Art and Design in the Interests of Well-being

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Tiivistelmä

Viime vuosien aikana on aktualisoitunut keskustelu taiteen ja estetiikan merkityksestä terveydelle. Monien hoitolaitosten tiloja pidetään steriileinä, persoonattomina ja pelottavina. TAIDE JA HYVINVOINTI on tutkimus- ja kehitysprojekti, jonka tarkoituksena on luoda estettisesti miellyttäviä julkisia hoitotiloja, jotka antavat kipinän positiivisille ajatuksille ja keskustelulle. Taideteoksia ja sisustussuunnittelua käytettään tähän tavoitteeseen pääsemiseksi. Projekti toteutetaan yhteistyössä Yrkeshögskolan Novian, eri suomalaisten hoitolaitosten sekä ammattilaistaiteilijoiden ja -muotoilijoiden kanssa.

Tämä lopputyö kertoo TAIDE JA HYVINVOINTI-projektista, sekä lyhyesti muista vastaavista projekteista Pohjoismaissa ja Iso-Britanniassa. Lopputyö pyrkii valottamaan eri tekijöitä, jotka tulisi ottaa huomioon taiteen ja designin kentällä kun työskennellään paremman hyvinvoinnin puolesta.

Avainsanat
Taide, valokuva, estetiikka, arkipäivän estetiikka, hyvinvointi, terveys, sairaalaympäristö, hoitoympäristö, soveltava taide, parantava taide, kestävä design, muotoilu

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ABSTRACT

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Abstract

Over the last few years, the benefit of art and aesthetics for health and well-being has become a heated topic of discussion.
Many health care environments are associated with sterile, impersonal and frightening surroundings. The research- and development project ART AND WELL-BEING aims to create aesthetically appealing public health care environments that can give rise to positive thinking and discussion. To this end, art and holistic interior design are used. The project is being carried out in cooperation between Novia University of Applied Sciences, various public health care institutions in Finland and professional artists and designers.

This thesis describes the project ART AND WELL-BEING and shortly refers to a few similar projects on art and well-being in the nordic countries and the United Kingdom. Further the thesis aims to illuminate different factors which need to be considered when creating art and interior design beneficial to well-being.

Keywords
Art, design, photography, aesthetics, everyday aesthetics, well-being, health, hospital environment, applied art, healing art, supportive design

CONTENTS

Introduction

This thesis describes an on-going research and development project called *Art and Well-being* at the *Novia University of Applied Sciences* in Finland. I initiated the project in 2007 and since then I have been the project leader. The project is about creating aesthetically appealing hospital wards at different public health care institutions in Finland. To accomplish this holistic interior design, context sensitive art and special design are used. The project is conducted in cooperation with health care, art and design students, professional artist, designers and interior designers. The cardinal aim with the project *Art and Well-being* is to conduct research into whether and how human beings are affected by the physical environment.

The intention here is to describe the project *Art and Well-being*, map out a few similar projects in the nordic countries and in the United Kingdom and highlight different factors that need to be considered when creating environments beneficial to well-being.

Although many theories on aesthetics presented in this thesis have not necessarily focused on public health care environments, I have taken the liberty to apply them to the work with the project *Art and Well-being*. The terms aesthetics and public health care environment are used broadly. In this thesis aesthetics represents the total experience quality provided by our surroundings as perceived by our senses and intellect. This included many factors other than art, interior design and beauty. Regarding the term public health care environment, it is necessary to point out that the needs and conditions vary widely according to the type of health care environment discussed. A polyclinic which people visit for treatment during the day is a very different environment from a nursing home where people spend the rest of their lives. Nevertheless, both constitute public health care environments. This needs to be taken into consideration when reading this thesis.

Art and Well-being is a work in progress. When this thesis is written in autumn 2011 the project has been going on for more than four years. I have learnt a lot, as well from the project as from writing this thesis. My ambition with this thesis is to illuminate different factors that need to be considered when creating environments beneficial to wellbeing. Writing the thesis has

helped me sort my thoughts and learn more about different methods and previous research on the topic art and wellbeing. The work with the thesis has given me a well-needed time to read and learn more from other similar projects. The knowledge gained from writing this thesis will help me in my further work with the *Art and Well-being* project. The thesis is presenting the project work, from where it all started, the pilot project and how the work has developed. The thesis also includes information about a few similar projects on art and wellbeing.

My work with the project will continue after finishing the thesis. We need, first of all, to finish the two on-going partial projects. Thereafter I will be faced with the extensive, challenging task of collecting data, reflections and analyses. As well as trying to find the answers to the questions whether and how art affects our well-being, I also plan to compile a manual for how to conduct similar projects in cooperation with public health care institutions. Parts of this thesis will be the framework for initiating the draft of this manual.

When describing *Art and Well-being* in this thesis I often use the pronoun 'we'. Although I initiated and lead the project, it would be inappropriate to use 'I' in the light of the project's achievements; it has been a predominantly team effort throughout. I regard myself here as the instigator and the 'mother' of the project. As project leader, I am responsible for all project planning, organizing, budgets and financing, communication with cooperating partners (e.g. decision-makers, hospital managements, health care staff, artists, designers, students and other institutions), evaluation and working methods. Hithert, the project has involved three wards at public health care institutions (to which a fourth will be added in 2012), about 65 members of staff at the various cooperating wards and units, technical planning departments at the health care institutions, about 30 students of photography or design at the *Novia University of Applied Sciences* and about 20 professional artists and designers. Defining my role in the project is complex: I am a photographer interested in learning more about the effects of visual communication; I am a teacher aiming to teach my photography students various ways of working with art and applied photography; I am a project leader organizing and leading the work of about 50 artists and designers (both students and professionals); I am the link between the project and the cooperating institutions; I am the one ultimately responsible for all the different project components. At the same time I serve, to some extent, as an art curator, though not in the conventional sense. I have been influential in choosing the artists and works of art for the project, more by being the link between the artists and the users than doing the selection myself. Since *Art and Well-being* is a unique project, my role is also unique. In this project I work on a daily basis with art and design, without personally having the role of artist or designer. I have the opportunity to use my creativity and implement my ideas, even though my principal roles are organizing and leading. As a pragmatic person, I want to see results for the ideas implemented. The project *Art and Well-being* constitutes a variety of creations resulting from my personal curiosity and determination to make a difference. In the future, I will also have the role of a researcher, evaluating the results of our activities currently in progress.

Many of the theories and thoughts in this thesis are very obvious. We naturally feel better in a place which we can call our own, where we can enjoy familiar and beautiful surroundings, as opposed to a place where we find it difficult to cope. Nevertheless, this work has given me a wider theoretical base for continuing my work. Parts of this thesis present methods and results from research which, in a practical way, will be helpful in future research with the project *Art and Well-being*.

Background and choice of subject

In early June 2007 my father was diagnosed with cancer. A month later he died. During that month my family and I spent hours and hours in the hospital. Those last four weeks my head was filled with all sorts of thoughts: life and death, pain and sorrow, growing up – which, I realized, one inevitably experiences when losing a parent. Not only these, but also thoughts about what would become a major part of my professional life in subsequent years. From not ever really having paid any attention to hospital environments, I found myself thinking about how the aesthetical environment affects our well-being, our way of thinking and our ability to cope in certain situations. As I walked up and down the corridors with my father, a feeling of incarceration and claustrophobia washed over me: I felt trapped and short of breath. Not just because of my immediate location, but also because of the environment. The question which kept coming to mind was whether it might be easier to breathe in an unfamiliar location if the aesthetical environment were not so depressing and unappealing. I asked my father for his opinion of this environment. His response was one of total indifference. But I kept thinking that I would probably cope with the situation a little better if the hospital ward offered a more appealing environment or a more appropriate type of interior design. Although it would not have made that particular month any easier, I might not have dreaded visiting the hospital as much if the environment had not been so clearly associated with sickness and death. I would describe my father's ward as dark and gloomy with few, if any, paintings on the walls. No holistic planning was evident in the colour schemes and textiles while the patient's clothing was totally unappealing. The ward gave me a strong sense of disharmony, discomfort and distress; three aspects which (families of) patients – in such terminal conditions - could certainly live without.

My father died and I became a different person – in many ways weaker, but in some ways also also stronger. A few months later, back at work as senior lecturer in photography at the *Novia University of Applied Sciences*, I could not stop thinking about this question concerning aesthetical elements and interior design. Could they offer moments of relief when life was painful? I was wondering whether it was just me who was affected. Could there actually be some kind of public use for more aesthetically appealing environments. My professional mindset dominated my personal thinking and the photographer and lecturer in me wanted to know if art and aesthetics could be used for the sake of well-being. With so many questions running through my mind I did what most people would do - I googled: art + well-being, aesthetics + well-being, art + health. Not surprisingly, I found a lot of information on the subject. Clearly, I was not the only one thinking about these issues. I realized that many successful projects had already been carried out with regard to art in hospital environments. I kept looking and found a Swedish professor at the medical research institute - *Karolinska institutet* - in Stockholm who had been doing research into aesthetics and health since the 1980s. Britt-Maj Wikström´s research shows that art and art-related discussions can help us forget pain for a moment. Wikström´s findings also reveal that discussing art can also be a way of increasing one's sense of security and decreasing the feeling of being on the outside (Wikström 1997, 111). I gave this experienced researcher a call, introduced myself and informed her of an idea that had come to mind: carrying out a project in cooperation with my students which focuses on photography at the local hospital - photographic art for a surgery unit within a specific context. Professor Wikström welcomed the idea straightaway and became my supervisor for the length of the project. Her enthusiasm for my idea was immediate because she knew very few health care environments which had context-sensitive art done in cooperation with the users. Establishing contact with this surgery ward was a stroke of good fortune. Since I happened to know that this particular ward was about to be renovated, I contacted the head of health care and asked whether there would be any interest in receiving special art designed for the ward. The answer was an instant yes. Little did I know at that point that the project would also comprise interior design, many cooperating partners, accountancy work and many other related tasks. I had no idea that I would still be working on the project today, more than four years later. And probably for several years to come. After the first pilot project was completed in cooperation with the surgery unit at the local Malmska Hospital and

health care centre in Pietarsaari, this project grew into something much larger than I had ever planned. With the help of internal and external funding the Research and Development department at the *Novia University of Applied Sciences* decided to continue the work by creating aesthetically appealing health care environments in cooperation with different groups of art students, professional artists and designers, three different health care institutions and several other cooperating partners. I have had the chance to turn a very personal question, as a result of a personal bereavement, into a professional activity for the sake of art and well-being. As project leader, I have been faced with many challenging, and rewarding, tasks over the last few years. The most important question still remains – can aesthetical beauty, art and art-related discussions make us feel better, physically and/or mentally, when life is hard? Many other related questions have arisen, to which few answers have as yet been given.

The current project plan aims, first of all, to create three or four health care environments where the aesthetical and artistic elements are put into focus. When this practical work has been completed at the end of 2012, a comprehensive evaluation will be carried out. The evaluation will occur on several different levels, focusing on the experiences of the users, artists and students involved in the project.

The project *Art and Well-being* cooperates exclusively with public health care institutions. No private institutions have been involved. The total budget for the project is about 250,000 euros. Financing comes from the Research and Development department at the *Novia University of Applied Sciences*, the Finnish Ministry of Education and Culture, the *Swedish Cultural Foundation in Finland* and, to some extent, from the participating health care institutions and municipalities. Chapter 2 provides a more detailed description of the on-going project.

1. Art, design and well-being

Over the last few years the benefit of art and cultural activities has become a heated topic of discussion and there is much research confirming the positive effect music and different kinds of cultural activities have on our well-being. Art is increasingly used in a wide range of health and social care settings. Art in health care projects and programmes seek to improve health and quality of life as well as address issues such as stigma through encouraging engagement and participation. Still, most of the research on art, cultural activities and well-being is about participating in art activities and on music (Daykin 2004). There is much less research on the effects of visual perception and on how aesthetical environments affect human beings. Daykin claims that there is a need for robust and reflexive qualitative research on visual perception and well-being. Common sense tells us that an appealing environment will give rise to positive thoughts, but there is little academic research to confirm this (Daykin 2004). Talking to researchers from this field I have learnt that one reason for the lack of studies on the topic might be the difficulties with presenting evidence based results since measuring well-being is very complex.

1.1 What is health and well-being?

One fundamental premise when focusing on art and well-being is to understand and define the term well-being. Well-being is not a synonym for health. Being healthy does not necessarily mean one experiences well-being. Measuring common well-being is very difficult since well-being is a personal state of mind, affected by a variety of subjective factors.

The World Health Organization defines the word health as a "state of complete physical, mental and social well-being and not merely the absence of disease" (WHO, 1946). The former editor of British Medical Journal, Richard Smith, discusses this definition in his article *Spend (slightly) less on health and more on the arts – health would probably be improved* (Smith 2002, 1432). Smith argues that health must be more than the absence of disease and that the physical aspect of health

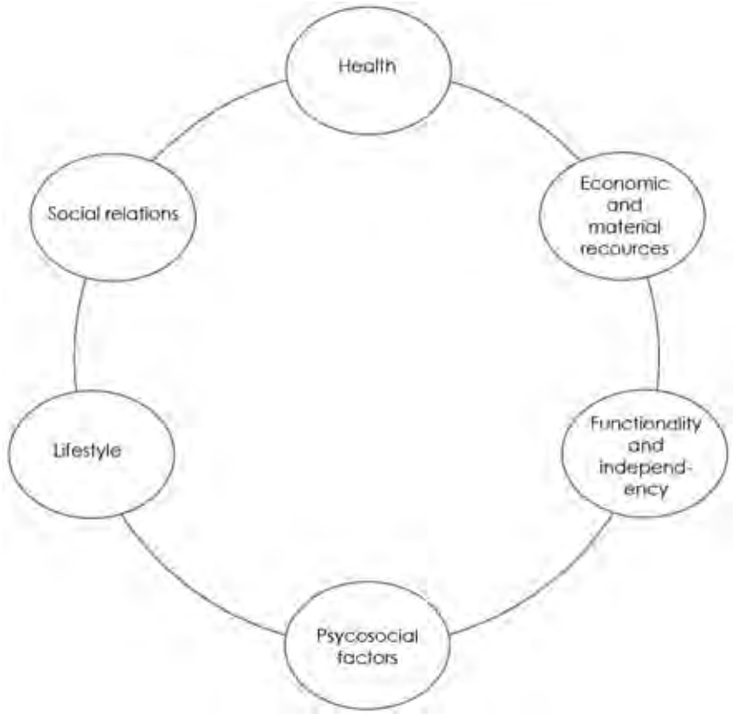


Figure 1. Model of well-being areas (Halleröd, 2011)

may be the least important. According to Smith, it is possible to be severely disabled, in pain and even close to death and still be in some sense 'healthy' and experience well-being. Health is to do with adaption and acceptance. We will all be sick, suffer loss and die; health does not imply avoiding these givens but accepting them - even making sense of them (Smith 2002, 1433). More and more of life´s processes - pain and discomforts - are being treated medically. Medicine cannot solve these problems; it might help sometimes, but often only temporarily and at a substantial cost. People become stigmatized patients and large sums of money are spent. Worst of all, according to Smith, is that people are diverted from what may be far better ways to accept and adjust to their problems. If health is about adaptation, understanding and acceptance, then the arts may be just as good as anything medicine has to offer (Smith 2002, 1433). There is an on-going debate about how to enhance the quality of life of individuals, groups or populations. The concept well-being is widely used in research on physical health, consequences of scarce material resources (Bohnke 2008), underprivileged social positions, psycho-social instability (Mirowsky & Ross 1989) and destructive lifestyles (Grant, Wardle & Steptoe 2009). But even though general well-being is a widely varied and dynamic phenomenon, most research focuses on only certain aspects of it (Halleröd & Seldén 2011). Defining and measuring one's well-being is difficult. Comparing one´s own well-being to that of someone else is even more difficult. Björn Halleröd and Daniel Seldén at the department of Sociology at the University of Gothenburg have developed a model for measuring well-being and six areas which all affect our well-being (figure on page 14). There is a strong correlation between these six areas. Depending on an individual's life and situations, the areas affect each other in different ways and to varying degrees. Measuring an individual´s or a group's well-being without taking all six areas into consideration is to oversimplify matters (Halleröd, 2011).

Being in a hospital for medical treatment or living in a nursing home, the area health is naturally important for one's experience of well-being. But I tend to think that the areas functionality and independency, social relations and psycho-social factors are just as important. Functionality and independency refer to performing activities in daily life. Depending on the age group social support can vary in importance. In later life it tends to become increasingly important, especially in the quality of emotional support and instrumental assistance. The psycho-social sense of control and mastery or its opposite - hopelessness, meaninglessness and anxiety - can be seen as a subjective remark on objective circumstances. The feeling of control can include having the material means, the functional capacity, the social support, but also the psychological strength to mobilize these resources in order to handle an upcoming situation (Halleröd, 2011).

In her presentation at a seminar called *Well-being at Work* in Kokkola (November 2010), Professor Kate Broom from the department of Art, Health and Well-being at *Birmingham City University* presented a list of how to achieve the state of well-being:

1. Belonging (being coherent)
2. Activity (be engaged/needed outside one's private zone)
3. Experience (curiosity, ability to see and appreciate both normal, everyday life and the extraordinary)
4. Lifelong learnin
5. The experience of giving

Broom´s definition of well-being is that it is a positive feeling in body and soul. Well-being is about security, quality of life and joy. Being healthy does not necessarily mean you experience well-being, or vice versa. Further, well-being is about being able to cope with situations, solving problems, making decisions about one's own life, communicating feelings inwardly and outwardly and being coherent. Individual and common well-being are both cost-effective; striving for enhanced well-being is a good investment (Broom, 2010)

The word well-being cannot easily be defined. There will always be numerous ways of understanding the phenomenon well-being. Important in this specific context (of the project *Art and Well-being*) is that the needs of the users vary considerably depending on the desires of the target group. Using art and design to achieve enhanced well-being must be done in different ways depending on the conditions of a specific unit where people may spend just a few days and then return to their normal lives. In this case the art and aesthetics used play the role of temporary amusement leading to stimulating discussions, daydreaming or memories. If, however, the context is rehabilitation, the art used should be more challenging and offer greater stimulation and (positive) resistance to the viewer. Living longer periods of time in a health care environment - making the place one's home - requires a third kind of usage of art and design. In this case the art used should give the feeling of homeliness, security and recognition. Also, the different needs of the target groups - patients, staff and visitors - should be taken into consideration when planning and making the environment. Let us not forget all relevant technical, practical, hygienic and legal requirements. With all this in mind, it is not hard to understand that trying to enhance well-being with different physical elements such as art and design is a very complex ambition. But not impossible.

A nursing home room for a long-term patient. In rooms like this patients might spend several years.

1.2. Current situation in Finland

Before going into the presentation of other projects similar to *Art and Well-being* I would like to present some pictures from a few Finnish hospitals and reflect on the common way of creating health care environments. The pictures presented here show wards and institutions in Finland where patients spend a few weeks, many years, or the rest of their lives. I find these environments far from aesthetically appealing and the feeling of disharmony is all too apparent. Globally speaking, Finland is a wealthy country with a considerably high standard of health care. Yet popular belief within the field of health care suggests constant problems with budgets and lack of money. I am very aware of the economic limitations in municipal health care in Finland, but I believe that many aesthetical improvements could be made on small budgets. I also know that there are a lot of wards and institutions which - thanks to committed staff - create wonderful, caring aesthetical environments with virtually no money at all. The problem, as I see it, is that there is no common ground for this matter.

After working with several different municipal health care institutions I have experienced that when building or renovating a ward, a lot of money and time is spent on technical planning and construction. This is, of course, very important. Yet so often, I have noticed that when it comes to interior design and artistic decoration the projects have often run out of money and time. According to the head of the technical department at one of our cooperating institutions, this is because the decision-makers and technical staff know too little about how the use of aesthetical elements could be optimized. The considerably low costs of evaluating the needs of

Corridors in nursing homes and hospital wards are often used for storage.

Common rooms where patients can read newspapers or spend time with their visitors.

the users, planning an optimal interior and offering practical solutions are rarely prioritized - even though this is something which will affect the everyday life and comfort in wards and units for many years to come. It is not a question of buying a lot of extra expensive materials and objects. It is about spending more time and some extra money on planning and choosing the right materials and objects.

When I started working with one of our cooperating institutions, I discovered that the engineer who had made the technical drawings was also responsible for selecting colours and doing the interior design. In discussions with this gentleman I realized he really did not want to do this. He admitted that he knew nothing about colours and interiors, but was still expected to carry out these tasks. This was clearly not an isolated case. He told me that he often did jobs concerning interior design which he was not really qualified or willing to do. It was just common practice.

Many Finnish health care institutions do ask an architect to plan the interiors. Many obviously do not. In several cases, some users have told me of situations where they have felt excluded when the technical department and architects made decisions about their environment without involving or even consulting them. I realized very quickly that one of the most important roles in our projects was to serve as a bridge of communication between the users and the technical departments at institutions. This key responsibility is so often overlooked.

1.3 Projects on *Art and Well-being* in the nordic countries and the United Kingdom

One of the aims of this thesis is to map out and study similar projects using art in health care institutions in the nordic countries and the UK. I have mainly focused on Finland, Sweden, Denmark and the United Kingdom - the reason being that I think it is very important to know more about other similar projects. There is no point in making the same mistakes already experienced (and rectified) elsewhere. I am also interested in learning more about the similarities and differences between projects around Europe. After giving a presentation on the project *Art and Well-being* at a conference called *Cultural Activities and Health* in Stockholm in 2010, many researchers from the field of art and well-being commented that my project was unique in several ways. This gave me the inspiration to get to know more about other projects. Including this in my thesis gave me the reason to visit a few health care organizations using art in special contexts. There will now follow some examples of institution and organization using art, design and cultural activities as a part of their ambition to create good conditions for well-being.

In Finland there have been several successful projects of installing art in hospital environments. For example, the University Hospital in Turku has an extensive collection of art and as does the Central Finland Health Care District (Simpanen 2007). Senior Lecturer Ilkka Taipale and Professor Seppo Seitsalo at Orton Hospital have started a campaign to collect 10,000 works of art for various hospital environments (Alblad 2010). In 2010 the Finnish Ministry of Education and Culture published an action plan on how cultural activities can benefit well-being for the years 2010-2014 (Liikanen 2010). Many other successful ventures have also taken place with the intention of creating better health care environments through art.

In Sweden there have also been many projects which involve placing art in hospital environments. Currently, the new *Karolinska Hospital* is being built in Solna outside Stockholm. The hospital will have room for 800 patients in a building costing 15–20 billion Swedish crowns. The municipal administration in Stockholm and the building company will spend a total of 118 million Swedish crowns (about 11.5 million euros) on art for the hospital. This is considered to be the largest investment in public art in Sweden, using even more than the recommended one per cent of the building costs for art. Professor Britt-Maj Wikström is one of the delegates in the working group involved in these extensive art acquisitions.

Considerate Design, Gothenburg

I would say that everyone engaged in planning and creating public health care environments has something to learn from the experiences of this organization. In March 2011, I was privileged to meet Birgitta Nilsson, architect and director of *Considerate Design*. The organization was established in 2001 and has been working ever since with user-orientated, sustainable design for public environments (Nilsson & Pahlén 2004). Many different architects and cooperating partners have been involved in the organization's work over the last ten years. According to Nilsson, their experiences clearly show that committed participation from the users and solid preparation before building/renovating begins will produce a more profitable result. When staff and visitors thrive, the result is more satisfying and effective. *Considerate Design* aims for creativity in which aesthetics combine with ethics, ecology and economics, in order to contribute to sustainable development. Hearing Nilsson share experiences of lack of interest in terms of collaboration from many technical departments at public institutions I realized our project was not the only one in that situation. It is surprising that such an obvious starting point as user-orientated design is not always natural when planning public environments. The project *Art and Well-being* has been inspired by a ten-step working process developed by *Considerate Design*.

Three Foundations, Gothenburg

In Gothenburg another inspiring organization actively uses art, interior design and cultural activities for geriatric care. The organization *Three Foundations* was founded in 1988. *Three Foundations* run three geriatric units for almost 400 patients altogether in the city of Gothenburg. They are financed by the Swedish government (like other municipal, non-private, geriatric health care institutions in Sweden). What is unique with this organization is that they focus on the aesthetical environments; their wards look more like private upper-class homes or hotels than normal municipal geriatric units. In addition, *Three Foundations* have an extensive programme of cultural activities (some of which are held every day at all the wards) for the patients. There is a coordinator employed for organizing different cultural activities and events at the units. Director of *Three Foundations*, Monica Berglund told me that their aim is to create an everyday lifestyle that gives the patients a reason and motivation to get out of bed every morning, regardless of physical condition. In different ways they try to bring the world into the ward since most of the patients are no longer able to leave the health care environment. *Three Foundations* wants to give patients a meaningful, understandable and manageable environment (Arvidsson & Carlson 2010).

What surprised me most during my visit to *Three Foundations* was how much could be done with no external funding, but simply with the same governmental financing as for all municipal health care institutions. It is just a question of prioritizing, good planning, engagement and leadership. To my disappointment, no research has been done on the results at *Three Foundations*. Berglund admitted it should be carried out. They simply have not considered it important enough to spend money on academic analysis of something which they can see every day when witnessing the well-being of their patients.

A municipal nursing home interior with a difference. *Three Foundations* are able to offer a standard of living not usually associated with public health care institutions.

***Design and Neuro-research and Design and Brain Research – Enriching Environments*, Gothenburg**

This is an artistic development project carried out by several cooperating partners. During my visit to Gothenburg I spoke to Kristina Sahlqvist, the project leader. She presented the project´s research question as follows: "How can knowledge from basic research into the effects of enriched environments on the healing of the brain lead to improved rehabilitation environments through explorative design methodology?"

According to Sahlqvist, basic research shows that the brain's capacity to recover is significantly improved by physical activity, multi-sensory stimulation, an enriched environment and the appropriate diet. Further clinical observations suggest that aesthetical and emotional stimulation may be equally important. Designers, architects and specialists from *Högsbo Medical Rehabilitation Unit* have launched this interdisciplinary project aiming to redesign the rehabilitation environment at *Neuro Högsbo*, in a collaboration venture between *Sahlgrenska University Hospital, Sahlgrenska Academy,* and *School of Design and Crafts, Gothenburg University.* The project´s design strategy implies a conscious and methodical approach to create attractive environments and products, genuine care for human well-being, participation and access. The project explores new forms of cooperation between design, architecture, art and medical science; forms that hopefully can produce giant steps in our development of knowledge. The goal is to create an improved environment for neurologic rehabilitation and gain better knowledge about how the environment and products affect well-being and a person's recovery of functions when trying to return to normal life after brain damage. This project has not yet been implemented. So far it has all been about doing research and collecting/developing ideas, material and plans. No specific or practical work has been conducted on the environment. The project group does not yet know if they will be able to use the strategies developed to implement the plans at the neurologic rehabilitation unit.

Compared with Finland, the UK has a long tradition in using art and cultural activities in health care institutions. *The British Arts Council* has set guidelines for working with art in public health care environments. According to Kate Broom, course director of the Master's programme in Art, Health and Well-being at *Birmingham City University*, many hospitals in UK have a full-time art manager. The art managers are in charge of art acquisitions, administrating and arranging exhibitions and other cultural activities at the health care institutions. The beneficial effects of art and cultural activities are no longer questioned in the same way in the UK as in Finland. Professional art is a natural element in most hospital wards around the UK. Yet critics still voice concerns about how British hospitals look and about the lack of holistic aesthetical planning when it comes to the use of interior design and art (Hosking & Haggard 2003).

Chelsea and Westminster Hospital – Hospital Arts, London

In April 2011 I visited *Chelsea and Westminster Hospital* in London. I met Katherine Mellor, manager of the *Hospital Arts Foundation* at *Chelsea and Westminster Hospital*. *Hospital Art* is an integral part of the *Chelsea and Westminster Hospital's* philosophy of health care. The aim is to create a healing environment where visual and performing arts combine to help relieve anxiety and assist recovery. Since the hospital opened in 1993, the Charity has acquired over 1,000 paintings, drawings, prints and photographs that enliven wards, clinics and treatment rooms. There is also an art gallery in the hospital that holds quarterly exhibitions by established and upcoming artists. The art collection at *Chelsea and Westminster Hospital* was the first 'arts-in-health' programme to gain museum collection status from the *Museums, Libraries and Archives Council* in the United Kingdom in 2010.

As I walked around the hospital afterwards taking pictures and absorbing the atmosphere, an old lady came up to me and asked why I showed such an interest in the art exhibited. I explained the purpose of my visit and she immediately started discussing the art and usage of colours. Zoe, who was born in Italy, had been living in the UK for almost 50 years. She told me she had to come to the hospital every week and had been giving much attention to the art and colours over the last few months. When I asked about her personal opinions, she was unwilling to say at first, then modestly admitted that she was "kind of picky" with art and especially with colours. After walking down a few more corridors, Zoe could not longer hold back her opinions: "Isn´t this just too much? Most of it looks like an over-decorated children's room!" she exclaimed, somewhat embarrassed. I must admit that I agreed, to some extent, with Zoe. The visit to *Chelsea and Westminster Hospital* made me feel that art in a hospital environment is something positive. However, too much art in a hospital environment is just as unappealing as any over-decorated environment. Many of the rooms or corridors I visited were very appealing, but in some places – especially by the main entrance – it was rather overpowering.

One of the few recent studies I have found on the effects of visual and performing arts in health care institutions was conducted at *Chelsea and Westminster Hospital* (Dunkan, Staricoff, Wright, Loppert, Scott 2001). Later on in this thesis (section 3.4 - Art in the hospital environment) I will return to the positive results of this study.

More than 1,000 paintings, drawings, prints and photographs enliven wards, clinics and treatment rooms at Chelsea and Westminster Hospital in London.

The Royal Hospital in Copenhagen. To the left *"Livets efterår"* by Lars Ravn and to the right *"Crusaders - Korsridderne"* by Steinunn Thórarinsdóttoir.

Rigshospitalet, Copenhagen

At the *Royal Hospital in Copenhagen* there is an extensive permanent art exhibition on display. In 2007 the hospital published a folder presenting some of this art (Kunst på Rigshospitalet 2007). The art draws one´s attention since it is given a very prominent role in the environment. The hope is that the pieces displayed will provoke thoughts and experiences for those visiting the corridors and public areas in the hospital.

Herlev Hospital, Herlev

Opened in 1976 and located about 15 km northwest of Copenhagen, this hospital has a very interesting, unique interior design. The use of bright colours is very evident. Most of the decorations and wall paintings were made by the artist Poul Gernes. These inviting colours create a feeling of well-being in the hospital.When visiting these two health care institutions last summer I especially enjoyed walking down the corridors in Herlev. I cannot say I normally like bright colours in interior design, but here the colours made me smile. I learnt that all the colours are very carefully planned. Not only the colourful paintings on the walls in the corridors, but also at the wards. The colours are chosen to interact with the daylight and varies depending on from which point of the compass the light comes into the room.

The modern and functional architecture of the exteriors caught my interest, looking more like a space ship than a hospital. The architects behind the rather untraditional hospital buildings in Herlev are Gehrdt Bornebusch, Max Brüel og Jørgen Selchau.

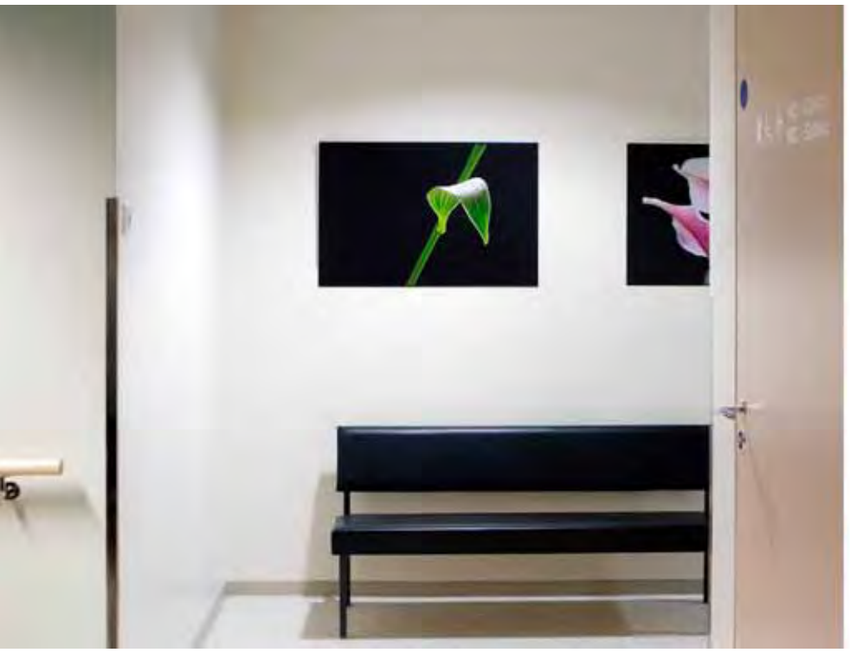
1.4 What is unique about the project *Art and Well-being*?

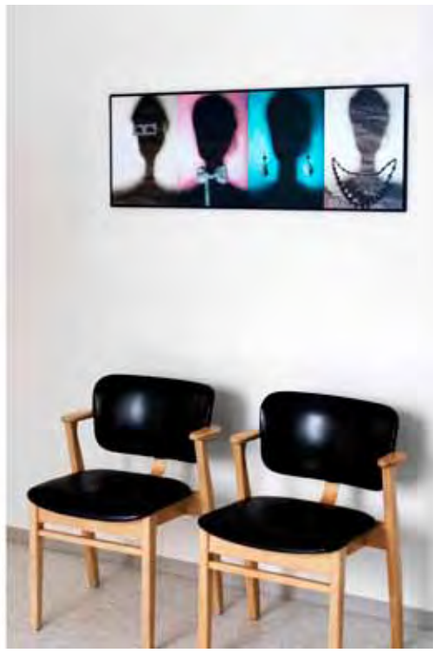
Since visiting these institutions and talking to the driving forces behind their cultural activities, I have tried to map out the differences between the above-mentioned hospital environments and the project *Art and Well-being*. To start with, there are many similarities - most importantly, the aim to enrich health care environments with art and cultural activities. All the people I have met and all the literature I have read share the conviction that art, design and cultural activities can make a difference. There are, undoubtedly, many more projects around Europe employing the same pattern of thoughts.

What I have discovered to be unique with *Art and Well-being* is the interrelated nature of holistic planning of interior design and art. Most of the institutions I visited do exhibit high-quality art in their hospital environments, but none of them has invited the users to take part in the planning and selection process to the same extent as we do. It seems more natural to focus either on the interior design (for example, *Considerate Design*) or on the art exhibitions/collections (for example, Finnish hospitals and *Chelsea and Westminster Hospital*). Combining both from the very start seems surprisingly uncommon.

Our concept of mounting art in double-sided frames is not practised anywhere else. This concept has still to be evaluated and developed further. Involving art students with the intention of making an art and well-being thought process a part of their education is another aspect unique to the project *Art and Well-being*.

In Herlev both the exterior and interior design offfer those visiting a non-typical hospital experience.





In February 2009 the pilot project at at the surgery ward at Malmska Municipal Hospital in Pietarsaari was finished.
All together 66 pieces of photographic art mounted in dobuble sided frames were placed in the ward.

2. Description of the project *Art and Well-being*

The development and research project *Art and Well-being* at the *Novia University of Applied Sciences* offers holistic planning of interior and artistic decoration to wards in public health care institutions. The work offered consists of user-analyses and planning, interior design – in some cases, special design – context-sensitive art, pedagogical structures for art usage by the nursing staff, and evaluations. The project is a collaboration venture involving different hospitals around Ostrobothnia in Finland as well as professional designers, artists and students from the field of art and design.

2.1 Aims of the project

The aims of each partial project (unique, practical work in the creation of an aesthetically appealing public health care environment) within the project *Art and Well-being* are as follows:

- to create health care environments that stimulate positive thoughts, a good working environment, a sense of security and genuine care
- to enhance staff well-being
- to create a positive health care environment for patients and relatives/visitors
- to investigate possibilities of long-term, financial profitability in such projects
- to teach art and design students how to create working opportunities
- to investigate whether the region benefits from the various partial projects

One of the goals is that the students involved in the project (and those from the pilot project) will have the capacity, in the long term, to offer corresponding projects to public environments. The concept being developed can also be used and applied in the planning and renovation of other public environments.

The long-term aim of the project *Art and Well-being* is to answer the research questions if and how art and aesthetics affect the well-being of humans. After finishing the practical part of the project, an extensive evaluation will begin (probably in late 2012 or early 2013). Finishing the practical part means finishing two ongoing partial projects – at an intensive nursing home in Oravainen and at the oncology polyclinic in Kokkola – and carrying out a further partial project (probably in a middle school medical room as of early 2012).

Evaluation work will also include the pilot project carried out in a surgery unit in Pietarsaari. The evaluation will be conducted on various levels - investigating how the users (patients, staff and visitors) experience the new environments created by the project by means of interior design, aesthetics and context-sensitive art to a wider extent than normal in public health care environments in Finland.

2.2 Pilot project 2008-2009

A pilot project was carried out in 2008-2009 through the photography programme at the *Novia University of Applied Sciences* in cooperation with the *Department of Social Services and Health Care* in the city of Pietarsaari. The work carried out involved a complete renovation of the surgery unit at *Malmska Municipal Hospital and Health Care Centre*.

The project *Art and Well-being* planned the interior and produced photographic art for the unit. Interior designer Minna Östman planned the interior while the double-sided photographic art was produced by photography students at the *Novia University of Applied Sciences*. All the interior design and art were holistically planned, from the very outset, in cooperation with the unit staff. The external project supervisor was Senior Lecturer Britt-Maj Wikström from the medical research institute, *Karolinska Institutet* in Stockholm.

The result of the project was an aesthetically appealing health care environment where double-sided photographic art and interior design play a central role. The goal of the project was to use aesthetics and art as tools for creating an environment that gives rise to positive thoughts amongst the patients, staff and visitors. Sometimes this might happen consciously and at other times perhaps just spontaneously. The art placed in the unit will hopefully also stimulate discussions and serve as a pastime.

One of the aims of the pilot project was to give the photography students experience in working with applied art for a specific context. In evaluations the students stated that they had found the assignment both exciting and meaningful (Westerlund 2009). They felt it was a challenge to create the right works of art with enough variation in the imagery. The art was chosen in cooperation with the nursing staff. For visual communication students, it was very interesting and challenging to meet the viewpoints and tastes represented by the health care staff. Communication between representatives from the field of art and the field of health care is not always easy. The meeting of two different aesthetical perspectives can produce misunderstandings and also a new common understanding.

After the renovation at the surgery ward where the pilot project was carried out.

"When the surroundings are looked after, I feel looked after too." (Male patient, aged 43, pilot project evaluation).

The publication *Dubbelsidigt // Kaksipuolista* was made for the surgery ward.

As a result of the pilot project, there is a publication called *Dubbelsidigt // Kaksipuolista* (Double-sided). A copy of this book is available in every patient room of the surgery unit. All the pictures from this unit as well as short descriptive texts are included in the book.

From the experience gained from the pilot project, the Research and Development unit at the *Novia University of Applied Sciences* decided to continue working with art, design and aesthetics in health care environments.

2.3 On-going partial projects 2010-2012

Solängen intensive nursing home in Oravainen, Vöyri municipality, 2010-2012

In the autumn of 2010 the project *Art and Well-being* began cooperating with Vöyri municipality on an intensive nursing home for 16 patients. The new building comprises two identical wings beside the already existing health care centre. *Art and Well-being* provides all the interior design, context-sensitive double-sided art and some specially designed furniture. In this partial project there are several cooperating partners: Vöyri municipality (technical and nursing staff), the photography and design students at the *Novia University of Applied Sciences*, interior designer Minna Östman, technical engineer Christer Lindgren, various professional artists and designers and an expert group from the field of art and design comprising the project leader, an architect, an art critic and an artist. This expert group - in collaboration with the users – selects the works of art to be installed in the nursing home. For some groups - e.g. many elderly in nursing homes and long-term hospital patients - chronic understimulation can constitute a significant threat to well-being (Ulrich 1991). This is something we try to bear in mind when planning the interior and art for this specific nursing home.

Solängen intensive nursing home is planned to be ready in the spring of 2012. Also included in the project is a pedagogical structure for how art and art-related discussions can be used as tools by the health care staff. The project will provide further training and inspirational days within the field of art and well-being for staff at the unit. During the partial project those involved from the fields of art and health care have meet to discuss the types of aesthetical language and art appropriate for the new nursing home.

Part of the financing for this project is provided by the Research and Development unit at the *Novia University of Applied Sciences*. The project *Art and Well-being* has also received 80,000 euros from the Finnish Ministry of Education and Culture for employing young professional artists and designers in the Ostrobothnia region. The art installed at *Solängen* will be made by professional artists and photography students at the *Novia University of Applied Sciences*. There will be a total of 80-90 works of art at *Solängen*, all mounted in specially made double-sided frames. Every patient room will have a 100 x 80 cm frame with different types of art on either side. The idea of having the same frame size in each patient room is to enable the art to be moved easily from room to room, which will provide more than two options. In discussions with the staff, we have likened the changing of art in the rooms to the changing of curtains. In corridors and communal areas (such as dining rooms) there will be a series of art in the following dimensions: 80 x 80 cm, 60 x 80 cm or 100 x 80 cm.

In autumn 2010 interior designer Minna Östman and I held a few workshops with the nursing staff. The aims of these workshops were to invite staff to come up with ideas for the interior design and to map out the needs of the users - through discussions, interviews, collages, photography and a questionnaire.

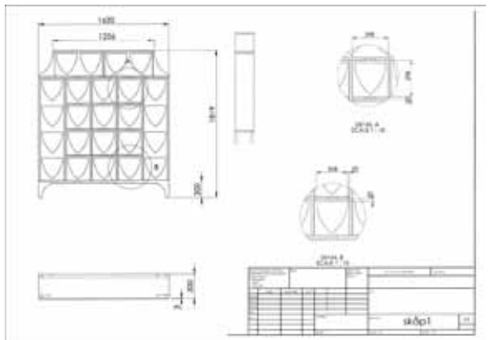
The mood-boards made by the eleven nurses inspired the interior designer when plannig the new unit.

Solängen intensive nursing home. The building process started in October 2010 and was finished in December 2011.

During the spring term of 2011 design students at the Novia University of Applied Sciences took part in the project.

Under the supervision of design teachers Anders Aromäki and Elina Rebers and interior designer Minna Östman, the students designed four different specially planned items of furniture for the *Solängen* unit. This furniture was produced by a young carpenter also involved in the project.

The nursing staff asked for a large and stylish armature for the lobby. Their hope was that this also could be seen as a piece of art, an eye-catcher as you step into the unit. The design students Nina Rimmi and Marcus Nissilä designed a armature made of oak to fit toghether with the other wooden interior details. Teachers Anders Aromäki and Elina Rebers to the left, interior designer Minna Östman to the right and students Nina Rimmi and Marcus Nissilä in the foreground.



The specially designed furniture for the nursing home also include a display unit for memorabilia (left) and a TV and magazine storage unit which will also serve as a divider (right).

November 2011. Project assistant Lisen Julin-Qvarnström, interior designer Minna Östman and project leader Emma Westerlund do the last preparations before mounting the art to *Solängen* service housing.

Students at the photo department at *Novia University of Applied Science*s, Verena Eckl and Eva-Stina Kjellman, mount the art chosen to the unit in double sided frames.

New collection of working clothes

The clothing in a hospital ward constitutes a large part of the aesthetical perception. Most people who have ever worn hospital pyjamas know the feeling of discomfort and lack of appeal of these clothes. Clothing has a depth of meaning - both intimate and public - and plays a significant role in our psychological well-being. In western culture, well-being is defined in terms of internal beliefs about the 'self'. As a result, if we can incorporate positive attributes in our 'self', then we improve our sense of well-being. Two commonly used indicators for measuring well-being are satisfaction and self-esteem. In its various aspects, clothing can be seen to address both (Boultwood 2011). I think dressing in awful clothes makes one feel even more ill or uncomfortable in a difficult situation.

Providing the market with a new collection of patient clothing is still on my agenda list, but at least we have made a start on staff clothes. As a part of the partial project at *Solängen*, a brand new collection of clothing for the nursing staff is being made by clothes designer Tina Nylund. This work is also done in cooperation with the users. Ergonomic, practical, hygienic and aesthetical factors combine to provide new solutions. The long-term aim is to help this young designer go further with this collection, present it to the industry and, in time, have it produced on a larger scale. For now, the project *Art and Well-being* will produce a complete collection of all the garments required at *Solängen* nursing home.

When first starting to think about the clothes used in hospital environment me and my colleague Tuula Bergqvist (from the department of Design) made a artistic project trying out what happens with ones identity when dressing in different clothes. We found out that both Tuula and I lost a lot of our self-esteem when dressing in the patients and nurses clothes. This even though we just wore the clothes for a moment for taking pictures. Posing and smiling is natural when being dressed in ones owns clothes, dressed in the clothes provided by hospitals it is not.

Sketches on the new working clothes being made to the personnel at *Solängen* nursing home. Design: Tina Nylund

Dressing in hospital clothes, loosing a part of our identity, Tuula Bergqvist above and Emma Westerlund below.

December 2011. *Solängen* nursing home is almost done. The armature designed by the students is lightening up the lobby and the double sided art is mounted to the walls.

To the right: Interior designers Minna Östman and Andreas Haals.

Illustration: Andreas Haals & Tanja Krokvik

Tanja Krokvik is mounting the double sided art works at the oncology policlinic in Kokkola. A specially designed hanging system enables the double-sided pictures to be turned easily.

KIURU, Oncology Polyclinic, Kokkola, 2011-2012

The second on-going partial project is the redesigning of the spatial environment in the oncology polyclinic in the city of Kokkola. This partial project began in January 2011 and will be completed in early 2012. This ward is where patients receive cyto- toxic treatment. The unit has a staff of eight nurses, one doctor and facilities for 13 cancer patients. In this partial project, designers Andreas Haals and Tanja Krokvik are responsible for the interior planning. In cooperation with the nursing staff they have planned a totally new aesthetical environment for the unit. This unit is not undergoing a total renovation, just surface renovation. This renovation work will involve 13 rooms of about 250 m^2. The interior design and art work for this unit began with some (rather demanding) visual elements which have not been changed. Examples of such elements are bright yellow doors which remain after renovation work is completed.

Also in this patial project both students and professional artists were involved in creating context-sensitive art. All togheter 36 pieces of art ,photgraphs, paintings and graphic prints, were chosen to this ward.

Choosing the art to the hospital environments is a time-consuming process. This picture shows some of the photographic art being tested on the walls at the oncology polyclinic.

Upcoming project, 2012-2013

It is very likely that a third partial project will be carried out in 2012. The project *Art and Well-being* has received financial support for a smaller project in cooperation with a middle school health clinic. It is important for this project to incorporate the views of young people in terms of visual communication and well-being.

2.4 Experiences of cooperation between the fields of art and health care

When I began the first pilot project in 2008, I very soon realized that when building or renovating a health care environment lack of communication might cause problems. When we were involved in that renovation project, there were already four cooperating partners involved in the process: the decision-makers (politicians and hospital management), the technical department at the hospital, a technical planner (an external engineer) and the users (the nursing staff). To my surprise, I realized that the last-mentioned partner had very little to do with the planning. Generalizing quite freely, you could say that the users often have to be content with what they get. I got two of four cooperating partners on our side: the hospital management and the users. The technical staff regarded our involvement in the process as a complication. I was sorry to see that there was such emphasis on gender and power. The exclusively female nursing staff were constantly overrun by the male technical staff in matters of great importance to the users. The project group and I became a type of bridge of communication between the technical department and nursing staff, encouraging the latter to make their opinions heard and become more involved in the process. I cannot say that cooperation always ran smoothly, but in the end everybody was happy. Even if that pilot project had produced no result other than a change in attitude and improved self-confidence among the nursing staff, it would have been worth it.

By the time *Art and Well-being* next became involved in a building process, we had learnt a lot how to approach the cooperating partners. I cannot say that I have found the optimal way of communicating with representatives from health care, but I am learning. Working with three or four different professions will inevitably involve a lot of conflicting attitudes, obstructive mutual prejudices, lack of a common language and concepts which sometimes complicate the cooperation. One problem I have experienced, which is still unresolved, is that the staff working with elderly people seem to overprotect their charges. Admittedly, this is my personal opinion, but I still find it somewhat problematic. So far, we have not been allowed to talk to the patients at the *Solängen* nursing home. Instead the staff have spoken for the elderly. I am in no doubt that they know the needs of their patients very well, but I

do think that the staff are being too careful, traditional and restrictive when choosing the art for their unit. One lady I know, who is 94, once said that she finds it irritating when people start treating you like a child once you exceed a certain age, "Just because I am old does not mean I have dull, boring taste!" This keeps coming to mind. I find it difficult to know how to strike a balance between stimulation and the feeling of security.

It is important, when cooperating with health care institutions, to establish close relations with at least one representative from the nursing staff. Engagement by the staff is essential; without it, it is virtually impossible to conduct a good project. At two of the three wards where we have been working, we have managed to establish close relations with at least one enthusiastic key person from the personnel. There is a great difference in how smoothly work can proceed depending on such relations. One problem at the third ward was that the nursing staff did not seem to have any opinions, raise their voices and share their thoughts. I sometimes think, as project leader here, I should be more of a psychologist and engineer, rather than a teacher and photographer.

Despite some frustrations and differences of opinion, we have experienced many meaningful exchanges of experiences, good communication and rewarding feedback throughout the project. It is extremely important to maintain good levels of communication between all parties concerned for the sake of harmony and mutual understanding.

I have made a checklist for myself and the project group (from the field of art and design) regarding cooperation with the users/technical departments. It is mainly to remind me that not everyone thinks and prioritizes as I do. The list is very basic containing things which may seem blindingly obvious, but experience has shown that it is still important to point these things out.

- Be aware of, and respect, different points of view.
- Learn about the conditions of other parties involved. Trying to cooperate with a group of people who feel misunderstood about their everyday conditions will not be successful.
- *Art and Well-being* works in the users' interests. Artists and designers involved are not expected to surrender their own convictions, but they need to adapt to the needs of the users.
- Clarity in all communication is very important. Do not assume that someone understands you until you are absolutely sure. Never assume that you understand until you are sure.
- Common ground is needed for all the involved cooperating partners.
- Continuous reporting/communication is vital.
- Point out that no person's individual aesthetical taste/opinion can be fully realized. When meeting a group of users to map out their needs and desires someone might easily think that his/her personal opinion will be of greater importance than those of others.
- Do not fear or avoid discussions and disagreements.
- Do not always give in and do as someone else wants, but be prepared to explain and argue in a more descriptive way than when communicating with colleagues from your own profession.
- Listen to others.

In the long run a working model for doing cooperation between the fields of art and health care will be developed (on the basis of all the upcoming evaluations).

3. Art and aesthetics in different contexts

When I began considering hospital environments in 2007, I first thought about my own personal taste and views on aesthetic environment. I envisaged a hospital ward to be like my home with visual elements and objects which I – as a professional within the field of visual communication – would find appealing. Very soon I realized aesthetics value in such a context to be far more than personal taste. By the time this project started up a few months later, I had already come to understand that taste was subjective, and also that there is some kind of common aesthetical culture in our society. These two factors – subjective taste and common aesthetical culture – sometimes converge and sometimes diverge. Everyone should feel entitled to have access to the public space, regardless of aesthetical experience and cultural background. Everyone should have the possibility to feel secure, recognize familiar elements and be able to make the health care environment their own - as far as that is possible when spending time in an unknown environment away from home. This made me realize that I cannot work exclusively to suit my own or someone else´s personal taste, or exclusively to suit the common aesthetical culture. It is necessary to find a balance between the common and the personal. I think this balance is to be found by communicating with the users, giving them the possibility to be involved in the planning. Involvement affects the result. Giving users the chance to choose elements for their respective environments is an important aspect here. Working with the public environment will never produce the perfect place for each and every user since the cultural and historical backgrounds of users vary considerably. What one can try to do is to establish a foundation based on common aesthetical culture, derived from tradition and history, and gradually add different exchangeable options according to personal taste.

3.1 Levels of visual communication and aesthetical cultures

Saying that the project *Art and Well-being* is working together with the users is easy in theory. Actually working together with the users is difficult in practice. When it comes to taste on interior design and art there is, of course, no right or wrong. Still it is hard to find the proximal zone and the right level of communication.

Since we cannot work only with individual taste, we need to find some kind of common taste. And no such common taste exists. At least not in a way that can be proved and justified.

Before starting the pilot project in the surgery unit in Pietarsaari in 2008 I devised a questionnaire with eleven different photographs (appendix 1), showing some more artistic and abstract motives, some black and white pictures and some 'basic' objects such as nature and kittens. About 100 persons (mostly patients) responded to the question about what kind of pictures they would like to see in a hospital environment by marking the pictures they liked the most in the questionnaire. Not surprisingly, yet to my disappointment, most respondents preferred the kittens and the most common nature pictures such as nature and horizons. This result once again raised the question about my personal opinion in contrast to others. I really did not want to ask my photography students to produce, in my opinion, naive pictures with cute animals and kitsch. But this was what the users asked for. At that time, I was not willing to give the users what they wanted. I wanted to believe that by offering 'my' kind of art and aesthetic value they (the users) would realize their taste was not as good as mine. Of course, at the same time I realized that this was not an option – since it is not true. This is when we came up with the idea of double-sided art. By mounting different kinds of art in the same frame we could offer one 'basic' and one 'complex' work of art at the same time. This is one of the pedagogical aspects of *Art and Well-being*. By offering one 'complex' work of art on one side, we hope to create more interest in art and art-related discussions among people not normally interested in art. For each partial project there will be a publication with all the art showed in the ward. These publications, similar to the one that was made about the pilot project, will also include texts about the art works. In addition to this the personnel will be offered some kind of workshops and art education. This is something that is not yet planned in detail, but it is very important that the personnel "get to know" the art showed in their ward. This can be done in the most effective way through discussions and workshops. Not saying we (in this case probably me together with an art educator hired by the project) will offer any answers or explain the pieces of art. These workshops will be more about making the personnel familiar to the art, helping them to make the art "their own". My hope is that these workshops will "open" the art also for those not that very interested in art or help the staff to discuss also artworks they spontaneously do not like. The workshops will be held in autumn 2012.

Research shows that the most effective positive distractions are mainly elements that have been important to humans throughout the history of evolution: happy, laughing, caring faces; animals; nature elements such as trees, plants and water (Ulrich 1991, 102). This hardly surprising result is perhaps not the most exciting for an artist to accept and adapt to; but still it must be considered when making art for a public environment. In one of the discussions with the nursing staff involved in the pilot project one of the nurses admitted feeling stressed and irritated by art she could not understand. She felt it could be any type of art. Being an art novice (compared with someone working with/studying visual communication), you often feel inadequate when it comes to opinions on art and design. When someone feels inadequate, he/she tends to lose interest and becomes indifferent. Such reactions from users are undesirable for project work which aims to create a stimulating and inviting public environment. All this implies that we – the teachers, students, artists and designers involved in the project need to review our common, rather exclusive, way of thinking about other people's aesthetical tastes and opinions of art. The professional approach for dealing with art and art-related discussions is no better than an amateur´s in such a context. What professionals can do is offer users different solutions and present alternative ways of thinking; I am not presuming here that this is right or wrong. Professionalism is not about giving users what the professionals think the users should have; it is about communicating alternatives and inviting the users into discussions to open up the world of art; it is about welcoming new visitors instead of scaring them off with art which is too complex – as is so often the case with contemporary art.

In this particular context art can be seen as the traditional, institutional art (shown in museums) and a more applied kind of art. Not all works of art used in the project *Art and Well-being* are the 'applied' type. Some works of art by students have subsequently been shown at exhibitions in art institutions. The professional artists involved in the project do the same kinds of art for the hospital environments as they do for their own exhibitions. This mixture of 'institutional/professional' art and 'applied' art such as 'user- friendly' nature pictures and cute animals is a conscious strategy. By mixing different levels of visual communication, the project aims to increase the chances for everyone to recognize works of art they find interesting and appealing.

Yet working with art for an everyday environment such as a hospital ward is not the same as working with art in a traditional art context (for art museums and institutions). No one visits a hospital for the sake of art. In the hospital context art and design have no importance as such. Art in hospitals should, I think, be more than 'just a painting on the wall' - it should be integrated into the room and into the activity in the ward. The work of art should engage with the environment. "If we banish the art to the museums, we fail to give it a place in ordinary life. If the fine arts are set apart from everyday life, they become too precious and therefore irrelevant. When trying to give art a place in ordinary life the challenges of the activity should match the viewer's abilities. If the challenges are greater than the skills, anxiety will result; if the skills are greater than the challenges, boredom will result" (Csikszentmihalyi & Hermanson 1994, 154). It sounds so obvious, but still it is so hard to achieve an optimal proximal zone for the art viewers in everyday contexts.

There is a conflict between the lovers of art and the lovers of niceness in everyday life. Let me quote Tom Leddy from the book *The Aesthetics of Everyday Life:* "What the average person sees as nice is often abhorrent kitsch to the art sophisticate. Thus, within the art world, the term nice can be a put-down when applied to a work of art. The term 'nice' may even be inconsistent with such terms as powerful and intriguing. On the other hand, what the art novice considers 'nice' may not even be thought worthy of that term by the art expert" (Leddy 2005, 14). I consider this conflict mentioned above very interesting. It is of great importance for the art world to try to understand more of the minds and needs of art novices and people who are not used to visual communication - without giving up the fundamental ideals of art. With the project *Art and Well-being*, I hope to find at least some ways of communication to overlap the conflict Leddy is describing.

Understanding and being interested in art is not always simply about previous experiences in the field of art and education. Our surroundings, culture and background are all very important factors in our methods of assimilating different kinds of art and art-related discussions. "Esthetical experience is a manifestation of the life of a civilization, a means of promoting its development, and also the ultimate judgment upon the quality of a civilization. For while it is produced and enjoyed by individuals, those individuals are what they are in the content of their experience because of the cultures in which they participate" (Dewey 1934, 339). We do not only like or dislike a work of art in a subjective personal way, our understanding of aesthetical matters is also a result of the cultural tradition we belong to. This fact creates even greater demands when planning, producing and choosing art for hospital environments. The fact that users come from very different cultural and geographical backgrounds offers even greater scope for holistic planning and possibilities (for users) to choose aesthetical elements.

I think interest is essential in order to understand and experience art and visual communications on different levels – whether this personal interest in the visual communication is by accident or design. We are all born with a desire for knowledge. Interest is partly universal and partly the result of individual experiences. Saying that a viewer's interest is essential for enhancing well-being through art and art-related discussions leads us to the question of how this interest can be kindled.

This is even more important than the act of placing art in health care environments. My belief is that interest is born when some kind of understanding is acquired. If art is simply installed in hospital environments, it might stay 'locked away'. If a pedagogical structure is provided for how to approach the art, the conditions for experiences are enhanced. This is not to say that all art needs a key to be 'unlocked'. Most people do have sufficient experiences and imagination to absorb and interpret a work of art without any other stimulation than the work of art itself. This is all about considering different needs and options with the intention of finding the proximal zone of visual communication for as many viewers as possible.

Dewey presents a very pragmatic point of view when it comes to knowledge and experience. He claims that "the experience is the result, the sign and the reward of the interaction between the organism and the environment. This - when taken to its fullest extent - is a transformation of interaction into participation and communication" (Dewey 1934, 22). The participation where interest is born and understanding is received. Further, according to Dewey, "the work of art is complete only as it works in the experience of those other than the one who created it. Thus language involves what logicians call a triadic relation: the speaker, the message, the interlocutor. The external object - in this case, the work of art - is the connecting link between artist and audience. As a piece of paper, as paint on a canvas, or as a printed surface, the art is nothing. It is only as the work of art is esthetically experienced that it comes alive. What the work of art might communicate could be much larger than the art itself - since the art is put in relation to the viewer's earlier experiences and a unique communication occurs every time a person meets a work of art" (Dewey 1934, 111).

3.2. Everyday aesthetics

Everyday aesthetics can be separated from the traditional aesthetics of art and nature because they are not closely connected with the fine arts and established institutions. Everyday aesthetics are about the experience of beauty in ordinary things and personal appearance – e.g. enjoying the walk to work, the weather, interior decoration, gardening, environmental aesthetics, relationships. All these experiences of beauty allow us to talk about aesthetics even though they do not form part of traditional aesthetics (Leddy 2005, 3).

Traditional aesthetics focus more on what may be termed 'strangeness'. In the sense of traditional aesthetics art is the paradigmatic example of phenomenon which is special and not ordinary in our everyday life (Haapla 2005, 40). Of course, the line between traditional and everyday aesthetics cannot be clearly drawn - the latter is a very open category.

In modern western aesthetical practice an aesthetical object is typically identified as a work of art - shown or shared in institutions and on specific occasions which are not a part of our everyday life. However, the absence of formal aesthetical experience does not imply a lack of aesthetical experience in our everyday lives. Everyday experiences are rarely recognized or articulated; such experiences are often universally shared. This is not like the appreciation of art, which is confined to those cultures with institutionalized art worlds and those who have access to knowledge about the art world (Saito 2005, 156). Saito mentions weather as an example of everyday aesthetical experience shared by everybody, regardless of cultural or geographical background. Weather is not an object; it is constantly changing; it is experienced by all human beings and affects us through many senses.

Aesthetical experience can imply experiencing an object (e.g. a work of art) or a state of mind. What is extraordinary for one individual may be perfectly normal and 'everyday' to someone else. Aesthetical experience does not need to be connected to art institutions or traditional aesthetical theory. The majority of non-western cultures lack the equivalent notions of art, artists and the art world, although their aesthetical life is as rich as ours. The Balinese, for instance, reputedly have a saying: "We have no art, we do everything the best way we can." Modern western aesthetics, with its virtually exclusive focusing on art appreciation, are rather limiting (Saito 2005, 157). The Balinese saying has kept my thoughts busy for quite a while. I find it disheartening common in our culture to do things without doing our very best. Way too often things are done on routine, the way we always do, without any reflection. This I have seen several examples of in existing health care environments.

When I initiated the project *Art and Well-being*, I had problems defining the word 'aesthetics'. I still do. The whole idea is to try and make aesthetical experience possible in an environment that is mainly associated with negative feelings. However, the word aesthetics can be interpreted as objects only (works of art) and thus be very exclusive in its traditional definition. This is because it contains institutional standards and certain historical traditions. The feeling of pleasure which everyday appearances give us is often taken for granted in a different way from traditional aesthetics. It just exists without any active thought on our part. The value of beauty and pleasant experiences in everyday life is what the project *Art and Well-being* aims to illustrate in hospital environments - not necessarily as an obvious, explicit element, but rather as a quiet, sublime feeling of order and calmness, of beauty and care.

Although all the art and pictures created for the project are made by professionals (or student professionals), there are also pictures which I, personally, would not consider to be art. This is complex since I think it all *is* all art in this certain context. Even though some of the pictures are simply showing objects or landscapes, being more a kind of 'display box' than art, I consider them being art. This since they are framed, hanged on walls and presented as art in this context. These pictures have been made because the users have asked for them. The pictures and art itself is not the most important thing in this project. It is all about the communication achieved and thoughts risen. That is what I consider being the artistic result of this project. And that is when all of this might have the chance to result in increased wellbeing. This is Dewey´s theory saying that what the piece of art might communicate can be much larger than the art itself coming into practical use. Aiming for all users to find something to talk about is the reason for combining different levels of visual communication in this project. In the context of practical and very pragmatic working methods, I see no problem in combining pictures of everyday objects with artistic work. During the process of choosing the art to the nursing home in Oravainen and the oncologic polyclinic in Kokkola I have realized we are working with aesthetic values in many different levels. First of all the art exhibited can be 'everyday' to some, e.g. the personnel working at the ward, who has got used to the art, and 'strange' to others, e.g patients being there for just a few days. Secondly the motives and themes in the art can be both 'everyday' such as objects or nature or 'strange' as for example pieces of contemporary art. Thirdly one side of the art can be 'everyday' while the other side of the same frame might be experienced as 'strange'.

According to Leddy, everyday aesthetics do not provide as much of a role for evaluation and interpretation as one might find in the aesthetics of art. It seems as if we need special training in order to enjoy the pleasures of everyday life; training enhances our everyday experiences. Leddy argues that constant viewing of contemporary art helps us appreciate our contemporary everyday environments (Leddy 2005, 19). When evaluating the pilot project at the surgery unit at *Malmska Municipal Hospital and Health Care Centre* in Pietarsaari, I realized that the project had opened the eyes of the nursing staff to their aesthetical working environment. One nurse said during talks that the new appearance of her working place even inspired her to start decorating her home differently. She paid attention to her surroundings in a way she had not done before. The art, which was not too complicated or demanding, produced unprecedented discussion from another nurse as a result of one particular picture. These two instances I recognize are examples of the training Leddy writes about - experiences of visual communication, art and aesthetical beauty creating interest by seeing in a different way. Many of the authors in the book *The Aesthetics of Everyday Life* (ed. Light & Smith 2005)

explain everyday aesthetics as an experience of pleasure and meaning which results through the existence of a special relationship, or is established between a subject and an object or between several subjects brought together and coordinated by one object. Being aware of one's working environment from a different perspective and establishing a new kind of relationship with it, I believe, constitutes one step towards fully experiencing the aesthetics in everyday life.

So what makes an environment or an experience aesthetical? What brings out the feeling of well-being and pleasure known as the sense of aesthetical beauty? Qualities like "order" and "right" are important in aesthetics (Leddy 2005, 9). These are naturally very basic and rarely even considered. If something is in order, we normally do not pay attention to it. Order often arouses the senses of safety and control - two very important feelings for human well-being. Leddy goes on to mention more complex qualities – symmetrical, proportional, balanced, integrated and harmonious. Judgments about the more complex qualities are generally based on prior judgments about the fundamental qualities. We cannot tell whether something is symmetrical until we know how to apply such terms as ordered and straight. The above-mentioned qualities have, through the history of traditional aesthetics, been frequently discussed and applied to the arts (Leddy 2005, 9).

One area in which the aesthetics of everyday life clearly diverge from the aesthetics of fine art is in the word "clean". According to Leddy, "clean" is another relevant word belonging to everyday aesthetics. And not simply "clean", but also "looks clean", "smells clean", "feels clean". Something can be clean without looking clean, and vice versa. All the above-mentioned qualities have great importance to everyday aesthetics, in our homes, at restaurants, in the streets, in our erotic lives and most importantly, in the case of the *Art and Well-being* project, in working and health care environments. I cannot stop thinking about why such obvious qualities are so often missing in Finnish health care institutions. In the technical and hygienic domains, I am convinced that most Finnish health care institutions are cleaner than they look - probably cleaner than most health care institutions elsewhere in the world - which, naturally, concerns quality and safety. At the same time, I still think it would not be too difficult to establish more visual order, balanced spaces and integrated harmony in these environments. Being clean is very important, looking clean and orderly creates the feeling of harmony.

Let me provide two instances of lack of balance and harmony at the hospital in Kokkola. In both cases, external visitors educated in the field of visual communication raised the question about lack of balance and harmony. The users, in this case nurses, who spend many hours every week in these environments had not reflected on the visual "disorder" until someone from outside commented on it.

The interior designers involved in the partial project at the oncology polyclinic in Kokkola were Andreas Haals and Tanja Krokvik. When first visiting the ward before the renovation started they reacted to the overfurnished unit. Objects and furniture which were not really being used, had simply been placed in a narrow corridor, creating a sense of disorder. The designers asked the nursing staff about all the furniture and visual elements. The staff, who clearly had never given these items any attention, replied that they had always been there adding that they would be happy to have most of them removed.

Walking around the hospital with a nurse a few months earlier I had a similar experience. We visited a ward where I reacted immediately to the disharmony of the numerous colours used. A two-metre wide corridor featured as many as 16 different colours used for walls, doors, floors and other painted interior details - excluding furniture and decorative objects. I was not allowed to take any pictures, but the colours used were principally various tones of green, pink, yellow and blue. I asked the nurse with me of her opinion of the corridor. She hated it and always felt uneasy walking along it. I asked if she could explain why. She simply did not like it. I suggested that the colours and the various visual elements might be the reason. She said that she had never even considered the colours, or the furniture or the decorative aspects. Two days later she sent me an email: after our discussion she looked around her place of work and realized that some areas made her feel calm, others uncomfortable and concluded that, in most cases, these feelings seemed to correlate with the usage of colours and decorations. The more diverse the colour scheme in one room, the more stressed she felt there. When I confessed to her my sense of guilt about making her aware of the unappealing environment, she responded that it was a relief for her to finally understand why she liked some areas and disliked others; she simply had not understood why before. This experience convinces me that we should not forget the other side of aesthetic experiences - the feeling of displeasure, being stressed by 'ugliness' (or lack of appeal) caused by a sensuous/imaginative apprehension of certain things, as in the case above.

Let us return to the question about what makes an environment or an experience aesthetical. I come to the conclusion that order and, in many cases, simplicity are very important factors. And so is the opportunity to understand the environment and make it one's own - in other words, the sense of familiarity. Understanding a place and making it one's own is difficult if there is no sense of order - not only practically, but also emotionally and visually. To adopt a place as our own, we need to understand it and recognize elements relating to our own lives - from our homes and other familiar places. In the essay *On the Aesthetics of the Everyday – Familiarity, Strangeness and the Meaning of Place* (ed. Light & Smith 2005), Arto Haapala discusses the philosophical problems of everyday life through an analysis of the concept of place. By place he means the "area" in which everyday life is realized. A place can be defined as an abstract location but also as concrete things having material substance, shape, texture and colour. Together these elements determine what Haapala (referring to Ossi Naukkarinen) calls "environmental character", which is the essence of place. Normally, we talk about a place having an atmosphere, which includes both the material and the non-material aspects of the place. When an outsider enters a new place (e.g. a house, a room, a city), it often feels different from his/her own background. When we come to a new place, we all try to make sense of the unknown environment. When we are admitted to a hospital ward as a patient, we are often in a state of pain, chock or fear. Such feelings make the process of adapting to the new place much more difficult. Experiencing these different surroundings for the first time can make a patient feel insecure and lonely.

The process of acquainting oneself with the environment through the various senses may be called "sensing" (Haapala 2005, 44). When we enter a new environment we pay attention to things we may not see at home or in familiar environments. In making the environment "our own" we establish a relationship between ourselves and the place, looking for personal similarities and familiar elements (Haapala 2005, 44). This is one of the reasons why I find it very important to place different kinds of art in a hospital ward, inviting patients and visitors to choose and create relationships with the art displayed. Also, the motives in the art will naturally play an important role in the process of "sensing the place".

The length of stay at a health care institution varies widely from patient to patient – from just a few hours to a the rest of one's life. For some the hospital ward is a temporary location, for others it becomes their home. "If we find ourselves staying longer in a place - by accident or by design - we start to settle down, once we have acquainted ourselves with the place and recognized familiar elements. We assimilate things from the environment which are in accordance with our own existence - at least not contrary to it - and thus make the environment accessible" (Haapala 2005, 46). Reading Haapala nothing really surprises me; most of what he discusses is obvious in some way or other. But still it is not the most common way of thinking about the places where we spend our lives.

The emotional relationship we have with a place is attachment. The concept of attachment, according to Haapala, is the key to understanding the aesthetics of a place. We might like a place because it constitutes a part of our essence (Haapala 2005, 49). In the con-

"The grasshopper says hello" Photo: Lisen Julin-Qvarström.

text of the project *Art and Well-being* I tend to think more about the staff working in a hospital ward than the patients. When planning and creating public health care institutions, there are three main target groups to consider: the patients, the staff and the visitors. They all come to the same place for very different reasons. When we create an environment which staff can cherish and consider their own, I am convinced that well-being at work will improve. This is such an obvious factor. But the question is how many working places are actually planned and created to fulfil this emotional relationship? Surprisingly few, I should think. Involvement of staff in the planning and realization of their working environment will increase the chances of their emotional attachment to their ward. Although we might not always be able to choose the environment we work (or live) in, we are - at least to a certain extent - attached to the place. It would be impossible to work or live in a constant state of strangeness and not be rooted in the environment (Haapala 2005, 49). Central to understanding the aesthetics of the familiar (in this context, a working place), according to Haapala, is the level of attachment. This attachment most often involves a positive emotional connection. As an extension to that attachment, the feeling of well-being at work is more likely than in an environment where one feels no attachment.

Something that is strange at first can turn into being something safe and perfunctory, something that give us pleasure on a daily basis, without being strange or new to us. One nice example of this is an experience shared by one of the nurses at the surgery ward where we carried out the pilot project. In the evaluation she told that she had "got to know" a grasshopper pictured in one of the photographic series hanging in the corridor. When we first mounted the pictures at the ward they were all strange and new, after a while this nurse established a special 'relationship' to this particular series with the grasshopper. She told that she after a while realized that the grasshopper in the pictures greeted her good morning every day she came to work. This being kind of a funny story, but I am convinced that it is nicer to come to work if there is a grasshopper greeting you. And that this special relationship to a piece of art, being unique for this nurse, makes her feel more attached to the place.

The story about the grasshopper talkning to the nurse is something I every now and then need to remind myself about. I tend to forget about the joy in everyday objects. My point being that the photographer in me found this particular series rather boring when it was chosen to de ward by the personnel. I would have preferred them to choose something more artistic, something more 'exiting', something that would be more interesting to discuss. After hearing the nurses story, I realized that it could not be much more exiting. Even though the pictures might not be the most exiting, the result is. Meeting a grasshopper that says hello every morning is great, that is when the art becomes larger than itself. In this story there is one part of familiarity and everyday and one part of strangeness and wonder. Experiences like this with the grasshopper helps me realize the need of different kinds of art, also rather simple an 'unartistic' work can give rise to thoughts and meaningful experiences. With time and experiences like this I tend to widen my viewpoint on what is suitable art in the context of this project.

As a conclusion for these thoughts about everyday aesthetics and traditional, aesthetical elements, let me quote Arto Haapala (2005, 50):

"Ordinary everyday objects lack the surprise elements or freshness of the strange. Nevertheless they give us pleasure through a kind of comforting stability, through the feeling of being at home and taking pleasure in carrying out normal routines in a setting that is 'safe'".

I consider a public health care environment to be simultaneously 'home' and 'everyday' for some but 'strange' to others. The aesthetical elements in the environment will be experienced differently according to subjective matters such as one's position in the environment - working, visiting or being a patient there - and background. As a result, I see only one direction in which to proceed when planning and creating these environments – basic elements of order combined with maximizing the possibilities to find/choose things for the environment which are familiar and appreciated. This is no easy task - in fact, virtually impossible. However, by cooperating with the users and by maintaining on-going dialogue with technical staff, interior designers and artists, I am convinced that the optimal criteria will produce the optimal result.

4.3 Interior design in the hospital environment

Traditionally, the design of health facilities has prioritized functional concerns above aesthetical ones. This emphasis often produces health care environments which are functionally effective but psychologically 'hard' (Ulrich 1991, 97). There is growing recognition that hard designs and lack of aesthetical elements are unsatisfactory from the standpoint of patients, staff and visitors in health care institutions. The increasing scientific evidence that poor design works against the well-being of patients and that some institutions can even have negative effects on physiological indicators of wellness shows that further studies and research are required in this field (Ulrich 1991, 97). According to Ulrich´s studies, these negative feelings may be anxiety, delirium, elevated blood pressure and an increased intake of painkillers.

Despite all recent efforts, the conclusions of various studies on how the spatial environment affects human well-being are invariable: there is insufficient data from research to provide architects and designers with what they need to begin designing an evidence-based construction. Studies so far conducted - which often focus on a selection of isolated features - cannot be generalized to meet the requirements of complex, real-life situations (Van den Berg 2005). Even though this statement is six years old, it is unfortunately still valid; the questions far outnumber the answers.

In a complex world we need to understand a human's psychological needs and conditions when planning and building indoor environments. Alexandra More, architect and economist, is one of the few researchers who has carried out various studies on the profitability and benefits of good environments. She aims to come up with a modern design philosophy with a holistic point of departure in terms of planning environments. She believes that many instances of irritation and conflict are caused by poor acoustics, poor lighting, bad communication and bad planning. With such elements in the environment people will feel as if that they are

neither seen nor heard, which eventually leads to a vicious circle and even physical problems (Nilsson & Palén 2011). More´s research shows that the environment affects our well-being far more than we think. For example, people experience more energy in strong and warm colours. The quality of one's outlook, the location of one's work station in relation to those of one's colleagues and the surrounding interior space are also factors influencing our experience of the working place. A poor or a lack of outlook may, according to More, lead to physical problems such as neck or back pains or overexertion. The results also show that if a person has the chance to set eyes on something beautiful – attractive plants, a colourful wall or a work of art - in their working environment, his/her attitude towards work is more positive. However, More points out that even if design factors do have a strong impact on well-being at work, these factors must be combined with effective organization. People perform better when they enjoy their working place - obviously. Yet a good interior design is not always used to achieve this. If one enjoys one's work and appreciates one's spatial environment, the risk of work-related health problems decreases. Since labour costs form a significant part of the total budget at many places of employment, it would be worthwhile reducing the instances of sick leave. According to More, this can be done with more effective interior design - which should stimulate our minds and social interaction in the working environment (Nilsson & Palén 2011).

It is essential to involve all types of user – specialists, nursing staff, patients and the general public – in the planning and designing of health care facilities. This kind of well-informed advanced planning leads to efficient, effective, flexible facilities in which medical staff have more time to spend on caring for patients and advising their families. It allows staff to concentrate on what they do best, reduces levels of stress and fatigue, and minimizes the risks of errors. Patients in wards carefully planned are easier to observe and monitor, which gives patients greater reassurance. Single-occupancy rooms offer more privacy and are less prone to the kinds of error, accident and airborne infection that can afflict larger wards. Effective, user-orientated design by integrated teams of (design) professionals and users can give us the hospitals and health care facilities we all want. Sufficient upfront investment in time and resources for properly planned wards and units for patients will result in these people experiencing longer, healthier and happier lives (Reed 2011, 13).

The Center for Health Design and the *Picker Institute* have conducted a study of what patients experience in different health care settings. The results provide the following conclusions:

Patients from acute care settings emphasized the following:

- they see clinicians as their "lifeline"
- the hospital room is the focus of their experience
- they often feel acutely ill, experiencing pain
- they often feel a loss of their own sense of "self", and a sense of passiveness
- the hospital admission process is a stressful ordeal
- they often experience sensory changes (e.g. relating to the effects of medication or the disruption of diurnal patterns).

Patients from long-term care settings emphasized the following:

- they often sense an irreversible loss of independence or functional decline
- they feel a loss of control and often become passive
- they often have physical limitations
- they value activities and recreation
- they often have special relationships with staff.

What matters to the users?

While the concrete details of users' perceptions varied depending on their particular care setting, the themes that emerged from the focus groups - *The Center for Health Design* and the *Picker Institute* - were remarkably consistent across all three settings of care. The analysis revealed seven consistent themes that consumers looked for in the physical environment of health care. Regardless of the setting, users want an environment which:

1. facilitates a connection with staff and carers
2. is conducive to a sense of well-being
3. is convenient and accessible
4. promotes confidentiality and privacy
5. cares about the family
6. is sensitive to physical impairments
7. is close to nature and the outside world.

These findings give us an insight into how the patients experience their health care settings. Although hardly surprising, I should emphasize that these rather obvious results might not otherwise be considered as carefully as they ought to be when planning health care facilities.

Stress is one of the main problems patients (and staff) experience in hospital wards. Stress has many different sources - the most common ones in the case of patients being: painful medical procedures, reduced physical abilities, uncertainty and physical-social environments. These physical-social environments may be due to noise, lack of appeal, invasion of privacy or lack of social support. Negative distractions in the form of environmental elements making their presence felt can be very difficult to ignore and thus cause stress - especially if imposed on patients who have no chance to control or choose. Staff are often under a great deal of stress due to the demanding levels of work involved. Supportive design and an aesthetically appealing environment may be positive factors in marketing a facility for prospective employees for the purpose of increasing productivity and efficiency levels, thereby enhancing job satisfaction and stress reduction (Ulrich, 1991).

When the surgery unit of our pilot project reopened, we witnessed how facilities could prove to be a marketing factor and also a source of pride for staff. The personnel working in the surgery unit felt proud and privileged when nurses from other wards at the hospital asked what they should do to be transferred to this aesthetically appealing unit. I not only hope, but also believe, that such comments and reactions will lead to a sense of well-being which can result in greater comfort in the working environment.

Ulrich presents a theory called 'supportive design', where he claims that health care facilities - in order to promote wellness - should be designed to foster coping with stress. He formulates three conditions for planning health care institutions:

- Health care facilities should not put up barriers to
- avoid coping with stress, contain features which are stressors, per se, and thereby compound the state of illness.
- Health care environments should be designed to facilitate access or exposure to physical features and social situations with stress-reducing influences.
- The target groups should be patients, health care staff and visitors.

When planning such environments, designers need to use their intuition and call upon their own aesthetical tastes, due to the lack of evidence-based theory - according to Ulrich – as a reliable basis for working on. He suggests three components, based on evidence from the few scientific studies available, which could be the point of departure for working with stress-reducing design:

1. a sense of control with respect to physical-social surroundings
2. access to social support
3. access to positive distractions in physical surroundings (Ulrich 1991, 99).

The first component - creating conditions for a sense of control of the situation - is an important factor influencing stress levels and wellness. For a patient, pain or medical illness is difficult or impossible to control, in many cases leading to stressful reactions. Other potentially stressful factors may include: levels of noise, different types of undesirable perception, difficulties in finding one's way around, invasion of privacy and no possibilities to control lighting and temperature. Health care staff experience stress because their work

is conditioned by low levels of control and high levels of responsibility (Shumaker & Pequegnat 1989). This problem can worsen because of poorly designed work environments. Ulrich mentions as examples: insufficient communal areas for breaks, no possibilities to escape the work demands, work stations located too closely to one another and unnecessary interruptions by visitors. With careful planning and effective design, these kinds of problem could be avoided, and possibly release both patients and staff from some of their stress relating to lack of control.

The second component - social support in design - refers to the creation of environments offering social interaction - for example, by means of furniture arrangements and room layouts to enhance levels of social communication. Chairs arranged side-by-side, for instance, in corridors do not encourage as much social interaction as chairs arranged in flexible groupings. Planning rooms where patients and visitors can talk and spend time together without interruption is another important element for supporting social interaction for enhanced well-being. To conclude Ulrich´s theory of social supportive design, good conditions are needed for patients to feel like humans interacting with their surroundings, regardless of their age and predicament. This is more a question of ethics than aesthetics and design, but that is why I find this field interesting. There is no doubt that aesthetics, design and very practical elements can be used to benefit the ethics and influence the considered opinions of individuals in health care environments.

Ulrich´s third component - positive distractions in physical environments - is perhaps the most interesting from the perspective of the project *Art and Well-being*. Before looking at Ulrich´s last component, let me again point out the differences between various health care environments. In some environments stress-reducing elements and calmness are required; in others, stimulation giving rise to activities, thoughts and discussions. It is thus very difficult, on such a broad spectrum, to deal with the common term 'health care environments'. Research into environmental psychology suggests that human well-being is usually fostered when physical surroundings provide a moderate degree of positive stimulation – where levels of stimulation are not too high or too low. If the levels of stimulation (sounds, intense lighting, bright colours, visual perception and other environmental elements) are too high, the cumulative impact on patients will likely be stressful. At the other extreme, minimal levels of stimulation will produce boredom and often negative feelings such as depression. When external positive distractions are lacking, patients tend to focus to a greater extent on their own worries, discomforts or other negative feelings (Ulrich 1991). When planning different kinds of health care environment, the aim must be to find the proximal zone for the users - often two or sometimes three parallel proximal zones - to meet the needs of patients, staff and visitors. I do not believe that this can be done properly without comprehensive analyses of, and cooperation with, the users.

As already mentioned the most effective positive distractions are, according to Ulrich´s studies, mainly elements like happy, laughing, caring faces and animals in their natural habitats. And further elements such as water, trees, plants and landscapes. Natural scenes and elements seem to elicit stress-reducing feelings, indicated by positive physiological measures for muscle tension and blood pressure. Studies show that pets, fish aquariums and rooms providing a view of nature significantly reduce anxiety and discomfort among patients (Ulrich 1991, 103). In a study in the late 1980s, Ulrich & Lundén investigated whether exposure to visual stimulation in intensive care units would enhance a sense of well-being. 166 patients who had undergone open heart surgery were randomly offered visual stimulation which comprised pictures of nature (dominated by water or trees), abstract pictures (dominated by curvilinear or rectilinear forms), or a 'control' condition featuring a white panel or no picture at all. Medical findings from this study suggested that the patients exposed to the pictures of nature (with water) experienced less post-operative anxiety than the 'control' patients and those exposed to the other types of image. The abstract pictures reflected higher levels of anxiety (Ulrich 1991, 105-106). Ulrich refers to Coss (1990) showing similar results from studying the effects of displaying various types of ceiling picture to acutely stressed patients who where in a pre-surgery room. Patients exposed to landscape pictures had lower levels of systolic blood pressure than patients exposed to arousing pictures or no visual stimulation at all. Nevertheless, the arousing pictures were considered aesthetically pleasing.

3.4 Art in the hospital environment

Let us stay with Ulrich for a moment. He is critical of the popular belief that paintings and other visual art in hospitals constitute positive distractions. Since style, quality and art content can be very subjective emotionally, one cannot necessarily assume that art will always offer the patient a positive distraction (Ulrich 1991, 105). It is all about finding the right kind of art for a certain context. This means that you must, first of all, analyze the target group and their needs.

During a visit to the city hospital in Kokkola about one year ago, I reacted strongly to a graphic print installed in a ward for child psychiatry (where I was not allowed to take any pictures) - not the quality of art, but that specific context. The dark, rather small print framed in white 'passe-partout' featured a little angelic girl in a birdcage. The print, like other works of art displayed in the ward, had been produced by a professional artist, selected by an interior designer and a group of other professionals within the field of art. There was no question about the print's high standard, but it was totally unsuitable for an environment for mentally disturbed children. Different examples of research (Ulrich 1991, 104) suggest that patients usually had positive attitudes to art displayed in hospital wards if the content was a nature theme - such as rural landscapes or vases containing flowers. Art showing abstract or unclear motives elicited negative comments from the patients. I find these results interesting, challenging, somewhat limited and, to an extent, discouraging.

When creating stress-reducing environments artist and designers should think about methods which incorporate and combine different components. It seems possible that programmes enabling patients to select at least some art or pictures would foster access and to positive distractions and control (Ulrich 1991, 106-107).

One of the very few extensive studies I have found on the clinical effects of visual and performing arts in health care was carried out at *Chelsea and Westminster Hospital* from 1999 to 2002. Unfortunately, this study does not make a distinction between the experiences of viewing exhibited art and experiencing different performing art forms. This research provides the evidence that the integration of visual and performing arts into the health care environment can have an effect on the psychological, physiological and biological outcomes which may have clinical significance. Units of research were established at nine different clinics of (medical day unit, antenatal clinic, high-risk clinic, maternity, post-natal ward, day surgery unit, trauma and orthopedics ward, HIV/AIDS services and staff evaluation). The conclusion of this study is that the integration of visual and performing arts in health care includes significant differences in clinical outcomes, reduces amounts of drug consumption, shortens length of stay in hospital, improves patient management, contributes towards increased job satisfaction and enhances quality of service (Lelchuk Staricoff, Duncan, Wright, Loppert & Scott 2002, 3). The art activates the viewers and builds bridges between life inside and life outside the hospital. The art can produce feelings of belonging and fellowship.

Art exhibited in a hospital environment must extend far beyond the role of beautification. Art for health care should be therapeutic. Images that impart the appropriate message - hope, dignity, joy, concern - enhance the healing process. They impart a subliminal signal to the patient that his or her well-being is the carer's prime concern. It is the therapeutic value of art that gives it its marketing and public relations value. Throughout history, art has touched the human soul. Its ability to provide solace, inspiration and hope makes it an indispensable element within the total health care environment (Hathorn 2008).

A few years ago Liisa Juhantalo carried out a study of art in health care environments in the district of Satakunta. In 2006 the project *Taide hoitaa* (Art heals) - an art exhibition - was shown at six different health care units around Satakunta. Before the exhibition was held, patients and nursing staff were asked about what kind of art they considered to be healing art. Nature, abstract and non-abstract themes were suggested. The healing elements in the art were considered to be calmness, relaxation, embracing and motives provoking discussions. After asking the patients and nursing staff about what kind of art they would like to see in the health care environment, a group of artists and art students were asked to create art for the units. Juhantalo concludes her study by saying that art in health care environments offers experiences of beauty and meaningfulness. The art gives patients and staff a feeling of security and well-being (Juhantalo 2007). Similar findings are presented in Kaija Helin´s study from 2011. The aim of her study was to bring light to a caring and healing dimension through encounters with suffering humans and works of art. The results show that visual art has potential on both an environmentally decorative level and on a deeper individually symbolic level. The world of images motivates the viewer´s consciousness to the transcendent movement (Helin 2011, 162).

Artistic taste and aesthetical preferences are sets of judgments which we consciously and subconsciously develop over time by means of comparisons, peer discussion, intellectual enquiry and practical experiences. Naturally, those who are professionally involved with art are more used to discussing, analyzing and trying to understand aesthetical elements and art than those with no such profession. That does not mean that a professional's point of view is always the right one, especially in the context of art in hospitals. There are fundamental problems existing between 'elitist' art and 'popularist' art. The main one is that artists - ever since mediaeval times - have never considered it to be their responsibility to please the general public (Hosking & Haggard 1999, 127-128). I agree and disagree here. My experience is that some professional artists will certainly not work with 'applied' art through considering a user's needs and taste in the creation process. Some artists, on the other hand, seem to find a viewer's point of view interesting and challenging. Of course, "pleasing the general public" can be interpreted in different ways. However, in this particular area of producing context-sensitive art for hospital wards and units, I think most of the artists involved are inspired and influenced by the thoughts and ideas of the users. But I also know artists who chose not to hand in any portfolio or participate in the project because of the very applied way of working with art. I believe that each individual artist is entitled to have his/her own standpoint on this matter. My own standpoint is that art can be reflected in a variety of applied ways without losing the effects or ideals of the art involved. My purpose with the art used in this context is to encourage thoughts, memories and discussions. I hope that this art will offer viewers a way of looking at, dealing with and understanding the world around us. The art might well become an additional tool for communication and imagination extending beyond the bounds of the spoken language.

Art in hospital wards and units can help foster a physical, social, psychological and person-to-person environment which supports health and well-being. Art offers a means to a common end: mutual understanding between patients, staff and visitors – with the intention of supporting all parties concerned. Art can help reshape the physical environment so that people can live their lives to the full. Further, art can help rebuild a community based on trust and confidence, and also foster creative exploration and reflection on the inner worlds we all inhabit (Kirklin 2003). These are rather long-term aspirations about what art can produce in health care institutions. I do agree to some extent with Kirklin, but I also believe it is important to continue studying *why* and *how* art affects our mental and physical well-being. Unfortunately, I think it is far more complex than just installing art in hospital wards. Without holistic planning and the involvement of users, doing so might prove futile. My question is whether it is simply the viewing of art that gives rise to the supposedly positive effects, or whether it is also about attention, recognition, social interaction and time shared with others. As I see it, the art used is a way of providing conditions for the psychological effects mentioned above.

Art in a hospital environment can be decorative - positively or negatively - distracting, stimulating, comforting, provocative and evocative. Regardless of the level on which a work of art communicates with the viewer, my belief is that it always has a purpose. It is wrong to assume that any type of art will benefit a particular hospital ward. Much more research is required on this topic.

3.5 Further Research

Scientific research, art and design can share the common goal of creating health care facilities promoting wellness. Yet research within this field is very limited. Scientific research can give designers and artists more credibility in fields where we mainly work on with insights derived from intuition and subjective taste. One general need is to conduct more evidence-based research, which extends beyond collecting verbally expressed information or data obtained from questionnaires, to include information on physiological, behavioural and health-related effects of aesthetics, art, art-related discussions and design.

In the future I hope to work closely with medical researchers and behavioural scientists who know how to measure well-being in health-related and sociological ways. My hope is that results from further research will help designers and artists achieve solutions which can successfully meet the needs of patients and other user groups in public health care institutions. Credible evidence is also required in terms of the role of art and design for creating greater awareness of the issue among health care decision-makers and financiers.

Research into visual perception and visual communication will also need to be conducted by different target groups within the field of health care. I am interested in learning more about what kind of art is appreciated in different contexts, is there any common opinion to be found? Also the effect of offering patients the possibility to choose art in double sided frames should be evaluated.

Summary

To sum up, I realize how much work is still ahead of me. This thesis serves as an interim report for a project still in progress. Summarizing the thesis is easier than summarizing the project *Art and Well-being*. While writing this thesis, I have had the possibility to learn about other such projects and their methods. I am now convinced that art and aesthetics can benefit well-being. I have learnt that the project *Art and Well-being* is unique for the following reasons:

Firstly, we use specially designed double-sided frames for all art installed in health care institutions. While most other projects focus on either interior design or art, my project attempts to combine both in order to create the 'complete' picture. Secondly, we select and create art for hospital environments by actively involving the users.

Writing this thesis, even before the project evaluation, I have come to the conclusion that it would not require much effort to make a great aesthetical difference to Finnish health care institutions. This change will require careful, user-orientated planning. This type of planning, astonishingly, is a low-priority activity when building hospitals and similar facilities. Installing just any type of art in hospital wards or units will not necessarily enhance the well-being of the users; both the interior and the art need to be context-sensitive. Creating health care environments which aim to benefit the well-being of target groups should be analyzed carefully. The environments can feel 'everyday' to some people, but 'strange' to others. Different levels of visual communication should thus be applied. Mixing decorative art with more challenging art and inviting the user to contribute to the selection process will hopefully optimize the positive effect of art installed in hospital environments.

Working on this thesis has given me the opportunity to collect ideas and tools for continuing my project work. I have found some common key aspects to positive aesthetical experiences: order, recognition, attachment and positive distraction. None of these aspects really surprises me. What does surprise me is that aspects which seem so obvious are still not taken into consideration when building or renovating Finnish health care environments.

The project *Art and Well-being* has taught me a great deal about communication between the fields of art and health care. These two fields are not used to sharing the same language. The involvement of personnel is sufficient in projects like *Art and Well-being*. Much time is needed to establish good relations with the staff working in these environments. Without their interest the project will not achieve its optimal effect. The pedagogical structure of the project - discussions, workshops and articles - are central to helping the users acclimatize themselves with their new aesthetical environment by means of the art used. Writing this thesis has enabled me to reflect on the above-mentioned experiences.

I have had the time to focus on earlier research, talk with people working in this subject field and organize my own thoughts on *Art and Well-being*. I have still not found the answers to all my questions, but this thesis has given me a wider theoretical base on which to continue my project work.

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Valitse alla olevista kuvista yksi josta pitäisit sairaalaympäristössä.
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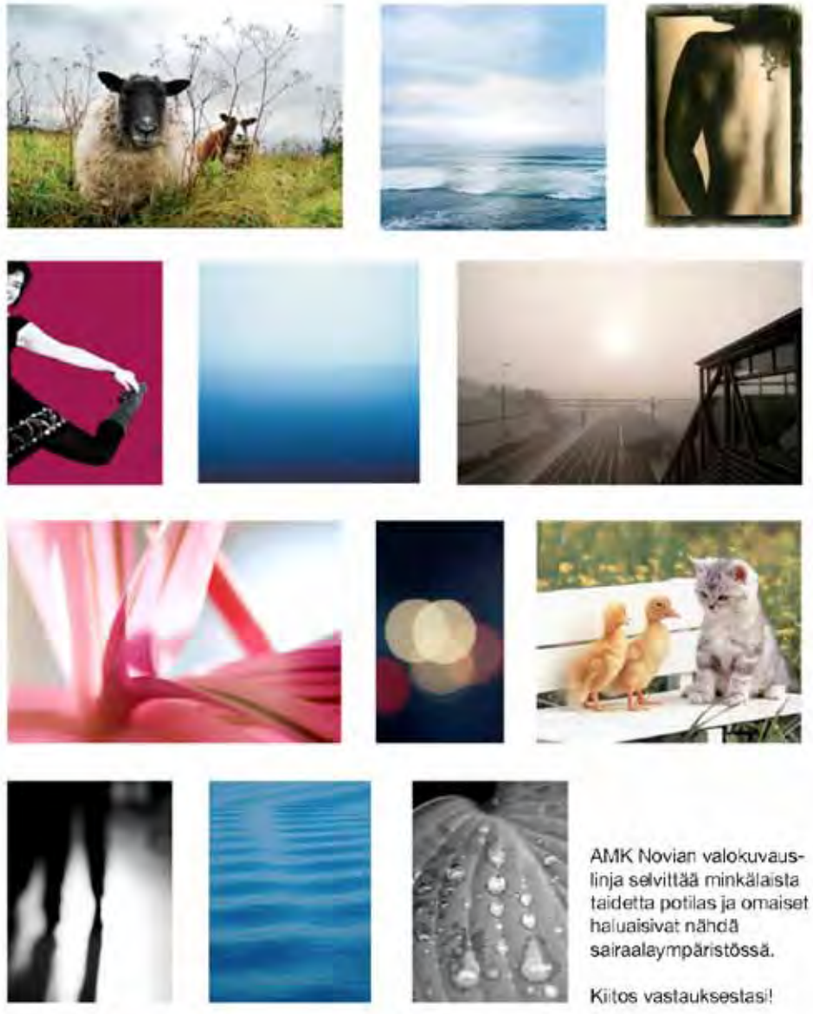

AMK Novian valokuvaus-linja selvittää minkälaista taidetta potilas ja omaiset haluaisivat nähdä sairaalaympäristössä.

Kiitos vastauksestasi!