded by the older and newer provisions. Matters of light and dark, as elements of institutional fabric and design, pepper these papers, while their broader perspective as the prime framing of our inquiry here, echoing prior

1.1. Badiou in Black

Badiou investigates oppositions between black and white, addressing the entanglements both of light (the diffusion of whiteness) and dark (the lingering of blackness) and of day (the time of daylight) and night (when natural light absents itself). He recalls his childhood fears of “[I]the black dog in the dark” when walking a hilly path at dusk menaced by a big dog with a black coat: “[I]n this case, darkness symbolised fear, anxiety, monsters and ghosts” (Badiou, 2017, p.12, p.14). (We will meet with ghosts shortly.) Crucially, Badiou shows how black/darkness/night are often imaginatively ranged against life, indeed against anything ‘vital’ animated by lively forces and generative of life (notably sunlight as the ultimate source of earthly energies and organic growth). Another familiar association is of black with death:

In the service of death, the black of mourning is the extinction of all the lights of the human parade: all bodies are subject to the equality of which, as the negation of light, prevents any one of them from shining more than the others. ... Black circulates omnipotently ... (Badiou, 2017, p.69, p.70)

Black as the absence of light extinguishes life, prevents singularities (particular things, nameable humans) from being distinguishable, cloaking them in “[d]ark repetition” (Badiou, 2017, p.69), obscuring them in an excess of extinctions – mass deaths – that cannot be perceived, apprehended, or made useful. Relatedly, Badiou (2017, pp.91-104) acknowledges “the white invention of black” as folded into “the worst evil” perpetrated by “the Europeans and their colonial offspring,” perpetrated through the trade-routes of slavery and the “lashes of the bullwhip on the plantations.” He is writing here specifically about ‘the human parade’, the legions of humans plundered of life, but elsewhere he offers claims generalisable to all the multitudes that live and die. Indeed, “[b]lack ... consolidates one of its great affirmative functions: marking the location of what exists only by lacking” (Badiou, 2017, p.65), in which regard black, by this token, is not existence so much as simply signalling its absence, and hence standing in lieu of life, vitality and anything usually accorded (human) value.

Badiou (2017, p.33) nonetheless sees “[d]ialectical ambiguities” everywhere in these oppositions. He ponders the black ink of writing on white paper: “[e]verything in the world is the result of a creative and careful dosing of black as it is projected on to the formidable invari-
ability of white” (Badiou, 2017, p.18). Then, in a chapter entitled ‘The secret blackness of plants’, Badiou muses that, “[f]rom what we can see of it, the plant world has hardly any black in it,” and that “plants are the symbol of nonblack, of the dethroning of black by the brilliance of the colours on the green felt of the world’s gaming table” (Badiou, 2017, p.80, p.81). Plants seem to be all about light, the prime processors of sunlight, converting it into the energy sustaining their own growth and that of all who eat them, the epitome of vitality. But Badiou queries such
an easy conclusion, reflecting that “the true essence of flowers, and stems, and branches, and leaves, is what tethers them to Mother Earth, that immense system for capturing water, sap, beneficial bacteria, and mushrooms … – in a nutshell, the subterranean blackness of roots” (Badiou, 2017, p.82):

What would that enormous tree, that hive of bee-leaves, that solar buzzing high above our heads be if it hadn’t grown one day from a rotten fruit fallen on the ground, and if, at every stage, it hadn’t secured its foundation through a tangled underground web as big as itself, and far stronger, gnarly, and riddled with rootlets? On the invisible underside of the green ground and its panoply of colours lies the black network of roots … (Badiou, 2017, p.82, p.82)

Drawing from nineteenth-century French poet Victor Hugo, Badiou identifies Hugo’s “sure instinct that made him see everywhere the hidden blackness all life requires and produces,” adding that what “the plant worlds devouring produces, against a backdrop of subterranean blackness, is ultimately also the flowers of shimmering light and constant, comforting colour” (Badiou, 2017, p.83, p.85). Loosely echoing the wider ‘subtractionist’ logic of his wider philosophy, Badiou envisages what might be subtracted from the liveliness of the vegetal world in order for it to lose its vitality: namely, the ‘subterranean blackness’ of gnarly rootlets in the quiet dark of soil, mud and chipped rock.

1.2. Light and dark studies

Related claims – if rarely expressed so poetically – arise in the emergent interdisciplinary field that we term ‘light and dark studies’, to which geographers, historians, healthcare architects, light designers-engineers and others increasingly contribute. Much of the literature here considers how light moves, reflects, dances and sometimes gets swallowed up in the context of artificially lighted human environments, with the city – and its variegated socio-spatial arrangements linked to unequal distributions of light (in terms of intensity, quality, hues and more) – as the prime empirical focus for theoretical comment and (often mobile-) methodological experiment (eg. Billé and Hauge, 2022; Ebbensgaard, 2022; Ebbensgaard and Edensor, 2020; Sumartojo and Pink, 2018). Attention is given in these studies to the purposeful designing of ‘lit worlds’ or ‘light infrastructures’, and also to the often ingenious – more-or-less conscious – ‘choirographing’ of how light enters, is shut out from, or manipulated within a variety of spaces both public and private. The qualities of light, dark and their many modulations also come to the fore, with evidence adduced of what affects the true essence of flowers, and alongside several smaller geographical entities, there is warrant for revisiting (also Dunn and Edensor, 2022; Orange, 2018), as well as from Badiou in 2015, p.564) and thereby so much more than merely the absence of light. Citing examples, he “revalue[s] those attributes of darkness that have been sidelined in the quest for bright space: the potential for conviviality and intimacy to be fostered in the dark, [and] the aesthetics and atmospheres of darkness and shadows” (pp.447-448).

Edensor questions standard (especially Western) cultural sensibilities around light as ‘good’ and dark as ‘bad’, wondering if an obsession with artificial illumination is necessarily always healthy, asking whether there is warrant for rescuing darkness from century-long associations with “the primitive, evil and dangerous” (Edensor, 2013, p.447). Amplifying his point about what, more positively, might be enhanced in the darkness, he proposes that until spaces can vitally enhance human communion with self and others, “unhindered by multiple visual distractions that sidetrack conversation and story-telling” (Edensor, 2013, p.463). Shaw expands this proposal, speculating that “light acts as a protective field which holds objects at a distance from the self”, whereas when light fades – dimming any sense of self visibly set over and against ‘the other’ – so “the self is instead rendered open to the other, dissolving or at least reducing our sense of bounded selves” (Shaw, 2015, p.586).

As the light dims and the shadows deepen – as “this more diffuse version of illumination” allows us “to appreciate the world for all its shades of difference” (Smith, 2003, p.129), irrationality or mental difference included – so an enhanced openness to the other may follow, and possibilities for ‘conviviality and intimacy’ simultaneously thicken.

In a more philosophical register, Smith (2003) deconstructs the extent to which the concept of ‘enlightenment’ entails a conjoint ‘metaphysics’ and ‘techniques’: a wish to banish all ‘ghetto shadows’, along with their troubling intangibility and unfathomableness, met by artificial illumination, from the candle to the oil lamp and electric light, to ensure a supposedly even diffusion of ‘bright light’ through civic interiors. “Shadows … epitomise the illusive, the irrational, the irrational …, as Plato’s famous simile of ‘the cave’ makes plain” (Smith, 2003, p.121), whereas rational seekers of ‘truth’ quest for the unalloyed clarity of full-surround brightness hostile to shadowiness. Precisely such a fusion of ‘metaphysics’ and ‘techniques’, including clinical interventions, has infused debates and practices around using light to dispel the darkness of mental institutions. Six different themes present in the nineteenth-century discourses about mental ill-health – seeing into lunatic asylum design – are teased out by Allmond (2016, pp.118-120), all placing light and dark in opposition to each other: ‘darkness is madness: light is sanity’; ‘darkness is barbaric: light is humane’; ‘darkness promotes disease: light prevents disease’; ‘darkness is tranquilising: light is stimulating’; ‘darkness depresses: light elevates’; and ‘darkness is unhygienic: light is hygienic’. Taking our cue from light and dark studies (also Dunn and Edensor, 2022; Orange, 2018), as well as from Badiou in Black, there is warrant for revisiting – even reversing – the polarities here, as we will now seek to demonstrate with our empirical inquiry.

2. Gartnavel study

The project informing our paper reconstructs the experiences of different cohorts of patients, staff, and others for whom Gartnavel Royal Hospital in Glasgow, Scotland, has been a central focus of encounter, activity and meaning. Gartnavel comprises a near-unique site (McGeachan and Parr, 2018, 2020), having housed an asylum since the 1840s – now closed and in partial ruins – alongside several smaller wards added subsequently and also a state-of-the-art acute inpatient facility opened in 2007-2008 under a conjoint public-private –
Social Science & Medicine 333 (2023) 116137

4

century, can be rendered as ‘Let There be Light Again’ and share reminiscences, raise debating-points and venture opinions with this staff participant sets past experiments with ‘light and space–moral therapy’ ( Philo , 2004 , Chapters 6 & 7) is hence recalled as just the first in a long history of innovating with ‘light and space’ by Gartnavel’s authorities: … this has been about light and space … [I]f you go back and read the historical evidence … about Gartnavel Royal, one of the first things that the medical profession and the nursing profession tried to provide on this site was about therapy and light … So, it was about getting the benefit of your surroundings. So, … I think it’s went … full circle with what we’re trying to create here. (B1) This staff participant sets past experiments with ‘light and space’ in the context of “the sort of dark ages that they [the Gartnavel staff] were working in” (B1), rehearsing that common theme in psychiatric historiography about ‘enlightened’ ideas and practices arising to counter earlier ‘dark ages’ of (non)trement ( Philo , 2004 , pp.85-95). Another staff participant speaks of improved anti-psychotic medication and better early-onset care: “So, I think you get better care, really, in comparison to the dark ages where people would have long-term admissions to the old asylums” (B14). In this manner, the terms of light and dark – and allusions with family resemblances to this pairing – often arose in our study, entirely unbidden, usually but not always denoting suppos edly better or worse modes of mental healthcare.

2.1. Dark old Gartnavel ( Fig. 1 )

Numerous participants comment on the darkness of ‘Old Gartnavel’, meaning the original buildings, West House (for relatively well-to-do patients) and East House (for poorer patients), comprising the 1843 establishment on its originally isolated estate west of the city edge. They recognise that these buildings had decayed due to years of overcrowding and constant wear-and-tear on their fabric, fixtures and furnishings, enhancing a sense that they ceased to correspond with the founders’ original enlightened intentions. Some remarks echo the familiar trope of the asylum-as-foreboding-Gothic-castle-on-the-hill ( eg. Showalter , 1985 ), with one recreational user of the site, familiar with it since childhood, suggesting that, “for me, … it still looks a dark, scary Victorian asylum place”, before commenting on “the ingrained image … this is Gartnavel Royal, a big dark, scary building with towers” (E1).

For one patient participant, with an extremely unusual condition (Flytche, 2004) leading them to picture the asylum upside-down, the feelings are even more intense:

**Respondent:** 1989, I was put into Ward 1, Gartnavel Royal old building. Before I came in here, when I closed my eyes, I could see Gartnavel building upside down. That happens to me when I’m getting ill. … Not pleasant, so dark, upside-down.

**Interviewer:** Dark. Upside-down also? You see it from the inside?

**Respondent:** No, from the outside, like a castle at the top. (A8).

The vaguely castle-like form, the dark stonework, the tendency to create a black silhouette against the skyline when the sun is in certain directions: all these features combine to create this impression of a dark place cross-coded with scariness and fear. One staff member whose job necessitated movement around the site at night, laughingly states that, despite “lots of stories about ghosts … and being haunted, … I would walk around these grounds in total darkness, I’m not scared by it” (B4).

For others, these ghost stories have been more disturbing:

… in Ward 6 … the forty bedded house, that was in the West House … you always heard stories of haunting, and there was one called The Grey Lady. … Staff would be quite unnerved, patients would actually become unnerved as well, because they saw this grey lady walking from what was then the dormitory into the kitchen down to the stairs; and apparently she was a nurse who killed herself there. (B4)

Inside Old Gartnavel is remembered as dark, particularly the East House originally built for less well-to-do patients:

… it was quite a dark building inside it. It wasn’t light, although they were using the light outside, but it certainly wasn’t light. It felt dark, lights on all the time. … In the East House it felt quite small, the areas we had: a lot of windows in them, but it always felt quite dark. (B1)

There is reference to the deployment of ‘light’ outside the old buildings, a nod to the ‘moral’ therapeutics of the original rustic site as noted above, but also concern about the darkness inside owing to limited natural light entering through the windows and necessitating
continuous artificial lighting. Another staff member recalls ‘the tunnel’ or corridor housing a lot of services: “The barber was there, the union office was there, the dentist was down there,” but no windows, and it was “dark, dingy, lots of pipes obviously, because it’s an old Victorian building. … No light, no windows, claustrophobic … it felt very oppressive” (B12); while another compares the old buildings with the

Fig. 1. ‘Old Gartnavel’ – a collage of images depicting the (now abandoned) spaces of the old buildings. (Photographs by Ebba Högström).

Fig. 2. ‘New Gartnavel’ – a collage of images depicting the spaces of the old building. (Photographs by Ebba Högström).
newer ones: “it’s a different style of building, it’s a Victorian type of building, it’s smaller windows. You’re maybe not getting the same light and the ability to let light in” (B1).

2.2. Light new Gartnavel (Fig. 2)

‘New Gartnavel’, specifically the new acute inpatient facility, was planned to be flooded with light, a central stipulation from the hospital side in the ‘clinical brief for the facility design (GGPCD, 2004)’ accepted by the architects who won the contract for the site design. As the architect explains about a prior project fringing the Gartnavel campus: “the Homeopathic Hospital … was viewed as … a success – integrating space, gardens, light, and … mind, body and soul” (D1). This equating of light design and therapeutic elements is significant, representing a Zeitgeist influencing the new light and dark studies (see above) and found in numerous statements praising New Gartnavel and the wider psychiatric transition being enacted ‘on site’. The majority of quotes on light and darkness, can seemingly accomplish (akin to what is reported in Curtis et al., 2007, p.603). The majority of quotes on light lauded New Gartnavel, although one staff member commends the(lightness of the establishment, as the vegetal world outside nourished by light – that gives the place that feeling of care rather than constraint” (A4).

“So I think this building provides a space that’s modern, it’s got a nice clean feel about it,” claims another staff participant, since “[i]t’s light, it’s airy, people have their own bedrooms, showering facilities, you can give them a bit of privacy” (B1). This ‘modern’ allusion is revealing, and Gesler et al. (2004, p.120) identify the apparent necessity for the UK’s new generation of PFI-funded hospitals to ‘symbolise this [modernity] through designs that made great play of the ‘white heat’ of modernity: the clinics were light (especially white) airy spaces that denoted high standards of cleanliness and hygiene.” Another remark from a staff member, reflecting their involvement in university groupwork assessing mental healthcare facilities from a spatial design perspective, is worth quoting fully:

So we’d take into consideration lighting, size of the room, what kind of chairs you are sitting in, how the senses are affected … And it does make a difference if you have a nice space, … you find you can have a more positive outcome than if your space is cramped and dark and smells of damp. (B9)

Throughout the study, meanwhile, interviewees (from all cohorts) lent praise to the bright and well-appointed private bedrooms of the new building, particularly when contrasted with the dingy, congested collective wards of the old buildings.

The subject of light surfaced prominently when discussing the new main entrance area, also known as The Hub, configured as a gathering place at the centre of the reorganised institution. The Hub, including reception desk, café, seating (both armchairs and chairs by tables) and noticeboards (in a glass vestibule), is characterised by the architect as “an expression of … light and openness” (D1). Comparing it with a much larger atrium development at a new general hospital in the city, one former staff member states that “what we did here is in keeping with those sorts of developments: light, space, fresh air” (B8). “[I]t’s certainly very spacious and bright, which usually improves people’s moods” (B14), adds another staff member, while one volunteer speaks about “the big window bays which attract a lot of light” (C2). The front windows of The Hub are distinctive, with an arboreal pattern printed on film and mounted on the glass to a design from an artist commissioned to add something inspiring to the building’s feel: “Just at the other end of this site there’s a plaque and it tells you that it [the window] was about light and space” (B1). ‘Light in the building’, meaning natural light – as well as the vegetal world outside nourished by light – diffusing throughout the building, is a compelling vision that technical design and artworks have realised in practice: “And the way that we have lit both these buildings … is through that kind of split, monopitch roof which gets light into the deep plan spaces” (D1). Daylighting the ‘deep spaces’ of the asylum, lifting its supposed darkness, isundeniably central to this reworking of Gartnavel.

3. Too light, too white?

Our findings complicate matters, however, and we can use the words of our participants to approach Badiou’s ‘dialektical ambiguities’ about light/white and dark/black and to reflect Edensor and Bille’s (2019, p.955) statement that “[s]trategies to maximise brightness have emerged from an overwhelming focus on calculative and quantitative approaches,” but arguably “at the cost of a more ecologically attuned, variegated and balanced relationship between light and dark.” A common refrain is hence that, for all the undoubted gains of New Gartnavel, it continues to feel like the (bio)medical setting of the white-coated clinician, partly through being too clinically ordered, clean, partitioned and even, to use Foucauldian language, ‘disciplined’ (Foucault, 1976). One volunteer sandwiches together positive and negative assessments:

The impression is of an intimate relationship between outside and inside, allowing the outside and its natural light into the interior spaces of the facility: “the larger the windows and the brighter the light coming in from outside, … anything that can take away from that feeling of being trapped, anything that gives the place that feeling of care rather than constraint” (A4).
But they were … private-financed buildings, which meant that you couldn’t do things like hang pictures up. So they felt very clinical, they felt very white. And the problem with clinical is that it’s quite de-personal … but you could see as well, though, there was lots of light and that people were using the environment. There was lots of green space, lots of light and it was, you know, it was good. It was an improvement, definite improvement. (C2).

‘Dialectical ambiguities’ indeed, but note the point about walls without pictures – apparently pictures can create hygiene problems, comprising health and safety risks if mounted improperly due to being hard to clean properly (Curtis et al., 2013, p.207) – as potentially ‘very white’ if not painted another colour, creating a highly ‘clinical’, even ‘de-personal’, atmosphere. One staff member openly criticises the interior design:

Respondent: I don’t think it is ideal, no. I think it is very clinical.

Interviewer: Clinical in what sense?

Respondent: … I mean, obviously it’s clinical because it’s a hospital so it has to be clinical to a certain extent but just the decor, the flooring is cold, those plastic things on the walls to prevent damage to the walls. Very standard hospital issue sort of things. (B13).

A related objection is that some parts of the new building have become over-lit to ensure the flood of light into its ‘deep spaces’ at night or on the (many) grey days that Glasgow endures. Artificial light is a problem for some, resonating with Edensor’s critical stance, since for them it becomes over-bearing, too Starkly illuminating of everything, not allowing for shadows, shading or the subtler textures of surfaces to create a less white or clinical ambience. As one patient suggests:

Respondent: … so I think the lighting in here is a bit harsh. Lighting plays a big part in mood. I think the lighting could be softer …

Interviewer: How is it during the night here?

Respondent: It’s quite bright sometimes. (A4).

In this context lightness or brightness becomes oppressive, a hindrance to sleep or to relaxation free of over-stimulation, leading to speculation – apparently pictures can create hygiene problems, comprising health and safety risks if mounted improperly due to being hard to clean properly (Curtis et al., 2013, p.207) – as potentially ‘very white’ if not painted another colour, creating a highly ‘clinical’, even ‘de-personal’, atmosphere. One staff member openly criticises the interior design:

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In this context lightness or brightness becomes oppressive, a hindrance to sleep or to relaxation free of over-stimulation, leading to speculation about whether more attention might valuably be given to the therapeutical potentials of dark. The Japanese writer Jun’ichiro Tanizaki (2001, p.63) – discussed by Edensor (eg. 2013, p.451) – believes that what promotes wellbeing cannot exist without shadows: “beauty [for instance,] lies not in the object itself, but in the pattern of the shadows created by each object, the light and the darkness.” Seeing drawbcks in the shiny white hospital spaces of Western biomedicine, he trusts the gloomy and the shady to create a softer, less stressful atmosphere: “a treatment room featuring traditional earth walls and a tatami floor where patients [are] able to lie down while receiving health care would definitely lessen the anxiety that patients often feel” (Tanizaki, 2001, p.33). A bright-white-light atmosphere is here considered as making worse patients’ ill-being, whereas darker or earthly colours and dim lighting accomplish the opposite, as does lighting that permits the casting of shadows (also Curtis et al., 2013, p.87).

In a similar vein, our architect participant, taking one new building corridor as a cue, reflects on technologies of lighting that might be deployed to prevent both over-lighting and the sharp disjuncture between natural day/sunlight and artificial light:

You know that’s just too severe … and you know we’ve probably over-lit that corridor. Interesting thing about the Homeopathic Hospital: there is a similar corridor and they had a budget for accent lighting to illuminate the art, the pictures and the wall-hanging, … At night, they turn on the more ambient accent lighting and it’s a lovely subdued level. … So this place [the new Gartnavel building] at night, I feel could be horrible … (D1).

New Gartnavel staff keep on the uplighters much of the time, even during the day, because there is no ambient lighting:

They have none, and there’s no changing level of light … Roger Ulrich’s – whether it’s him or his team – have gone on to study … Circadian lighting, where … you can change the colour, the lighting colour … to follow the day and that it will be warm light [Ulrich, 1984; Ulrich et al., 2018; Edensor, 2017, p.15] … So, I wonder now if, through research like that and … then through lighting technol- ogy. … [it] will take us into another era of more sophisticated lighting control and design which will help healthcare environments.

And I’m thinking of mental health in particular. (D1).

It is instructive that this passage, paralleling reflection by Badiou, Edensor and others on alternative lighting scenarios, scrambles light/ white by introducing other colours – or, rather, considering different balances of white’s component colours – in much the same way as, by implication, a previous quote had queried why the building’s interior walls might not be painted colours other than white (something that Gartnavel management has now authorised). More simply, what is thrown into relief is the extent to which overly bright-white-light spaces are indeed sometimes disliked by study participants, including patients, staff and even the architect.

4. Back to black?

A final empirical twist is to repeat arguments from participants that, while not straightforwardly praising the virtues of darkness, effectively counter the usual devaluing of darkness in the mental-institutional landscape. Edensor and Bille (2019, p.95S), when researching the Tivoli pleasure gardens in Copenhagen, found a distinctively ‘gloomy’ corner of the gardens to be ‘cherished’, leading them to conclude that, “at Tivoli, darkness is positively construed in fostering intimacy, imagination, mystery and attunement to non-visual sensations.” Such a statement would probably over-aestheticise what we found in our study, but an overall observation – confirming findings in Wood et al. (2015) – is that interviewees, from all cohorts, often lament the loss of aspects that they found positive, we might say ‘vital’, about the older spaces of the Gartnavel site and the activities and relations there occurred. There is a remembrance that Old Gartnavel, while dark, dingy and cramped in many of its areas, was nonetheless filled with a generous network of shared social relations, reaching across patient, clinical staff, nursing staff, support worker and volunteer groupings, coupled to a busy round of mixed-up activities and employments that staved off boredom and helped to foster meaningfulness in institutionalised lives. This claim is no simplistic, romanticised yearning for the old asylum, not least because some participants tell of problems, hardships and rare instances of real abuse there, but it is to acknowledge that many voices in our study speak, in various ways, of Old Gartnavel as “a happier place, I thought, then” (B6, our emphasis).

A common theme is to position Gartnavel in the 1970s-1980s as like a ‘village’ or a ‘cottage industry’, doubtless lubricated by drops of nostalgic warmth, but still raising provocative claims about what strikes as a thriving psychiatric milieu: “So in 1988 … it felt a busy … it felt like a village in itself, that’s the only way I can describe it. Obviously it had the wall around about it … but it felt like a village in itself at that point, there was so many people, so many staff” (B1). Another long-term participant, in an administrative-managerial position, remembers the old institution as a place of affinity: “You felt part and involved with the patients. … A lot of [them] had been there a long time, but they were very visible and you got to know the patients who would … wander around the site” (D2).

The canteen in the old buildings was a key site into which different constituencies of the Gartnavel establishment squatted, with one patient name-checking it alongside repeating the ‘village’ descriptor: “It was an old canteen there. It was like a wee [small] village. You went
down the stairs to the canteen and just had coffee or tea or sandwiches” (A3). Tellingly, Wood et al. (2015, p.86) heard near-identical remarks about the ‘recreational hall’ in the ‘Old Hospital’, “greatly appreciated by staff, patients and carers as a space where they could meet and socialise.” A staff participant adds the following sense of how staff business could be swiftly transacted here:

Well, you met people in the canteen and there seemed to be a culture of being creative and trying things out. And by trying things out, you didn’t have to run it past the five thousand people, … pan-Glasgow, to make sure it was okay. You could operate as a cottage industry in some respects and just do your own thing: try, fail, and try again. (B7).

Veiled reference is made here to current arrangements, necessitating extensive consultation (including beyond Gartnavel) if anything novel is going to be implemented, and paralleling other remarks heard from staff members about managerialism – despite recognition of the institution’s currently supportive, flexible management – alongside risk, health, safety, ethics, quality control and other distinctly modern (we might say ‘neoliberal’) tools of healthcare governance (also Curtis et al., 2013). Such tools, with their highly-regulated and strictly partitioned (one-issue-at-a-time) character, tend to be associated with New Gartnavel, with its shiny new (and to some extent compartmentalised) spaces, rather than with Old Gartnavel, with its grubby, entangled and in most cases now abandoned spaces.

The just-mentioned phrase ‘cottage industry’ also captures the swirl of activities running through the spaces-veins of Old Gartnavel, with mentions of industrial work – “[t]hey had more space [in the Old Buildings] … because most of the buildings that were up the hill there were always full: woodwork, metalwork, the OT [Occupational Therapy] department” (B6) – and ones about patients leaving the old wards to do agricultural-horticultural work on site, tending pigs to provide pork for the canteen and growing vegetables and fruit for the kitchens or to do agricultural-horticultural work on site, tending pigs to provide pork for the canteen and growing vegetables and fruit for the kitchens or sometimes for sale, and also to ensure a constant supply of flowers for the wards. One staff member encapsulates what another registers as having been “a busy place” (B4), adding something of how this busyness tied into what was already acknowledged to be the ‘decayed’ environment of Old Gartnavel: “There was still a lot of activity, there was a lot of activity going on, but I think at that point probably the environment was the main sticking point. … [T]he wards were starting to decay a bit, it was an old place” (B1). Other participants describe what made the old buildings work as supports for all this activity, and more significantly perhaps for the social encounters animating these activities, at which point relatively small size becomes relevant:

It’s a vast area of factors in terms of one, the size: I mean look at that building up there [the Old Gartnavel buildings]. You know? And you used to converge on the staff dining room and you’d catch up with everybody with every ward. … [E]verybody would be there, so you’d see people from all the different wards. So, there was a sense of a small community. (B7).

Or, as one patient remembers, “I think … the other place [Old Gartnavel] was more condensed and it was easier to get on and you had the wee pool table and you got your meals and went out for walks and you went out for bus trips” (A3). Wood et al. (2015, p.86) similarly learned how “the sense of community in the Old Hospital was lacking in the new facility,” often associated with the former having been “a smallish place … you were in one door and out” (quoting a participant).

Combining these ingredients, a picture emerges of the old buildings as relatively dark – as established earlier – and hosting relatively small, ‘condensed’ spaces crammed to the gunnels with people and activities, but at the same time still affording “this sense of community” (B2) or “a great sense of community” (B4). There might even be mileage in extrapolating Shaw’s phenomenological claims noted earlier to infer the richer possibilities arising in the gloomy spaces of Old Gartnavel for opening up to ‘the other’, whether patient, nurse, clinician, volunteer or whoever, in contrast to “the reduction of otherness that comes from the dominance of light” (Shaw, 2015, p.570). In sum, something glimmers here about the vitality, the liveliness, even the positivity, of darkened old asylum spaces where a decaying material fabric was dialectically entwined with what could also be adjudged an ‘enlightened’ social fabric. Proceeding from precisely this conclusion about Old Gartnavel – in the following quote described as ‘dumpier’ than New Gartnavel, as in ‘like an old rubbish dump’ – one staff member advances a challenging line of thought about how to assess the merits of New Gartnavel:

I’ve got to say [that] I think it’s a great example of a build of this nature … I think we’ve got lots of light, and I think … the building is smashing. This is where we should be at this time in terms of society, [but] I think it’s more about how people engage with each other and value each other, because we managed to engage and work with each other far better in an old, dumpier building. (B7).

In the compound phenomenological-sociological guise in which we are now exiting our empirics, the message here, when contemplating what most readily nurtures both personal wellbeing and social existence in somewhere like Gartnavel, becomes – to paraphrase Edensor (2017, p.15) – ‘let there be light’, but not excessively so, and also ‘let there be dark’.

5. Conclusion: Vital light and dark at the asylum

As Foucault (1965, 2006) argues, the Enlightenment’s elevation of Reason went hand-in-glove with its capture of Madness (or, more broadly, Unreason) in eighteenth-century Europe, and we see many subsequent efforts to ‘enlighten’ the asylum – and its mental healthcare descendants – as continuing moves in the struggle of Reason, of in-junctions to be reasonable, against all those who appear to lack reason, to be ‘clouded’ in mind. While evoking larger claims beyond substantiation here, we see this trajectory arcing through into the progressive modernisation of the asylum: during post-WWII dehospitalisation, post-1960s deinstitutionalisation and even post-1980s neoliberalisation, the latter with its new regulatory regimes, efficiency-savings, health-safety-and-risk protocols, technological and design innovations, and more. These later changes sit in the background of many experiences retold by our Gartnavel participants. Echoing Smith’s (2003) reminder that Enlightenment entailed both a ‘metaphysics’ and a ‘techniques’, the langue durée here saw the ideological enlightenment of the asylum and mental healthcare doubled with a technological enlightenment, partly focussing on environmental siting/landsaping but also on windows, illumination and architectural/design innovations for brightening the most interior of institutional spaces. Again, our participants had much to say, affirmatively and critically, about such matters.

Throughout our paper, then, we have been working towards an interpretation of the asylum – or, rather, of a variegated mental healthcare campus – as one that thrives on light, benefitting from how older moral visions of ‘let there be light’ have now been upgraded by a fresh toolbox of ideas, practices, technologies, artworks and more, all thoroughly designed, engineered or emplaced to (en)lighten institutional spaces, indoors and out. Numerous participants speak precisely to this theme when praising New Gartnavel, but we have also shown that it warrants qualification because, it turns out, not all light may be an unqualified good. There can perhaps be too much light, certainly too much bright-white-light, constant and unvarying, risking spaces being experienced as too clinical, too sterile, even too empty, perhaps detrimental to mental and physical health. More subtly, we also detect a feeling that something about Old Gartnavel may now have been lost, a ‘mad sense of place’ perhaps: of a less clinical, partitioned and timetabled establishment, one that could be quite cluttered, topsy-turvy and full of movement, with smaller spaces, fewer windows, more dark corners, more shadow and shade, that nonetheless possessed a kind of accidental,
organically-grown and widely distributed vitality. It was far from perfect, to be sure, but it arguably had its successes – in terms of ‘happiness’, ‘fun’, ‘busy-ness’ and ‘purpose’ (to borrow words throughout our transcripts concerning Old Gartnavel) – germinated in the entangled gnarly root-networks of that dark old building, grounds and surrounds.

In sum, we believe it not too fanciful to speak of finding here the institution’s roots, set in, if not quite Badiou’s ‘subterranean blackness’, then at least partially in the greyness or half-tones – after Edensor (2013; also Tanizaki, 2001) – composing the vital worlds of Old Gartnavel. What we conclude, though, is not about opting either for light/white or dark/black – or for favouring either ‘enlightened modernity’ or previous ‘dark ages’ – but, as with Badiou and his ‘dialectical ambiguities’, working creatively between the options and seeing how the one may balance or even flourish the other. We thereby parallel Ebbengaard (2022a, p.751) in ‘resisting’ the temptation of suggesting a simplistic solution or ‘fix’, such as redistributing light and dark in equal measures, and instead drawing attention to the often-contradictory ways that people relate to the spaces in which they dwell.’ Indeed, as the last staff participant quoted in the previous section implies, the secret will be to derive as much benefit as possible from the well-lit ‘smashing new building’, but at the same time never forsaking what arguably enabled staff and patients to ‘engage and work with each other’ in the darker hues of ‘an old, dumpier building’. Such a message is precisely in tune with Andrews’s open-ended, interimderivative recipe for what a vitalist health geography should take seriously, should discover and perhaps advocate.

Data availability

The data that has been used is confidential.

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