From safe places to therapeutic landscapes

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From safe places to therapeutic landscapes: The role of the home in panic disorder recovery

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ABSTRACT

The concept of therapeutic landscapes explores the interactions between people and their environment, and the impacts that these interactions have on health and wellbeing. However, authors have so far not engaged in-depth discussions of what recovery might mean and how therapeutic landscapes work. In this paper, I draw from the findings of my doctoral study and offer a discussion of the spatiality of recovery for panic disorder sufferers. I argue that, in order to deepen our understanding of how therapeutic landscapes 'work' (beyond a temporal palliation of symptoms), we must explore how therapeutic landscapes can yield a deeper transformation for those seeking a therapeutic effect. I do this by exploring the spatiality of panic disorder and the emergence of the home as a temporary safe space in the process of recovery.

1. Introduction

The spatial and contextual nature of panic and agoraphobia has been deeply emphasised out with clinical literature, particularly in the work of Davidson (2003, 2000) and Trigg (2018, 2013). Trigg (2018), for example, offers an account of anxiety that is embodied, spatial and intersubjective. In order to do this, Trigg (2018) draws from Merleau--Ponty's embodied phenomenology and argues that when we do not feel anxious, we experience our body spatiality as a unified agent. In other words, when we move from A to B or reach across the table to pick up a pen we do so as the *agent of our own movement* without questioning those movements. Our *body motricity* remains intact. The implication of this is that we experience space also as a seamless unified whole. In panic disorder or agoraphobia, body motricity is disrupted by anxiety, and as a consequence the world is now experienced as spatially fragmented in phobic and safe places.

This paper expands on these spatial and phenomenological approaches to panic disorder by exploring processes of recovery. So far, non-biomedical studies on panic and agoraphobia such as Trigg's (2018, 2013) and Davidson's (2003) have focused on providing a re-conceptualisation of the notion of what panic and agoraphobia *are*. However, they do not explore how these spatial and phenomenological approaches might affect our understanding(s) of recovery (both theoretically and in practice).

In light of this, in this paper I explore the spatiality of recovery by investigating the emergence of the home as a key 'third place' (Moore et al., 2013) in processes of recovery. I examine the home through the lens of therapeutic landscapes, and in doing so, I offer two contributions to existing research in the field of therapeutic landscapes. First, I add to research on 'third spaces' and 'affective sanctuaries'; and second, I address questions around what 'the therapeutic' might mean in therapeutic landscapes. I do this by exploring how the home 'emerges' as a therapeutic landscape that enables the participant of this study to repair panic's spatial fragmentation.

2. Therapeutic landscapes

Therapeutic landscapes was first introduced and developed by Wilber Gesler in the 1990s (Gesler, 1996, 1993, 1992; Wilbert 1998) out of theories on cultural ecology, humanism and structuralism. It was defined as a particular setting that "has an enduring reputation for achieving physical, mental and spiritual healing" (Gesler, 1993, p. 171). Since its introduction, therapeutic landscapes has been applied in a number of different scholarly areas as a way to investigate how environmental, societal and individual factors "interact to bring about healing in specific places" (Gesler, 1993, p. 735).

The concept of therapeutic landscapes emerged out of the discontent that some geographers had with medical geography at the time (Doughty, 2018). Traditional medical geography conceptualised landscape in terms of epidemiology, and place and space in terms of

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distribution and access to health resources (Doughty, 2018). The concept of therapeutic landscapes drew on cultural geography's understandings of place. This had two important ramifications. The first is that it opened new ways of understanding place as something that was "an operational 'living context' that was important for health processes" (Kearns and Gesler, 1998, p. 2). Thus, therapeutic landscapes broke away from positivist and Cartesian understandings of space and place. Instead, it provided a sociocultural framework for exploring the ways that place impacts health. This included the environmental, societal and individual factors that work together in certain natural or built environments to promote health and wellbeing through the amalgamation of place-specific experiences, perceptions, ideologies, attitudes and feelings (Gesler, 1998). The second ramification therapeutic landscapes led to, was the departure from traditional understandings of health and healing. The breaking away from medical geography and the introduction of a new conceptualisation of landscape invited holistic understandings of health as "a state of becoming that takes place in place" (Kearns and Gesler, 1998, p. 2).

Since its inception, therapeutic landscapes has remained a lively term and field of research which has pushed the conceptual boundaries of a) what 'therapeutic landscapes' mean; and b) how they 'work' (Bell et al., 2018). The first strand of developments has yielded discussions around landscapes with a lasting reputation of healing, 'green', 'blue', everyday, non-physical landscapes, marginal, extreme and 'third place' therapeutic landscapes (Butterfield and Martin, 2016; see DeVerteuil et al., 2007; DeVerteuil and Andrews, 2007; Foley, 2011; Foley and Garrido-Cumbrera, 2021; Foley and Kistemann, 2015; Havlick et al., 2021; Milligan and Bingley, 2007; Oeljeklaus et al., 2022; Reyes-Riveros et al., 2021; Smith, 2021; Vaeztavakoli et al., 2018). Alongside these studies, a number of authors have warned against uncritical assumptions about which places may be regarded as therapeutic (Bell et al., 2018). In line with Williams (2007, 1998) and Andrews (2004) early critiques, researchers within the field of therapeutic landscapes have called for more nuanced and subjective analyses into what this concept means. Places traditionally regarded as health promoting, such as woodlands, could simultaneously be experienced as unpleasant, scary or simply unmoving by some people (Milligan and Bingley, 2007). Andrews and Holmes' (2007) examination of gay bathhouses also highlighted the way elements of restoration can coexist with elements of riskiness. The same applied to the other side of the coin; ordinary places that have become stigmatised as particularly risky, such as the inner city areas of Hamilton, Ontario (Wakefield and McMullan, 2005) or Vancouver's Downtown Eastside (Masuda and Crabtree, 2010), were shown to also be spaces of safety, support and solidarity. In addition, Glover et al. (2013) have highlighted the absence of certain types of 'bodies' in some care (and therapeutic) settings, particularly those of black and minority ethnic groups, highlighting the potential exclusionary geographies of therapeutic landscapes.

In light of some of these limitations – and influenced by the relational and posthumanist turn in the social sciences more generally – authors have sought to put more emphasis on exploring the relationships between places and people. This relational approach to therapeutic landscapes seeks to understand, not the properties that therapeutic landscapes have, but the interactions between individuals and landscapes (see Conradson 2005, Cummins et al. 2007, Curtis 2010, Milligan 2007). This interest has expanded therapeutic landscapes further by opening up discussions around how we might conceptualise landscapes relationally. Indeed, this problematising of 'landscape', understood as a cartographic, and visual 'site' that holds specific therapeutic inducing resources, has fuelled the coinage of alternative terms such as 'therapeutic assemblage' (Foley, 2011), 'taskscapes' (Smith, 2021), 'therapeutic mobilities' (Gatrell, 2013), 'enabling places' (Duff, 2012, 2011), 'affective sanctuaries' (Butterfield and Martin, 2016), 'affective atmospheres' (Anderson, 2009; Bissell, 2010; Lin, 2015; Shaw, 2014) and 'affective atmospheres of recovery' (Duff, 2016).

The relational turn in therapeutic landscapes has revived a more nuanced understanding of the *interactions* between people and place and how the 'therapeutic' actually takes place. However, geographers have so far neglected in-depth discussions about what 'therapy' might mean[1] in the concept of therapeutic landscapes (Bell et al., 2018; Laws, 2009). This has privileged understandings of therapy associated with the palliation of symptoms (see Huang and Xu, 2018; Zhang et al., 2021). As Willis (2009, p. 87) points out: "Leaving the ordinary places where one dwells in order to spend a small amount of time in a place deemed to be therapeutic is more likely to result in palliation than healing. Palliating painful emotions may pose a danger to individuals, places and societies if it defuses an urgent need for healing." In their latest review of the literature on therapeutic landscapes, Bell et al. (2018) echo Law's (2009) critique. They highlight that ambiguous meanings of 'therapeutic' have left a number of questions still to explore in the field of therapeutic landscapes: To what extent are encounters between people and therapeutic landscapes a temporary source of palliation, versus a deeper transformative experience? What are the implications for those living with chronic conditions? And do these 'therapeutic effects' persist, or dissipate as people return to their more 'ordinary' spatiotemporal contexts of their everyday life (Bell et al., 2018).

This paper seeks to explore some of these questions in more detail. To do this, I draw from some of the results of my doctoral research project. This project sought to understand the phenomenology and spatiality of panic and panic recovery. In this paper, I argue that, in order to deepen our understanding of how therapeutic landscapes 'work' (beyond a temporal palliation of symptoms), we must explore how therapeutic landscapes can yield a deeper transformation for those seeking a therapeutic effect. Furthermore, I argue that we must explicitly examine the *set of relationships* that constitute these landscapes. This includes, not only the relationships between individuals and given therapeutic landscapes (that is, already defined landscapes), but also the spatial relationships and boundaries that are essential to defining these therapeutic landscapes in the first place. The very concept of therapeutic landscapes involves the notion that some places are therapeutic, *in relation to* other places that might not be particularly therapeutic, or might even be anti-therapeutic (Doughty, 2018). I argue that exploring therapeutic landscapes by engaging directly with the boundaries of these places, forces us to ask questions about the nature of therapeutic landscapes, their emergence, their disappearance, and what the 'therapeutic' means.

3. Methodology

In this paper I draw from stories produced as part of my doctoral research project. The focus of this research project was to explore the role of space and place in the experience of panic and panic recovery.

The four individuals who took part in this research are Theresa, Anna, Raul and Grant.[2] They all have had a long history of panic experiences, have been formally diagnosed with panic disorder and have received some form of professional support at different stages of their lives – whether this is pharmacological treatment, cognitive-behavioural therapy (CBT), or other types of counselling. In addition to this, Theresa, Raul and Grant have experienced panic disorder with agoraphobia for a number of years. At the time of this study, they all expressed that panic was still a part of their lives, but it had become much more manageable.

I conducted three one-to-one interviews with each of them over the course of ten months. The first of these was a semi-structured interview, the second was a drawing-based interview and the third was a go-along interview. Each of these interviews explored different aspects of their experience of panic, place, and panic recovery. Special care was taken to

[1] With the exception of Rose (2012). In her paper, Rose (2012) explores therapeutic landscapes using psychotherapeutic theory, in particular the concept of 'mentalising'.

[2] Pseudonyms.

ensure participant anonymity and confidentiality, both in the production of these interviews and in the analysis that followed.

The interviews were recorded and transcribed verbatim. I analysed the material using a modified version of the voice-centred relational method (VCR). The VCR method, initially developed by feminist psychologist Carol Gilligan (Gilligan, 2015; Gilligan et al., 2003), is a method of psychological analysis which draws on the relational ontology of the self and voice resonance as ways to understand someone else's psyche (Gilligan, 2015; Gilligan et al., 2003). Voice resonance, here, refers to the collection of all different aspects that make up someone's voice: range, pitch, harmonies, dissonances, rhythm, accents, language, and their use of that language. The VCR method ultimately seeks to a) provide a more reflexive and comprehensive method for analysing complex qualitative material; and b) understand meaning making through researching people's narratives (Gilligan et al., 2003).

VCR sits at the intersection between relational theory, developmental psychology and hermeneutics (Doucet and Mauthner, 2008). It builds on the assumption that the self is ontologically relational and draws from object relations theory (Gilligan et al., 2003). It understands the self as always existing and developing within both inner and external relationships. This means that the psyche is a) layered and composed by a multiplicity of internal relationships between different parts of the self; and b) the self is inextricable from our relationships with others and with the cultures in which we live – and, I would like to add, inextricable from the spaces in which we are too. Given that this piece of research investigates place and recovery as relational phenomena, VCR became a particularly fitting approach to analyse the relational structures that make up these.

Conducting a VCR analysis involves at least three separate listenings of the interview voice recordings (Gilligan et al., 2003). The first listening has two parts. Part (a) is a listening for the plot of the story that the person is telling us; and part (b) is the listener's response to the interview (Gilligan et al., 2003). For this I also created visual timelines to help me make sense of the story being told. The second listening, or 'I poems', focuses on listening to the 'I' voice of who is speaking. These poems are constructed by selecting a) every first person 'I' within the interview transcript along with the verb accompanying the 'I'; and b) maintain the sequence in which these appear in the transcript. This step is crucial in VCR because it allows the researcher to listen to the individual voice of the narrator and to form a relationship with them – and this works against the tendency to objectify research participants (Gilligan et al., 2003). The third listening is a listening for contrapuntal voices. This listening links VCR analysis to the specific research question at hand (Gilligan et al., 2003). While conducting this third reading, I focused on the relationships present in the narrations. Through this process, three key relational themes emerged: relationships with other people, with their own panicking body, and with place. The discussion that follows is based on the analysis of these relationships.

4. Results and discussion

As I mention in Section 2, therapeutic landscapes literature, so far, lacks in-depth discussions of what healing means, and how therapeutic landscapes contribute to processes of recovery. In this section, I discuss what recovery means for the participants of this study and the role of the home as a therapeutic landscape that becomes central to this process.

When examining the ways in which Theresa, Anna, Grant and Raul spoke about their process of recovery, there are two elements that stand out. For them, recovery involves a) regaining a sense of safety in themselves and in place, enough for b) transform their relationship to places that had become phobic for them. Therefore, recovery does not equal the palliation of panic attack symptoms; it also does not mean reducing the number of panic attacks alone. Recovery involves a deep transformation (and restoration) of the spatial fragmentation that is central to the experience of panic and/or agoraphobia.

Regaining a sense of safety involves finding new ways of living while also allowing themselves to avoid all places in which they do not feel safe, using their home as an 'affective sanctuary' (see Moore et al. 2013) to retreat and to rest. Importantly, the second stage of their process of recovery is not just a matter of transforming *all* places that they have avoided. Instead, the process that Anna, Theresa, Raul and Grant have taken is much more intuitive and selective. They chose which particular places they actually wanted to go back to, allowing themselves to still avoid some.

Theresa, for example started with challenging places that she actually wanted to go back to, like cinemas and swimming pools, because she used to love them, and she wanted to enjoy them again. In a similar way, Anna still avoids her family home, but this is a conscious decision that she has made and which is part of her recovery process. What this highlights is that, for them, recovery is not about stopping to avoid *all* places – in order to fulfil what an image of a 'healthy individual' might be – but is instead about restoring the places that are important for them. Thus, as Duff (2016) writes, finding a kind of health in illness.

Following this two-stage conceptualisation of panic recovery, the remainder of this section is divided into two parts. The first part draws on Malpas' (2012) relational theory of space and place to explore how the home emerges (and becomes) a therapeutic landscape. The second part discusses what the home *does* in the processes of recovery. By doing this, I contribute to existing discussions on relational conceptualisations of therapeutic landscapes. I addition I provide an in-depth discussion of how therapeutic landscapes can work, and fill some of the gaps identified by Law's (2009), Willis (2009) and Bell et al. (2018) in regards to how we might conceptualise 'therapeutic'.

4.1. The emergence of the home as a safe place

Throughout our interviews, all four participants emphasised the need for a safe place, and their home became such place in their processes of recovery. This project has shown that their home becoming such a safe place is tied to their experience of phobic places. What defines 'safety' for each of the participants in this study stands in opposition (and defined by) what they experience as deeply fearful. This clearly and seamlessly translates into the spatial realm. What makes a place safe is defined by what makes a place phobic. Thus, the specific elements of the home that makes these homes as safe (and a potential therapeutic landscape, as I discuss in the following section), are always *in relation* to the experience of panic and phobic places.

The intricate relationship between the experience of panic and the emergence of safe spaces offers a particularly fruitful case through which to examine relational conceptualisations of therapeutic landscapes. A relational conceptualisation of place involves understanding place as a fluid phenomenon, always in construction (see Malpas 2018, 2017, 2012; Massey 2005). Malpas (2012) offers three key concepts to help us think of space and place relationally. These are (a) boundedness, (b) openness, and (c) appearance.

The easiest way to think of these is with an example. Imagine a box with some marbles in it. Thinking of space in regard to that box could mean the space taken by the marbles, but it can also mean the open expanse in the box that is partially occupied by the marbles. And so, in this way, space can be both *enclosing around* or *making room for*. Thus, space is both openness and boundedness. And these are not untangled concepts, for the idea of openness cannot exist independent of the notion of boundedness and vice versa. This is simply because the concept and phenomenon of openness rests on the concept of boundedness; and the concept and phenomenon of boundedness rests on the concept of openness. In addition to this, the concept and phenomenon of emergence is tied to both openness and boundedness. Because any emerging of any thing takes place as boundedness within a certain openness. It is this concept of emergence, or appearance, what Malpas (2012) associates with place, and also what separates it from space.

If place is to be understood as appearance; this also means that appearance is always appearance of something, in some place. This has

two further conceptual ramifications. First, Malpas (2012) understands the appearance of something in terms of *salience* and *withdrawal*: "The structure of place is such that it draws towards its centre — towards the *there,* the *here*, the *this* that is salient within it — but as it draws in towards so place envelops and surrounds, but in a way that also itself draws away, withdraws." (Malpas, 2012, p. 237). Second, the tension between the salience and withdrawal of place yields the boundaries of place, thus *producing* a place.

Malpas' relational theory of place offers an interesting theoretical framework to think through the interplay between safety and fear. The tension between the salience and withdrawal of safe places defines what the boundaries of that safe place are. Crucially, this is always in relation to the salience and withdrawal tension that defines phobic places.

Raul's experience of panic and of phobic places surrounds a deep sense of not belonging and not feeling comfortable within some social and cultural groups, and also, places. He spoke of not feeling accepted in his own family home when he was younger. In opposition to this, he speaks of his apartment as a safe space where:

> "just the place where I can do self-care… or have the things that I need… …to regulate myself… or to… reconnect with myself. I guess… em… … I feel like it's more when I can be alone"

Raul describes this apartment as offering safety, also, because it was in the gay neighbourhood of the city, which carries specific cultural, social and political associations of which Raul feels part. His-apartment also has a particular aesthetic in which Raul feels at home and which he treasures.

> "it was in the gay village… you had to walk into this… beautiful back yard which always had… plants… and a water fountain… and go up the stairs… and then there was like a… studio… like a bachelor's… with just like one big, big room… and bathroom. Then there was a balcony looking out to the… garden […] so you could just sit like naked outside on the balcony. Nobody could see you. You could see like… gardens… really quiet… em… yeah, that place was amazing… and… eh… just very open… all one big… it was quite big… I had my… mattress on the floor in one corner… and a guitar and… there was like… a hardwood floor… you know…"

Anna, on the other hand, experiences panic through a critical voice that accuses her of being attention-seeking. For this reason, a place where she can be alone is a key aspect of what a safe space is for her. When she knows she is alone there cannot be any critical idea that she is being attention seeking. Privacy has become central for her.

> "That is why I feel safer at home […] No one will disturb me, nobody would come in unless I wanted them to, it's my space even if that is just because the bathroom door has a lock"

Grant's experience of panic partly surrounds not having a clear sense of his own sense of self and his own unpredictability. His-experience partly surrounds not having a clear connection with his sense of self and also to a feeling of his own unpredictability. As he explains, his room became his safe place partly because it was a symbol of his own identity, which importantly, in the way it was expressed in the room, remained constant:

> "[…] It was my room. It was an expression for me, it was what I wanted the world to see and I would rather have people see my room than me cause it was always the same and it was always how I wanted people to see me. You know […] the music selected, the first thing you would see it was what I wanted you to see. That was the façade, and it was, it was symbolism of what I wanted to be which is ultimately this consistent person who could react the same to every situation, which I guess my room was that."

For Theresa, retiring to a safe place involved moving countries and creating her own home in a new place. Moving countries offered her a blank slate in terms of relationships to places. Moving to Scotland, for instance, had the advantage that she had no prior phobic experiences there, and that she was cut off from her previous lifestyle in which she felt compelled to return to places where did not feel safe.

Thinking relationally about the emergence of the home as a safe space has important implications for the way in which we may conceptualise therapeutic landscapes. Therapeutic landscapes emerge *through the experience of illness*. Therapeutic landscapes appear (and disappear) relationally, through each person's individual experience of illness. Moreover, the boundaries of that therapeutic landscape will be constantly in flux, depending on where a person is in their own process of recovery. We can see this clearly when Theresa and I conducted our go-along interview in the cinema. Even though Theresa initially spoke of the cinema 'as a whole', it soon became apparent that, actually, the cinema is not a homogeneous 'phobic place'. There are safe spaces within it, and there are also worse spaces within it. These safe places emerge *in relation* to the rest of the space. In a similar way, for example, when Conradson (2005) or Huang and Xu (2018) explore wellness retreats as a form of therapeutic landscape, the emergence of these places as a therapeutic landscapes only does so in relation to the problematic relationship that the individuals who visit it have with their everyday spaces. And indeed, Conradson (2005) explores the distance from everyday places and relations as one of the constitutive elements of therapeutic landscapes.

4.2. *From safe places to therapeutic landscapes: repairing spatial fragmentation*

After having discussed how the home emerges as a safe place, I now discuss how these safe places become therapeutic landscapes. As I have established, the home offers Theresa, Anna, Raul and Grant a space to rest, recover and care for their own anxious body, when each are disrupted by the experience of panic attacks. The home is a safe place because it creates boundaries and provides distance and isolation from phobic places. This is crucial, because it is precisely this relationality between safe places and phobic places that renders safe places effective. Yet, as this study has shown, the home becomes a therapeutic landscape because it allows Theresa, Anna, Raul and Grant to restore (partially or in full) the spatial fragmentation that occurs in panic.

Crucially, all four participants are young adults who have moved away of their own family or childhood home into their own homes. This is important because this 'new home' provides a 'third space', away from their family home (first space) and away from education or work (second space) (Moore et al., 2013). The notion of third spaces becoming 'affective sanctuaries' has been discussed by Moore et al. (2013) in relation to palliative care facilities. Third spaces are places where non-demanding social interaction and afford a delicate balance between emotional retreat and everyday ways of being and socialising (Moore et al., 2013). These settings bring about what Moore et al. (2013) describe as a movement from *drifting* (the chaos of illness), to *shelter* (safety), to *venturing* (seeing beyond illness). The concept of third spaces is particularly useful in thinking about the spatiality of panic and panic recovery, precisely, because it captures this movement from panic, to safety, to venturing into (and transforming of) phobic places. In the remainder of this section, I discuss how Theresa, Anna, Raul and Grant venture into phobic places, and take with them the sense of safety that their home has allowed them to feel.

I identify three ways in which Theresa, Anna, Raul and Grant are able to manage, challenge and transform phobic places. The first is by using elements of place as affective resources. The second is by introducing objects inside phobic places, and thereby altering the embodied being-in these places. And the third is by creating exits, and therefore enabling a sense of safety and mobility within phobic places.

4.2.1. *Elements of place as affective resources*

The notion of place being an affective resource has been discussed by Duff (2011) within the context of therapeutic landscapes. Duff (2011)

conceptualises affective resources through a relational understanding of place and affect theory. According to him (Duff, 2011), an affective resource refers to the affective experience that can be produced within a particular therapeutic landscape, which in turn is one of the enabling resources that would make up a therapeutic landscape in the first place. He argues that the material aspects of these affective resources have not been explored. And in light of this, he then goes to offer an account and exploration of the production and development of these affective resources through the use of affect theory (Duff, 2012, 2011, 2010) and later, posthumanism (Duff, 2016).

Anna's walk to her place of work is one of the places that she used to, and still sometimes, finds very difficult to be in. She uses spatial elements in the walk as affective resources that act as anchors for her to maintain her sense of safety in a potentially phobic place.

> "If I'm having a bad day… I add something to my walk… Which is… I get here. And if I go right, it's the most efficient way to work. Um, but… if I… don't want to go into work that day because I'm having anxiety or dreading something. I go left, and… it's… well it's just a nice thing that I found. […] So, it takes longer to get into my office that way a little bit, like a minute or two. […] But it adds something to my day"

She explained that she is an environmental scientist and loves the outdoors, and so she focuses on elements of this walk through which she can produce and maintain positive feelings in her. These are plants and flowers and bird nests and cats. These, in turn, enable her to manage her feelings of anxiety; not by trying to push them away, but rather by allowing them to stay while also retaining a sense of safety through these spatial anchors. These elements are not intrinsically therapeutic by themselves and for anyone and everyone; what is therapeutic is the coming together, the relational dynamics between Anna and them. These are formed through social and cultural meanings of spatial elements and objects that make up 'natural spaces', but also Anna's own meanings, associations and experiences.

Theresa is also someone who utilises elements of place as affective resources as a way to regain a sense of safety, manage her feelings of anxiety and, ultimately, transform her own phobic places. Theresa explained how she would *"concentrate on the place"*, on elements of that place – like the furniture that she would find beautiful, for example – that she could enjoy despite the whole place having a phobic sense of place for her.

> "[…] So yeah try to notice things I haven't noticed before, or so, you know, eh… take my concentration away from my panicking belly to 'oh look, there's like a mural there or, like there's this bit of the,' so… trying to… [sighs] yeah trying to look somewhere else than inside your own self and concentrate more in the place where you were. […] To try to find the bits that, [sighs] yeah, that you could find pretty. […] It was all about uhm… trying to, you know, look at what was painted on the wall, or look at this bit of… this […] furniture that I would try to find… pretty or find, kind of appreciate the place in a different way. So yeah it was focusing on something else, trying to, I don't know if I can find, I don't know if I can call that beauty, but enjoyment… in details of the place, or aspects of the place that… I didn't pick up before."

Theresa also chose to start venturing into some places at night as a way to re-learn to experience them in a different light (no pun intended). Interestingly, while places at night may take on a risky or scary sense of place for many, for Theresa exploring phobic places at night enabled her to re-experience them as calming and welcoming.

4.2.2. *Transforming the embodied being-in-place with objects*

A slightly different, although related, way in which Theresa and Raul managed to regain a sense of safety was through the introduction of objects in phobic places. According to Roestone Collective (2014), introducing objects in a place can alter the constitution and possibility of safe spaces. As I discuss through the examples of Theresa, introducing objects in a place also can serve as 'openings' for possible intervention. Objects can fundamentally change the way in which places are experienced, and therefore, the ways in which feelings of safety can be produced and maintained within those places.

Theresa calls these objects her "safety blanket", and this safety blanket can take many forms: a plastic bag, ear plugs, or *"the boyfriend's hand"*, as she said.

> "So… I was avoiding all those places… and always carrying with me… a plastic bag to be sick in and… ear plugs to be able to kind of isolate myself. My safe blanket. […] So the plastic bag… I know I probably had a plastic bag in my bag for 2 years. And I, I had to have a plastic bag on me cos… I don't know… the idea of vomiting on a carpet was not acceptable. Whereas vomiting in a bag was slightly more acceptable. So it was kind of a safety blanket… that I had to have on me. I still, I still was avoiding, eh, actively some place but, eh, it did help with the bus, for example, like, you know, this kind of [deep breath]… OK, I've got the option of vomiting in a bag instead of vomiting on the per-per… two persons sitting in front of me, so that…"

These objects allow Theresa to create a boundary between her body and space, and in turn, they allow her to feel safer in her own body. This allows her to manage being in the place where she is – more safely: *"So… because I started using that in airports and stations because it was just too loud, but even without panic attacks it was just really making me feel very tired. So, I used to carry ear-plugs so that's something that also helped. […] If it was something, it was just too loud or too noisy I would just kind of put the earplugs in to kind of turn the volume down a wee bit. […] And then, I would be able to, yeah, breathe a bit more slowly because it would be less… yeah the level of noise used to be, indeed, a big problem."*

Carrying that plastic bag was something that created a body boundary in which to contain her panicky body, in the event that she did need to vomit suddenly. In a similar way, carrying earplugs and being able to use them when she needed to create a boundary and isolated Theresa from the noise of places that were too loud for her to bear, particularly at the start of her recovery process. Theresa's "safety blanket" provides a way to reinforce her bodily boundaries, while also lowering the intensity of being-in phobic places. This allows her to transform her embodied experience of phobic places.

This analysis can further our understanding of therapeutic landscapes. Focusing on human-object relations allows for potentially any place to become therapeutic. And if we start approaching therapeutic landscapes relationally, then the questions that we ask turn from examining what makes a place therapeutic to what relational dynamics between selves and places become therapeutic. As I have already argued, the key here is not the particular object in question, but the affective and therapeutic relations between an individual and it, in place.

4.2.3. *Creating exits*

The last element I discuss is the creation of exits. A common issue with phobic places is the perception that there is no escape from them, although as I discuss, what this means exactly depends from individual to individual. One of the most common spatial issues associated with the experience of agoraphobia and panic disorder is what Taylor (2000) terms 'agoraphobic situations' – or situations where leaving immediately may be difficult. And I would add also situations or places where leaving *unnoticed* may also be difficult.

It is not surprising that exits out of phobic places are a theme present in my participants' accounts. As I have already discussed, one of the reasons why Theresa finds pubs and restaurants difficult to be in is because leaving unnoticed would be difficult, and even if she would manage to leave unnoticed, she might need to explain to her friends or flatmates why she left suddenly. In light of this, for Theresa, exits involve not only the ability to physically exit the place where she is, but

also the "guilt-free" exit: leaving without feeling shame about it, or having others questioning it. Another way in which Theresa created exits, particularly when she started going to cafes and restaurants again, is by choosing to sit near the door or near the bathroom. In a similar way, Raul spoke of his need to sit on the aisle seat in cinemas or public transport, because as with Theresa's example, getting up and leaving a cinema theatre if one is sitting in the middle of the row would involve 'disturbing' others sitting in that row. Raul and Anna both talked about making sure that there are toilets near in case they need to isolate themselves away from the place where they are. Finally, Grant uses the word cupcake to allow him to create exits by letting others know that he needs to leave the place where he is.

There are two reasons why creating exits is important for panic disorder sufferers. First, it allows *safe* movement from a phobic place to a safe place, in this case their home. Mobility is an important element in the experience of panic recovery because of the need to exit a particular place when it might become too much and access a safe place to regulate and take care of oneself. As Trigg (2013) discusses, for people who experience agoraphobia, the body becomes one of the main ways in which they assess how 'safe' they feel in the world. Therefore, once they begin to feel their body panicking, they will feel the urge to leave immediately to a safe place. In this study, being able to return home, allows Theresa, Anna, Raul and Grant to take care of their panicking bodies and regain a sense of safety in themselves. Mobility between phobic and safe places is, therefore, key in allowing the person to explore and re-experience phobic places in a safer way. The second reason why creating exits is important has to do with the image of place of phobic places. An important element present in places that take on a phobic sense of place is the perception that they do not have exits. Incorporating or creating exits, in whichever form that is, starts to transform phobic places because the notion of them being inescapable is part of what makes them phobic in the first instance.

5. Conclusion

This paper explores the spatiality of panic recovery by discussing how the home emerges as a safe space in the experience of panic and becomes a therapeutic landscape. By doing this, I contribute to existing spatial and phenomenological studies on panic and agoraphobia. Although Joyce Davidson's (2003) work remains a key text in geographical understandings of anxiety and agoraphobia, there has been very little work on this area since then. This paper seeks to revive this thread of work in geography, and to complement Davidson's (2003) work, particularly surrounding practices of recovery. Given the lack of research on panic outside the clinical model, the findings and discussion that I present here could prove a valuable resource for those, who Theresa, Raul and Grant, found that clinical understandings and diagnoses did not quite match their own experiences.

In this paper, I contribute to some of the therapeutic landscapes research gaps highlighted by Bell et al. (2018). These are the lack of in-depth discussions around what healing means, and how therapeutic landscapes work. In line with Willis' (2009) critiques, I argue that in order to deepen our understanding of how therapeutic landscapes 'work' (beyond a temporal palliation of symptoms), we must explore how therapeutic landscapes can yield a deeper transformation for those seeking a therapeutic effect. I draw from Malpas' (2012) relational theory of space and place to investigate the relationship between safety and fear, and how safe places are produced. Although I have argued for a conceptualisation of place that is ontologically relational, I acknowledge that places are very much experienced as a bounded 'whole' (which gives rise to Malpas's (2012) concepts of salience and withdrawal), and this wholeness is experienced as a dyad, that is, experienced in relation to something else (its withdrawal from phobic places).

After my discussion of the home as a safe space, I offer a discussion into how the home enables the participants of this study to transform phobic places. By using the safety that the home offers as an anchor, the participants of this study are able to move from sheltering to venturing and exploring phobic places from a position of safety. I identify three strategies in which Theresa, Anna, Raul and Grant do this. The first of these strategies is using elements of space as affective resources, the second is bringing in objects that help them transform the embodied being-in these phobic places, and the third is the creation of exits. By doing some or all of these, they can be in these phobic places with a sense of safety, enough that they may manage their feelings of anxiety. This is key, because this allows them to create new experiences, new meanings of these places, and more importantly, the *possibility* of being safe in these places. This, in turn, slowly dissolves the spatial fragmentation that panic creates by blurring the boundaries between phobic and safe places. As a result, when Theresa, Anna, Raul and Grant are confronted with these phobic places, the surge of anxiety that would normally take over them is managed and lowered. Their mobility is not interrupted as much (or not at all), and their sense of security remains intact. And it is this, that slowly chips away this spatial fragmentation.

These insights can advance relational approaches to therapeutic landscapes and what Bell et al. (2018) have termed the 'third phase' in therapeutic landscapes research. More specifically, this paper has provided an in-depth examination of what recovery means for the participants of this study, and how the home as safe place can become a therapeutic landscape. This paper highlights the spatial nature of recovery, not in terms of access to health care or health resource distribution, but in terms of the effects illness and recovery have on the personal geographies of individuals (see Willis et al. 2016) and their mobilities. In doing this, my research also encourages us to question and critically assess commonsensical understandings of space and place.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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References

Anderson, B., 2009. Affective atmospheres. Emot. Space Soc. 2, 77–81.
Andrews, G., 2004. (Re)thinking the dynamics between healthcare and place: therapeutic geographies in treatment and care practices. Area 36, 307–318.
Andrews, G., Holmes, D., 2007. Gay bathhouses: transgressions of health in therapeutic places. Williams a Therapeutic Landscapes: Advances and Applications. Ashgate.
Bell, S.L., Foley, R., Houghton, F., Maddrell, A., Williams, A.M., 2018. From therapeutic landscapes to healthy spaces, places and practices: a scoping review. Soc. Sci. Med. 196, 123–130.
Bissell, D., 2010. Passenger mobilities: affective atmospheres and the sociality of public transport. Environ. Plan D 28, 270–289.
Butterfield, A., Martin, D., 2016. Affective sanctuaries: understanding Maggie's as therapeutic landscapes. Landsc. Res. 41, 695–706.
Conradson, D., 2005. Landscape, care and the relational self: therapeutic encounters in rural England. Health Place 11, 337–348.
Cummins, S., Curtis, S., Diez-Roux, A., Macintyre, S., 2007. Understanding and representing "place" in health research: a relational approach. Soc. Sci. Med. 65, 1825–1838.

Curtis, S., 2010. Space, Place and Mental Health. Ashgate Publishing Limited, Aldershot.
Davidson, J., 2003. Phobic Geographies: The Phenomenology and Spatiality of Identity. Ashgate Publishing Limited, Aldershot.
Davidson, J., 2000. The world was getting smaller: women, agoraphobia and bodily boundaries. Area 32, 31–40.
DeVerteuil, G., Andrews, G., Williams, A., 2007. Surviving profoundly unhealthy places: the ambivalent, fragile and absent therapeutic landscapes of the soviet gulag. Therapeutic Landscapes. Ashgate Publishing Limited, Aldershot.
DeVerteuil, G., Wilton, R., Klassen, S., Williams, A., 2007. Making clean and sober places: the intersections of therapeutic landscapes and substance abuse treatment. Therapeutic Landscapes. Ashgate Publishing Limited, Aldershot.
Doucet, A., Mauthner, N.S., 2008. What can be known and how? Narrated subjects and the Listening Guide. Qual. Res. 8, 399–409.
Doughty, K., 2018. Therapeutic Landscapes. The Routledge Companion to Landscape Studies. Routledge, pp. 341–353.
Duff, C., 2016. Atmospheres of recovery: assemblages of health. Environ. Plan. A 48, 58–74.
Duff, C., 2012. Exploring the role of "enabling places" in promoting recovery from mental illness: a qualitative test of a relational model. Health Place 18, 1388–1395.
Duff, C., 2011. Networks, resources and agencies: on the character and production of enabling places. Health Place 17, 149–156.
Duff, C., 2010. On the role of affect and practice in the production of place. Environ. Plan D 881–895.
Foley, R., 2011. Performing health in place: the holy well as a therapeutic assemblage. Health Place 17, 470–479.
Foley, R., Garrido-Cumbrera, M., 2021. Why green and blue spaces matter more than ever. COVID-19 and Similar Futures. Springer, pp. 281–289.
Foley, R., Kistemann, T., 2015. Blue space geographies: enabling health in place. Health Place 35, 157–165.
Gatrell, A.C., 2013. Therapeutic mobilities: walking and 'steps' to wellbeing and health. Health Place 22, 98–106.
Gesler, W., 1996. Lourdes: healing in a place of pilgrimage. Health Place 2.
Gesler, W., 1993. Therapeutic landscapes: theory and a case study of Epidauros, Greece. Environ. Plann. D Soc. Space 11.
Gesler, W., 1992. Therapeutic landscapes: medical issues in light of the new cultural geography. Soc. Sci. Med. 34, 735–746.
Gesler, W., Kearns, R., Gesler, W., 1998. Bath's reputation as a healing place. Putting Health into Place: Landscape, Indentity and Wellbeing. Syracurse University Press, Syracuse.
Gilligan, C., 2015. The listening guide method of psychological inquiry. Qual. Psychol. 2 (1), 69–77.
Gilligan, C., Spencer, R., Weinberg, M.K., Bertsch, T., 2003. On the Listening Guide: A voice-centered relational method. In: Camic, P.M., Rhodes, J.E., Yardley, L. (Eds.), Qualitative research in psychology: Expanding perspectives in methodology and design. American Psychological Association, pp. 157–172.
Glover, T.D., Parry, D.C., Mulcahy, C.M., 2013. At once liberating and exclusionary? A lefebvrean analysis of gilda's club of Toronto. Leis. Stud. 32, 467–486.
Havlick, D.G., Cerveny, L.K., Derrien, M.M., 2021. Therapeutic landscapes, outdoor programs for veterans, and public lands. Soc. Sci. Med. 268, 113540.
Huang, L., Xu, H., 2018. Therapeutic landscapes and longevity: wellness tourism in Bama. Soc. Sci. Med. 197, 24–32.
Kearns, R.A., Gesler, W.M., 1998. Putting Health Into place: Landscape, Identity, and Well-Being. Syracuse University Press.
Laws, J., 2009. Reworking therapeutic landscapes: the spatiality of an "alternative" self-help group. Soc. Sci. Med. 69, 1827–1833.
Lin, W., 2015. Cabin pressure': designing affective atmospheres in airline travel. Trans. Inst. Br. Geogr. 40, 287–299.
Malpas, J., 2018. Place and Experience: A Philosophical Topography. Routledge.
Malpas, J., 2017. Thinking topographically. Place, space, and geography. Il Cannocchiale: Rivista di Studi Filosofici XLII, 1–2.
Malpas, J., 2012. Putting space in place: philosophical topography and relational geography. Environ. Plan. D 30, 226–242.
Massey, D., 2005. For Space. Sage.
Masuda, J.R., Crabtree, A., 2010. Environmental justice in the therapeutic inner city. Health Place 16, 656–665.
Milligan, C., Williams, A., 2007. Restoration or risk? Exploring the place of the common place. Therapeutic Landscapes. Ashgate Publishing Limited, Aldershot.
Milligan, C., Bingley, A., 2007. Restorative places or scary spaces? The impact of woodland on the mental well-being of young adults. Health Place 13, 799–811.
Moore, A., Carter, B., Hunt, A., Sheikh, K., 2013. 'I am closer to this place'—space, place and notions of home in lived experiences of hospice day care. Health Place 19, 151–158.
Oeljeklaus, L., Schmid, H.-L., Kornfeld, Z., Hornberg, C., Norra, C., Zerbe, S., McCall, T., 2022. Therapeutic landscapes and psychiatric care facilities: a qualitative meta-analysis. Int. J. Environ. Res. Public Health 19, 1490.
Reyes-Riveros, R., Altamirano, A., De la Barrera, F., Rozas-Vasquez, D., Vieli, L., Meli, P., 2021. Linking public urban green spaces and human well-being: a systematic review. Urban For, Urban Green. 61, 127105.
Roestone Collective, 2014. Safe space: towards a reconceptualization. Antipode 46, 1346–1365.
Rose, E., 2012. Encountering place: a psychoanalytic approach for understanding how therapeutic landscapes benefit health and wellbeing. Health Place 18, 1381–1387.
Shaw, R., 2014. Beyond night-time economy: affective atmospheres of the urban night. Geoforum 51, 87–95.
Smith, T.S., 2021. Therapeutic taskscapes and craft geography: cultivating well-being and atmospheres of recovery in the workshop. Soc. Cult. Geogr. 22, 151–169.
Trigg, D., 2018. Situated anxiety: a phenomenology of agoraphobia. Situatedness and Place. Springer, pp. 187–201.
Taylor, S, 2000. Understanding and Treating Panic Disorder. John Wiley & Sons, Ltd., Chichester.
Trigg, D., 2013. The body of the other: intercorporeality and the phenomenology of agoraphobia. Cont Philos Rev 46, 413–429.
Vaeztavakoli, A., Lak, A., Yigitcanlar, T., 2018. Blue and green spaces as therapeutic landscapes: health effects of urban water canal areas of Isfahan. Sustainability 10, 4010.
Wakefield, S., McMullan, C., 2005. Healing in places of decline:(re) imagining everyday landscapes in Hamilton, Ontario. Health Place 11, 299–312.
Williams, A., 2007. Therapeutic Landscapes. Ashgate Publishing Limited, Aldershot.
Williams, A., 1998. Therapeutic landscapes in holistic medicine. Soc. Sci. Med. 49, 1193–1203.
Willis, A., 2009. Restorying the self, restoring place: healing through grief in everyday places. Emot. Space Soc. 2, 86–91.
Willis, A., Prior, S., Canavan, S., 2016. Spaces of dissociation: the impact of childhood sexual abuse on the personal geographies of adult survivors. Area 48, 206–212.
Zhang, Q., Zhang, H., Xu, H., 2021. Health tourism destinations as therapeutic landscapes: understanding the health perceptions of senior seasonal migrants. Soc. Sci. Med. 279, 113951.