

The Architecture of Care  
The Role of Architecture  
in the Therapeutic Environment.  
The Case of the  
Maggie's Cancer Care Centre

Caterina Frisone

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## **Abstract**

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The belief that architecture plays a role in enhancing people's physical and emotional well-being is now widely recognised. In the field of healthcare, the Maggie's Centre has attracted attention since 1996 for its ability to increase psychological flexibility and engender therapeutic effects in people with cancer and their caregivers. Its unconventional architecture based on a concise and emotional architectural brief in synergy with its psychosocial support programme is what lies behind its success. With historical reference to the ancient Greek tradition of the therapeutic architecture of healing temples and to the model of organisation of the medieval Benedictine monastery, this research investigates what has a positive impact on users in the Maggie's Centre. Within the academic world, this topic has so far only been investigated by scholars mainly in the social sciences; the results should encourage further architectural research to study and reconsider architecture as a form of care. Starting from an investigation into the design of the twenty-six built centres, focused on the 'place' and continuing with a phenomenological ethnography within three of the centres, centred on 'people', the two-step methodological process adopted reveals a distinct narrative of the consecutive yet separate stages. By thematically analysing the dynamic, hybrid, and contradictory aspects of the physical space combined with the psychological programme offered by Maggie's, this study extrapolates the key elements that identify the Maggie's Centre as a therapeutic environment of which *flexibility* gives its universal definition. Furthermore, by discovering the experiential spatiality essential to finding ways to tolerate traumatic transitions and promoting the role of users in the process underlying Maggie's 'Commissioning of Architecture', this research highlights the paradigmatic qualities of Maggie's model that can be applied to other health and non-health facilities. If the principles drawn from the Maggie's Centre to enable well-being and flexibility work in such realities, they should also be effective when applied to architecture in general.

*Keywords: Architecture of care, therapeutic environment, Maggie's Centre, architectural brief, movement, hybrid, enigma, psychological flexibility, phenomenology, United Kingdom.*



*In memory  
of  
my brother  
Francesco*

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definitely comes from the opportunity (and sometimes even luck) to find truly exceptional supervisors like the ones I've had. My supervisors on this adventure were Cathrine Brun and Andrea Placidi, with external support from Lesley Howells (Maggie's Psychologist Lead, already nominated as a member of Maggie's), who with her insights further stimulated my interest in this topic. I cannot thank them enough for the constructive criticism and support they gave me. A special thanks goes to Andrea for his 'dynamic' criticism and to Catherine for her unique ability to locate the weakest points in my work and transform them into the strongest. Challenging me at a high level, they pushed me to go beyond myself. Together with them, I thank the Faculty of Technology, Design and Environment, of which Sue Brownill has been a constant reference for the theoretical part of the PhD Training course. While I have not had the opportunity to personally get to know all the researchers involved in the Research Degree Program, I would like to mention here those I have known most, whose comments and advices during these past years were of great help to me: Salem Al Qudwa, Ali Alsaied, Jane Anderson, Ricardo Assis Rosa, Rachita Chauhan, Juliet Carpenter, Edoardo Ferrari, Serkan Gunay, Fatima Hashmi, Grace Khawam, Edwina Kinsella, Isabel Irigoyen Zozaya, Rebecca Johnson, Zoe Jordan, Lukman Lawal, Catalina Morales Maya, Aline Moreira Fernandes Barata, Oscar Natividad Puig, Luka Oreskovic, Juliet Sakyi-Ansah, Orit Sarfatti and Ben Spencer. I also thank Allison Stevens, Jill Organ and Bridget Durning, who facilitated all the administrative and ethical parts.

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# List of Terms Used in a Maggie's Centre

- NHS = National Health Service (public healthcare system established in UK in 1948)
- Maggie's Centre = the building
- Maggie's = the organisation
- Maggie Keswick Jencks = founder (1941–1995†)
- Charles Jencks = Maggie Keswick's husband and Maggie's co-founder (1939–2019†)
- Laura Lee = Maggie Keswick's oncological nurse (1993–95) and Maggie's CEO
- Marcia Blakenham = Maggie Keswick's best friend
- Maggie's Legacy = President, Vice Presidents, Centre Board Chairs, Honorary Patrons, Ambassadors, Board of Directors, Executive Board, Architecture Co-Client, Centre Staff
- Architecture Co-Client = Laura Lee and Marcia Blakenham (in this thesis 'Client-expert')
- Blueprint = text by Maggie Keswick (1993) on which the Architectural Brief is based
- A View from the Front Line = Maggie's description of what it is like to be diagnosed with cancer and then to cope with it (1995), updated by Marcia Blakenham (2007)
- Architectural Brief = Maggie Keswick's philosophy and instructions for the architects
- Architectural and Landscape Brief = updated version of the Architectural Brief
- Maggie's Architects = all the architects who designed the Maggie's Centres
- Maggie's Programme of Support = free practical, emotional, and social support
- Users = Visitors and Staff
- Visitors = people with cancer, their family and friends
- People with cancer = cancer patients
- Staff = Maggie's Team (Centre Head, Psychologist, Cancer Support Specialist, Benefits Advisor, Fundraiser, Relaxation Therapist, Sessional Staff, Volunteers)
- Centre Head, Psychologist and Cancer Support Specialist = 3 basic clinical staff figures
- Benefits Advisor, Fundraiser = 2 basic non-clinical staff figures
- Centre Head = oversees everything that happens in the centre, supporting the needs of people with cancer, managing the programme of support and mentoring Staff
- Psychologist = supports people to address a complex range of psychological issues through a range of therapeutic approaches
- Cancer Support Specialist (CSS) = experienced professional who welcome newcomers and offers high-quality individual and group support to centre visitors
- Volunteers in a centre = people who provide a warm welcome and cup of tea to visitors

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## NOTE

All the bibliographical, video, and online references can be found in the List of References; all the research data and interview details can be found in the Appendix; moreover, the latter are in *Italics* and contain the full date (for example *Aabø, 02.11.2018*), or they include a description of the data type (for example *Move-along Dundee no.1*). Additional support material is in the Appendix (for example *Appendix\_I*).

# Chapter 1 - Introduction

“The role of architecture in the therapeutic environment” is a research thesis on the healthcare environment, but with a look towards wider horizons. The study analyses the Maggie’s Cancer Care Centre and considers various aspects – from the physical condition of the building to the state of mind of the people with cancer – in order to emphasise the human value of dignity as a fundamental principle of the Architecture of Care. Within this context, it seeks to identify the conditions that define an architecture as a therapeutic environment, give a ‘universal’ definition of the term ‘therapeutic’ and, ultimately, generate a new paradigm for designing other healthcare facilities. As a consequence, in the attempt to extend the discussion to architecture in general, a subsequent aim (and ultimate question) of the research is: how does the discipline of architecture convey the message that ‘design matters’ in facilitating people’s well-being? In this regard, the Maggie’s Centre represents a significant example: as Maggie’s Psychologist Lead Lesley Howells affirms, the unconventional architecture of the building in synergy with the support programme increases users’ psychological flexibility, enabling therapeutic effects in them (Howells, 2016). In being unconventional and elusive, open and flexible, as Maggie’s organisation states, the architecture arouses feelings and emotions in people. From the findings of this thesis it also appears that the building adds a new experiential dimension to the way we perceive architecture that suggests that we should change the way we design. Using this case as the object of study, this thesis aims to:

1. identify the link between the adopted architectural design methodology and the positive experiences users report in Maggie’s Centres;
2. extract the key elements that identify the Maggie’s Centre as an effective therapeutic environment;
3. critically evaluate the Maggie’s Centre as a model to be applied to healthcare facilities of other diseases, to specific units within large hospitals, to other non-healthcare facilities or other types of community centres, and to architecture in general.

Although much has been written about the relationship between the healthcare environment and patients’ physical and psychological conditions and the influential role of ‘healthcare

buildings’, little is known about the beneficial impact on people with cancer of ‘healthcare buildings that don’t look as such’. This study investigates the case of a healthcare programme that considers unconventional architecture vital to generating positive psychological effects in its users. To this end, Maggie’s organisation argues that architects’ expertise is fundamental to creating flexible environments in a continuity of “spatial interaction rather than walls” (Howells, 2017) which enables feelings of safety, value and comfort, in an atmosphere that stimulates imagination yet “should not pat you on the head” (Maggie’s Brief, 2007, p. 1) (*Appendix\_I*).

The Maggie’s Centre, founded in Edinburgh in 1996 by Maggie and Charles Jencks represents an eloquent case study in this respect: a ‘non-standard’ but repetitive building; original but with elements common to the others; independent but in harmony with the surrounding context; and whose positive effects on people are surprisingly similar in all the centres, despite the differences in the geographical, historical, and cultural context. “The result is a series of buildings that are often unconventional in their external appearance, sculptural and challenging pieces of architecture. They are unfamiliar in form and dissimilar in aesthetics to the buildings they neighbour” (Martin, 2017, p. 16). Similarly to the healing centres of ancient Greece dedicated to Asclepius (V B.C. - IV A.D.) which, with the aim of reaching the majority of the population in ancient Greece, spread throughout the territory keeping the same model of architectural complex adapting to a new site and transforming over time, the Maggie’s Centre has proliferated. In history this has happened in other circumstances with other objectives; the most notable example is the Benedictine monastery (479 BC) which with its 75,000 buildings has brought the Christian faith throughout Europe.

In this transmission of models and matrices that have crossed history, just like these previous examples, since 1996 the Maggie’s Centre has multiplied twenty-three times in the UK and three times abroad; and more centres are under construction or in the planning stage in different countries. Each centre is a ‘hybrid’ of four types: “A hospital that is not an institution, a house that is not a home, a religious retreat that is not denominational, a place of art that is not a museum” (Jencks, 2015b, p. 7). Always built alongside the hospital, Maggie’s Centres stand out for their unconventional architecture which seems to have proven to be a key component of their success. To convey the message that “design is a form of care” (*de Rijke, 17.12.2018*), the Maggie’s Centre project is based on the Architectural Brief (2015). This concise document, which has remained substantially unchanged over time, collects all the wishes and ideas that Maggie had for the visitors of her centre, which she could not see realised due to her death from cancer on 8 July 1995. Handed to the

architect called to design a Maggie's Centre, the Brief establishes a strong triangular relationship in which Maggie's organisation and the selected professional work closely together to design the building with the common goal of benefitting Maggie's users. In this Triad 'Client-Architect-User', each component plays a role but, as we shall see, there appear to be discrepancies in the internal balance.

With the intent of bringing a new contribution to the 'Construction of health', Maggie's organisation is a free-of-charge, non-clinical, non-institutional charity that provides practical and psychological support to people with cancer, their families and friends. As declared by Maggie's, the core programme of support, open and flexible, is based on evidence and has shown to improve people's physical and emotional well-being during treatment and recovery (Maggie's Evidence, 2015). Though it began as one person's idea, today Maggie's has grown and strengthened into a dense network of people in the UK and abroad, welcoming over 290,000 visitors each year (Maggie's Volunteer Handbook, 2020). Despite this, in this thesis I will generally refer to "the Maggie's Centre" meaning the first of the centres, as I will focus on the strong concept of the original idea that transformed "a small stable building within the hospital grounds into a flexible space from which the centre could operate" (Blakenham 2007, p. 3). As Richard Murphy, the architect of the first Maggie's Centre, said, recalling when he was commissioned by Maggie and Charles Jencks in 1995, no one initially thought the project would be replicated so successfully. "Well, the first thing to say is that nobody I think at that time would have used the expression 'you are the first architect', because we didn't think there were going to be any more. It was a one-off, really". This thesis aims to investigate the case study of the Maggie's Centre and extract from it its essence. In architecture this means defining an archetype, a type or a model whose essential aspects are repeatable. The object of evaluation is therefore the essence of the Maggie's Centre. Consequently, the unit of analysis is the Maggie's Centre as the original model itself and not the proliferation of its many centres, although this fact – its reiteration – ultimately reinforces the concept of a repeatable model.

All equally considered 'visitors', Maggie's people with cancer, families and friends are free to enter the centre from their very first visit without any kind of registration. People are offered a cup of tea and invited to take a look at the information board or sit in the welcome area where the Staff will provide them with more details, listen to them and reassure them about their concerns. The atmosphere is welcoming and feels domestic, with no signs of "sanitary" architecture, where "sanitary" (as used in this thesis) is a term that finds its roots in the Latin *sanus* (healthy) and refers to the conditions affecting hygiene and

health (Glosbe Dictionary, 2021). So, if we enter a Maggie's Centre, we will not find furniture such as reception desks nor signage on the wall or name badges, but rather comfortable armchairs and a large kitchen table at its centre. As reported by Maggie's, this environment helps establish the informal relationship between staff and visitors from the very first moment. Professional Maggie's Staff, who have previous work experience in the healthcare environment, say that they are backed by the building to support the visitors. The flexibility inherent in the architecture of the centre seems to enable the staff to collaborate more effectively, which is why they refer to the building as a "silent carer" (Butterfield and Martin, 2017).

According to Maggie's, right from the beginning, the unconventional architecture of the building together with the professional support generates an open and flexible state of mind in visitors: the sense of calm, control and safety that they feel inside a Maggie's Centre are the expression of a state of well-being arising from a therapeutic environment. However, its effectiveness has never been tested, and many emotional phenomena observed by the Staff have not yet been interpreted. For this reason, with the aim of verifying these effects, I firstly interviewed twelve Maggie's Architects about the interpretation of the Architectural Brief in their design, and secondly immersed myself for almost four months in three centres in order to test Lesley Howells' claim: the psychological impact that the unconventional architecture in synergy with the presence of people has on users, gives life to an effective therapeutic environment.

This introduction aims to highlight the position of my work with respect to the academic context and the debates on Architecture of Care, healthcare institutions and the role of architecture and design, as well as outlining the foundations of the thesis. Adding a phenomenological perspective, this study aims to contribute to the research by explaining what exactly it is in the Maggie's Centre that has a positive impact on its users. Despite numerous studies on the Maggie's Centre (Martin 2014; 2016; 2017; Butterfield and Martin, 2016) there have been no real attempts to explain what generates those therapeutic effects, apart from attributing this origin to "generators of architectural atmospheres (materials, light, colour and shape of the buildings)" (Martin, Nettleton and Buse, 2019) together with the good care that the staff offer to visitors. As a study of the structure of experience, phenomenology investigates the structure of the experiential field generated by the architecture together with the presence of people. By extracting the architectural principles explaining the logic behind the atmosphere of a therapeutic environment, this study has connected architecture to therapeutics.

In this regard, in a broader sense, the first foundation of this research lies in the notion of ‘therapeutic’ usually being linked to nature as a source of well-being (Cooper Marcus and Barnes, 1999). By giving an explanation of what the conventional understanding of ‘therapeutic’ is and what differentiates it from ‘healing’, I begin to narrow my scope. With reference to the ancient Greek mythological healing temples of Asclepius at Epidaurus, the etymology of ‘therapeutic’ lies in the Greek term *therapeia* (service, attendance; healing, cure), which usually refers to a healthcare setting. As such, in general ‘therapeutic’ means “having a good effect on the body or mind; contributing to a sense of well-being” (Lexico, 2021a). In a specific sense, the second foundation of the research is the ‘Architectural Brief’ (2015), the essence of Maggie Keswick’s philosophy which regulates the Architects’ design of the building, informs the support programme offered by Maggie’s organisation, and guides the lifestyle of the centre visitors. As we will see later when I explain how it was identified among other historical briefs, the historical reference of the Benedictine Rule (457 A.D.) is the closest example to Maggie’s Architectural Brief. As with the ancient chart that concentrates the values, architecture and organisation of the monastery, it emerged that the Architectural Brief is the cornerstone of the Maggie’s Centre - where ‘organisation’ is an essential factor that interacts with the design, use and therapeutic process - becoming the basis of Maggie’s triangular Client-Architect-User relationship.

In order to identify the specific contribution that I will make to this area of research, this introduction will close by illustrating the discussion occurring about the Maggie’s Centre and what has been done until now. As just mentioned, I will explore the strength of the original concept of the Maggie’s Centre, which is demonstrated by the fact that, in twenty-five years, it has never substantially changed. Both for this reason and due to its potential impact on architecture in general, the ultimate goal of this thesis is to show how my contribution goes beyond the current research on the Maggie’s Centre.

## I. Disciplinary Context of the Architecture of Care

More and more evidence show that the built environment can affect human experience and well-being (Sternberg, 2009; Mallgrave 2013; Williams Goldhagen 2017). Despite the general consensus that the related concept of a therapeutic environment affects patients, ongoing research has had limited impact as architects rarely consulted the results and applied them to the design of modern hospital buildings. (Tétreault and Passini, 2003). In 1984,

Roger Ulrich had demonstrated, measuring health outcomes, that the hospital environment affected the healing of patients undergoing surgery: patients in a room with a window overlooking nature were discharged earlier than those in a room with a blind window overlooking a wall. Yet, the context and the debate on healthcare institutions, healing architecture, therapeutic environment, Architecture of Care and design did not seem to have significantly changed this trend (Tétreault and Passini, 2003). It is only recently and with serious delay that architects have begun to address the subject of what should have been done in the architecture of healthcare and in general (Francis and Glanville, 2001). Through “Architects for Health”, an organisation that shares an interest in the planning and design of healthcare facilities, the architectural practice of healthcare around the world has taken action and together with the “Salus Global Knowledge Exchange”, in 2015 has launched the European Healthcare Design Conference, a forum that brings together architects, designers, artists, academics, clinicians, and policy advisors (Architects for Health, 2021). In the literature, however, for years, architects had left concern for the consequences of the built environment on human health and well-being to the scholars of other disciplines. With the exception of isolated theoretical contributions from architecture (Wagenaar et al., 2006) architects had relied on environmental psychologists (Ulrich, 1984; Kaplan and Kaplan 1989; Gesler 2003), anthropologists and philosophers (Bachelard 1994 [1958]; De Botton 2006; Bollnow 2011), human geographers and sociologists (Relph, 1976; van den Berg 2005; Degen, DeSilvey and Rose, 2008; Martin 2014; 2016; 2017; Atkinson, Fuller and Painter 2016), those with phenomenological approach to people-environmental studies (Rasmussen, 1964; Tuan 1974; 1977; Seamon 1982; 1985; 2000) and those with cognitive scientific approach (Sternberg, 2009; Mallgrave, 2013).

In the field of neuroscience, Esther Sternberg has given great help to designers during the last decade. Her book “Healing Spaces” (2009) proved the efficacy of the physical environment in affecting the brain, influencing people’s health by acting on the immune system. With the simple questions “But do our surroundings have an effect on us? Can the spaces around us help us to heal?” (2009, p. 1) Sternberg explains how the characteristics of an environment (colours, smells, flavours, shapes, tensions) can produce calm or anxiety and changes in our health. An example of well-being that recurs in the book is the ‘room with a view’, for which hotel guests are willing to pay more, and whose beneficial effects are perceived in two zones in the frontal area of our brain. Reminding us that natural environment was, for the ancient Greeks, part of the practice of the healing process and that this fact was largely forgotten when science began to require empirical proof as the standard

of scientific evidence, Sternberg calls into question the hospital environment. She points the way for practitioners on how to design hospitals, communities and neighbourhoods that promote healing and health for all.

In the nineteenth century, to allow sunlight and facilitate the healing process, hospitals had big windows and skylights. This idea started in 1860 with Florence Nightingale who, in devoting herself to human care and becoming the founder of modern nursing, was revolutionary in her conviction that sunlight and open windows were healthful while darkened rooms were harmful (Sternberg, 2009). Providing sunlight and views became a priority of the Rationalist architects who were designing hospitals in the 1920s and 1930s. A good example, yet not a major general hospital that contributed to the international movement (Willis, Goad and Logan, 2019), is Alvar Aalto's *Sanatorium* in Paimio (1933), which represents the best expression of this architectural language for health (Heathcote, 2015).

The establishment of the National Health Service (NHS) in Great Britain in 1948 represented a new revolutionary moment for the British healthcare: health was “universal, comprehensive and free” for all (Gorsky, 2008, p. 438). This led to the concentration of all public hospitals, from large urban institutions to small rural clinics, in a single system characterised by a unified language of architecture. The first architecturally notable building was Princess Margaret Hospital in Swindon, designed by Powell and Moya, opened in 1966 and demolished in 2004, an example of a stacked hospital, made of a series of wards above a ‘podium’ containing the public areas. With the intention of separating the functions, occupying the land with an urban volume accessible to the public and, for hygienic reasons, raising the tower of the wards above it, the model ‘podium + tower’ became the architectural typology of all the hospitals in Great Britain. Adopted immediately afterwards throughout Europe, the tower model for the wards, with natural light and views of the landscape, was intended to be the manifesto of the ‘charitable’ action of the NHS. However, this honourable intention almost immediately changed direction, transforming itself into the desire to flaunt, through architecture, the strength of the healthcare system. Influenced by Taylorism theories and a belief in scientific research, NHS architects began designing huge repetitive buildings that led to the construction of dehumanised hospitals (Heathcote, 2015).

Unfortunately, while there are valid initiatives in design practice to prevent this from happening, hospitals in Britain are getting bigger and bigger supported by the fact that, despite the scientific advances that have led cancer patients to survive longer (NHS, 2020), the cancer diagnosis rate is increasing. “Currently one in two of us born after 1960 will be

diagnosed with cancer at some point in our lives” (UK Government, 2020). So, the question is still: “Can we design places so as to enhance their healing properties?” (Sternberg, 2009, p. 1).

In October 2017, the Chicago symposium “Architecture as Experience: Human Perception and the Built Environment” (Mallgrave, 2017) explored how science is informing us that our perceptual engagement with the built environment is enacted at the most basic level as a multisensory ‘whole-organism experience’. Among the speakers, the phenomenological architect and thinker Juhani Pallasmaa (2012) explained that architectural design is more than a symbolic or conceptual language – it is a process by which minds, bodies, built environments and cultures interact with each other on multiple levels over the generations. This understanding of architecture is applied in the Maggie’s Centre, where people of different backgrounds interact easily. This environment is special in that it acts on the body and mind, contributing to a sense of well-being in people through stimulation of the senses. Architecture is an art that has the power to arouse emotions. Through space, material and light, it affects our conditions of calm, tension, self-confidence; in short, it has a psychological effect on us (*McVoy, 26.05.2018*).

Today, some architects do recognise the importance of guaranteeing their users a positive sensory experience in transposing the space of their project. In the experience of architecture through the senses (Malnar and Vodvarka, 2004; Holl, Pallasmaa and Pérez-Gómez, 2006; Pallasmaa 2012), we know that what we see, smell, touch, or feel with our body influences our mental state (*McVoy, 26.05.2018*), and the impressions we receive from the space around us impact our way of being (Anderson, 2009; Zumthor, 2006; Pérez-Gómez, 2016). The senses are key factors for experience (Ingold, 2000). It is we who implement our perceptual experience (Noë, 2006) and our body becomes a sense for itself; body and space are no longer separate entities but exist in exchange and fusion (Mallgrave, 2013).

In speaking about the content of her book “Welcome to Your World: How the Built Environment Shapes Our Lives” (2017a), former lecturer at Harvard Graduate School of Design Sarah Williams Goldhagen explains that besides controlling spatial navigation and containing what we now know “place-recognition” neurons are, the hippocampus is the area of the brain where we consolidate long-term memories. This means that we cannot develop a long-term memory that does not contain something from where we were when we had that experience.

“We navigate space using some of the same neural pathways we use to develop autobiographical memories. This means nothing less than architecture and the built environment are central to the formation of our identities. This discovery alone gives the built environment a kind of importance and weight that no one would have thought” (Williams Goldhagen, 2017b, para. 10).

Although there are good examples around the world of innovative and human-oriented health structures, sanitary architects designing hospitals in the UK today do not, despite the scientific research, sufficiently take into account the impact the environment has on people’s emotional state, which can be decisive in situations of high stress (Worpole, 2009). The architecture of hospitals is still considered a field of action for ‘specialists’ (*de Rijke, 17.12.2018*) and this can only be explained by going back to the source – that is, their architectural education. With very few examples in history (such as the Bauhaus and its descendants), what has always been absent in the design process taught by schools of architecture is the topic of the built environmental experience, hence how the users experience spaces. As Sarah Williams Goldhagen argues, architecture education has a responsibility.

One thing I was struck by when I was teaching history and theory is how off limits, not just at the GSD [Harvard University - Graduate School of Design] but everywhere I taught, the topic of built environmental experience was. If you brought it up, it often wasn’t long before someone would say — this was in the 1990s and the 2000s, when I was there — ‘Oh, that’s too subjective, we can’t talk about this. (...) I found that the paradigms that I saw students being taught, so-called “critical architecture’, left the user experience out of the equation. (...) In school, there were the ‘tectonic’ people on the one hand, and the ‘critical’ people on the other hand, and the ‘parametric’ guys on the third hand. What was absent from a lot of these discussions was how the users would actually experience these spaces. (Williams Goldhagen, 2017b, para. 14, 17)

By teaching students to understand what experiential design means and what ultimately really matters, which is how people respond to our surroundings, we will ensure a better built environment.

## II. Healing vs. Therapeutic

The current conventional understanding of a healing versus a therapeutic environment is quite substantial. Although the online Cambridge Dictionary (2021a; 2021b) describes them both as ‘curative’, the first one has medical references (process of becoming well again,

especially after a cut or other injury, or of making someone well again), while the second is mostly psychological (causing someone to feel happier and more relaxed or to be more healthy) though sometimes with reference to the physical, too (having a healing effect; tending to make a person healthier: for arthritis sufferers, moderate exercise is therapeutic). In both cases, it is the process in which a bad situation or painful emotion ends or improves. The online Merriam-Webster Dictionary explains that etymologically ‘heal’ comes from Old English *hælan* (cure; save; make whole, sound and well) (Merriam-Webster, 2021a), while ‘therapeutic’ comes from the ancient Greek θεραπευτικός (*therapeutikós*) (useful, curative) (Merriam-Webster, 2021b). In current usage, people treat these terms as somewhat interchangeable, even if ‘healing’ is used more in a healthcare context, e.g. “achieving a degree of relief from physical symptoms” or “stress reduction”, while ‘therapeutic’ is generally applied to any situation aiming to “increase the well-being” of people, even in spas or in the workplace (Danna and Griffin, 1999). Difficult to summarise in a few lines, in short, the concept of well-being - more complete than comfort - reflects the feelings of oneself in relation to the world. Therefore, the being of an individual in relation to the factors that characterise the built environment (ethical, social, physical) depends on personal factors (satisfaction, happiness, sense of freedom, quality of life) (Clements-Croome, 2011). With respect to factors that characterise the built environment, because buildings have a dynamic interaction with people, good architecture extends and improves human capacities by influencing mood, feelings and emotions (Clements-Croome, 2011), which, ultimately, influence people’s decision-making process (Iurato, 2020). As for personal factors, human beings have physiological, psychological and social needs (Heerwagen, 1998); if these needs are met, the combination of physical, emotional and social conditions lead to good health and a state of well-being (Stokols, 1992).

Within health facilities, the term ‘healing architecture’ indicates that the built environment has the ability to impact patients’ physical health and well-being. In the past, in Europe, the first hospitals were infirmaries in monastic communities in which the cloister of curative herbs, functioning as both ‘healing’ and ‘therapeutic’, was an essential part of the environment. Over the centuries, with the advancement of medicine and the disconnect between ‘healing’ and ‘nature’, there was a separation between body and mind, and the idea that access to nature could be therapeutic was completely lost. “Landscape” in hospitals came to be considered a decoration (Cooper Marcus and Barnes, 1999). However, lately, specially designed ‘healing gardens’ have begun to reappear in health facilities. In relation to nature, as demonstrated by Roger Ulrich (1984), features such as bright rooms with large

windows and exterior views onto nature rather than onto a wall, in a hospital accelerate the healing process by providing patients with psychological and physical support. Within buildings, the goal of ‘healing architecture’ is to promote medical recovery by eliminating environmental stressors, such as noise, glare, poor air quality and lack of privacy, whilst offering quiet versus animated waiting areas, plus different lighting levels and types of music. Providing patient rooms with adequate seating favours the possibility of having guests, while in the common areas providing distractions such as art, fireplaces, aquariums, an internet connection, and music suitable for the healthcare environment helps recovery of the patient, including shortening the period of hospital stays (Podbelski, 2017; Ulrich and Zimring, 2004). Recent examples have shown how careful architecture and design, focused on promoting healing, can have a significant impact. Based on a strongly patient-centric approach, drawing on in-depth research in healthcare innovation and the design of healing environments, the New Karolinska Solna project in Stockholm (White Arkitekter, 2019) offers an example of patient facilities and public spaces where all the details – colours, materials, acoustics, artificial sources and windows – are effective and efficient.

While a historical reference for healthcare architecture is usually associated with the birth of modern hospitals (Willis, Goad and Logan, 2019), the therapeutic one dates back to the Greek temple of Asclepius (Heathcote, 2015). In classical Greece, the *Asclepion* was not only the temple dedicated to the worship of the god Asclepius, but also an example of holistic healthcare. For more than eight centuries the ancient Greeks practiced medicine with mythological contents, offering care and solace within refined architecture in places of great natural beauty. The *Asclepeion* of Epidaurus (V B.C.- IV A.D.) – which Maggie and Charles Jencks visited in the 1970s – was, among the approximately three hundred built, the most celebrated therapeutic centre in the classical world (Machinist, 1995). The complex of buildings of the sanctuary included not only the healing temple dedicated to the god, but also the *abaton* or sacred dormitory for the sick and the *katagòghion* where the family members who accompanied them were welcomed. Next to it were the gym, the stadium, the common baths and the theatre (Torelli, 2005). After a phase of purification consisting in giving the sick a series of baths and therapies using nearby mineral springs and purifying emotions through art and leisure activities, Asclepius healed the sick by means of ‘incubation’, during which the sick had to have a dream to be healed by the God who appeared to them in their sleep. Any individual in need of comfort and healing was welcome. Upon awakening, patients had to leave a thank-contribution and remember their dream, because it was in the phenomenological experience of the dream that was the healing (Suárez De La Torre, 2005).

As Michael Kearney explains in his book “A Place of Healing” (2009) “the practices and rituals at the temple were organised by the priests (*therapeutes*) and their assistants who tended the newly arrived invalids (2009, p. 41). Within a beautiful landscape, moving between the thermal baths and the stadium, combining therapies with theatrical performances, therapists and patients created a synergistic collaboration between places and people, a ‘fluid’ dance aimed at recovering inner harmony. In addition to offering therapeutic effects, the peculiarity of a therapeutic space is in fact that of inviting everyone to attend and participate (from *therapeuein* “to attend, treat” and from *theraps* “attendant”), and to get involved, together, through a remarkable stimulation of the senses. “Asklepian healing depends on both patients and carer using the ‘inner senses’ of emotion, instinct, intuition, and somatic awareness” (2009, p. 46) to be found “within patients’ subjective experience of inner transformation and healing, and in the compassionate and caring attitude of those who attend them and stay with them in suffering (Kearney, 2009, p.xxii). The holistic approach, which consisted in recognising the importance of combining medical intervention with the positive psychological condition of the patients, was achieved with the simultaneous presence (synergy) of *therapeutes* and *invalids* (people) in a beautiful and harmonious therapeutic environment (place). “Here was an integrated system of healthcare which attended to patients as whole person: body, mind, soul, and spirit” (2009, p. xxii). The cosmos, based on the Platonic view that “mind and soul are two sides of a single coin” and that “the body is a temple”, is a metaphor of harmony and perfection for both medicine and architecture (Christopoulou-Aletra, Togia and Varlami, 2009, p. 259). What unites these two disciplines, which began at the same time in ancient Egypt in 2800 BC. under Imhotep – an architect deified not for his architecture but for his health-making – is their orientation towards the future. Both professions, medical (or health) and architectural, are utopian and hope-oriented in sharing the goal and the ideal for a better future, a future that can change (Jencks, 2019).

There is a turning point in the course of healing when you go from the dark side to the light, when your interest in the world revives and where despair gives way to hope. And you lie in bed, you suddenly notice the dappled sunlight on the blinds and no longer turn your head and shield your eyes. (...) This is the point when destructive forces of illness give way to healing. In every sense, it is a turning point – a turning of your mind’s awareness from a focus on your inner self to a focus on the outer world. Physicians and nurses know that a patient’s sudden interest in external things is the first sign that healing has begun. (Sternberg 2009, p. 1)

If hospitals heal by acting on the body and allowing patients to move towards the ‘turning point’, other healthcare facilities or any architecture can be therapeutic by acting on the mind and soul, which consequently will help the body react. This is the case with the non-clinical Maggie’s Centre, in which the sensory space, support programme and engaged people are key to initiate the therapeutic process as “a product of the human mind and of material circumstances” (Gesler 1992, p. 743). In this debate, this thesis – aiming to identify the conditions that define an architecture as a therapeutic environment and, ultimately, to convey the message that design matters in transforming the quality of the built environment and facilitating people’s well-being – wants to remind the reader that this division is only recent and that, traditionally, “pain and disease have been inspiring art and architecture”. Totally lost today, this thesis aims to re-unite ‘therapeutic’ with ‘architecture’, “an intimate cocktail, the necessary relationship between the social and the physical, the spiritual and the painful, the service and the architectural setting” (Jencks 2015, pp. 13–14).

With this message that urges ‘integration’, finally, this thesis proposes a model of collaboration with hospitals by extending Maggie’s model to other healthcare structures or into specific units within large hospitals which, in a *continuum* system, should also include non-health structures to support special needs. With a totally different perspective with which to assist more and more people at the ‘turning point’, the future integrated healthcare / non-healthcare network, inspired by Maggie’s, will lead to a new vision of hospitals, which will possibly be achieved with a major cultural shift (Gray, 2021).

### III. The Architectural Brief

“Architecture is organisation. You are organisers, not drawing board artists”.

*Le Corbusier*, in «Focus» no.1, London, 1938

The Maggie’s Centre is designed and run upon Maggie’s Architectural Brief. Although it has been renamed “Maggie’s Architectural and Landscape Brief” (2015) due to an integration of requirements regarding nature, in this thesis I will refer to it indiscriminately as “Architectural Brief” or “Maggie’s Brief”.

An Architectural Brief is a written statement of a client’s needs, on the basis of which an architect will be appointed to respond to the Brief with a project that conforms to the original request (Salisbury, 1998). As described by Merriam-Webster, in law it is a concise

statement of a client's case made out for the instruction of an attorney usually by a law clerk (Merriam-Webster, 2021c). Seen as a set of instructions, in architecture it is a two-sided document and it serves to guide the architect, especially at the beginning, to narrow the scope, but also to back the client, during the design development, to ensure consistency with the original requirements. In healthcare, in particular, the brief is a central document in the decision-making process during the early stages of the planning and construction (briefing/programming) of the facilities (Elf, Svedbo Engström and Wijk, 2012). In the design and construction, in fact, the term brief means both instructions and the instruction process. As we will see, the briefing process aims to assist the client and the designer in the series of steps that will lead to the built object (Blyth and Worthington, 2010).

Born in the architecture of the United Kingdom of the 1950s to regulate public sector construction (housing, hospitals and schools), as understood today, the brief was first theorised during the 1970s in the United States where the architects less convinced of 'form-follows-function' such as Louis Khan (1901-1974) at University of Pennsylvania and Horst Rittel (1930-1990) at Berkeley, questioned the principles of the architectural brief accepted until then. A great contribution came from Christopher Alexander who with his book "A Pattern Language" (Alexander et al, 1977) helped identify the structures of the architectural language that served as a brief for architects of later generations, including the first Maggie's architect, Richard Murphy. While previously a brief was static and passively accepted, the new way of seeing was more dynamic and critical, fostering strategic attitudes within a post-occupation type briefing process (Nutt, 1993, cited in Jensen, 2006).

As I will furtherly discuss later, as part of the development of briefing practices, research has shown that clients are the main providers of information, even though they often lack knowledge and experience, thus creating obstacles to an accurate briefing process (Barrett and Stanley, 1999). Since the correspondence between the qualities of the design team and the attributes of the client directly influences the delivery of quality buildings (Norizan Ahmad et al, 2012) - and a quality product must correspond to "fitness for use", which is the ability to function according to the performance required by the user (Baccarini, 1999) - the success of the project's output in achieving its purpose depends on how well the strategy of the brief has been formulated (Norizan Ahmad et al. 2012). This strategy, aimed at dialogue and the creation of a shared vision between the actors, gradually becomes an iterative development process which, in addition to the functional programme, contains a strong social component (Stordal and Van Meel, 2017). In addition to giving a physical description, in fact, the Brief can also define the way in which users will use the future

building. In the ancient history, examples of architectural briefs that describe the technical requirements while also suggesting the social, religious or philosophical mission of an upcoming building range from the papal *brevis* - documents with the meaning of “letter, short communication, summary” containing instructions in a more succinct and less solemn form than a *bull*a (Santacroce, 2015) - to the more extended chart of the Rule of St. Benedict of Norcia (480–547 A.D.) and to the more recent regulations of Rudolf Steiner (1861–1925). While Steiner’s regulation is based on rigid rules drawn from ‘esoteric’ philosophy which are reflected in both the disciplinary model of life and the imposing architecture (Heathcote, 2015, p. 75), the Benedictine Rule offers a significant reference for its human contents as well as its order and tacit organisation.

Composed of seventy-three short chapters, direct and concise, this apparently modest and simple short text, has for centuries given illuminating indications even to the greatest rulers of Europe such as those of the French domination (VII and VIII centuries) who felt the need for a more orderly organisation, which makes the Rule unique for practicality and flexibility among other historic brief frameworks (Folador, 2006). Inexhaustible of principles, values and citations never out of time, it continues to represent today an example of organisation for the use of the modern company (Bini, 2016). Addressing individual monks with a clear structure and a pragmatic message, the Rule, rich in human content with which it addresses the problems of its users, calls them to daily work and to create a building whose architecture is large and powerful, reflects the strength of the community and where anyone can feel it as their own. In fact, in the Benedictine culture, in addition to the religious one, the lay part linked to the uniqueness of the person plays an important role, having been Benedict aware of the fact that everyone, with a specific task, is an integral part of the community and contributes in a personal and decisive way (Folador, 2006).

Benedictine monasteries have been for 1500 years an illuminating example of what it means to live and work in a context where everyone has clear goals and objectives, roles and tasks and knows how to make the community their strength. A perfect organisation that has spanned the centuries and that can say many things to the managerial world, thanks to the correct management of shared values, widespread leadership and the ability to work together motivated people who are aware of their responsibilities. (Folador 2006, back cover)

The construction of Montecassino (529 A.D.) saw St. Benedict engaged as architect, engineer and organiser of the new monastery, where he remained until his death in 547 A.D., dedicated to writing his *Sancta Regula*, the Rule or ‘brief’ of the Benedictine monastery. In describing the life of the community, the rigor and clarity, and the objectives to be achieved

by always looking ahead and trying to work as a team, the document also describes the various spaces that make up the monastery (the reception area, the kitchen, the refectory, the dormitory, the church) built by Benedictine monks, skilled architects and designers. Unlike most buildings which make up the monastery, the cloister as a specialised building is not explicitly mentioned in the Rule of St. Benedict. Despite this, the cloister (from the Latin *claustrum*, ‘separated from the world’) constitutes the heart of the monastery, around which all the other constituent elements are arranged (church, chapter house, washbasin, etc.). This centrality of the building must be seen both in an architectural sense – all monastic buildings are articulated around the cloister – and a metaphorical one, highlighting the great importance of this space in monastic life, of pray and share. Finally, the document does not think only of Montecassino but of the approximately 75,000 monasteries that, unforeseeably at that time, will be born from it throughout Europe (Folador, 2006). The Rule of St. Benedict has been the beacon of these monasteries for centuries, and still today represents a strong reference to the common roots of organised life, its rules of belonging and the values shared in a community. Founded on the spiritual and concrete pillars at the same time, Rule and Montecassino constitute a single work, which Benedict knew would never die because it was entrusted not to the stones of a building, but to a small book which, even before being multiplied into parchments, it was already preserved in the memory and in the heart (Salvatorelli, 1983). This concept is replicated, today, in the Maggie’s Centre through a new “Rule”, the Architectural Brief.

Maggie’s Architectural Brief was born from the “Blueprint for a Cancer Caring Centre”, written by Maggie before she died in 1995. In the Blueprint, Maggie moves from the idea of simply transforming a room in the Edinburgh hospital (where she was treated) to creating a “welcoming place, near the hospital with an office and a library” (Blakenham 2007, p. 3). The previous year, in her paper “A View from a Front Line” (further developed in “Empowering the Patient”), Maggie had already proposed to patients how to be self-sufficient. With growing impatience to see her idea realised before she died, Maggie left a clear description of her programme reported by Marcia Blakenham (2007) as:

Each person visiting the centre would be helped to find his or her own best way of coping with the disease. There was to be no ‘right way’. The centre was to be a haven, where the range of use would extend from a cup of tea you could make yourself in a friendly kitchen to attending weekly support groups led by a clinical psychologist. (Blakenham, 2007, p. 4).

A reflection of Maggie's philosophy, the Architectural Brief is not a list of technical requirements but rather a description of the emotional and sensory states; it is a descriptive, very short text, apparently very simple and not difficult to respond to. Piers Gough (CZWG), one of the architects I interviewed, said that "it is very 'British'". "You have to read between the lines. It is not obvious what they are asking you. Just the idea that they challenge you on what you can do for them stimulates your imagination (*Gough, 16.05.2018*). In the open and flexible interpretation that Maggie's architects have given of the Architectural Brief, they will respond to the same stimulus by delivering buildings different from each other but all with the same invigorative effect. The idea of a stimulating architecture is confirmed by the Brief itself:

These little buildings should not pat you on the head, patronise you by being too cosy. They should rise to the occasion, just as you, the person needing help, is having to rise to the occasion of one of the most difficult challenges any of us is likely to have to face. (Maggie's Brief, 2007, p. 1)

Written by Maggie's husband Charles Jencks, her best friend Marcia Blakenham and her oncologist nurse Laura Lee, the first Brief (1998) was only two pages long (the 2007 version is in *Appendix\_I*). Edited twice in the first five years with other minor variations over time, the original Brief has evolved into the current one, nine pages long, which is still both concise and fairly vague. With the re-edit in 2003 and 2007 of Maggie's "A View from the Front Line" (Keswick, 1994), and the addition of the 'Preface' and the chapter "Maggie's Centres: Marching On" by Marcia Blakenham (2007), it became clearer that despite the brevity of the document the Architectural Brief had come to ask a lot.

The Maggie's Architectural Brief is a demanding one. We have learned to be more ambitious about what we ask for. We want more than functional spaces. A building which has quality makes you feel valued. We believe that kindling curiosity and imagination is fundamental to feeling alive, and we want this spirit embodied in our centres. We choose architects who have the imagination, the confidence, the ability and the understanding to respond to such a brief. (Blakenham, 2007, p. 29)

The functional programme that an architect can extract from the document consists of the entrance/'pause', welcome area/library, kitchen, a large sitting room or group activity room, consultation rooms, office and toilet. These ideas came partly from Maggie's own experience in helping patients derived from her family background believing in charity work and partially from a trip that Maggie and her nurse Laura Lee – then only nineteen years old, and already fascinated by Maggie's ideas – took together in California to visit the *Wellness*

*Foundation* hospice in Santa Monica. The two women returned home with two very clear concepts: 1) unlike the American hospice that is an alternative to the hospital, the new centre had to be a ‘buffer’ between home and hospital; 2) just like the American hospice, the new centre had to have a multifunctional nature in a pleasant environment where patients were encouraged to follow a healthy diet and exercise routines. The first observation influenced the decision that the future centres should not include any clinical function, but would be located within hospital grounds; the second observation suggested Maggie and Laura that, besides nutrition and physical activity, beauty and art should be prioritised within the building, not only to ‘decorate’ and ‘embellish’, but also and above all to ‘solicit’ and ‘stimulate’ people’s senses, to surprise and open a ‘window’ to the world. Later on, thanks to Marcia and all the artist friends Charles and Maggie knew, who donated many pieces of art, the Maggie’s Centre became a “place of art” (Jencks, 2015b, p. 7).

I remember how Maggie’s Architectural Brief was born. It was 1998, I think. It involved writing down the blueprint that Richard Murphy had done in an attempt to incorporate all of Maggie’s ideas. Maggie’s Edinburgh therefore already contained all the elements of the Brief. The idea of writing a Brief was quite sudden and it was Charles, Laura and Marcia who wrote it. I remember it because it just happened just before they interviewed me for Maggie’s Infirmary. We were in a house in Glasgow, I think it was Laura’s house. (Page, 01.10.2018)

The first Maggie’s Centre, Maggie’s Edinburgh, designed by Richard Murphy and completed in 1996, represents the founding moment of Maggie’s project, containing within itself the quintessence of the Architectural Brief. In addition to influencing every architect who has succeeded him, Murphy’s work on Maggie’s Edinburgh set the key principles and established an unprecedented architectural archetype. By placing the open kitchen near the front door and joining it to the open staircase, completely banishing corridors, Murphy established a spatial typology that would later become one of the central concepts of the Architectural Brief and a distinctive feature of future centres. Murphy’s spatial model of the open-plan house at Maggie’s Edinburgh is the starting point of the sequence of spaces and functions in continuous contact with nature, which came to be adopted in all future Maggie’s Centres.

As mentioned, the Architectural Brief does not prescribe technical solutions, but rather asks for spaces that would allow centre users to experience a variety of emotions. Leaving the designers free to come up with their own interpretation, the customised architectural solutions all communicate the same feelings although they differ in shape and location. Since we cannot predict how people feel, especially when they have a serious

illness, the space must be open and flexible to change. In response to the Brief, the architects therefore provide a “menu” of spaces accessible to all (*von Loon, 15.05.2018*), a shell that allows people to feel a range of emotions. And, going beyond the Brief, the architects adopt a sensory design that affects body and brain through space, light, and materials. The forces that are created in these experiential fields are able to move visitors within the centre, making them feel wholly individual emotions. Moving from one space into another, where flexible walls allow continuity of space, the visitor can enjoy the landscape through large windows or glimpse the sky through the skylight, being continuously surprised in an evolving experience. This state of mind generates flexibility and ultimately well-being.

During this thesis I will return to the Architectural Brief several times (Chapters 4, 6, 8). Apparently very simple and “very British” with “not much said”, the Architectural Brief is an endless source where the theoretical references of Phenomenology, Reflexivity, Performativity, and Flexibility find a constant confirmation.

#### IV. The Context of Existing Research on the Subject: Position and Focus

This research contributes to a growing literature exploring architecture’s impact on patients’ healing process (Gesler 2003; van den Berg, 2005; Nickl-Weller and Nickl 2009; Sternberg, 2009; Van der Linden, Annemans and Heylighen, 2015; 2016), contrary to the current tendency of hospital architecture being noisy, cluttered and institutional with no consideration for the potentially harmful effects on the physical and psychological well-being of patients (Ulrich and Zimring, 2004; Marsh, 2018). Catalogued under ‘healthcare facilities’, the already quite extensive existing literature on the Maggie’s Centre refers to its twenty-six current non-clinical buildings as ‘healing architectures’, attracting the attention of many journalists and researchers from various disciplines. Yet, of these authors, apart from those with a strong relationship with Maggie’s organisation such as Charles Jencks (co-founder, architect and critic) (2005; 2012; 2015b; 2017), Lily Jencks (honorary patron, architect) (2021), Edwin Heathcote (architect and critic) (2010; 2015; 2019) very few are architects (Annemans et al. 2012; Van der Linden, Annemans and Heylighen, 2015; 2016), with most instead being economists, sociologists, or environmental psychologists (Stacey and Tether 2015; Martin, 2014; 2016; 2017; Watson 2017).

In addition to expanding the existing literature of the discipline of Architecture, this research contributes to adding a new point of view coming from an analysis of the Maggie's Centre made not so much by an architect-designer, but by an introspective architect-storyteller of the experience of the people whose presence and interaction with the built environment is fundamental. With the main objectives of this thesis in mind, and in particular the one aiming to identify the link between the architectural design methodology and the positive experiences reported by Maggie's users, my contribution therefore consists in telling what is known about the so-called 'healing power' of the Maggie's Centre through the concrete addition of the phenomenological component. The way I approached phenomenology as a study of the structure of subjective experience and as a study of what generates experience, was through highlighting the structure of the experiential field in which architecture, the supporting programme and the human contribution come together, providing the reason for people's well-being. In regard to the 'healing power of architecture' over the last years, the number of research studies on the Maggie's Centre has grown exponentially. Numerous masters and doctoral theses (Poncelet and Uzzell, 2018; Cumming and Uzzell, 2018; Tekin, 2022), academic papers and articles (Martin, Nettleton, and Buse, 2019) and journalistic reports (Heathcote, 2019; Griffiths, 2019; Crook, 2019; Block, 2019; 2020) have been published, establishing an interdisciplinary network of scholars interested in this theme, an indicator of both increased interest and awareness.

In regard to the 'healing environment', among the non-architects, Daryl Martin, lecturer in Sociology at the University of York, had distinguished himself by his many studies of the Maggie's Centre. Perhaps the only one with several publications to his credit, he advanced the hypothesis of "synergism" and "working in tandem" of people and places. Martin talks about the excellence of the artefact and the harmony displayed in how the everyday spaces of Maggie's are orchestrated (Martin, 2016). Among these, the kitchen and its large table (on which 'illness is placed at its centre') are fundamental to creating a familiar atmosphere, as are the objects and furniture scattered around the centre (Martin, 2014; 2017). While investigating users' experiences in the Maggie's Centre, both inside and outside the building, Angela Butterfield and Daryl Martin (2016) argue that "Maggie's has been most often noted for the buildings it commissions, but we argue that the gardens prompt a re-evaluation of the integrated healing environment" (2016, p. 695). They see Maggie's buildings and gardens together as contemporary examples of "therapeutic landscapes", starting the debate on the ability of the designed built environment to enhance the experience of well-being. This experience arises in the common areas where visitors find within the social space private places for their emotional retreat, describing them as "affective

sanctuaries” that offer feelings of retreat, refuge, healing and social support (Butterfield and Martin, 2016).

In highlighting the provision of offerings for socialisation, environmental restoration, perspective and shelter and the balance between social interaction and privacy, within two different studies, Poncelet (and Uzzell, 2018) and Cumming (and Uzzell, 2018)’s analysis reveal that the kitchen table is the only area in the centre where all three different social behaviours (social interaction, privacy, counselling) occur and where most conversations begin. In addition to social interaction, the table lends itself to private conversations because Maggie’s users respect each other’s privacy. This fact was already evident in the work of Van der Linden, Annemans and Heylighen (2015), which speaks of the phenomenon of “shared understanding” between users, which leads to there being no need to go to a room to have private conversations because the whole building is perceived as private. In order to understand which elements of the environment are responsible for the healing process, the qualitative study by Annemans et al. (2012) compared the architect’s vision with the daily experience of visitors at Maggie’s West London. Van der Linden, Annemans and Heylighen (2015) built on this study and looked at the user’s experience of Maggie’s Dundee. Interviewing designers from five different Maggie’s Centres, Van der Linden, Annemans and Heylighen (2016) then went on to investigate how architects respond to the concept of healing environments during the design process. In Annemans et al. (2012) and Van der Linden, Annemans and Heylighen (2015) the analysis of the users’ experience starts to uncover the meaning of a ‘healing environment’, an understanding which is deepened in Van der Linden, Annemans and Heylighen (2016) thanks to the direct testimonies of the architects.

In regard to the ‘Architectural Brief’, like Annemans et al. (2012), Van der Linden, Annemans and Heylighen (2016) recognise the importance of an effective brief based on the users’ needs, an engaged architect and a well-suited client. They observe that it’s also important to transfer knowledge directly from users to designers in order to improve healing environments, because “a lack of direct user engagement introduces the risk of an unrealistic user image” (2016, p. 531). From my analysis, it could be said that this misstep is avoided because the Client-expert advocates Maggie’s users. As we will see later, users and designers are indirectly connected through the Architectural Brief,-and the role of the Client-expert is to keep this correspondence at the highest level. However, this is not satisfactory for fully understanding the user experiences of the environment, so this thesis will recommend hearing the voice of users directly from them. With the ultimate goal of giving the

therapeutic environment a ‘universal’ definition, hence knowing how people recognise it and how they describe its characteristics, the implicit aim of this research is to disseminate the experience of Maggie’s users to all architects. The study by Butterfield and Martin (2016) goes deeper in understanding that the Architectural Brief prompts “extraordinary spaces that help to organise very ordinary encounters and acts of kindness, between healthcare professionals, volunteers and visitors” (2016, p. 704), despite suggesting that Maggie’s does not offer “a checklist of design features that can be applied in different places with predictable results” (2016, p. 704), Supported by Charles Jencks (2017), what I argue in this thesis is, on the contrary, extracting design principles that can be applied to different places with results that will be expected.

As regards the ‘methodology adopted’, in Poncelet (and Uzzell, 2018) and Cumming (and Uzzell, 2018)’s research at Maggie’s Oxford, despite the in-depth analysis that revealed the social and emotional experiences of users, their methodological choice of observation only, ‘minimising the involvement of participants’ did not allow the possibility of their fully understanding users’ experiences of the beneficial effects of the therapeutic environment.

All these non-architect authors concluded that the environments considered “healing” are defined by the context in which they provide therapeutic social practices in support of people with cancer. In other words, inspiring and supportive social places makes people feel better. This is a good start for this thesis, which looks into the therapeutic environment of the Maggie’s Centre as the result of the synergic co-habitation of people and unconventional place. But, beyond that, what this thesis seeks, and what these studies don’t, is a deeper investigation of the space that *engages* people and place. In order to find the source that defines a therapeutic (or even healing) environment and makes Maggie’s users feel well, what is missing in these geography and psychology (and architecture/engineering) studies is, in general, an extra-disciplinary vision that appeals, for example, as suggested by Sternberg (2009), to cognitive sciences. Aware of my limited knowledge, the reference to this suggestion aims to add something to the discussion that is important to consider showing the reader the potential for future investigations. Within my theoretical framework (Chapter 2), the importance of adding neuroscience to other disciplines such as psychology, geography, sociology etc. in support of phenomenological architecture and phenomenological psychology it improves our understanding of how the built environment influences our sensory experiences as well as giving an interdisciplinary reading to this field of study. In the specific, however, what the ‘non-architectural’ research on Maggie’s Centres lack is an in-depth understanding of the triggers or causes of well-being; ‘generators of

architectural atmospheres’ - such as materials, light and colour and shape of the buildings (Martin, Nettleton and Buse, 2019), along with comfort and restoration, are important, but I argue not sufficient to describe the therapeutic environment of the Maggie’s Centre. Focusing on the continuity of “spatial interaction rather than walls” that allows feelings of empathy and compassion in Maggie’s users, what this thesis therefore proposes to do is to investigate the hidden structure (its components and origins) of the experiential field which, acting on the human body (senses) and brain (perception), encapsulates and fuses together people and place, generating the therapeutic environment of the Maggie’s Centre. While not a neuroscientist, I consider neuroscience a discipline that studies empathy, which is our general ability to resonate with the emotions of others, both positive and negative, accompanied by a desire for sharing and help (Singer and Klimecki, 2014), so something that would implement the discussion. Due to Maggie’s multifaceted reality, more perspectives are needed from which to look at the Maggie’s Centre and delve into the subject.

Regarding the ability to design a ‘healing environment’, among these previous studies, only architect-engineers Van der Linden, Annemans and Heylighen (2015; 2016) have addressed the topic of whether and how much scientific knowledge of healing architecture Maggie’s architects have applied in designing their unique solutions. As Van der Linden, Annemans and Heylighen (2015; 2016) understood, Maggie’s architects’ design is based only on intuitive knowledge and personal involvement. In fact, none among the twelve Maggie’s architects I interviewed said they had scientific knowledge of healing environment. Ivan Harbour, from Rogers Stirk Harbour + Partners, even declared himself against the idea of being a ‘specialist’ in the sector (*Harbour, 20.07.2018*). Equally, David Page from Page\Park said that scientific knowledge would have never taken the project off the ground (*Page, 01.10.2018*), and Chris McVoy from SHA (Steven Holl Architects) added that there is not enough literature on how architecture and spaces impact our senses and psychological well-being, although in the recent times there has been progress in the field of Cognitive Science (*McVoy, 26.05.2018*). In this reference, Laura Lee, Maggie’s CEO, is aware of the fact that there are elements such as sound and water that heal and some books on the application of sensory design principles to hospital architecture, but she never suggested that architects consult them, as they would prove unsuitable for her purpose.

Despite the gaps in the theoretical research on how design influences people’s well-being in the field of healthcare architecture, within the extensive literature on the topic that spans over different kinds of healing (physical, mental, psychological), subjects (patients,

carers, doctors, nurses, workers) and healthcare facilities (public, private, hospital, nursing homes), there are several exceptions.

In reference to the distinction between ‘healing’ and ‘therapeutic’, in the field of ‘healing architecture’ for hospitals, starting from the principle that “well-designed interior architecture concepts for patient rooms can benefit the patient’s process of recovery and, through its atmosphere and functionality, improve the quality of the hospital experience”, in her book / manual “Designing the Patient Room: A New Approach to Healthcare Interiors” Sylvia Leydecker (2017) explains how addressing particular senses such as visual, acoustic, haptic, tactile and olfactory triggers “brainscripts” which people in turn associate with specific experiences. Within ‘visual’, for a patient the presence of artificial nature (woods and flowers) or a virtual view of the horizon can evoke associations with other “worlds”. In thinking of integrating real nature in hospitals, Clare Cooper Marcus (2006) gives an important contribution on the relationship between meaningful hospital architecture and patient health within the substantial volume “The Architecture of Hospitals” (Wagenaar et al., 2006). As Cooper Marcus (2006) mentions, in building a set of design guidelines for hospital outdoor space, one must begin with Roger’s Ulrich’s “Theory of Supportive Garden Design” (Ulrich, 1999) as much as in listing sensory design principles one should begin with Ulrich’s “Theory of Supportive Design for Healthcare Facilities” (Ulrich, 1997).

Within ‘therapeutic design’, literature appeals to that for architecture in general released by organisations such as the Centre for Sensory Studies (2021). This includes a good number of publications on the understanding of how the built environment influences our sensory experiences. In particular, within the research context of the effects on our sensory system, now we know that sunlight and vitamin D improve bone health and heal inflammation (Sternberg, 2009), that artificial light helps our circadian rhythm if modulated to appear different during the day than at night (Rius, 2021) and that reducing the sense of crowding and having a distant view of space create healthy environments (Mostafa, 2008). However, despite the efforts, the existing manuals on both “healing architecture” and “sensory design” are taken into little consideration in the design of modern regional hospitals. This once again underlines the discrepancy between the ideal world of the academy and the mechanistic world of practice, which is dictated by the ‘constructors of health’ and still tied to a functionalistic logistics and non-personalised spaces of care.

My academic work on the ‘therapeutic environment’ of the Maggie’s Centre, small as a sprout compared to the vast but perhaps inefficient literature on the influence that architecture has on our well-being, has already given its first results. By exploring the

enigmatic nature of the Architectural Brief which I connected to the Benedictine ‘Rule’, through my thesis I was able to highlight the power of the essential Brief and the fact that it is in the “space between the lines” (*de Rijke, 17.12.2018*) that the architects’ freedom resides. Besides, by extracting the design principles from the Maggie’s Brief and leaving guidelines for future architects and clients, I have provided a way to build upon a perfect example of organised context where space, people, and programme co-habit, have a clear identity and, like in the Benedictine monastery, base their strength on the community. Finally, after participating in and presenting the subject of my thesis at the Amps conference “Experiential Design – Rethinking Relations Between People, Objects and Environments” that took place on 16–17 January 2020 at Florida State University, I was able to publish the relative paper in the Amps Proceedings Series 18.2. Experiential Design (Frisone, 2020).

Out of all the literature that influenced me during my research, the scholars and writers who have had the most profound impact are Charles Jencks (2005; 2012; 2015b; 2017), Juhani Pallasmaa (2012), Esther Sternberg (2009), Yi-Fu Tuan (1977), David Seamon (and Mugerauer, 1985), Norberg-Schultz (1979), M. Reza Shirazi (2014) and M. Merleau-Ponty (2012 [1945]). Coming from different backgrounds, all these authors have as an object of interest how humankind moves in built spaces, although their arguments and points of view follow different parameters and frames of reference. In spite of this, their thoughts, once intertwined, are able to answer a question in architecture. This thesis reconciles the thoughts of many different disciplines, referring back to the healing traditions of Greek temples and the organisation of Benedictine monasteries. As per the statement of one Maggie’s architect that “architecture is the absolute mother of the arts” (*Gough, 15.05.2018*), since opposing views would argue that architecture has a poor understanding of how to obtain solid and valid information from users about their experience of the built environment, I argue to maintain a broad and comprehensive but also detailed and critical view as often the user knows more than the Client-expert.

## V. Why the Maggie’s Centre

With the aim of being a support and complement to hospital primary care, Maggie’s Centres are always located next to a large hospital, while strongly maintaining an anti-institutional character and anti-clinical attributes. Due to the increasing number of requests from hospitals around the world, the Maggie’s Centre has emerged as an interesting subject of research.

This stems from the growing need for similar facilities to support the increase in the number and age of the sick population, who are now surviving chronic diseases and need to spend more time in healthcare facilities (Bernam, 2016). For these two reasons, but more than anything else for the therapeutic nature of its unconventional architecture, in 2017 I selected the Maggie's Centre as the object my research.

Before then, research on the therapeutic environment of the Maggie's Centre had outlined the concept of 'synergy between people and place' as inherent in a place where the co-operation or active co-presence of humans with/within a sheltered artefact or architecture achieves a result that is grander than the sum of the two entities. "A therapeutic environment is the meeting point between building and people, and if the building is designed in a particular way, this environment is able to transfer energy to people" (Howells, 13.03.2019). In her TedxDundee talk (2016), Maggie's Psychologist Lead Lesley Howells speaks about this "synergy between people and place", explaining that psychological flexibility is embodied in Maggie's quote: "Above all what matters is not to lose the joy of living in the fear of dying". This encourages people to open towards the concept of moving with reality rather than struggling against it, "finding freedom in the choice that we are offered" (Howells, 2016). As Butterfield and Martin (2016) observed during their studies, Maggie's Centres are buildings facilitating different conversations. They help to create what they call "narratives of resilience", whereby individuals may articulate their understandings of their cancer and begin to craft their response.

Starting with these findings, in order to verify the outcome of the flexible state of mind of Maggie's users thanks to the synergic co-presence of people and place, I started my investigation. However, when I was about to undertake my fieldwork, the following questions arose: How does the Maggie's Centre constitute an effective therapeutic environment? What are the most therapeutic areas or rooms within the centre? What are the parameters that measure the level of 'therapeuticity' of the building? I realised that the simple definition concept of 'synergy' – as an exponential effect of the joint contributions of two entities – between people and place' was not sufficient and satisfactory to describe the Maggie's Centre as a catalyst for psychological flexibility in the definition of a therapeutic environment. I needed something more. Starting from the question of "what buildings do to people" (Gieryn, 2002), I found the 'red thread' that has guided me through the research, which is the same one that will guide the reader through the chapters of this thesis. After almost four years of study, I have come to the realisation that the reason why the Maggie's Centre needs to be studied and further investigated lies in its phenomenological

and paradigmatic nature. It is my growing belief that this model can contribute to move architecture beyond the digitised system the current discipline has become, bringing its focus back to emotions and human values.

This Introduction has provided two basic ‘clues’ that will help the reader to focus on the goals of this thesis. First of all, it has restricted the field between ‘healing’ versus ‘therapeutic’ architecture that will allow me to make my way into the investigation of the therapeutic space. Secondly, it has laid out the fundamental role of the Architectural Brief, the official document which contains the essence of Maggie’s philosophy and on which the Maggie’s triple system “Client-Architect-User” is based. Using the historical reference of the Benedictine Rule as a model in which ‘architecture, programme and values’ coincide, in giving indications on the feelings that the architect’s design must evoke in its visitors, the Architectural Brief gives a glimpse of how the building has to appear, how people will use it and how life will unfold in a Maggie’s Centre.

## VI. Thesis Structure

The structure of this thesis and the organisation of its chapters follow a progressive investigation based on the refinement of the research parameters as the data from extensive site analysis and theory sources have emerged.

After the Introduction, in order to be prepared to access the research field by adopting a phenomenological approach and investigate the flexible state of mind enabled in Maggie’s users by the ‘synergy between people and place’ (Howells, 2016), I start Chapter 2 by discussing some of the theories deriving from phenomenology, in particular architectural phenomenology. I follow this with a framework of social and anthropological theories that study human behaviours generated by/which can generate a therapeutic environment. In order to add more perspectives to the study of how the built environment impacts on our sensory experiences, I close the first part, by introducing references to neuroscience and phenomenological psychology. The second part describes the method of psychological flexibility towards which Maggie’s psychologists now tend to orient themselves, and which in the Maggie’s Centre is evident in the feelings of encouragement and action that people with cancer experience, enabling them to find ways to tolerate what was previously intolerable.

In Chapter 3, I expose the methodology of my investigation, which took place at two different times. The first investigation was reconnaissance fieldwork, consisting in visiting the centres and interviewing the architects (with related archive research) and the Client-expert (revealing the first in a long series of Maggie's paradoxes, including its apparent non-therapeutic nature). The second – in search of the 'therapeuticity' level of the Maggie's Centre – consisted of onsite fieldwork done in three centres and lasted almost four months. Although the two stages are consequent and develop in a logical progression of the methodology, providing a distinct narrative I show how the two stages are actually separate. Having found the parameters in the first stage and used them in the methods of the second stage, I did not look for confirmation on what the architects said, but rather I tested the architects' intention, that is, architecture. By remaining open to what users have told me, I came closer to an understanding of the interaction between the intention of the buildings and the experience of the user and created the link between the two stages of my fieldwork. The first part of the chapter talks about the principles governing my methodology, lists the methods, outlines my role of auto-ethnographic researcher and my reflective position as well as telling about the methods (visits of the centres and interviews with Architects and Client-expert). By describing the four methods and twelve parameters I used in the centres, the second part explains how I conducted the ethnographic fieldwork providing an account of the empirical material collected, on which the arguments of this thesis are based. I conclude the chapter with a description of 'steps and obstacles' within stages 1 and 2 of the fieldwork and some ethical considerations outlining the ethical approach adapted and reflect on it and how this could be valuable to future researchers. The chapter on my methods is intended to be a testimony of my learning process, recounting an experience that has left a strong mark.

After presenting the story of Maggie Keswick and the origins of the Maggie's Centre through the literature review, Chapter 4 discloses Maggie's foundations from which the research departs, including the structure of Maggie's organisation and the details of the support programme. It continues with unfolding the relationship, which I call "Triad", between the 'Client-expert' (Maggie's), the 'architect' (the selected designer) and 'users' (Maggie's visitors and staff); the three subjects are strictly related to each other through the Architectural Brief. Keeping this relationship in balance is actually a difficult task in architecture in general and this is also true for Maggie's. However, while the link 'architect-user' was weak or missing in the past, it has recently strengthened as Maggie's architects have become more willing to interact with users. Through the section about the Client-expert, Maggie's enigmatic nature starts to emerge; through the interviews with the

architects, the design themes of the Maggie's Centre are delineated; through the users' section, which explains life at the centre, it becomes clearer what happens between the moment cancer patients receive the diagnosis and the one they are welcomed at the centre by the staff, now called 'people with cancer'. Finally, through the building section I give a more systematic description of the architecture of the typical Maggie's Centre and through the gardens and landscape section I explain the importance of the landscape being designed together with the building and not subsequently. The chapter concludes by providing an account of a more personal experience of my first visit to the three fieldwork centres and examining the issues (differences and imperfections) and attributes advanced by Charles Jencks of Maggie's Centre seen as so many metaphors of a hybrid nature and a placebo effect.

Chapter 5 presents my findings on the therapeutic environment of the Maggie's Centre. It narrates the participants' experiences, highlighting their voices with reference to the section on psychological flexibility in Chapter 2. It begins by describing the five-step healing process, as seen from both the staff and visitors' points of view. After being welcomed at the centre, visitors start moving along their pathway from a shocked condition towards psychological stabilisation. In particular, within the relationship between affection and cognition, the appreciation of the environment allows for action and decision-making in them. Furthermore, by speaking with the users, I realised that, despite attending different centres located far away from each other, the participants say exactly the same things, using the same terms to describe the same feelings. This important 'clue' opened my eyes onto the spatiality of the three buildings united by the 'red thread'. The second part of the chapter discusses and analyses these similarities and communalities. By mapping the visitors' favourite places, tracing the movement of participants in the space devoid of signs of sanitary architecture, I was able to measure the level of 'therapeuticity' and support of the building, and what Maggie's 'does' to its users to generate flexible effects in them. Noting the consequences of this condition in people's behaviours, the therapeutic environment begins to emerge.

Having allowed the participants to express themselves in the previous chapter, Chapter 6 is my reflection on their considerations. With reference to the theories of Chapter 2, in the synergic 'fusion' between people and the surrounding experiential field, through 'empathy' and 'intersubjectivity' of people, I discover the phenomenological nature of the Maggie's Centre and I help the reader to understand the process that connects cancer, experiential field, and psychological flexibility; in other words, the therapeutic process. In

search of the link between design methodology and psychological flexibility I start by describing the reality of cancer in a Maggie's Centre and how, taken as a whole, the building feels like much more than its 'many' aspects. After going back to carefully review the Architectural Brief and analyse the sensory space of the centre, I discover in the 'movement' the link I was looking for, the one between design methodology and psychological flexibility. In the search for confirmation, in the second part of the chapter, I return to an analysis of psychological flexibility. Looking to history, I find an analogy between the fluid synergy between therapists and patients, who moved between architecture and landscape in the Greek healing temples of Asclepius (V B.C. - IV A.D.) finding healing and flexibility in the suffering, and the movement that enables Maggie users to accept reality in order to access a state of psychological flexibility. Hence, I analyse the data through the lens of the flexibility, reflexivity and performativity of the space that moves around the users. Following these reflections, I conclude that in a Maggie's Centre not only design methodology and psychological flexibility are linked by 'movement' (objective 1), but also flexibility and movement coincide, and phenomenology is essential to trigger the process of psychological flexibility that underlies a therapeutic environment.

In Chapter 7, I shift my focus from the participants to the space so as to explore its dynamic, multi-faceted and contradictory nature. After an analysis of 'movement' in relation to a restricted historical-theoretical framework and a reinterpretation of the 'hybrid', I realise that in Charles Jencks' statement "the power of the hybrid" lies the second element that defines the Maggie's Centre as a therapeutic environment. Just the 'non-definition' of spaces and feelings is key for people to choose, stand out, and be free. Finally, an analysis of the space devoid of signs of sanitary architecture leads me to say that the 'non-therapeutic' condition of the Maggie's Centre is paradoxically what makes it, in an evident way, a therapeutic environment. Feeling normal, being in a normal environment, and behaving normally around people helps people with cancer feel normal again. By describing various configurations of the 'presence-absence' of the therapeutic attribute, I discover in the apparent contradiction of the 'non-therapeutic-therapeutic' the third and last of the key elements that identify the Maggie's Centre as an effective therapeutic environment. Accompanying the three phases of psychological flexibility therapy according to the *triflex* (Open up, Be Present, Find Your Values), the phenomenological synergy that the architecture of Maggie's Centre offers will lead to uniting people with the place. The chapter closes by reunifying the three elements into the single and summarising concept of flexibility, which gives the 'universal' definition of the term 'therapeutic' (objective 2).

In Chapter 8, I add a final aspect to the case study of the Maggie's Centre, and, on Charles Jencks' will, I propose to elect it as a paradigm. Having confirmed in the previous chapter that the Maggie's Centre is definitely a 'therapeutic environment', on the basis of its values – on the one hand, the unique product of the Triad (Client-expert, architect, users) which originates a new way of 'commissioning architecture', and on the other hand the type or model of 'Architecture of Care' that has proliferated over the years – I outline the Maggie's Centre as an emerging paradigm. The two key elements of 'unique' and 'repeatable' helped me to extrapolate a set of principles to be applied to future healthcare facilities – and a Brief model to be allocated to other 'Triads' – in order to give a concrete follow-up to Jencks' ideas and promote the Maggie's Centre as a paradigm (objective 3). In addition to other chronic disease facilities, these principles could also be applied to non-healthcare facilities or other types of community centres to support special needs as well, so as to be integrated in a *continuum* of an extended healthcare environment, with each facility maintaining a distinct identity, in a logic of a future 'Construction of Health'. If the constructor of health will accept criticism about the mechanistic view of the current hospital, according to an architect's suggestion, I finally propose to extend Maggie's model into specific units within large hospitals in which to plant the seed of the Maggie's Centre.

Chapter 9 summarises and returns to the research questions, helping the reader to understand how I responded to them. In particular, I explain how I reached my findings, where they are located within the larger theoretical framework, and how decisions were made. First, by adopting mobility methods and dynamically participating in the life of three Maggie's Centres, and analysing the Architectural Brief with a new lens, in Chapter 6, I was able to discover in 'movement' the link between the design methodology adopted by Maggie's architects and the state of psychological flexibility generated in Maggie's users. Second, in reflecting more deeply on 'movement', 'hybrid' and, above all, the 'non-therapeutic-therapeutic' paradox, by adopting a phenomenological approach and an enigmatic method that looks at the 'opposite of the obvious', in Chapter 7 I came to understand and extract the key elements that identify the Maggie's Centre as an effective therapeutic environment. This was then translated into a 'universal' definition of 'therapeutic'. Finally, following the results obtained from my data analysis and based upon Charles Jencks' theories, in Chapter 8 I gave practical action to his will in suggesting that, within healthcare, the Maggie's Centre offers a new paradigm of Architecture of Care that should be taken in consideration by other healthcare and non-healthcare facilities or other types of community centres. Bringing my findings into the general discussion and beyond

the healthcare realm, in the second part of the chapter I examine the old paradigm of architecture that classifies buildings by ‘type’ or ‘function’ and, asking for help from Maggie’s users - now User-experts - I virtually lay the bases for the construction of a ‘user experience manual’ in which to report one’s emotions for the places now catalogued for the *effects* they will release and the *feelings* they will generate. Finally, examining the meaning of ‘architecture and its relationships’, I close the chapter and my doctoral thesis, returning one last time to the ways my experiences over the past almost four years have marked my life deeply, as I remember a special person at Maggie’s.

## Chapter 2. Theoretical Context

This chapter provides the theoretical reference framework – mostly based on phenomenology and human geography – for answering the research questions and for understanding the nature and various aspects of the therapeutic environment of the Maggie’s Centre. The chapter is divided into two parts. The first part introduces the reader to phenomenology, which was initially investigated as a methodological approach for the fieldwork, but which was later discovered to be relevant to various aspects of the therapeutic environment of the Maggie’s Centre. Although anthropologists, behaviourists and psychologists generically use the term ‘phenomenology’ to describe an observation, this philosophy, and in particular the phenomenology of perception developed by Maurice Merleau-Ponty (1908–1961), provides an understanding of experience and how people’s brains perceive and respond to a social environment (Merleau-Ponty 2012 [1945]). The theoretical discussion will then expand to architectural phenomenology – awareness of the sense of place – and the so-called ‘human geography of architecture’, in order to substantiate a research project on completely human geographic topics such as ‘feelings of buildings’ and ‘affectivity’. Together with phenomenology, phenomenology of perception, architectural phenomenology and human geography, Box 1 summarises a picture of socio-anthropological and psychological theories (performativity and manifestation, action and reflexivity, authenticity and some aspects of acting) that helped me to understand how Maggie’s environment induces, in a reflexive way, making its users feel like actors performing in an authentic way. A section on neuroscientific research and on phenomenological psychology helps to transit into the second part of the chapter. To improve our understanding of the impact of the built environment on our sensory experiences, neuroscience provides an extra lens, important to consider to test whether the results indicate that there is more that needs to be further developed, while phenomenological psychology can explain how people are ‘personally affected’ by their environment.

Having started my path from architecture, then enriched with phenomenology, I finally understood that in order to grasp the relationship between people and place, or people and environment, I needed to investigate architectural phenomenology. From here I then expanded with the inputs of phenomenological psychology that helped me to explain the relationship between ‘affect’ and ‘cognition’. Since architectural phenomenology and

phenomenological psychology, with the support of neuroscience, are the perspectives with which I can look at the Maggie’s Centre, by linking them, these fields intersect, fertilise and give more perspectives from which to look at Maggie’s multifaceted reality.

<b>Phenomenology</b> (pp. 18, 34, 47, 49, 50, 53, 55, 58, 67, 68, 70, 76, 77)	A research methodology that studies the structure of experience, developed by Edmund Husserl (1859–1938), the ‘father of phenomenology’. The task of phenomenology is to analyse what appears in its aspect. It posits that only through experience will we know anything that appears to us in the world while we move with intentionality. This, the “object as it appears”, is what Husserl means by the term “phenomenon” and is why he called his philosophical method phenomenology (Husserl, 2001 [1901]).
<b>Phenomenology of Perception</b> (p. 51)	The philosophy that was developed by Maurice Merleau-Ponty (1908–1961) based on the work of Edmund Husserl (2001 [1901]). Merleau-Ponty, however, distances himself from Husserl both on the theory of intentionality and on the role of the body in perceptual experience. For Merleau-Ponty, intentionality is not mental representation, but bodily reactivity to direct engagement with the world. He suggests that the moving subject should not be understood as a consciousness within a body, but as a lived body, the medium itself of the experience (Carman, 1999).
<b>Architectural Phenomenology</b> (p. 52)	Born from Heidegger's phenomenology (1971 [1954]) characterised by the combination of mental with practical activities such as speaking or dwelling, architectural phenomenology is based on the ability to think and design architecture so to merge us with the field of experience and bring us closer to being existential (Shirazi, 2014).
<b>Human Geography of Architecture</b> (Feelings of buildings) (pp. 55, 57)	It’s the area within human geography that began with the studies of architectural forms and developed to study the effect of the dominant built environment on people (Kraftl, 2010) Affectivity is one of three approaches to architectural geography termed a non-representative or ‘critical’ method, with emphasis on practice, materiality and affection (the other two refer to vernacular buildings and skyscrapers or buildings as dominant signs) (Kraftl and Adey, 2008). Within affectual geography, the main focus is studying the feelings that buildings may provoke in users.
<b>Performance and performativity</b> (pp. 58, 212, 214)	Performance is the act of doing something, such as your job (Cambridge Dictionary 2021), while performativity is the power of language (or corporal acts) to effect change in the world. Language (and acting) not only describe the world, but also constitute a form of social action (Cavanaugh, 2018).
<b>Agency</b> (pp. 60, 212, 214)	In Anthony Giddens’ (1994) structuration theory, it refers to knowledge, ability, and intentionality as manifested in individuals’ actions (in opposition to the view that behaviour is determined by social structures).
<b>Reflexivity</b> (pp. 60, 77, 211)	Its meaning differs according to the context. In quality research, it is the practice of critical awareness of one’s position and positionality in a research process, and how this affects research results and knowledge production (Finlay, 1998).

Box 1. Main references of theory and discursive practice used in Chapter 2.

The second part of this chapter prepares for interacting with the therapeutic environment of the Maggie’s Centre on a psychological basis. It outlines the psychological method of ACT (Acceptance and Commitment Therapy) and the derived psychological flexibility which, based on a six-step process (*hexaflex*) simplified in a three-step process (*triplex*), invites people to ‘be present’, ‘open to new perspectives’ and ‘orient themselves towards their own

values'. This discussion is mainly driven by the writings of Steven Hayes (and Smith 2005; 2011; 2017) and Russ Harris (2009; 2013). By creating a 'vicinity' between people and the surrounding spatial field, Maggie's architecture allows people to simply be present, open towards reality and able to act upon their values.

This thesis was profoundly influenced by the architectural thought of contemporary and non-contemporary thinkers on the phenomenological matrix such as Norberg-Schulz (1979), Holl, Pallasmaa and Pérez-Gómez (2006), Zumthor (2010) and Pallasmaa (2012), because in addition to producing theoretical frameworks about sensory experience and embodiment of space, they have distinguished themselves for their built architectures that know how to bring about and form the background to such experiences (Boyle, 2013).

## I. Phenomenology

The investigation into the positive synergy between people and place in the context of the Maggie's Centre derived from the socio-philosophical discipline of phenomenology, founded by Edmund Husserl (1859–1938), a disciple of Franz Brentano (1838–1917) and Carl Stumpf (1848–1936) and member of the Brentano School. Although Phenomenology is not a philosophical approach, but rather a research methodology, it has had a profound influence on existentialism in Germany with Martin Heidegger (1889–1976) and in France with Maurice Merleau-Ponty (1908–1961) and on today's cognitive sciences and phenomenological psychology.

Phenomenology (from the Greek *phainómenon* 'what appears' and *lógos* 'study') is literally the study of appearances, as opposed to reality, through first-person experience. As defined by the online Stanford Encyclopedia of Philosophy (Stanford, 2021), this experience is acted out by intentionality, directed towards something and effective through the encounter with objects. Although fully adopted by Hegel (1770–1831) in his "Phenomenology of the Spirit" (2018 [1807]), it was Husserl who first proposed the term as the basic concept of his thinking. In the work "Logical Investigations" (2001 [1901]) and in Husserl's conception, the task of phenomenology is to analyse what appears in its aspect. This is what Husserl means by the term 'phenomenon' and why he called his philosophical method phenomenology. The method has two sides: it always takes into account what appears, and always takes into account the modalities of its subjective outlet. Furthermore, the guiding idea of this method is the assumption that nothing we encounter in the world that

we can generally speak of is accessible without a corresponding subjective way of appearing. The encounter between reality and subject is always a relationship of correlations. Hence, phenomenology, in its methodological principles, is an inquiry into correlation (Held, 2003). In this sense, phenomenology is an appropriate methodology to be adopted for this research, as the Maggie's Centre deliberately attempts to create a strong blend of "correlations" by placing people with cancer in a social context, to stimulate synergy between people and place. As explained by Held (2003, p.9) Husserl (1970 [1936]) used "correlation" – a term used in statistics to refer to a relationship between two (or more) variables in which one changes as a function of the other – to signify more than a relationship. Aware of the "obviousness that everything seems different to everyone" (Held 2003, p.9), Husserl invites us to focus on the correlation, a relationship of reciprocity "between the world (the world we always talk about) and its subjective manners of givenness" (Husserl 1970 [1936], p.165), opening the exploration to this ever-changing relativity (Pakes, 2011).

As per Husserl's work, phenomenology calls us to return to the 'things themselves', where 'things' (*Sachen* in German) do not mean real (concrete) objects, but ideal (abstract) forms and contents of experience as we live them and not as reported or referred to in the categories of science and external opinion (Carman 2012, p. viii). Described by Hegel (2018 [1807]) as the "Science of Logic" (1812-16), the phenomenological approach – the experience of "things themselves" – is rooted in *intentionality*, that is, in Husserl's future theory of consciousness, which was first developed by Brentano. *Intentionality* represents an alternative to the previous Cartesian-Lockean representational theory of consciousness, based on the assumption that reality cannot be grasped directly because it is available only through the presence of 'ideas' (for example, Kant's 'representations') or 'impressions', which are objects of consciousness, actually a construct of the mind triggered by sensory experience. "Husserl's solution was to distinguish between the *objects* and the *contents* of consciousness" (Carman 2012, p. ix), differentiating between the things of which we are aware and the content of our awareness of them. "An intentional attitude is therefore not a *relation*, but a mental act with *intrinsic* content" (Carman 2012, p. ix). Husserl argued that consciousness is not an entity in the mind, but an awareness of something other than itself, whether the object is a substance or an invention of the imagination. Thus, the phenomenological method is based on the description of the phenomena of reality delivered to consciousness in their immediate nature, not as objects of perception that strike one's eye (an apple on a tree in a garden) but rather as the content of one's sensory experience or 'perceptual sense' (memories of and associations with an apple on a tree in a garden). In this

way one’s experience is immensely enriched as well as acquiring a sense of familiarity (Carman, 2012, p. ix). This fact is very important in the Maggie’s Centre, where domestic and welcoming spaces bring to mind memories and associations, fuelling the perceptive awareness with which a person lives their experience. Box 2 introduces the reader the terminology of Phenomenology used in this thesis.

<b>Intentionality</b> (pp. 49, 50, 51, 199)	Borrowed from Brentano’s intentionality and described as ‘aboutness’ (Searle 1983), for Husserl it is the notion that consciousness is always aware of something. For Merleau-Ponty (2012 [1945]), it is the body that is the motor of intentionality.
<b>Intuition</b> (p. 234)	In phenomenology, intuition is considered a methodology of knowledge that involves openness, questioning, and taking nothing for granted. In fact, one cannot speak of a true reality and a false one, it is simply a matter of comparing two points of view, two perspectives. This methodology has no certainties and knowledge and must always be questioned and renewed (Armezzani, 2019, pp. 2–3).
<b>Evidence</b> (p. 234)	If we replace objectivity with the criterion of evidence, we can accept that anything appears different to different subjects. Starting from this assumption, the obvious cannot be taken for granted and the obvious is therefore to be enigmatic. This way of looking at the world undermines what we are familiar with (Armezzani, 2019, p. 7).
<b>Empathy</b> (pp. 57, 66, 67, 137, 156, 174, 179, 195, 198, 200, 203, 232) <b>Intersubjectivity</b> (pp. 67, 115, 194, 198)	Intended as emotional imitation, it refers to the experience of one’s own body as or mirroring another. This experience of empathy is important in the phenomenological account of intersubjectivity. In the experience of intersubjectivity, one experiences oneself as being a subject among other subjects; and one experiences oneself as existing objectively for these others; finally, one experiences oneself as the subject of another’s empathic experience (Zahavi 1994, p. 73).

Box 2. Terminology of Phenomenology

## II. Phenomenology of Perception

In his book “Phenomenology of Perception”, Merleau-Ponty (2012 [1945]) makes us aware of the daily experience deriving from the interaction between brain, body and world that we usually take for granted. Through the notion of ‘primordial encounter’ with the everyday world, he describes how the senses are part of the bodily experience and how the body acts as an interface between the individual’s inner world and the outer social world (Hale, 2017). One of the most misleading interpretations of the architectural discipline is, in fact, that in phenomenology the individual is an isolated rational subject who is able to create meaning and constitute the world as a product of consciousness (Hensel, Menges and Hight 2009). The perceiving subject is no longer seen as a consciousness located within a body, rather the body itself is the means of experience and the subject should be understood as a situated

‘lived body’, where “to understand is to experience, the accord between what we aim and what is given, between the intention and the realisation – and the body is our anchorage in the world” (Merleau-Ponty 2012 [1945], p. 146). Overcoming both versions of Cartesian and Husserlian representationalism, Merleau-Ponty’s intentionality is not mental representation, but bodily reactivity to direct engagement with the world. “My body has its world or understand its world without having to go through representations” (Merleau-Ponty 2012 [1945], p. 141).

The new way of looking at phenomenology suggests a radically alternative view: as read by many (Kelly 2002, McBlane 2013, Simonsen 2013, Hale 2017, Lewis and Owen 2019), Maurice Merleau-Ponty is a ‘proto-posthumanist’ thinker, someone who believes in a fluid definition of the individual self or subject, as *dependent on* and at the same time *inseparable from* its natural and cultural environment (Hale, 2017). Supporting the biological concept of *Umwelt* (‘the surrounding world’) developed by Jakob von Uexküll (1864–1944), according to whom all organisms effectively construct their environment by selecting the characteristics with which they can interact, Merleau-Ponty argued that it is our ability to perceive a particular quality (a colour or a shape) that makes it become part of our world. “The world is inseparable from the subject, but a subject who is nothing but a project of the world” (Merleau-Ponty 2012 [1945], p. 454).

In “The Structure of Behaviour” Merleau-Ponty (1963 [1942]) conceived a powerful argument he called the ‘primacy of perception’, the idea that perception is a whole-body act, central to our experience of understanding the world (Hale, 2017). As mentioned, the ‘lived body’ is not a static object, but rather a body in action, the only means of ‘having the world’ and achieving what he describes as “this gearing of the subject into his world that is the origin of space” (Merleau-Ponty 2012 [1945], p. 262). As we move our bodies towards the world, within a process of exploration and discovery, we learn to ‘come to terms’ with the world, through our continuous change of bodily capacities and behaviour patterns. Our initial way of perceiving a space is based on its practical opportunities: we grasp it as a structured spatial field of action, inviting us to use it in a certain way. For architects, the idea of experience as a continuous interaction between perception and action is fundamental to the way we think of architecture that aims to engage and stimulate people (Hale, 2017). This is central in a therapeutic environment like the one of the Maggie’s Centre, in which the design is itself a process of discovery and learning, and even a form of research (Lawson et al., 2003).

## IIa. Architectural Phenomenology

Since its inception, phenomenology has stimulated and influenced other disciplines (mathematics, biology, psychology, psychopathology, sociology, history and the study of religion) and, as we have seen, more recently it has influenced research in some areas of cognitive science. In architecture, the phenomenological approach was introduced in the 1980s with the aim of understanding the built environment (Seamon and Mugerauer, 1985). By identifying the essence of “things” and phenomena, architectural theorists argue that phenomenology could bring us closer to being existential (Shirazi, 2014). Borrowing from Heidegger’s “Building Dwelling Thinking” (1971 [1954]), Christian Norberg-Schulz (1985) sees phenomenology as a method by which he is able to explain the world of “everyday existence”. In “The Concept of Dwelling” Norberg-Schulz (1985) evokes the idea of living as a return to our origins. He suggests that only by dialoguing with the primordial place, integrating and drawing inspiration from it, can the built environment generate a complete embodied experience in individuals, strongly related to a sense of belonging, the mutual influence between people and dwelling, and the meaning of the place.

The meaning of a work of architecture therefore consists in its gathering the world in a general typical sense, in a local particular sense, in a temporal historical sense, and, finally, as something that is as the figural manifestation of a mode of dwelling between earth and sky (Norberg-Schulz 1985, p. 30).

In the same year that Norberg-Schulz published his book on dwelling, David Seamon, a phenomenological geographer in the Department of Architecture at Kansas State University, published his anthological volume “Dwelling, Place and Environment. Towards a Phenomenology of the Person and the World” (Seamon and Mugerauer, 1985), still of Heideggerian origin. The book is a collection of multiple essays written by well-known architects, urban planners, geographers, philosophers and psychologists (including Relph, Hill, Lang, and Grange, to name just a few) on possible phenomenological approaches for understanding the relationship between the person and the environment.

As Reza Shirazi (2014) points out, the reason why Heidegger (1971 [1954]) is the figure most often indicated in architectural phenomenology is that, while for Merleau-Ponty (2012 [1945]) the “lived body” plays a key role in human spatiality (Carman 1999, Hale 2017), for Heidegger (1971 [1954]) the human-in-the-world not only interacts with the place but is always rooted in the place, which he identifies as “dwelling” (Sharr 2007; Malpas

2006; Mugerauer 1994, Seamon et and Mugerauer, 1985). Heidegger's fundamental text "Building Dwelling Thinking" - presented in a conference in Darmstadt in 1951, published in 1954 and translated into English in 1971 - is one of the philosophical texts that had the greatest influence on architects and their ways of thinking about architecture in the second half of the twentieth century, and has become one of the key sources of modern and postmodern architectural thought (Holst, 2014). The simple historical fact that this was the first time in more than a century that a great philosopher had expressed himself directly on the subject of architecture is significant. After Heidegger all architecture, philosophically speaking, has undergone a transformation (Jarzombek, 2007).

Unfortunately, what modern and postmodern architectural thought extracts from Heidegger's text is the understanding of building and dwelling as an abstraction of forms of being. This does not take into account the people who inhabit the space and forgets the most important aspect of architecture: well-being, understood as human well-being (Holst, 2014). Although it seems obvious that the main concern of architecture is to create an environment in which the inhabitants feel well, much of the built environment of the twentieth and early twenty-first centuries seems to show little intention to promote human well-being (Pallaasma, 2012). As already underlined by the philosopher Hannah Arendt (1958), one of the sources of the worsening human condition in modern mass societies is the growing schism between people and their objects. and further, between people and their built environment (Arendt, 1958). This insight is an important warning for this research that aims to assess the synergy between people and place enabled by architecture.

Very different from the line of phenomenological architects interested in the built environment, those who approach the practice are more inclined towards the sensory power of architecture, the feelings it evokes, and the role that form, space and materiality play in the way we live in the world. In this regard, among phenomenologically inspired architects, focused on the centrality of the moving body in the perception of architectural space, the sensory qualities of materials generate the integration of sensory perception as a function of a constructed form. Matter, as a tactile form of phenomenology, allows the body to move in space through memory and sensory experience (Shirazi, 2014). Peter Zumthor, a Swiss architect renowned for his sensory architecture, describes some of his most "vivid" memories through the expression of texture and material (Zumthor, 2010). The phenomenon of materiality leads us to consider light as a real material in all respects. As Steven Holl's partner, Chris Mc Voy stated during his interview: "That's the beauty of translucency as a material and light as a material and, not only the daylight, but also the electric light at night"

(McVoy, 26.05.2018). And again: “Space is oblivion without light. A building speaks through the silence of perception orchestrated by light” (Holl, Pallasmaa and Pérez-Gómez, 2006, p.63). Among phenomenological architects and theorists, through his numerous publications and lectures, Juhani Pallasmaa has underlined how architectural experiences are multisensory and they are understood as an atmosphere, an environment or a feeling.

Atmosphere is an exchange between material or existent properties of the place and the immaterial realm of human perception and imagination. Yet, they are not physical ‘things’ or facts, as they are human experiential ‘creations’. (Pallasmaa, 2012, p. 232)

Since architecture can characterise the architectural experience of the body in the perception of space through the sensory qualities of light, sound, temperature and materiality, in the next section I will analyse the role that the latter plays in the geography of architecture.

## Ib. Human Geography of Architecture

In the 1970s, among geographers who viewed phenomenology as a potential approach to take, Edward Relph was the first to study human experience by interacting with the natural and built environment. Inspired by Eric Dardel’s book “L’Homme et la Terre” (1952), in his book “Place and Placelessness” (1976), Relph focuses on four main aspects: the different components and intensities of human experiences linked to a place; the role that place plays in evoking such feelings; the nature of the identity of places; and the ways in which ‘sense of place’ or ‘without place’ make people feel like they belong in, don’t belong in or are alienated by a place (1976). As Anderson (2004) notes “places then, are not only a medium but also an outcome of action, producing and being produced through human practice”. They can “open up the senses to allow the re-calling of incidents, feelings and experiences that were constitutive of that individual’s understanding of the life world” (Anderson 2004, pp. 255 and 258).

Among human geographers deeply concerned with the ‘feelings’ of the buildings, besides Relph (1976) and Seamon and Mugerauer (1985), the phenomenology-inspired work of Tuan “Space and Place” (1977) constituted for many scholars after him a fundamental invitation to explore the interactions between space, place and experience, and hence, the feelings elicited by particular places or buildings.

In their study at Milton Keynes, Degen, DeSilvey, and Rose (2008) point out that, although many geographers of architecture (those more inspired by the work of Bruno Latour and other actor network theorists) are interested in the way that ‘feelings’ of different kinds are part of ‘building events’, none of them have given attention to and explored how the relation of human subjectivity to the materiality of ‘big things’ might be complex, multiple or ambiguous. On the contrary, architectural geographers of another sort of feeling – the ones of ‘affect’ – look at architecture with a different spirit: “it is constantly being transformed by use and open to tactile appropriation by everyday spatial practices” (Amin and Thrift 2002, p. 49). The two rather distinct theoretical positions in current human geography take opposite approaches when considering the feeling of a building or a social artefact – in particular ‘big things’ – and how to measure its perception. Those geographers inspired by actor network (ANT) constructivist approach to buildings (Latour, 1987) “acknowledge human experiences, but in very limited ways”, while those geographers inspired more by the ‘affect’ theory focus on the ‘feelings’ that buildings provoke, but remove human subjectivity from their accounts of buildings ‘performances’ (Rose, Degen, and Basdas 2010, p. 334).

In their article “More on ‘big things’: building event and feelings”, Rose, Degen and Basdas (2010) propose a third position that considers buildings more in connection with human experiences: the ‘feeling’ of the building (2010, p. 335). By considering the aspect of the ‘practice, embodiment and performance of buildings’ they argue that central to the making of this particular ‘big thing’ is the feeling experienced as being ‘inside’ the building. The strong feeling of being ‘inside’ the building, involving both ‘bodily behaviour and sensory perception’ developed by Kraftl and Adey (2008), seems to strike a good balance between the two arguments of geographers of ‘big things’. Echoing Kraftl and Adey (2008), although moving forward from them, Rose, Degen, and Basdas (2010) propose to work with ‘affect’ as just one element of both human and non-human geographies. They suggest that emotions and sensations, as well as other aspects of human subjectivity need to be considered in relation to the materiality of the building, so that geographers will get a more complex account of how the human interacts with buildings.

Within affectual geography of architecture, human and human body are much emphasised by those geographers inspired by ‘the phenomenality of practices’ and ‘philosophies of becoming’, and by ‘that whole realm of human life that is outside consciousness’. That realm is constituted by the senses but also by the various and many ‘reflexes and automatisms’, which are not conscious and which constitute “the bulk of (...)

activity” (Amin and Thrift 2002, p. 28), whose vitality and ‘push’ is what Thrift has described as ‘affect’. The ‘affect’ in relation to buildings has two aspects. The first is about the ‘bodily connection with architecture’ and claims that buildings orchestrate human movements within them by “supplying the perceptive body with a set of possible actions or movements to perform” (Kraftl and Adey 2008, p. 227). The second refers to the sensory ‘feel’ of a building and is concerned with “affective, tactile, sensual effects” (2008, p. 214). From this, we can deduce firstly that through movement a connection with architecture is established, and secondly that through materials our senses are stimulated. Considering that in buildings materials are ‘held together’ in specific assemblages and they become incorporated into a range of human activities that Jacobs (2006) calls ‘building events’ (a hybrid between human and building), embodiment in motion and ‘fusing’ with architecture are central to the way we choose the buildings where we like to stay. In this ‘rational’ process of perceiving and categorising an object, we can say that affect is a form of cognition (Duncan and Feldman Barrett, 2007). Many psychologists, indeed, believe that affect interact with cognition (Storbeck and Clore, 2007). Hence, cognitions can trigger affective feelings or behaviours, and affect can influence cognitive processes such as memory and attention. No longer seen as separated forces, as a result of a sensory experience, affect performs several basic “cognitive” functions appearing to be necessary for normal conscious experience (Duncan and Feldman Barrett, 2007). There is, in fact, an a-priori ‘selectivity’ that depends on our emotional relationship with another subject, in this case an architecture. The Maggie Centre creates such an affective sense of place among its users that the same adjectives used in reference to people (loving, cuddly, supportive) are used for the building. In this affective exchange in a “realm of human life that is outside consciousness” (Amin and Thrift 2002, p. 28), people’s empathy joins that of the building.

One of the things that people say about the Maggie’s Centre is that there is empathy in the building, and when it meets the empathy of the staff then this incredible emotional chain reaction can happen. Something that is extraordinary entitled to the person, because they can generally turn towards reality, whatever stand they want. (Howells, 2016, 14:28)

From this quote, in addition to the affection felt indiscriminately towards the building and people, the psychological flexibility generated in a Maggie’s Centre begins to emerge.

## IIc. Posthumanism and the Lived Body

Posthumanism has had a major impact on human geography over the past few decades. The ongoing discussion between human and non-human geographers has been useful in clarifying issues such as the system of knowledge of power, representation and ‘new materialisms’, but it has also worsened our understanding of lived experience, notions of action, and politics (Simonsen, 2013). Rose, Degen, and Basdas’s (2010) decision to adopt human subjectivity in their research on Milton Keynes suggests that phenomenology (particularly Merleau-Ponty’s) still offers solutions: “even within a declared posthumanist approach such as non-representational geography, some proponents feel uncomfortable with the total erasure of the human subject” (Simonsen 2013, p. 12) The reinterpretation of phenomenology through Merleau-Ponty’s writing allows Kirsten Simonsen to focus on three issues: ‘thinking the body’, ‘orientation and disorientation’, and ‘travelling down the anti-posthumanist lane’. This leads the author to suggest “a new humanism that avoids the rationalist and hypocritical claims of the old but retains elements of the experiential dimension of social life, the recognition of the other and the meaning of human agency” (Simonsen, 2013, p. 1).

Although ‘orientation and disorientation’ are part of the experience of discovery, for this research I am concerned with her category of ‘thinking the body’ since—in the next chapter I will propose to use my body in a method I term “move-along”. This method belongs to the posthumanist methodology; yet in posthumanism there is still hesitation in clarifying a strong posthumanistic commitment to the body (McBlane, 2013). The re-reading of Maurice Merleau-Ponty’s thought, centered on the phenomenology of perception, as suggested by Simonsen, should help to clarify the position.

Once we are in a space, we let ourselves be struck by phenomena-things that are always phenomena for a subject and expression of a profound link between subject and world. This concept is re-proposed to us by Merleau-Ponty (2012 [1945]) when he says that the *Leib* (the living body in lived life) is a view of the world (2012 [1945]). Contrary to Husserl’s Cartesian phenomenology, the phenomenological method that Merleau-Ponty proposes does not foresee that the subject is a consciousness located inside a body, but rather the body itself – a lived body – which becomes the means of experience. Hence, experience is the link to our perception of the world. For Merleau-Ponty the relation between perception and the body is parasitic; it coincides with us by virtue of being embodied perceivers. To understand the world, the subject must therefore incarnate and situate itself and move in the

world. The phenomenal field is constituted by the sensorimotor structure of the body (Carman, 2012). The structure of perception is nothing else than the structure of the body: my body “is my point of view upon the world” (Merleau-Ponty 2012 [1945], p. 73).

The concept of ‘body in space’ or ‘being-in-the-world’ and Merleau-Ponty’s phenomenological field provides the link between phenomenology and posthumanism. The perception of the world that occurs in an experiential space made up of “possibilities, impossibilities, and necessities constitutive of our perceptual world” (Carman, 2012, p. xv) will give us an understanding through a ‘posthumanist’ experience where the post-human mainly refers to a ‘paradigm shift’ that moves away from the humanistic anthropocentric *Weltanschauung* (worldview). By decentralising its own constitutive anthropocentrism, human nature is experienced in the encounter with the non-human referent. Furthermore, in the posthumanist perspective, the human is no longer a self-sufficient and autarchic entity, but is constructed in the dialectic with the otherness that looks at the act as conjugative and not disjunctive (Marchesini, 2013). In a Maggie’s Centre, both of these conditions occur in the dialectic with otherness and in experiencing the encounter with the non-human referent. Considered as a member of the staff and seen by its visitors “like a friend”, the non-human referent of the Maggie’s building becomes humanised, while the human identity of Maggie’s community emerges as a hybrid product of continuous rhizomatic processes of exchange and contamination with otherness “able to bring out new predicates and to inscribe the need of alterity into humans themselves” (Marchesini, 2013, para. 2). Overcoming objective knowledge and absolute truth, the posthumanist methodology stands as a critical reinterpretation of the classical humanistic tradition.

A post-humanist methodology is in no way definitive, but dynamic, mutant, shifting; it has to be aware of the state of things in order to acknowledge current challenges and be open to possibilities. It should be engaging in pluralistic epistemological accounts, not in order to comply with external requirements of political correctness, but to pursue less partial and more extensive perspectives, in tune with a posthuman future which will radically challenge human comprehension. In so doing, Post-humanism may ultimately become a mode of existential inquiry to be applied in everyday life. (Ferrando 2012, p. 16)

Highlighting the need to be less partial and broader in perspective, this quote gave me confidence in proposing the mobile method of “Move-along” for my fieldwork. As we will see, the intent of the chosen methodology was to be applied and then reflected in the critical discussion of the results.

## IId. Performativity and Manifestation

The growing body of literature on users' experiences of Maggie's Centres and how architects respond to the concept of healing environments during the design process (Annemans et al. 2012, Van der Linden, Annemans and Heylighen (2015; 2016), in addition to the attempt to understand what buildings do to people and how people react (Amin and Thrift, 2002; Rose, Degen, and Basdas, 2010) further extends to anthropology, and in particular to the concept of 'performance'. Performance theory analyses the performative nature of society, and how it becomes a reason for human understanding to adopt a performance code that guides events in our daily life. In the past, this theory has focused on performance in rituals adopted in American judicial courts and colleges (Goffman 1969), and on how it strengthens and transfers our identity into society (Derrida 1972, Butler 1993). Often considered by the authorities as a dangerous way to express ideas of rebellion, over time, performance has become an expression of ways that individuals act, react and 'resist' in society. This concept of how people situate themselves in the world, for themselves and for others, is the subject of study in the related area of performativity.

According to her concept of performativity, American feminist, gender theorist and philosopher Judith Butler explains that people perform as though rehearsing a script, realising a reality through repetition just like actors who follow a script (Butler 1993, pp. XII). Within the theatrical space of the Maggie's Centre, through the repetition of phrases such as 'make a cup of tea' and repeated movements such as sitting around the kitchen table, staff and visitors become actors who recite the script of the show that celebrates the ceremony of life. In this, Butler emphasises the role of words and language that have the ability to help or hurt people. Indeed, written and spoken words have different effects. In our society, "written laws define what is or is not allowed by representing an authoritative statement that expresses the power of those who wrote the law" (Butler 1997, p. 23). In this sense, Maggie's proves not to impose itself. In addition to the pamphlet advertising the Maggie's Centre with a single line, 'Just come in', leaving to the staff the task of giving verbal explanations to visitors who enter, the lack of written words inside the building leaves room for action and gives people the opportunity to situate themselves and communicate in the world of Maggie's. In this respect, e.g. the formation of one's identity, Butler's work helps to identify the role of words/rules written within the Architectural Brief or spoken in everyday natural conversations in a Maggie's Centre,

And human beings are naturally conversant when they know what to do. If they are making a cup of tea, then their conversation will deepen, and this may seem a very simple kind of act. (Howells, 2016, 7:19)

Spoken words are the way we present and represent ourselves in the world. British philosopher John Langshaw Austin (1911–1960), who never used the term performativity, gave the name ‘performative expressions’ to situations where ‘saying something’ meant ‘doing something’, rather than simply describing “what we say is what we do and what we are” (Austin, 1962, p. 16). ‘I do’ is an example of an authoritative statement and, at the same time, of how words interpret an event. Performativity therefore implies the definition of how spoken words are used to describe. This is important in relation to the past, because the words and structure of our past interpretations confirm the ‘performance’ of the past. From the kitchen table to the private rooms of the Maggie’s Centre, rivers of spoken words pour out to tell a past that no longer exists and that needs to be reset to live a present which is at once intense yet hopeful, in tears yet accepting.

Through acts (performance) all arts realise themselves shifting the emphasis from ‘works’ to ‘events’ which increasingly involve the recipients, listeners, and spectators (Fischer-Lichte, 2008). At the Maggie’s Centre, the “cup of tea” is a constant ritual involving space and people, stage and actors. At the same time, the rite is a manifesto for life. In psychology, the manifestation process is the act of aligning with our intentions and taking the necessary steps to accomplish the desired goals. It is a process that requires understanding and a great deal of effort on our part (Allen, 2006 [1902]).

## Ii. Agency, Reflexivity and Authenticity

Agency is our ability to act independently and to make our own free choices, in contrast to the notion of ‘structure’, the “recurring dispositions, which influence or limit the choices and opportunities available” (Barker 2005, p. 448). With reference to Simonsen’s article on posthumanism, the ongoing discussion between human and non-human geographers has worsened our understanding of the notion of agency. By making an empirical analysis of social life and proposing a ‘new humanism’ that retains elements of the experiential dimension, human agency is still possible (Simonsen, 2013). The debate hinges on whether the two notions of structure and agency conflict or are complementary forces, since

‘structure’ influences human behaviour, but at the same time human beings are able to change the social structures in which they live (Bourdieu, 1990).

To reconcile structure and action, objectivism and subjectivism, Pierre Bourdieu uses the concept of *habitus*, which can be defined as a system of dispositions (long-lasting and acquired patterns of perception, thought and action). The key concepts of Bourdieu’s work are *habitus*, *field* and *capital*. The agent is socialised in a *field*, an evolving set of roles and relationships in a social domain, in which various forms of *capital* are involved, such as prestige or financial resources. The central aspect of Bourdieu’s *habitus* is its incarnation: “*habitus* – embodied history, internalised as second nature and so forgotten as history – is the active presence of the whole past of which it is the product” (Bourdieu 1990, p. 56). According to the history, the *habitus* becomes autonomous, guaranteeing “the permanence in change that makes the individual agent a world within the world” (Bourdieu 1990, p. 56). The *habitus* differs from more classical concepts of socialisation: internal structures embody and work in a deeper, more practical and often pre-reflective way.

Reflexivity generally means examining one’s beliefs, judgments and knowledge and how these can affect a study during the research process. For a researcher, activating reflexivity means questioning one’s own assumptions by implementing openness and acceptance that the researcher is part of the research (Finlay, 1998). Reflexivity then means self-awareness (i.e. reflecting back on oneself) (Harvey, 1988) and concerns the ability of an agent to consciously change their place in the social structure (Giddens, 1994). This concept is evident in the life of the Maggie’s Centre, where reflexivity is expressed in a constant ‘bending’ with the changing environment that shapes the people around it. At the same time, within a reflective framework, Maggie’s and the Architectural Brief are somewhat self-referential, leaving very little freedom for the staff to decide on different solutions for arranging a room or change the position of things inside the space. If they transform something, in fact, it will have an impact on how the building should function.

The concept of Reflexivity originated from the work by sociologists William I. Thomas and Dorothy Swaine Thomas, with their book “The Child in America”, 1928: “If men define situations as real, they are real in their consequences” (Thomas, W.I. and Thomas, D.S., 1938 [1928]). Understood in this way, the “reflexivity” created at Maggie’s is not just a part of the performance – it becomes real. In the Maggie’s Centre, where people quickly become agents thanks to the work done by the staff, a strong sense of agency is activated even in the absence of the staff. Reflexivity was considered a problem in science by Karl Popper (1957), who pointed out how the influence of a prediction on the predicted

event, the ‘*Oedipus* effect’, comes into play as something equivalent to expectation, and can take action to achieve what was intended. Considered as a team member, the building is ‘something equivalent to expectation’; it is predictable because people can always count on it. This awareness helps to improve the subject-agent competence which consequently improves the reflexivity of the architecture, seen as an active agent rather than a passive context (Hensel, 2010).

As we have seen, the concepts of reflexivity and agency are closely linked. In Bourdieu’s work, reflexivity is constituted in circumstances in which there is a lack of ‘fit’ between the *habitus* and the field. This lack of ‘fit’ is particularly evident in the movement of the feminine *habitus* from the private to the public sphere. Lois McNay (1999a; 1999b) realises that the idea of *habitus* makes the theory of embodiment more dynamic for a feminist understanding of gender identity as an enduring but not immutable norm, and the idea of *field* provides a differentiated analysis of the context in which a reflexive transformation of gender identity takes place. This in turn offers a way of thinking about possible transformations within gender identity, as well as non-synchronous phenomena (McNay, 1999a; 1999b). Analysing the work of Judith Butler and looking at the exchange between Butler and Bourdieu on performative agency, McNay (1999a, 1999b) argues that we should overcome the negative connotation of agency rooted in current thinking that does not understand or take into consideration the creative dimension of the subjects that respond to changes in social relations. This fundamental understanding in a theory of autonomous agency could explain the ways in which people of different genders negotiate changes within gender relations. In this regard, the Maggie’s Centre has always been considered by its users a more ‘feminine’ place, for several reasons related both to objective facts (e.g. in general, breast cancer was the first cancer spoken about and the most common) and social and cultural conditions (e.g. women are generally more likely to open up and share). Lately, however, the ‘men’s group’ has become important to many and is one of the most active of Maggie’s facilitated groups.

Although it might seem contradictory for performativity, the concept of agency has been re-evaluated by Butler herself (1990) and by others (Bourdieu 1990, McNay 2000). By introducing the idea of performativity in the first chapter of “Gender Trouble”, Butler clarifies the fact that the body is not a “mute facticity” (Butler 1990 p. 129), i.e. a fact of nature, but like gender and sex can be performatively re-inscribed in ways that accentuate its ‘factiousness’ (constructedness) rather than its ‘facticity’ (existence). Such re-inscriptions, or ‘re-citations’ as Butler calls them in “Bodies that Matter” (1993), constitute the subject’s

agency within the law, in other words, the possibilities of subverting the law against itself (Salih, 2002). In her work on gender, Butler (1993) eliminates the sex/gender distinction in order to argue that there is no sex that is not always already gender. This does not mean ‘the death of the subject’, but the birth of a new one, built and characterized by subversive possibilities and agency. “Construction is not opposed to agency, it is the necessary scene of agency” (Butler 1990, p. 147).

Together with the potential role of self-efficacy in improving quality of life and reducing perceived stress in people with cancer, the notion of ‘authenticity’ is fundamental for recovery from a state of depression or anxiety (Kreitler, Peleg and Ehrenfeld, 2007) and is widely used and deeply embedded in Maggie’s psychological support philosophy. Given the enormity of the stories they listen to and the people they support, particularly when their lives are uncertain, staff need to spend time looking after their emotional self-control and authenticity. In fact, every week the staff team is asked to respond to a psychological test, a sort of game aiming to understand their psychological state and strength of mind.

Etymologically, the word ‘authentic’ is composed of *autòs* (oneself) and *entòs* (in, inside). Therefore, ‘authenticity’ refers to our true interiority, beyond what we want to appear as or believe we are. In existentialism, authenticity refers to that type of existence that reflects the true inner reality of the individual, characterised by singularity, by the anguished choice opposed to false external security. The search for authentic interiority is aimed at bringing out the authentic individual, with that “being” (*dasein*) that allows us to overcome Heideggerian inauthenticity and anonymous impersonality, and realising the centrality of one’s own person inserted in a social environment where beside the “I” there is also the “we” (Maletta, 2001). The concept of authenticity has, in fact, both a subjective and an objective connotation. For the first, authenticity is the sincerity that a person has with themselves, when it is genuinely what their character makes them be. This spontaneous and authentic interiority must correspond to a coherent external behaviour which is the one required of Maggie’s staff.

This work of being human is difficult. Sometimes we support each other in the most difficult moment. Feel is all about authenticity and being the professional who matters to you, who is required of you and in line with your values. (Howells, 2019)

## IIf. Neuroscience

Neuroscience is the science that studies our nervous system and the cognitive functions of the brain (Cambridge Dictionary, 2021d), the structures and processes that support our perceptions and our thinking and behaviour (Robinson, 2011). By providing an understanding of how the brain controls our senses and bodily activities, neuroscience explains why people behave a certain way when they interact with the environment, which impacts our senses and how we think, move, perceive, learn and remember and ultimately affects our psychological well-being (Eberhard, 2009). Neuroscience is an interdisciplinary science that works closely with other disciplines, such as mathematics, linguistics, engineering, computer science, chemistry, philosophy, psychology and medicine. When it comes to architecture, a noteworthy example of collaboration is the Academy of Neuroscience for Architecture (ANFA), founded in San Diego in 2002 to promote and advance knowledge that links neuroscientific research to a growing understanding of human responses to the built environment (ANFA, 2021). As explained by its founder, architect John Paul Eberhard (2009), architects and neuroscientists use our brains and minds in a very similar way. However, the link between architectural design and neuroscience knowledge is still very weak, because the conscious process of modelling this context is only partially understood by architects and most neuroscientists think of architecture as a profession interested in the aesthetics, perceived by the observer as harmony generated by symmetry and good proportions. But architecture is more than aesthetics (Eberhard, 2007). As stated more than 2000 years ago by Vitruvius in his architectural treatise *De Architectura*, an architectural structure must possess the three qualities of *firmitas*, *utilitas*, *venustas* at the same time, that is it must be simultaneously strong, useful, and beautiful. Unfortunately, this concept is still poorly understood by architects today. Knowing how people's minds develop and function in the different situations of the built environment helps to understand how to respond, firstly, to the functional needs of users and, secondly, to contribute to enriching human experiences. Expanding the horizon of neuroscience towards the discipline of architecture would therefore result in improving the design of places and spaces with the aim of raising people's quality of life (Eberhard, 2009).

While I have not used neuroscience in my research, I have found it useful - more as an inspiration rather than an approach - to engage with the ways in which neuroscience interprets how we can understand emotions and affect and hence cognition. Under this lens, the way we perceive the environment is based on the process of precognition of sensory

information through the five senses and haptic perception (Leydecker, 2017). The organisation of sensory information from the body that allows a person to interact effectively with their physical and social environment is called sensory processing (Ayres, 2005 [1976]) and plays a role in feelings - such as joy, fear, stress, anxiety and trauma - aroused in people by an experience both when it is lived and in future memory when it is remembered (Eberhard, 2009). To understand experiences and prepare appropriate responses, the brain organises, synthesises, integrates and uses this information. In fact, sensory inputs trigger emotions that we send to our nervous system, endocrine and immune system, but since individuals have different internal thresholds towards stress and self-regulation capacities, their behaviour towards the same environment can be also very different. Using well-established methods and approaches of environmental behaviour (E-B, Evidence Based), neuroscience helps evaluate the effects of physical environments on the nervous system (Zisel, 2006).

Since movement is needed when we want to explore and understand a built environment, in the context of neuroscience, one of the tools that we can use to move in an environment is “wayfinding” (Lynch, 1960) also called “spatial orientation” or “spatial cognition”, where “cognition” [from the Latin *cognitiōn*, *cognitiō* “act of knowing, comprehending, investigating”, derives from the verb *co-gnosco* - cognate of a Greek verb, *gi (g) nōsko (γι (γ) νόσχω*, ‘I know’, ‘I perceive’] (Merriam-Webster, 2021d) is the ability to understand a place. By elaborating a perceptual and cognitive mapping that derives from past experiences and our ability to imagine, we are able, while we move, to connect the typical elements of a place and recognise it (e.g. find the ticket office of a train station) (Zingale, 2006). The discovery in 1992 by a group of neuroscientists from Parma (Italy) (Di Pellegrino et al., 1992) of the existence of mirror neurons in monkeys as well as in humans has led to a review of the relationship between ‘movement’ and perception. The observation that in monkeys mirror neurons fired not only when they performed an action but also when they saw another monkey perform the same action, suggested that human action is the consequence of a visible, understandable and therefore imitable intention (Gallese, 2006). According to the Italian scientists, a person’s mirror neurons activate the interchangeability of points of view and the sharing of the other’s feelings, being able to see what the other sees, hears or feels. In addition to be an immediate understanding of the other, this ‘emotional imitation’ or empathy is also “motor equivalence between what has been acted and what is perceived” (Gallese, 2006, p. 305).

Although some scientists consider the discovery of mirror neurons to be one of the most important in the neuroscience field of the last decade, there are doubts about both the existence and role of mirror neurons in humans. To clarify the actual scientific basis of this fundamental discovery and what are the narrative suggestions evoked, in “What Happened to Mirror Neurons”, Cecilia Heyes and Caroline Catmur (2020) list the state of evidence for the various processes attributed to mirror neurons and explain where the research is. The comprehensive review of scientific studies published on mirror neurons over the past decade states that, in ‘understanding the action’ of others, their involvement in high-level processes, such as drawing conclusions about the intentions of those who perform the observed actions, is not proven, but it is proven in the low-level processing of observed actions, such as distinguishing a type of grip. Although it is unclear what kind of role mirror neurons play in ‘perception of language’, the involvement of the motor system seems to be demonstrated in language discrimination in perceptually noisy conditions; and, with reference to ‘imitation’, a response of the mirror neuron areas during the reproduction of the observed movements is strongly evident “in copying the topography of body movement” (Heyes and Catmur, 2020).

This fact is very important in a Maggie’s Centre, where thanks to the openness of the space, people can observe others and, while gaining confidence during their emotional state, thinking ‘if others do it, I can do it, too’ (Howells, 2016, 8:30). Since intersubjectivity is the ability of subjects to communicate with each other (Husserl, 1982 [1913]), it could be argued that the direct and first-person understanding of the emotions of others is the necessary condition for the empathy that underlies intersubjective relationships (Rizzolatti and Sinigaglia, 2019). Through empathy, the relation with the ‘other’ becomes a relation of similarity (‘they are just like me’) of which an important component is the common experience of action (sharing emotions at the kitchen table). This relationship of similarity is generated by the “as if” mechanism of *embodied simulation* (Gallese and Ebisch, 2013). After spending some time at Maggie’s, visitors say that being with other people has changed their attitude and personality.

It’s more than that, it is the ambience, the atmosphere that is therapeutic. That means that I am a totally different person from what I was three, four years ago. Everything that they’ve helped me with, changed over time. (*Focus group Barts*)

In interpreting memorable experiences of a place, neuroscience is an important support to architecture and other disciplines by informing the design of buildings and spaces that claim the role of the body and its senses (Erwine, 2016). In the design of health care environment, since the nervous system responses of traumatised individuals are more sensitive (Van der

Kolk, 2015), sensory input must come from a ‘connected and fully celebrated place’ (Erwine, 2016) that can be described as the process by which a “space” becomes a “place” (Mostafa, 2008).

## IIg. Phenomenological Psychology

M. Reza Shirazi (2014, p. 3) shows that for Husserl (2001 [1901]) phenomenology is “a return to things themselves”, for Heidegger (1971 [1954]) “a method” and “a way of seeing”, for Merleau-Ponty (2012 [1945]) the “essence of perception” and for architectural phenomenologists then it is a way to catch the essence of things and bring us close to our existential being. For architects, phenomenology is a method and a ‘way of seeing’.

It provides architects with a powerful and reliable ground from which they can establish their unique way of perceiving the built environment and develop their individual way of thinking” (Shirazi 2014, p. 3).

Being situated in architectural phenomenology, looking to phenomenological psychology may help to engage with the environment in order to understand how it affects people and their cognition, that is how people perceive their environment in their own way. By inserting this information into the system, I can see how the relationship between ‘affect’ and ‘cognition’ can actually contribute to and enhance my discussion of architectural phenomenology. In fact, so far, the discourse about ‘affect’ has been in relation to emotions, where emotions are seen as reflexive feelings. With the introduction of phenomenological psychology, the discussion on affect will be seen from a different angle, where ‘affect’ refers to any condition generated by an object or situation that affects a person’s perceptual experience (Duncan and Feldman Barret, 2007), while “the term ‘cognition’ refers to all the processes by which (...) sensory input is transformed, reduced, processed, stored, recovered and used” (Neisser, 1967, p. 4). In other words, compared to emotion, affect is more reminiscent of biological, rational sensations related to the type of cognitive reaction that occurs differently when each of us enters a space. Ultimately, the theory of affects - originated from Tomkins (1962) - can be understood as the study of the way in which we are ‘personally affected’ by the events of life and the environment and, at the same time, we become able to evaluate the meaning of these events or places in terms of cognition, planning and adaptation (Iurato, 2020).

Sedgwick and Frank (1995, cited in Wetherell, 2015) make a “transgressive” choice in shedding light on Tomkins’ theory (1962) which, following Darwin’s lead, hypothesised “the existence of innate, genetically determined ‘affect programmes’, i.e. ‘basic emotions’ (Wetherell, 2015). Subsequent interpretations (Schacter and Singer, 1962, cited in Wetherell, 2015), on the other hand, have indicated that to define a particular type of emotion (anger, discomfort, euphoria), affects require an involvement with the social context. In this perspective, the reading of one’s own body by the individual is strongly influenced by what can be found in a given context and by the responses of others. Despite, in reading Tomkins, according to Sedgwick and Franks (1995), Schacter (and Singer, 1962) is confused because his approach is biological in some respects and ‘cognitive’ at the same time. In interpreting Sedgwick and Franks’ critique of Schacter, which is based on a lack of analysis of what affects physical change in our bodies and how long that analysis might take, Wetherell reports what she thinks they should ask: “How long does it take to realise that you are scared or angry or joyful at the intrusion?” (Wetherell, 2015, p. 144). But in this, Sedgwick and Frank (1995) assume that emotion, excitement and affection are as stable as “terror”, once initiated, is always “terror”, while Stern (2004) thinks that emotions change and move flexibly, so he offers a phenomenological account of emotional transitions: affective experience flows, merges, develops and changes constantly.

After many years of discussion, a regarded point of view is that of psychologist Lisa Feldman Barrett (2006, cited in Wetherell, 2015) who states that it is a grave mistake to treat emotions such as anger, fear, disgust as if they were “natural kinds” with the type of ‘basic’ property that Tomkins (1962), Ekman (1994) and others have attributed to them (Wetherell, 2015). Despite other positions of thought, what emerges consistently is the flexibility of affective responses, the involvement of cultural and evolutionary learning in complex interactions with possible innate responses (Lewis and Liu, 2011, cited in Wetherell, 2015), and the impossibility of sustaining a sort of Darwinian simplicity regarding ‘lower’ emotions and ‘higher’ cognition (Adolphs and Damasio, 2001, cited in Wetherell, 2015). In summary, it is the human activity implied in being emotional and affected, in the analysis and categorisation of affects, and the complex intersections of body states, methods of recording and describing them, and the context (Wetherell, 2015).

For Thrift (2004, cited in Wetherell, 2015), being affected implies a form of “thinking”, but in a preconscious way, becoming the primary property and nature of human beings. Affect belongs to the small periods of time before consciousness awakens, and before we realise what we are doing (Thrift, 2000, cited in Wetherell, 2015). Thus, affect is

semiconscious and, similarly to William Harvey (1578-1657)'s conception of affect as 'certain sense or form of touch', it is a sensation registered but not yet considered in that subtle realm of consciousness that we call 'cognition' (Blakemore, 2005, cited in Wetherell, 2015). Moving between the bodies of human beings and other beings - not primarily originators of knowledge, but rather receivers and transmitters - affect is a set of flows that incessantly move messages of various kinds, usually outside of cognition (Thrift, 2008, cited in Wetherell, 2015).

While in the history, affect and cognition were thought to be separable or opposite processes of the mind (Aristotle (1991 [IV B.C.]); Plato, 1992 [about 380 B.C.]), today, although still considered separate or "ontologically" distinct, many psychologists think that affect and cognition interact (Storbeck and Clore, 2007): affect could impact cognitive processes such as memory and attention, and cognitions could trigger affective feelings or behaviours. Some scholars (2007) add the sensory dimension and suggest that by affecting the sensory processing, affect plays many basic "cognitive" functions (Neisser, 1967). In accordance to Neisser "the term 'cognition' refers to all the processes by which (...) sensory input is transformed, reduced, processed, stored, retrieved and used" (Neisser, 1967, p.4). Going beyond Neisser's deliberately broad definition of cognition, Duncan and Feldman Barrett (2007) focus on the idea that affect makes important contributions to both sensory and cognitive processing such as normal conscious experience, fluency of language and memory. With consequences on the 'somato-visceral' state of the organism, which means that pertains the internal body systems and organs (Medical Dictionary, 2012), all events and places affect the cognitive and sensory experiences that are to some extent infused with affect. As they say, there is no such thing as "non-affective thought". Even without feeling its influence, affect plays a role in people's perception and cognition (Duncan and Feldman Barrett, 2007).

Returning to my discussion of architectural phenomenology about Maggie's spatial condition of architecture, Phenomenological Psychology's input will help explain how, once immersed in the space, without realising it, Maggie's individuals develop a cognitive process at a personal level stimulated by affective thoughts that enable the individual's openness and flexibility to different degrees. In Maggie's multiple reality, deliberately left free and open to any kind of interpretation, affective states and their regulation influence the cognitive processes (including attention, memory, decision-making, agency) of individuals "being separate but equal to them, and yet in continuous and inextricable mutual interaction such as to be functionally indivisible" (Iurato, 2020, p.1). As Howells makes us notice, within a

Maggie's Centre "it is the subtlety of the level of the kitchen that allows that intimacy, despite the fact that people are very rarely far apart" (Howells, 2016, 11:20), thus allowing synergy between people and people, and people and place.

### III. Psychological Flexibility

The previous section has established a phenomenological basis and theoretical discussion and highlighted the key concepts that were used in this research, and on which I built the framework that I used to analyse my research material. The theoretical analysis was guided by sociological-anthropological and psychological concepts for evidence of the synergy between people and place that enables a flexible psychological state of mind in Maggie's users. In this section, I introduce the evidence-based concept of psychological flexibility, around which I framed my discussion and practical investigation. The reason why I decided to engage with this concept is, besides its strong evidence base, the relation that flexibility has with the therapeutic environment. Since antiquity, flexibility has been seen as the catalyst of healing. In ancient Greece (V B.C. – IV A.D.), the *Asclepeions* were healing temples connected with artistic and natural environments that created open, accessible and flexible total healing spaces. Revealing that Asklepius healing resides in suffering by enabling "that person to find a way of living with, and perhaps in time opening more to, the depth of his or her experience" rather than seeking "life as it was before" (2009, pp. 47), and finding healing perhaps even though they may not be cured, Kearney comes very close to the concept of psychological flexibility. Therapeutic flexibility may also have created the feeling that the articulated environment was a significant factor in health (Kearney, 2009). At Maggie's, psychological flexibility is a point of departure.

Psychological Flexibility is the premise I put as psychologist. When I sit down as a therapist to help people to find much more flexible way so they can adjust to the reality they find themselves constantly in, I could use the talking therapy, which is the classical in a room (...) What Maggie's does is creating the psychological space to move with reality rather than struggling against it. (Howells, 01.11. 2017)

Psychological flexibility concerns the ability to act in accordance with what is most important to us, along with what is offered by the present situation. It refers to the process by which individuals respond to changes coming from difficult situations and employ their mental resources to adapt their perspectives to the new conditions. Psychological flexibility

is not a talent or a characteristic with which one is born, but rather a way of responding to events, a way of behaving, which is based on skills that can be learned and exercised. It is not a way to avoid suffering (since this inevitably makes up part of human experience), but it is a way to maintain the guide of our existence, according to the possibilities offered to us by the moment and the context (Harris, 2009).

By trying to break away from the past and focus on the ‘here and now’ (Harris, 2013, p. 32), together with balancing fears and future desires, psychological flexibility and resilience in times of uncertainty constitute the ability to regulate emotions, a constant transaction between the individual and the context in which they move (Kashdan and Rottenburg, 2010). The definition given by Steve Hayes, one of the fathers of ACT (Acceptance and Commitment Therapy), is: “Psychological flexibility means contacting the present moment fully as a conscious human being, and based on what the situation affords, changing or persisting in behaviour in the service of chosen values” (Hayes, 2021). “Contacting the present fully” means being truly part of the current situation, including difficult thoughts and emotions, and being willing to accept them as part of the experience of life.

Acceptance is fundamental because the opposite, attempting to free oneself from difficult thoughts and emotions, actually increases their frequency, intensity and duration (Hayes and Smith, 2005, p. 3). Psychological flexibility means being able to bear thoughts and emotions lightly, seeing them as part of our daily experience as human beings. It is also a fundamental skill, as we learn from the second part of Hayes’ definition, “changing or persisting in behaviour in the service of chosen values” means accepting difficult thoughts or emotions in order to turn towards our values. And every time we turn to our values – or anything that matters – we know that we will have difficult thoughts and emotions.

As I will show in Chapter 5, in terms of Commitment and as opposed to other care programmes that may lose interaction with their patients, Maggie’s psychologists work to engage visitors and make themselves feel committed. In 2017, Charles Jencks reported in an article of a phone call made in May-July 2016 with Lesley Howells, then head of Maggie’s Dundee centre. In the phone call, Lesley was trying to convince Charles (who, then, dared justifying Maggie’s evidence of power with just a ‘the building supports the Staff, so the Staff supports the Visitors’) that what Maggie’s does is working with engagement in self-help mode. This manages to keep visitors busy so that they will come back next time and take part in further activities. “It is their commitment to variable and continuing self-help that is sustaining” (Jencks, 2017, p.75).

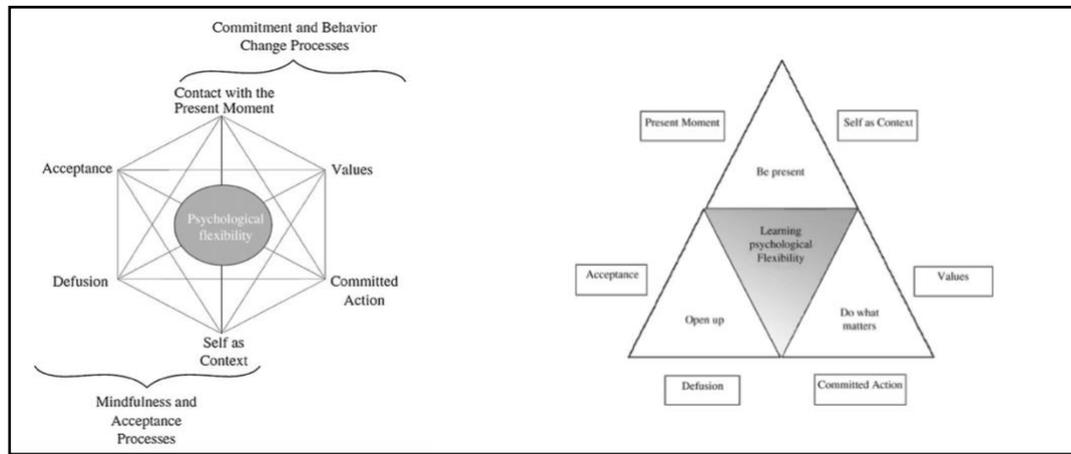
### IIIa. The ACT Model of Psychological Flexibility

Better known as ACT (pronounced as a single word), Acceptance and Commitment Therapy is part of the “third wave in behavioural and cognitive therapies” (Hayes and Smith, 2005, p. 2). ACT is able to generate a radical change of perspective of its experience, which aims to reduce the impact that psychological problems have on people's lives. It is based on the notion that a certain amount of suffering is a normal and natural condition of the human being, and that rigid attempts to get rid of this suffering become the source of the greatest damage.

In this sense, ‘accepting’ the suffering linked to thoughts, emotions and unpleasant memories does not mean resigning oneself or giving them pleasure, but it means to stop investing energy in behaviours that do not work in the long run, and turn us away from life as we wanted it (...) Accepting serves only to free your hands from a useless struggle, to be able to engage them in other places, in other areas where you can build something significant and important. (Harris, 2013, pp. 37-38)

ACT uses behavioural activation and mindfulness to increase the person’s psychological flexibility, that is, their ability to engage in behaviour based on their values while consciously experiencing difficult thoughts, emotions or sensations. “One major element of ACT is teaching people how to handle pain more effectively through the use of mindfulness skills. (...) Mindfulness means paying attention with flexibility, openness, curiosity” (Harris, 2013, p. 37). Together with mindfulness, ACT helps people to live by their values. In order to understand this concept, Russ Harris adopts the *triflex*, a triangular scheme that connects the key concepts that engender psychological flexibility. In reference to this, Heidegger’s concept of ‘being-there’ or ‘being present’ comes back into Howells’ thought: “not being haunted by your past or tormented by speculation about the future: being present, in the ‘here and now’ and life as it is” (Howells, 2016, 5:20).

Hayes’ ACT uses the *hexaflex*, a hexagon diagram that reassumes and associates the six core therapeutic processes that are associated with psychological flexibility: ‘acceptance’, ‘defusion’, ‘contact with the present moment’, ‘self-as-context’, ‘values’, and ‘committed action’. The representation of the six psychological processes in a hexagonal form states the fact that the six processes are strongly connected and actually inseparable, just like the six faces of a diamond used to represent psychological flexibility itself (Harris, 2009, p. 30)



Box 3. The ACT *hexaflex* and *triflex* models of Psychological Flexibility (Out of copyright, as confirmed by Steven C. Hayes)

In his TedxDundee Talk, Hayes (2017) explains the psychological process as follows. The first two psychological processes, *acceptance* and *defusion*, are processes of intellectual and emotional opening. The word ‘acceptance’ means neither tolerance nor resignation (2017, 53:34), but acceptance of painful private experiences. “This ‘problem-solving-mind’ gives you the impossible task of trying to avoid pain” (2017, 36:20), but, trying to get rid of unpleasant thoughts, memories or emotions results in worsening the problem. Derived from the Latin term *accipere* (‘to receive’), its original connotation was ‘to receive a gift’ – “here, take this”. The word ‘defusion’ is the opposite of ‘fusion’, a term that comes from Latin and indicates when something is poured together. In this case, it indicates ‘what someone is thinking’ poured together with ‘what someone is thinking about’ (2017, 44:48). ‘Defusion’ or distancing is therefore the ability to observe one's own thoughts without remaining ‘hooked’, and not acting automatically based on these thoughts.

The second two psychological processes – located in the centre of the *hexaflex* – are the ones that indicate ‘being aware’, in the moment, in the conscience. *Contact with the present moment* refers to the ability to direct one's attention voluntarily to events that are happening ‘here and now’, rather than focusing without control over the past or the future. The present moment is where we live. In this midway process, what we need to learn is how to be more flexibly in relation to what is present. Although we live in the present, because of our ‘problem-solving mode of mind’, we tend to continuously refer to the past and the future. Learning how to come into the present means doing so flexibly, fluently, and voluntarily. In psychological flexibility, ‘being able to focus on something’ and ‘knowing that you can do it’ gives us the capacity to control our emotions when something comes up. As Hayes tells us in the TedxTalk: “People need some help as dealing with the cacophony [oneself and the voice that we have inside] and attentional flexibility as part of that help” (2017, 1:02:17). The fourth psychological process is *self as context or perspective*. Hayes

says that ‘self-observer’ and ‘perspective taking’ constitute the ability to stay in touch with a ‘perspective of self’ that does not vary according to transitory emotions or thoughts, but which includes them without changing. Furthermore, Hayes says that the ability to assume the observer’s perspective implies the ability of seeing events from different perspectives. This practice or process is also known as mindfulness, a way of observing one's own experience intentionally, in the present and in a non-judgmental way. Mindfulness has to do with awareness, and it is a real training to bring our attention where it is needed. It is not a technique, but an inner ‘posture’, an attitude that gives the individual the opportunity to choose what to do in a conscious way, without necessarily blindly obeying thoughts, emotions, or old habits.

The last two processes of the hexagonal model are *values* and *committed action*. ‘Values’ is the identification of what is important to a person, of the qualities they intend to express and live in the various areas of their existence, of what they can achieve with their full and worthwhile life. ‘Committed action’ refers to the ability to take concrete actions to move in the direction of what the person considers important, even when this act exposes them to unwanted emotions and thoughts. Still in the same Tedx Talk, Hayes asks: “if we are no longer running away, if we are here and showing up, then there is another issue which is: ‘what are we gonna be up to in our life?’” (2017, 1:03:59). Many of us go through life running, fighting and hiding as we should focus on what we want to bring into our life. One of the biggest predictors of whether our life will move positively or negatively is whether we know what our values are and build our lives around them. This reflects the qualities of being and doing that we care about. And Hayes concludes: “The science of psychological flexibility says that when you are open, when you are aware, then you can connect with the possibility of caring and being and doing” (2017, 1:14:05).

### IIIb. Synergy Between People and Place

The term ‘synergy’ comes from the Greek word *synergos*, συνεργός, which means ‘work together’ (Merriam-Webster, 2021e). The online Cambridge Dictionary describes it in a social behavioural context as the combined power of a group of people, which is greater when they are working together than the total power achieved by each working separately (Cambridge Dictionary, 2021e). This is valid also if the two entities are humans and artefacts that, as mentioned, Jacobs (2006) calls ‘building events’, hybrids of human and buildings

(Rose, Degen, and Basdas, 2010). Within this synergy, the built environment clarifies roles and social relations (Tuan, 1977). As we saw in the Introduction, Daryl Martin advanced the hypothesis of “synergism” and benefits deriving from the co-presence of people and places in a Maggie’s Centre.

Working in tandem with the architecture, professional staff and volunteers are key to establishing the atmospherics of care in a Maggie’s centre, and their work includes elements of curating and cultivating the spaces within which that care is experienced. (Martin, 2016, p. 40)

Encouraged by an open architecture of continuous spaces this process takes place, in particular, in the kitchen, where the large table is fundamental to creating a welcoming and domestic atmosphere that at Maggie’s allows “therapeutic conversations” (Martin, 2014). All Maggie’s kitchens are large, glowing spaces, and the large table is considered the heart of the Centre. The philosophy of ‘kitchenism’ – a serious joke coined by Charles Jencks – expresses informality and good humour and allows people to find the best way to feel at ease before fully engaging with the Centre: simply offering to make a cup of tea helps in facilitating socialisation. “The centrality of food and drink allows people to enter and exit without declaring themselves, try things out, listen or leave without being noticed” (Jencks, 2010, p. 13). In her study of her “Kitchen-Table Society”, Norwegian anthropologist Marianne Gullestad reports that she spent two years participating in the life of working-class families in the Norwegian suburbs. The data coming from the discourse going on around the kitchen tables where, in each other’s homes, the young and divorced wives met, were about defending normative boundaries within their families and managing identities, identifying the kitchen table in everybody’s home like an ancient ‘forum’ (Gullestad, 1984). Thanks to the welcoming spaces and calming atmosphere, people can see. The synergic co-habitation of people within inspiring places makes people focus better and feel open and flexible to choose.

From this intuition Lesley Howells, who has been observing the positive synergies between users and place for more than fifteen years, built her hypothesis.

It’s a natural fact: if you can place somebody in the building, they can actually achieve very similar results to me with the talking therapy. It would be interesting from my point of view for Staff to say: ‘People say that the building is actually helping them to engage much more ‘here and now’ and ‘in the present’. (Howells, 07.02.2019)

It is with this insight that I was inspired to begin my research, and the concepts that emerged in this chapter helped me to navigate the rest of my thesis and seek and discover the

therapeutic environment of the Maggie's Centre. Taking into account that there is mutual influence between people and place, the architectural space – even a simple hut – can transmit this awareness and make the sensations come alive. “Man-made space can refine human feelings and perceptions” (Tuan 1977, p. 102). For this reason, I needed phenomenology as a method to investigate the phenomena that occur in people in a Maggie's Centre, which, as Husserl says, are ‘things’ which we must approach but suspending any pre-understanding or prejudice. In particular, by looking at the phenomenological method of perception proposed by Merleau-Ponty (2012 [1945]) I was able to access and begin to understand the spatiality of the Maggie's Centre. Unlike the classical conception of space, in which things are arranged in three dimensions and in which they remain the same regardless of the point of view of the observer, the space of experience is one in which the subject is embodied in it. The phenomenological territory of experiences can be understood as the interaction between perception and action (Hale, 2017).

As concerns place, and again with a view to synergy, phenomenology extended to architecture or ‘architectural phenomenology’ helped me to look at place as a necessary condition, yet one that is insufficient without human presence, because the human-in-the-world not only interacts with the place, but is always rooted in the place, of which materiality (including light and transparency) become fundamental generators of phenomena. Besides the work carried out by phenomenologically oriented architects, in terms of practice, geographers of affectivity, in terms of theory, helped me to understand how the “bodily connection with architecture” (Kraftl and Adey, 2008) occurs through the materiality of buildings that “orchestrate the possible human movements within them”, thus providing the perceptive body with a series of possible actions or movements to perform. From this point of view, the model of the living body as something that is inseparable from its natural environment (Hale, 2017) originated in the biological concept of *Umwelt* (‘the surrounding world’) developed by Jakob von Uexküll (1864–1944) and proposed by Merleau-Ponty, a proto viewer of post-humanism, helped me to immerse myself in the space of experience and to try what users feel on myself. Only by taking my distance from an anthropocentric conception, considering the non-human (the building) as ‘occupied performative events’ – a hybrid between building and human (Jacobs, 2006) – could I understand the symbiotic relationship between Maggie's users and buildings.

Seen as performative events, the discursive practices of performativity and manifestation, and theories of reflexivity, agency, and authenticity helped me to understand how Maggie's environment induces, in a reflexive way, making its users feel like actors

acting in an authentic way. Though agency and performativity oppose one another, Butler's (1990) concept of agency in particular helped me to understand that in a Maggie's Centre nothing is taken for granted, and that the concept of the body is no longer that of the patient in the hospital, but rather the one that can be re-inscribed in a performative way. These re-inscriptions constitute the agency of the subject, a new subject, constructed and characterised by subversive possibility and action. Particularly in reference to agency, phenomenological psychology (and the relationship between 'affect' and 'cognition') was key to understand how, in a favourable environment, people become aware, receptive and proactive. And it's precisely those feelings of encouragement and action that people with cancer experience at Maggie's that make them find ways to tolerate what was previously intolerable.

Thanks to the inputs of phenomenological psychology together with those of neuroscience and other socio-psychological perspectives, the research based on architectural phenomenology has become part of a multi-disciplinary field, understanding from various points of view how the built environment impacts on our feelings. At Maggie's, such feelings are the expression of a current condition of the building's architecture in which the experiences that users encounter are made possible "by the spatial interaction rather than the walls". In this spatial condition, the synergy between people and the place, which stimulates a state of psychological flexibility in its users, ultimately constitutes a therapeutic environment.

## Chapter 3. Methodology

With the initial question ‘what is it about the Maggie’s Centre that generates therapeutic effects on users’ and the aim of understanding the relationship between architecture and psychological flexibility in the constitution of a therapeutic environment, this chapter analyses the logical progression of methodology and rationale for the two-stage process adopted in the fieldwork of my research (Box 16). I gained my inspiration from the suggestion of Lesley Howells who, in 2017, urged that the first step of my research was to assess from an architectural point of view that the “synergy between people and place” enabled psychological flexibility. I therefore developed a two-stage strategy: the first stage was a reconnaissance stage necessary to collect data on the architecture (“place”) before moving on to the second stage of data collection with the users (“people”). Providing a distinct methodological narrative of the two consequent yet separate stages (Box 7), I discuss the two different experiences and the learning process that has derived from them. I begin by giving an overview of the guiding principles and listing the methods of my two periods of fieldwork. I continue by describing my role as an auto-ethnographical researcher and the adopted phenomenological approach, my relationship with the project participants, and the degree of reciprocal influence. I then move to illustrate the methods adopted in the two fieldwork stages 1 and 2 (reconnaissance and ethnographic). In the reconnaissance stage 1 section, I highlight the themes that I was able to extract during interviews conducted with Maggie’s Architects and the Client-expert from which I derived a set of parameters (6 + 6) that helped me to develop the data collection in stage 2. In the ethnographic stage 2 section, after explaining the intentions of my ethnographic work, I discuss the methods (2 + 2) aimed at understanding what the experience of users of the building was, which revealed the link between the therapeutic environment and phenomenology of the Maggie’s Centre. Despite the potential rigidity of my set of parameters, once I started my stage 2 fieldwork, my multi-method, open, flexible and continuously adaptable ethnographic work allowed me to go beyond the mere testing of the results of stage 1, letting user experiences speak in the analysis. With the aim of testing the architecture - and not the architects’ opinions - while keeping an open mind, I tried to understand the user experience to enable the analysis of the connection between users and architecture in order to understand 1) Maggie’s ability to constitute a therapeutic environment and 2) Maggie’s paradigmatic nature of becoming an ‘exemplar’ for other healthcare facilities.

I conclude the chapter by describing the steps and obstacles occurred during my fieldwork and explaining the way I designed my ethics along with the referred ethical requirements.

## I. The Sense of my Methodology

To investigate the Maggie's Centre 'therapeutic environment' (and what defines it), I followed the line of thought suggested by Mats Alvesson and Dan Kärreman, who propose a methodology of "active discovery" (Alvesson and Kärreman 2007, p. 1265). Many times, I read that researchers are like investigators, full of postulates and hungry for answers: with a magnifying glass, they go into the 'field' where the fieldwork is a vital tool for "learning through direct observation" (Gerber and Chaun 2000, p.4). As already seen in Chapter 2, Husserl's 'things themselves' are ideal (abstract) forms and contents of experience and the space surrounding them is neither neutral nor empty, but they are contextualised by what they themselves exist in.

For an architect and a researcher, this concept opens up the potential that context holds in informing our response to the things themselves that is a fundamental element of the approach to the understanding of place. (Tyrrel 2018, p. 24)

In collecting empirical data, the relationship between the researcher and the context is not a passive collection but an active form of production of knowledge. As Simmel claimed, sociology is a standpoint or perspective that it is a method for viewing and knowing man (Simmel and Wolff, 1950 [1917]). The empirical material should therefore be thought of as a dialogue partner who comes to the aid of the researcher by confirming or casting doubts on the path taken and the approach adopted, influencing the development of the research (Alvesson and Kärreman, 2007). 'Breakdowns' occurring in the research can have repercussions on the path of the study. If this is the case, we need to be ready to return to the original theoretical framework and revise it using the empirical material collected whose "data are seen as an inspiration for critical dialogues between theoretical frameworks and empirical work" (Alvesson and Kärreman 2007, p. 1265). Without thinking that the empirical material alone is enough to guide the research (Glaser and Strauss, 1967), Alvesson and Kärreman argue that it is necessary to have an open attitude towards both the theoretical framework and the methods used, where openness is to be understood as a

continuous expansion towards new theories, essential for improving the interpretations of one's empirical material.

Making this strategy my own, I decided to start my fieldwork at an early stage of the research, visiting all centres – at the time there were twenty (excluding Maggie's Tokyo and Maggie's Hong Kong), while today, in Europe/UK, there are twenty-four. During the first stage of my fieldwork, I interviewed twelve Maggie's architects at their offices, investigating the interpretations of the Architectural Brief they adopted during their design process and the Client-expert understanding their role and criss-crossing what architects said. This reconnaissance fieldwork stage 1 focusing on the "place" went on, at intervals, for about a year (November 2017 to November 2018) and was necessary to comprehend important clues on the context of the therapeutic environment of the Maggie's Centre. By identifying the salient characteristics that have provided the key to investigating in the right direction, I was able to move into the ethnographic fieldwork stage 2 that lasted about four months (September to December 2019) and focused on "people" (Box 7). Consequent to each other in terms of complementarity of the two stages, in terms of data collection the two phases were very separate. However, it was neither a simple separate data collection to compare, nor an extraction of data from the first stage to build focus groups and interviews in the second one that could have led to predictable results. Rather, the approach I took with the users in stage 2 was, by asking specific questions about their positive experience of architecture, to find out what users said to come closer to an understanding of the interaction between the intention of the buildings and the user experience. For example, the architects told me how important reflected light and transparency were to see the rest of the space and the people around. When I asked specific questions about the space, users and visitors would answer "I am very conscious, I am very aware of the space I am in. It helps us to realise colours, transparencies, light". From these examples follows that stage 1 was important in gathering principles and that I entered stage 2 by being open to explore the connection between the architects' intentions and the users' experience of the space.

As I explain further in the 'Interview with the Client-expert' section of this chapter, one of the links that connected the two stages and turned out to be the key that opened the door to the second phase - thus making it necessary to justify the two-phase process – was triggered in the interview with Laura Lee, Maggie's CEO, that Maggie's is not a therapeutic environment. She said: "that would be awful and assumptive that 'you need to be healed' and we are going to heal you in this environment" (Lee, 18.05.2019). I was curious about understanding this statement, and when I entered the 'field', I was trying to see how

Maggie's was not therapeutic, but the evidence gathered with the users continued to contradict Laura Lee's affirmation.

Based on the first stage of fieldwork, I was left with the question about Maggie's as a therapeutic environment. Analysing the data of the first phase, in combination with the literature and knowledge about the Maggie's Centres and the Architectural Brief, I derived a set of parameters that guided the planning of the second stage of the research where I intended to understand better the experience of the staff and visitors. My ethnographic fieldwork went on in the three centres that had been assigned to me by Maggie's Advisory Board: Maggie's Dundee, Maggie's Oldham and Maggie's London Barts. These centres were selected because their Centre Heads had less difficulty in having a researcher for 4 weeks. However, I was very happy with the non-choice and if I were to go back, I would probably choose the same ones because in the group of the current twenty-six centres, they represent a good example of combination and variety under different aspects (socially, culturally, geographically), but at the same time of comparability for similar architectural conditions (three single objects rather than a combination of many volumes). Here below I list the types of methods adopted and data collected.

*Reconnaissance fieldwork Stage 1 (November 2017 to November 2018)*

1. Visits to all the existing Maggie's Centres in Europe at the time (20) for informal conversations with staff and observations of their activities.
2. Semi-structured interviews with Maggie's architects in person (11) or by phone (1).
3. Collection of data from architects' archives (12).
4. Semi-structured interviews with the Client-expert (1).
5. Visits to Maggie's Centres which had opened since the start of my fieldwork (3).

*Ethnographic fieldwork Stage 2 (September to December 2019)*

1. 'Participation and Observation' (during the normal activities at the Maggie's Centre) mapping people's use of the space to understand the level of 'therapeuticity' of the building, with drawings and field notes (4 weeks at each centre x 3 centres = 3 sets of data).
2. 'Move-along' (during the normal activities at the Maggie's Centre) mapping individuals' physical movements, in order to find out what are the 'favourite places' of people, with mobile observation and a photo-diary/photo interview taken by the participants (8 sessions x 3 centres = 24 sets of data).

3. 'Focus groups' with Maggie's groups of 5-7 visitors (patients, friends or relatives) to extract key themes and help me to understand 'how the building supports' them, with recorded discussions (1 group x 3 centres = 3 sets of data).
4. One-to-one 'Semi-structured interviews' with staff in key roles (Centre Head, Clinical Psychologist and Counsel Support Specialist) to comprehend the 'level of cooperation' of the building in supporting the main psychological changes sought in the psychological therapy (3 staff members x 3 centres = 9 sets of data).

The reason why I decided to adopt so many different methods in my ethnographic stage lies in Maggie's multiform reality, open and flexible to any interpretation and with an enigmatic and paradoxical character. "Design research belongs to a realm that draws its creative energy from the ambiguities of an intuitive understanding of phenomena" (Swann 2002, p. 51). Of the four methods of stage 2, I adopted the three most common used in the practice of qualitative research (Participation and Observation, Focus Group and Semi-Structured Interview), while I composed the fourth on my own (Move-along). Having a creative and multi-method research approach that helped me to being open to users' multiple different experiences of the buildings, seemed to me appropriate in an environment where more truths are possible and which aims to understand social phenomena 'in depth' (Swann, 2002) by accessing the multiple meanings that people create and attribute to the place and their social life (Ujang and Zakariya, 2015).

During the participation and observation method, as a single autoethnographic researcher with a phenomenological approach, I wanted to analyse what exists within the Maggie's Centre, so I embedded myself into peoples' experience to become part of the data myself. Reflecting on my own positionality and potential bias though the research process and in the analysis of results, I have been regularly considering my thoughts and actions in the light of different contexts through critical reflection on my prejudices, to avoid a high degree of influence on the quality of the data (for this, see also the next section "The role of the Auto-ethnographic researcher").

During the follow-up interviews of the move-along method, the access to a series of "feelings" generated by the multisensory space of the Maggie's Centre and the detailed observation of the photographic review made both participants and me aware of the provenance of the sensations of the individuals. Listening to the story of a lived experience was a good way to be involved and accessing the participant's feelings, yet only as an evocative reflection.

Focusing on both architecture and people and reflecting on my role as a researcher and becoming a tool of my research, during individual and group interviews was able to understand through the visitors, the therapeutic effect they identified in the buildings. And as a researcher, not being a person with cancer ruled out any danger of my being incorporated into a cancer-oriented environment and any influence that would come with it. Although, since we know that the researcher's perspective or position shapes all research – quantitative, qualitative, even laboratory science (Malterud, 2001) – the use of mixed qualitative and quantitative methods constituted a good compromise for interacting with people in the 'field', becoming part of the whole, yet lifting above it by continuing to change scenarios and points of view, providing future research in the 'therapeutic environment' with new ideas and insights.

## II. The Role of the Auto-Ethnographic Researcher and the Phenomenological Approach

Starting from the assumption that the physical presence of the ethnographic researcher can influence the quality of the work, once in the 'field', the researcher often has to readjust the original investigation. During my ethnographic fieldwork (stage 2), trying to carry out my investigation according to the parameters and criteria I had set for myself, I too had to adapt my fieldwork to the programme of the three centres. However, because what Maggie's does is very quickly engage people to become part of them, despite the adjustments made to my investigation as a researcher I was immediately involved not only as an observer, but also as a participant interacting with the visitors of the centre. Using myself as a tool and monitoring my experience at particular moments, my fieldwork became a kind of performance.

Reading ethnographic essays from previous researches allowed me to understand the relevance of the embodied auto-ethnographic experience. Jonas Larsen's article about his cycling experience, 'slow' in his country (Denmark) and 'fast' abroad (London, UK), highlights the fact that only being 'active' and 'fast' allowed him to feel participant and to obtain a "richer understanding in research cycling" (Larsen 2014, p. 59). Similarly, Frances Morton could not have fully experienced "the live performance of Irish traditional music in pub sessions" if she had not "engaged with social practice in order to write about it in the 'now' moment" (Morton 2005, p. 661). Her research, in particular, set a good precedent for mine, because it gave me the tools to understand the performative choreography that people

compose in a Maggie's Centre. Indeed, just like Morton's "performing ethnography" involved a musical performance that lasted the time of a concert, my auto-ethnographic work in the Maggie's Centre involved multiple choreographic situations, each one lasting the time of an activity. As Lesley Howells says, "we are constantly rolling up the carpet and then unrolling the carpet as we change the backdrop for each of our courses and workshops. And that flexibility, that 'bending' with our environment is what we hope we model to those around us" (Howells, 2016, 15:50).

Within the critique of what in the researcher's background might shape research and what kind of knowledge derives from it, in general, during my fieldwork, I was aware of my position as a researcher while interacting with and relating to others. During the interviews with Maggie's Architects aimed at discovering how architects applied the Architectural Brief to their projects, for example, I continued to reflect on my position, trying to forget, as mentioned in the introduction, that I was an architect-designer and rather play the role of researcher-storyteller, introspective of the architects' experience and their ability to generate interaction between users and built environment. In this process, what was interesting was discovering the Architects' human side and the passion that they put into the design of a building to be delivered to users that never transpires through their drawings or a publication. Open to learning the solutions of Maggie's architects, during these meetings I tried to understand what in their projects facilitated the users of their centres, information that I was able to verify during my fieldwork, realising that, in general, the users knew the architecture of the building very well.

Regarding my relationships with the participants of the two-stage fieldwork – and the degree of mutual influence – deriving from Haraway's feminist discussion around "situated knowledges" I can say that in this collaboration, with mutual exchange of knowledge, the process created new insights for 'both subjects' (my participants and me). Originally, feminist doctrine fought for situated knowledge as political, yet with epistemological reasons. They argued that the non-localisable and disembodied vision from nowhere was a powerful political tool that produces universally true knowledge, hidden from their dominant point of view (Haraway, 1991). In her critique of feminist intervention in the masculinised traditions of scientific rhetoric and concept of objectivity, Haraway advocates an epistemology based on "situated knowledges" that synthesises the aspects of these two traditions. Haraway states that by recognising and understanding the contingency of their position in the world, and therefore the questionable nature of their claims to knowledge,

subjects can produce knowledge more objectively than if they claimed to be neutral observers (Haraway, 1988).

Besides the fact that it is common practice to offer research participants the opportunity to view and comment on interview transcripts (Hagens, Dobrow and Chafe 2009; Oliver, Serovich and Mason, 2005), as per Haraway's "situated knowledges" – in which both the subject and the object of knowledge are endowed with the status of actors – the interviews with Maggie's architects were conducted as a co-production: the transcript I made of each recorded interview was sent back to the architects for feedback. This was not intended as a way for the architect to take control over their narrative, but rather as a way of continuing the co-production of understanding the architectural process that went on into designing the Maggie's Centre. On the other hand, the A4 dossier that I made just after the interviews (an extract of it is in *Appendix\_IV*), which illustrated the correspondence between the emotional requests of the Architectural Brief and the emotional architects' responses, confirmed the co-productive relationship between them and me and proved that in this collaboration, with mutual exchange of knowledge, the process has created new insights for 'both subjects' (the Architects and me), ultimately representing a new lens for interpreting the architects' buildings. Nevertheless, thanks to the broad social science methodology that I trained during my doctoral studies I was able to surpass my position as an architect.

The same co-production also arose in the collection of the empirical material during fieldwork stage 2. On this occasion, thanks to my phenomenological approach, my lived-body experience was very similar to the one felt by the participants of my methods, and in an 'inter-subjective' relationship their 'subjectivity' had become mine, ultimately constituting an 'objectivity'. Compared to the one produced with the architects, this co-production with Maggie's users was of a broader nature, since, although the participants were all 'people with cancer', they could not be put under a single category such as the one of the architects. However, I still transcribed the follow-up interviews and sent them to my participants aiming at the same goal that I had set myself with the architects, that was to continue the co-production of the process of understanding architecture during the experience of the Maggie's Centre. Unfortunately, none of them replied to my request and therefore I was unable to pursue any printed form of co-production of their interviews which, however, due to anonymity, could not have been exposed publicly. The two roles I held as a researcher, the one I played during interviews with Maggie's architects at their offices (fieldwork stage 1) sharing mutual knowledge, and the other during my ethnographic work

inside Maggie's buildings (fieldwork stage 2), sharing the feelings of Maggie's users, were in my research very different but complementary.

As for the phenomenological approach that I adopted, I followed the indications that Husserl gives us. As he tells us, I searched in proximity, vicinity, or in contact with the things I intend to seek, and I did everything to suspend any understanding that can lead us to pre-ordain values for the 'things' we are trying to understand. Through the introduction of the concepts of *Körper* (the physical body) and *Leib* (the living body in lived life) I then listened to Husserl who opens the discourse of the body in space (Zahavi 1994, p. 69). "Thus, we experience the things around us in relation to our body, that is in a spatial, spatio-temporal relation to our *Leib*" (Shirazi 2014, p. 3). Since in accordance to M. Reza Shirazi, through the body, phenomenology provides architects with a 'way of seeing', although a phenomenological approach goes beyond the sensory experience, during the fieldwork researchers still need their senses to perceive the world. In particular, Norberg-Schultz affirms that it is the ocular experience that holds the authority within a phenomenological reading of the place. "The methodological method is based upon 'seeing'. 'Seeing' means, above all, recognising something 'as' something" (Norberg-Schulz 1996, p. 125). Merleau-Ponty also presupposes vision and the faculty of seeing for perception (Merleau-Ponty 2012 [1945], p. 147). However, I argue that for a blind person perception could be even more immediate, because the body is only an intermediary between us and the world. In the end, as Merleau-Ponty attributes the true power of seeing, or rather of perception, to our consciousness - "Consciousness is being towards the thing through the body" (2012 [1945], p. 140), it is the consciousness what binds us to existence, corresponds to perception, keeps us in balance when we move, shows us the way when we go out and advance with the body towards the world. Hence, it is within the 'things themselves' that we reach the transcendental experience, in silence and solitude (Holl, Pallasmaa and Pérez-Gómez, 2006).

### III. Reconnaissance Fieldwork Stage 1

In this section I will explain how I started my fieldwork and what considerations I departed from. When I met Lesley Howells in 2017, the first thing she told me was that the architecture of the Maggie's Centre in synergy with the presence of people allows a state of psychological flexibility in the users, thus constituting an effective therapeutic environment (Howells, 2016). This premise helped me to understand that, due to its function, the presence

of people within an environment seems essential to allow a building or a place to become therapeutic. Once this was stated, however the question that emerged was: what is it about the building that has this positive impact on users?

When I completed my reconnaissance fieldwork, I could testify what at that time I was just finding out. Alex de Rijke (dRMM), one of Maggie's architects I interviewed, explained to me that people who visit a Maggie's Centre get the very clear message that design is a form of 'care'. "It is really about letting architecture speak about care, and that is what design is" (*de Rijke, 17.12.2018*). As we will see, according to Maggie and Charles Jencks both designers for whom architecture was the key to their mission, people at Maggie's care about design.

This premise helped me to locate the unifying thread between the three phases of the reconnaissance fieldwork: visiting the centres (20+3) (bearing in mind that two are in Tokyo and Hong Kong) and speaking with the staff (experiencing Maggie's sense of human care); interviewing Maggie's architects (capturing the emotional involvement of architects in the design of care); and finally, interviewing the Client-expert (assessing that Maggie's delivers care through design by supporting the staff who supports the visitors).

### IIIa. Visiting the Centres

I started visiting the Maggie's Centres, informally, in November 2017, before submitting my PhD proposal. Having lived the experience of cancer directly with my brother's illness and death, and having met Charles Jencks and learning from him about Maggie's mission, those visits to the centres, as well as confirming my choice to study the role of architecture in therapeutic environments, certainly gave me the confidence to undertake such an emotionally difficult subject. Except for the two centres in Hong Kong and Japan, by early November 2018 I had visited all the centres (Box 4) built by that point, both in the UK (19) and elsewhere in Europe (1), developing a growing feeling that "architecture is there for you". My visits to the nine centres in Scotland in November 2017, took place on the occasion of a field trip with my Interior Architecture students, who that year were working on the 'spatial field' of the Maggie's Centre. The students collected original drawings to each build a model of a centre. Through the students' projects I had the opportunity to study the buildings in a much deeper way. Finally, in November 2018, during a school field trip to Spain, I visited the at-the-time most recently built Maggie's Centre, Kálida Barcelona

(2019). By the end of February 2020, just before the lockdown for COVID-19 pandemic that stopped the world, I was able to see the three centres inaugurated in Great Britain in 2019: Maggie’s Leeds, Maggie’s Cardiff and Maggie’ Royal Marsden; finally, as I write, Maggie’s Southampton has been inaugurated and I have yet to visit (*Appendix\_II*).

	<i>Name of the Centre</i>	<i>Country</i>	<i>Maggie’s Architect</i>	<i>Year</i>
1	Maggie’s Edinburgh	Scotland	Richard Murphy Architects	1996
2	Ex-Maggie’s Glasgow ‘The Gatehouse’) (now office)	Scotland	David Page (Page\Park)	2002
3	Maggie’s Dundee	Scotland	Frank O. Gehry Architects	2003
4	Maggie’s Highlands	Scotland	David Page (Page\Park)	2005
5	Maggie’s Fife	Scotland	Zaha Hadid	2006
6	Maggie’s West London	England	Ivan Harbour (Rogers Stirk Harbour + Part)	2008
7	Maggie’s Cheltenham	England	Sir Richard MacCormac of MJP Architects	2010
8	Maggie’s Glasgow Gartnavel	Scotland	Rem Koolhaas (OMA)	2011
9	Maggie’s Nottingham	England	Piers Gough (CZWG)	2011
10	Maggie’s Swansea	Wales	Kisho Kurokawa with Garbers & James	2011
11	Maggie’s Newcastle	England	Ted Cullinan of Cullinan Studio Architects	2013
12	Maggie’s Aberdeen	Scotland	Snøhetta	2013
13	Maggie’s Hong Kong	HK	Frank O. Gehry Architects	2013
14	Maggie’s Merseyside (interim) substituted by Maggie’s Wirral	England	Carmody Groarke Dennis Swain of HB Architects	2014 2021
15	Maggie’s Lanarkshire	Scotland	Neil Gillespie (Reiach and Hall Architects)	2014
16	Maggie’s Oxford	England	Chris Wilkinson (Wilkinson Eyre Arch)	2014
17	Maggie’s Manchester	England	Norman Foster of Foster + Partners	2016
18	Maggie’s Tokyo	Japan	Cosmos More	2016
19	Maggie’s Forth Valley	Scotland	Garbers & James	2017
20	Maggie’s Oldham	England	Alex de Rijke (dRMM)	2017
21	Maggie’s Barts	England	Steven Holl (SHA)	2017
22	Kálida Barcelona	Spain	Benedetta Tagliabue (EMBT)	2019
23	Maggie’s Cardiff	Wales	Dow Jones	2019
24	Maggie’s at The Royal Marsden	England	Ab Rogers	2019
25	Maggie’s Leeds	England	Thomas Heatherwick	2019
26	Maggie’s Southampton	England	Amanda Levete (AL_A Architects)	2021
27	Maggie’s at the Royal Free	England	Daniel Libeskind	2022
28	Maggie’s Northampton	England	Stephen Marshall	2022
29	Maggie’s Coventry	England	Jamie Fobert	2022
30	Maggie’s Taunton	England	Alison Brooks Architects	2022
30	Maggie’s Cambridge	England	Níall McLaughlin	-----

Box 4. List of the built and upcoming Maggie’s Centres

### IIIb. Interviewing Maggie’s Architects and Archival Research

Maggie’s instructs architects to design unconventional buildings in order to physically and psychologically support people with cancer, their families and their friends. But how is this

kind of support realised? What feelings are the building supposed to transmit? What are the senses that are stimulated? Or, more precisely, how does the feel of the building coalesce around the feelings individuals experience in and about that building to combine into an affective geography? (Rose, Degen and Basdas, 2010, cited in Martin, 2017, p. 18) In order to answer these questions, it is important to know, in their daily life, the point of view of those who inhabit the buildings we study (Degen, DeSilvey and Rose, 2008) and, at the same time, to recognise the action of architectural form itself and understand the ‘push’ that buildings give in shaping the practices of those who use them (Kraftl and Adey 2008, p. 219). This type of inquiry helps us to build a more vibrant understanding of architecture, to “get up close to buildings as occupied performative events” (Jacobs 2006, p. 10) and to recognise the atmosphere of the place they generate.

In order to reach all the architects of the Maggie’s Centres already built or in progress, I asked help from Maggie’s CEO Laura Lee. Out of twenty architects she had contacted, twelve showed interest in my project. The goals of the interviews were to examine how the Architectural Brief had been consistently applied to the design of Maggie’s buildings, and to verify the relevance of the architects’ contribution in building Maggie’s success and legacy. The interviews took about six months and the architects were the first official witnesses of my investigation. Through their stories, I began to explore the field from the inside, learning directly from the source the reasons for many design choices, from which I was able to extract new research topics. During the interviews, the architects started by briefly telling me their stories, and then went on to answer to specific questions on various themes. Based on the literature review, borrowing topics from past research, the key points of the interview discussion were: 1. Healing architecture (scientific or intuitive knowledge?); 2. Architectural Brief (how important is it?); 3. Going beyond the Architectural Brief (what was the biggest challenge?); 4. Relationship with the Client-expert (how do you judge it?); 5. Maggie’s Architects (are they a community?); 6. Change the way we design (how much did this project influence your work, and what did you learn?). Details of the interviewees and schedule of interviews with Architects can be found in *Appendix IIIa*. To these must be added casual conversations with other informants which proved very useful in finding the answers to many questions of my research (*Appendix IIIg*).

To gain a fuller knowledge of the design process in creating their buildings while responding to the Architectural Brief, I had one phone interview with the associate of the main architect, and went directly to the offices and met either the principals or the architects

in charge of the design of the other eleven Maggie's Centres. Aside from those in Great Britain, I visited two architects in the United States, one in Norway and one in Spain.

From the interviews with the architects and Client-expert, the three 'key practices' going on in the Maggie's Centre and emerging from the Architectural Brief of 'Social Interaction', 'Privacy' and 'Counselling' confirmed the findings from past research (Cumming and Poncelet, 2018). Keeping in mind that the Maggie's Centre has ultimately two goals – to give a sense of community and to assure a degree of privacy within it – by analysing these functional requirements, the Brief reveals that the three 'requirements' always coexist and are in balance with each other. Following the interviews, as mentioned the archive data collected on each project were organised in an A4 dossier aimed at illustrating ichnographically the correspondence between the requirements of the Brief and the responses of the designers. In addition to being liked by the architects, this document was later appreciated by the participants of the ethnographic fieldwork stage 2, as I showed it to them for explaining my research (an extract of it is in *Appendix\_IV*).

### IIIc. Interviewing the Client-expert

The semi-structured interview with the Client-expert (Laura Lee and Marcia Blakenham), which took place at Maggie's main office in London on 14.5.2019, focused on their tasks during the process that begins with selecting and instructing the architect and ends when the building is completed (*Appendix\_IIIb*). In carrying out this job, they follow step by step each design development and construction phase. The interview was intended to be a cross-check of the information received by the architects, discussing topics such as 'tuning time', 'the conditions for' and 'when exactly' the Maggie's Centre begins to function as such and, in particular, the moment in which it acquires its hybrid nature and becomes a therapeutic environment.

As soon as the interview began, to my surprise, I learned that Marcia did not know what a 'hybrid' or an "iconic" – terms always used by Charles Jencks – building was and that both she and Laura, with the exception of the gardens, never use the terms 'healing' or 'therapeutic' to define the Maggie's Centre. "I think we never say to someone 'we want you to create a healing environment' at all, because that would be awful and assumptive that 'you need to be healed' and 'we are going to heal you in this environment'. I think that's sort of an arrogant concept" (Lee, 18.05.2019). This fact, which constituted a real 'breakdown'

within my research, destabilised me for a moment and made me wonder if, due to the possible ‘passive’ or ‘clinical’ interpretation of the term someone could give, ‘therapeutic environment’ was not the right definition for a Maggie’s Centre. However, after recalling Lesley Howells’ words about the Maggie’s Centre being a therapeutic environment in relation to psychological flexibility, I came to the conclusion that the therapeutic connotation was indeed helpful by virtue of the efficacy of the flexible state of mind enabled by the ‘synergy of people and place’ in users. Although I had no proof of this at the time, it was in the thesis of being the intention of the design; because of the functions for which they were designed, users perceive buildings largely as expected.

Encouraged by that thought, I continued my interview. After reassuring myself that, although they did not use it, the term hybrid was part of Laura and Marcia’s mindset (for example, in the role they attribute to art within the building), when it came to referring to the Maggie’s Centre as a therapeutic environment, the ‘breakdown’ was more severe and needed a deeper understanding. In this case, Alvesson and Kärreman (2007) came to my aid by suggesting that I had to take empirical data as a discussion partner. Analysing more deeply the point of view of Laura and Marcia, as we will see later, this ‘breakdown’ proved to be one of the key elements in understanding the Maggie’s Centre.

Although there is freedom in the Architectural Brief and the Client-expert does not impose schemes or hypotheses, Laura and Marcia demonstrate that they have full control over every single detail of the building. From their experience they say that this is the only way to work if they want to complete the building successfully. While this may be true, this attitude suggests a firm structure behind a soft façade. This was already felt during the interviews with the architects. Although everyone agreed that Maggie’s is the best client an architect could have, common choices were not always easily reached. “We enjoyed working with them, not because it was open and free and you could do anything, that’s really not true” (*de Rijke*, 17.12.2018). Moreover, for Laura and Marcia, the staff must learn how to ‘live with the building’ with initiative though without much freedom to make alterations. During my ethnographic fieldwork stage 2 at the three Maggie’s Centres, I realised that the hierarchy of the ‘non-institutional-institution’ is more complex than what it seems.

#### IV. Analysing Stage 1 in order to move to Stage 2

Analysing the data from stage 1, in combination with the literature review about the Maggie’s Centres and the Architectural Brief, I developed the parameters which helped to

explain the intention of the building from the Client-expert's and Architects' side. The parameters became the tools for planning and to be used in the ethnographic fieldwork to be undertaken in the centres. Hence, I identified a total of twelve parameters ('Social Interaction', 'Privacy' and 'Counselling'; 'Identity', 'Agency' and 'Prospect & Refuge'; 'Acceptance', 'Defusion', 'Self as observer'; 'Present moment', 'Values' and 'Committed action'). The first six parameters came from my interrogating the Architectural Brief and talking to the Client-expert and the Architects; the second six came from my reviewing and understanding the concept of Psychological Flexibility and the 6 steps of ACT (Acceptance and Commitment Therapy). In fact, in order to measure the degree of 'therapeuticity', 'favourite places', 'kind of support' and 'level of cooperation' of the Maggie's Centre I needed parameters inherent in the sources that generate them in people, hence the Architectural Brief and Psychological Flexibility (Box 6). For the Architectural Brief, the first three parameters represented the balance among the three 'key practices' occurring in the Maggie's Centre of 'social interaction, privacy and counselling' –highlighted by one of the Maggie's Architects as the three main goals of Maggie's mission – that presented itself as fundamental in order to support people with cancer's confidence. Within the second three parameters of the Architectural Brief, 'identity', 'agency' and 'prospect and refuge' are among the main design goals of the Architectural Brief in order to obtain a building capable of transferring therapeutic effects to its users.

The first three parameters of Psychological Flexibility, 'acceptance', 'defusion' and 'self-as-context', represent the three past/present processes of psychological flexibility, essential steps to distract and move on from struggling with reality and to find the freedom to make choices. Finally, the second three parameters, 'present moment', 'values' and 'committed action' are the three present/future processes of psychological flexibility that the human state of mind necessitate to choose to react and be well. Although these six parameters, illustrated in the *hexaflex* (Box 3, p.74), are strongly connected and cannot be separated – just like the six faces of a diamond – I used the three 'past/present' processes to measure visitors' impressions and emotions with respect to the past and the current situation supported by the Maggie's Centre, and the three 'present/future' processes to measure the impressions and emotions of the staff with respect to the current situation of visitors and how the building comes to their aid when looking to the future. This subdivision of parameters is not a contrasting but a complementary way to frame the experience of the therapeutic environment from two different perspectives.

From the literature review and Lesley Howells' suggestions based on the past experience of other researchers' fieldwork I identified the 4 methods that constituted the research design for Stage 2 and to which I now turn.

## V. Ethnographic Fieldwork Stage 2

In this section I will explain how, moving into stage 2, I aimed to explore the relationship between the intentions of the building from the client-expert's and architects' side and the experience of the users, not by imposing the intention of the users, but with an open exploration by being there and engaging in ethnographic fieldwork, enable the connection between the users and architecture.

The purpose of the second stage of my fieldwork – occurring at the three centres Maggie's Dundee, Maggie's Oldham and Maggie's Barts during the last four months of 2019 – was, as mentioned to discover what is it about the Maggie's Centre that generates therapeutic effects on users, i.e. the link between the design methodology and the flexible mental state enabled in Maggie's users and, more precisely, how this link is capable of establishing an effective therapeutic environment. Thanks to a careful design strategy that divides the contiguous open spaces through non-invasive but decisive moves, guided by an essential Architectural Brief, the architecture of the Maggie's Centre encourages “spatial interaction rather than walls” and ‘vicinity’ between people within the spatial field in which they are immersed by establishing a state of psychological flexibility. This premise helped me understand how to strategically situate myself in the social space once I arrived in each centre which was usually in the kitchen area where such an interaction occurred most. The ethnography of it consisted in attending the centres, every day during the opening hours, and conducting my life according to the centre activity programme. In doing so, in my research I was able to apply four methods (‘Participation and Observation’ with Maggie's community, ‘Move-along’ with visitors, ‘Focus Groups’ with Maggie's groups, ‘Semi-structured interviews’ with Staff) (Box 5) framed by the twelve parameters identified in the previous section (Box 6).

The in-depth study of stage 1 obviously influenced the way I viewed the buildings of my ethnographic fieldwork. At the same time, however, being there with the users, I could also experience the buildings through their lens, which means experiencing the buildings “in use”. Usually architects refer to their projects as “just completed”, still with no people. For example, they will present their design choices regarding the entrance skylight, but they will

not say that it could be difficult to obscure it. Experiencing the building running at full capacity, during the ‘Participation and Observation’ method with Maggie’s community and the ‘Move-along’ one with visitors, I was able to see the ongoing adaptation of the building to the users and vice-versa and shake off the architect’s gaze, being open to what I was about to discover and what people were telling me. The ease with which the users (both staff and visitors) welcomed me in the three centres helped me to maintain this openness, making me realise that the more I was open to what users and visitors told me, the easier it was to identify what I was looking for. With focus groups and interviews, I was then able to juxtapose what the architects said with what the users said to come closer to an understanding of the interaction between the intention of the buildings and the user experience. Ultimately, my contribution was to be open to what people were saying to me, which created the main link between the two stages of my fieldwork, as well as creating a way to spread the voice of users with a much more open perspective, for potential architects who will do this work in the future.

## VI. Methods and parameters of Stage 2

Among the four methods that I identified, the first two, ‘Participation and Observation’ and the ‘Move-along’, focused on the architecture (building), assessing the use of the space through people’s movement, applying parameters extracted from the six requirements/goals of the Architectural Brief, using observation and people mapping. The second two methods, ‘focus group’ discussions and traditional ‘semi-structured interviews’, focused on people (visitors and staff), assessing their experience through the building’s support, framed through the six processes of psychological flexibility, and using traditional groups discussions and interviews. In dividing the methods into 2 + 2, we will note that the evaluation criteria were alternated: *collectively* for Method 1 and Method 3 and *individually* for Method 2 and Method 4 (Box 5). Within this investigation, aimed at highlighting the relationship between the building, the people, the activities, and the place. each method had a focus:

	DESCRIPTION	PARAMETERS	FOCUS	CRITERIA	DATA	MODALITY
Method 1	Participation and Observation	from the Architectural Brief (Social Interaction, Privacy and Counselling)	Architecture (Use of the building and space)	Collectively	Quantitative and qualitative	Behavioural observations. Mapping with field notes and drawings
Method 2	Move-along	from the Architectural Brief (Identity, Agency, Prospect & Refuge)	Architecture (Response of the building and space)	Individually	Quantitative and qualitative	Semi-active observation, tracking with drawings, transcription of audio recorded conversation
Method 3	Focus groups w/Visitors	from Psychological Flexibility ACT model	People (Visitors'/ Human experience)	Collectively	Qualitative	Transcription of audio recorded discussion
Method 4	Semi-structured Interviews w/ Staff	from Psychological Flexibility ACT model	People (Staff's/ Human experience)	Individually	Qualitative	Transcription of audio or video recorded interviews

Box 5. 2 + 2 Methods 1, 2, 3, 4

1. The 'Participation and Observation' method, carried out during the normal activities of Maggie's support programme aimed to understand 'how the building is in tune with the feelings of the people' and identify the degree of 'therapeuticity' of its environment in accordance with the pre-established parameters. In particular, by adopting the first three requirements/parameters (social interaction, privacy, counselling), I aimed to demonstrate *how the architecture of the therapeutic environment changes and transforms during the day* to accommodate the needs of people and activities. This method was traced with my mapping of the space use made by the visitors and captured through fieldnotes and charts (*Appendix\_V*) and by follow-up comments of the participants (*Appendix\_III f*). During my participation within the activities of the centre I had the opportunity to become one of Maggie's visitors; this participation became a tool of my research.
2. The 'Move-along' method, consisting of an architectural 'tour' during which individual participants showed me their 'favourite places' within the building, aimed to access 'the feelings that the building evokes in the participants'. In particular, by adopting the second three goals/parameters (identity, agency and prospect & refuge), As suggested by Lesley Howells (2017), I wanted to show *how the building*

*empowers Maggie's users (staff and visitors) with a sense of reference, mastery, and protection*, encouraging them to get sensorially involved. This method was captured with itineraries and photographs taken by the participants (*Appendix\_VI*), recorded and transcribed conversations, and by follow-up comments of the participants (*Appendix\_IIIe*). With this method I had the opportunity to be very close to the participants and 'see' through their eyes.

3. The 'Focus groups' method with five structured groups at Maggie's (men's and women's groups) of 5–7 visitors each allowed me to investigate the 'kind of support' the building provides people with, and then extract the key themes for my research. In particular, by adopting the first three processes/parameters ('acceptance, defusion, self as observer') I aimed to assess *how the architecture helps to distract and move on from struggling with reality* and finding the freedom to make choices. The group discussions of the three women's groups were recorded, transcribed and put them in parallel to extract common themes (*Appendix\_VII*).
4. The 'Semi-structured interviews' method with Maggie's staff in key roles (Centre Head, Clinical Psychologist and Cancer Support Specialist) and other roles (Fundraiser) helped me to understand the 'level of cooperation' of the building in supporting the staff in detecting the main psychological changes usually sought in normal therapy. In particular, by adopting the second three processes/parameters ('present moment', 'values' and 'committed action') I aimed to assess *how human states of mind are necessary to choose to react* and be well. They consisted of recorded and transcribed one-to-one interviews. A summary of interviews data and themes that emerged from it can be found in *Appendix\_ VIII*.

In relation to the four methods described above, below I describe in detail how I used the twelve parameters (already separated into 6 + 6 and 3 + 3 and 3 + 3), identifying them with the four categories A + B and C + D according to the reference method (Box 6).

During method 1, 'Participation and Observation', I assessed people's movement within the following three parameters:

- A1. 'Social interaction', which is the action of social exchange between two or more individuals. I tested it in the welcome area, in the kitchen area (kitchen table), and in the large living room.

- A2. 'Privacy', which is the condition for being free from public attention. I observed it in the kitchen (kitchen table), in the fireplace area, in the secluded areas of the open space and in the veranda.
- A3. 'Counselling', which is the provision of professional assistance and guidance in solving personal or psychological problems. I assessed it in the kitchen (kitchen table), in the fireplace area, and at the computer desk.

During method 2, 'Move-along', I assessed people's movement within the following three parameters:

- 4B. 'Identity', which is the way of making a transition and turning towards cancer; it is the necessary starting point for regaining self-esteem and awareness of self. I observed it in the public areas of the centre, especially in the entry/pause area and in the welcome area / library.
- 5B. 'Agency', which is the capacity of individuals to act independently and to make their own free choices. I measured it in the public areas of the centre, particularly in the welcome area / library, in the kitchen, computer desk and greenhouse.
- 6B. 'Prospect & refuge', which is the condition of humans seeking to satisfy an innate desire to have opportunity (prospect) whilst being safe (refuge) when reviewing a space. I assessed it in the spaces open to the public in the centre, especially in those overlooking other areas or towards the outside, discovering however that individuals have their own personal concept of prospect & refuge.

During method 3, 'Focus groups' with visitors, I framed people's experiences within the following three parameters:

- 1C. 'Acceptance', which is neither tolerance nor resignation, but the acceptance of painful private experiences (Hayes 2017, 53:34). I asked people to identify the areas they find more appropriate for it, indicating entry/pause and welcome areas as the possible ones, especially remembering their first visits.
- 2C. 'Defusion', which is the opposite of 'fusion', a term that comes from Latin and indicates when two or more things poured together. In this case it indicates the 'merging' of what 'someone is thinking' with what 'someone is thinking'. Defusion or distancing is therefore the ability to observe one's thoughts without being "hooked",

and not to act automatically on these thoughts. I talked about it by proposing the welcome area, the library and the kitchen (where you meet people with the same problems) as possible areas for discussion.

- 3C. 'Self-as-context', which is the ability to stay in touch with a perspective of self that does not vary according to transitory emotions or thoughts, but which includes them without changing. I talked about it referring to the kitchen table (where you start to observe yourself as part of a community), the fireplace area and the large living room. As Hayes puts it, the ability to take "the viewer's point of view" involves seeing events from different perspectives.

During method 4, 'Semi-structured interviews' with staff, I was able to understand how the building supports them through the following three parameters:

- 4D. 'Contact the present moment', which is the ability to direct one's attention voluntarily to events that are happening here and now, rather than focusing without control on the past or the future. I asked the staff if they noticed whether the architecture of the building helped focus visitors' attention on 'Be here now'.
- 5D. 'Values', which is the identification of what is important to a person, of the qualities they intend to express and live in the various areas of their existence, of what they can make with their full and worthwhile life. I asked the staff if they felt the building's empathy matched theirs, helping them focus visitors on 'Knowing what matters'.
- 6D. 'Committed action', which is the ability to take concrete actions to move in the direction of what the person considers important, even when this act exposes unwanted emotions and thoughts. I asked the staff if they observed whether the building that is always in need of maintenance has supported them in focusing visitors' attention in the "Do what it takes", reciprocity and generosity (within Kitchen, vegetable gardens, greenhouse).

PARAMETERS		METHODS	PARTICIPANTS	ROOMS	ACTIVITIES	
<b>DEFYING A THERAPEUTIC ENVIRONMENT</b>						
1	ARCHITECTURAL BRIEF	Social Interaction	Participation and Observation/ Mapping + Field notes	Visitors (People w/cancer, Family, friends)	Welcome area, kitchen, big living room	Conversing, discussing, listening, cooking
2		Privacy	Observation/ Mapping + Field notes	Visitors (People w/cancer, Family, friends)	Kitchen, fireplace area, retreat or conservatory	Thinking, crying, reading, listening to music, watching
3		Counselling	Observation/ Mapping + Field notes	Visitors (People w/cancer, Family, friends)	Kitchen, fireplace area, welcome area/library	Talking, listening, thinking
4		Identity	Move-along/ Tracking	People w/cancer	Entrance/pause, welcome area/library	Entering, pondering, deciding
5		Agency	Move-along/ Tracking	People w/cancer	Welcome area/library, kitchen, computer desk, greenhouse	Make yourself a cup of tea, go online, do some gardening
6		Prospect & Refuge	Move-along/ Tracking	People w/cancer	Fireplace, rooms with views, conservatory	Thinking, reading, listening to music, watching outside
<b>PSYCHOLOGICAL FLEXIBILITY</b>						
1	PSYCHOLOGICAL FLEXIBILITY	Acceptance (Open up)	Focus group	Visitors (People w/cancer, Family, friends)	Entrance/Pause, Welcome area	Entering, pondering, deciding
2		'Defusion' (Watch your thinking)	Focus group	Visitors (People w/cancer, Family, friends)	Welcome area, library, kitchen	Watching, getting comfortable, initiating a conversation
3		Self-as-context (The observing self)	Focus group	Visitors (People w/cancer, Family, friends)	Kitchen table, fireplace, living room	Self-help by imitating the others, 'self-observing' and 'perspective taking' by participating in activities
4		Contacting the present moment (Be here now)	Semi-structured Interviews	Staff	Empathy of the building	Direct visitors' attention voluntarily to events that are happening here and now, rather than focusing without control over the past or the future
5		Values (Know what matters)	Semi-structured Interviews	Staff	Empathy of the building	Interact with people to identify 'values' or what is important to a person
6		Committed action (Do what it takes)	Semi-structured Interviews	Staff	Kitchen, vegetable gardens, greenhouse	Engage to take concrete 'action' to move in the direction of what the person considers important

Box 6. 3 + 3 Parameters A + B and C + D

## Via. Observing While Participating

Conducting my ethnographic research in the field allowed me to fully understand the three practices that shape the uses of the centres (Social interaction, Privacy, Counselling) using them as parameters, paying particular attention to the flexibility and coexistence of the 3 practices and users' bodily compartments. To build an understanding of user behaviour within the Maggie's Centre and ascertain its nature as a 'therapeutic environment' - where people are able to help themselves by imitating others and participating in social activities - I participated in the daily life of the centre and in many of the physical and creative activities offered in the timetable. Observing the way and how the spaces in the centre are used, I have mapped with drawings the position of the users in the way they move inside the building. While I was using the parameters of 'social interaction, privacy and counselling' to frame my observations, my investigation aimed, on the one hand, to understand how people use the space of the building during the day, and, on the other, to locate rooms or circumstances in which people get the most therapeutic result from the building so as to identify the degree of 'therapeuticity'. At the end of my stay in each centre, I organised a short discussion with the participants who might have been interested in giving me their opinion on the experience and the results of my observation.

As participant in the social activities, among the many on offer, I took courses of yoga, tai-chi, art-therapy, nutrition, relaxation and sleep sound, which mostly took place in the big living room. During the breaks, in the kitchen, I conversed with the users, making cups of tea and, sometimes, helping with the dishwasher. During the quiet hours, I sat talking to visitors about my research or, if alone, observing the scenography and the choreography of the place that was so much influenced by the weather (therefore, the sunlight, the sound of the wind, the room temperature), the number of people in the building, and the activities going on that day. Finally, I observed those who were simply present in the centre but not taking part in activities. While, in fact, it is known how the building is used during the activities foreseen in the timetable, what was interesting for me to find out was how well the building is used when there are no programmed activities happening and to how often people actually use the space for non-social interaction. The final objective of this part of the study was to graphically represent the way in which the interaction between people and place contributes to establishing the therapeutic environment of the centre (*Appendix\_V*).

To define the degree of Maggie's therapeutic environment, the questions I asked myself were: where do visitors spend most of their time, and where are most of the three

social practices (social interaction, privacy, counselling) taking place in the building? By scanning the rooms and counting the number of people present in each room at different times of the day, I was able to understand how and for how long the various spaces were used, so finding the ‘density’ data. Within the ‘Social Interaction’ parameter, in social rooms such as the kitchen or the big living room, in a scale 1-5+ (number of people), a high density of people gave a high level of therapeutic environment. Within the ‘Privacy’ parameter, in private corners within public areas such as retreats or meditation corners, in a scale +5-1 (number of people), a low density of people gave a high level of therapeutic environment. Lastly, within the ‘Counselling’ parameter, in public areas such as the kitchen table, fireplace area and library, in a scale +1-5 (number of counselling), the presence of people in synergy with the building gave a high sense of therapeutic environment. Within the building, some areas revealed to be less therapeutic than others (the office, for example, was not therapeutic).

With this technique, I aimed at taking a ‘snapshot’ of the environment and release the graphic representation of its ‘therapeuticity’, which is the combination of spatial and people’s interaction. By mapping people’s movement and locating the areas that were more ‘therapeutic’ than others, I produced a coloured chart of the different rooms, able to describe the level of Social Interaction, Privacy and Counselling. The charts of the floorplans of the 3 Maggie’s Centres (*Appendix\_V*) represent the ‘density’ data in context. Different tones represent the different levels of therapeutic areas along with the positions of the users and show how many users are in each zone at a particular time and, eventually, how they move from zone to zone. The data analysis included the collected data from both participation and observation, both represented by maps and fieldnotes. The method used to analyse my data (Excel for maps and text for fieldnotes), was comparing the different ethnographic behaviours mapped in the different areas of the Centre. Three types of information have emerged from the maps and the fieldnotes were: a) users’ use of the building (in quantity), b) users’ experience of the building (in quality), c) the researcher’s personal experience of the therapeutic environment.

If ‘quantity’ is one of the components that generates well-being within the parameter of social interaction, ‘quality’ is certainly the condition that enables well-being in all the parameters. This means that, besides the ‘density’ (quantity) of people in a room, the level of ‘therapeuticity’ of the building depends on the ‘intensity’ (quality) of psychological effect on the users, as the result of the interplay between the stimulating and comforting aspects of each space and the beneficial response of the visitor (synergy between people and place).

For example, the kitchen table has the highest ‘density’ of people visiting and the highest therapeutic response, but the counselling room used for cancer support sessions, which is maybe underutilised, I was told is where the outcome of the therapeutic response is the most ‘intense’. Within the ‘synergy between people and place’, often replacing the staff, the building generates the flexible psychological state of mind of the visitors, if it derives from the interaction between stimulus (architecture) and comfort (Maggie’s), a trigger condition for the human brain which in a safe environment translates into therapeutic effects.

## Vib. ‘Moving-along’

As already mentioned, along the path of my methodology there have been tools or elements that have been given / entrusted to me (for example the three centres), others that I have borrowed (for example the three methods of Participation and Observation, Focus groups and Interviews and the six + six parameters) and one that I made up / composed (like the Move-along). As mentioned in Chapter 2, in their investigation of the two buildings in the Milton Keynes shopping centre, Rose, Degen, and Basdas (2010) used Kusenbach (2003)’s ‘go-along’ method of walking with participants doing daily chores.

To access our participants’ immediate ‘feel’ for the centre, we amalgamated two of these: the go-along (Kusenbach, 2003) and the photo-diary/photo-interview method (Latham, 2003), to develop what we have termed the ‘walk-along’ method. (Rose, Degen, and Basdas 2010, p. 340)

Unlike Kusenbach (2003)’s approach, Rose, Degen, and Basdas (2010)’s ‘walk-along’ method allows immediate and intensive access to very detailed ways to seeing, speaking, touching, hearing. As the bodies move around the mall for an extended period of time, the participants’ feeling of the place can be accessed (2010). My goal was to semi-actively observe, qualitatively, the participants in their movement inside the building. Monitoring is important to understand how people use the different rooms and practice in the building. Indoor monitoring of people can make sense in several situations. For Maggie’s, in the future, it could be useful for measuring visitor flows, especially in relation to the moments of overcrowding that sometimes challenge visitors. This can be done by analysing the walking routes of visitors to define process optimisations and support staff management, during the day or what hours of the day or week are more or less busy.

Starting from the question “what does a building do to people?” and in line with Kusenbach’s (2003) and Rose, Degen, and Basdas’s (2010) mobile methods, I proposed to name my own mobility method the “move-along”, a combination of two different methods: 1. A mobile observation which involves accompanying the participants during their normal activities; 2. The photo-diary/photo interview method, which sees the participants engaged in taking pictures and, once the images are downloaded, explaining the photographs during a follow-up interview. The final objective of this second part of the study was to identify how individuals perceive and respond to the building and how the building generates individual affects and corresponds to people’s expectations by evoking common impressions in them. As we will see later, in this method inputs from phenomenological psychology have been of particular help in connecting ‘affect’ with ‘cognition’.

A mobile observation usually involves accompanying the participants during their normal activities; however, due to the quiet life that Maggie’s visitors usually conduct within the centre, at the last moment I decided to adapt my ‘move-along’ to what I thought in that moment was best for my participants. Abandoning the idea of following individual participants in their normal activities, I asked them to show me the building in a sort of personalised ‘architectural tour’, while they allowed me to record our walking conversation. This followed the logic that “indeed, it seems intuitively sensible for researchers to ask interviewees to talk about the places that they are interested in while they are in that place” (Evans and Jones 2011, p. 2). As Lee and Ingold (2006) argue, too, walking with people, living and moving as others do, can help us to understand how other people perceive their multisensory environments and build a place through their daily practices (Hein, Evans and Jones, 2008). Participants had to choose an itinerary and take photos of the rooms or areas most meaningful to them as they made comments prompted by my simple questions.

In the ‘move-along’, movement speeds and pauses were established by the participants. If the person walked into a room and decided to sit down, I did the same. And if they decided not to proceed with the itinerary, but to continue their description while seated, I indulged them. The ‘sit-along’ (as some of these interviews were later named) depended on the will of the participants (who, for example, wanted me to admire the space from a one point of view, or who were tired, or who were busy doing something else while we were speaking). This methodological variation was possible thanks to the open space that allows people to observe spaces even from a certain distance; and the way in which the building solicits a photographic memory in people, who are able to describe in detail areas they cannot see at that moment. Even though the ‘sit-along’ did not involve much movement

and therefore a phenomenological ‘moving-in-the-world’, just sitting and participating in conversation with people who have a relationship with the immediate area allowed me to become very close to their experience (Holl, Pallasmaa and Pérez-Gómez, 2006).

Despite bringing the question sheet with me, during the Move-along I decided to only have casual conversations that were recorded and let the participant feel free to comment on the building. These questions, however, were used during the Move[Sit]-along, in an easier and more peaceful condition. A further follow-up interview done while reviewing the photographs that the participants took during the Move-along and then downloaded to my laptop improved the results with new insights. The participants were encouraged to discuss each image, explaining why they had taken it and what it meant to them. By observing the photographs that coincided with the participants’ emotional response in regard to the parameters of ‘identity’, ‘agency’ and ‘prospect & refuge’, I was able to measure the building’s ability to evoke these conditions in users. The follow-up interviews provided an opportunity to conduct a reflective analysis of the quality of the experience for both myself and the participants. Reflecting on the physical movement made during the ‘architectural tour’ and the participant’s point of view captured through the photographs, the interaction with the physical movement of the participants (where they headed, what they looked at, what they touched) showed that the participants’ experience had become embodied. Furthermore, by telling a self-reflective narrative of a range of ‘feelings’ generated by the Maggie’s Centre and by observing in detail sources of lights, reflections and colours, the photographic review made my participant and myself aware of further conditions that the naked eye in movement had not grasped (but the brain had), and where feelings experienced by individuals located ‘inside’ the Maggie’s Centre space originate.

The results obtained from the ‘move-along’ provided “immediate and intense access” not only to very detailed ways of seeing, speaking, touching, and hearing (Kusenbach, 2003), but also to what was directly experienced by my body and that of visitors. Again with reference to the feminist discussion of “situated knowledge” and the ‘subjective’ transformed into ‘objective’ (Haraway, 1988), the presence of the researcher and the unprecedented way of carrying out the ‘move-along’ influenced the participants; on the other hand, being alongside the participant was a new experience for me too, allowing me to embody myself, even if only temporarily, into Maggie’s experiential world and consider this experience in a reflective way (Pink, 2008). Observing a person while they are telling a story also evokes many memories. By listening to the participant, I was able to ascertain the emotional effect of the building on the person and, instead of being a passive observer, I was

an active one. Since the knowledge of experience and the environment was co-produced in a collaborative way, a “dialogue in which all the actors participate in a conversation creating geographic and informational paths” (Anderson 2004, p. 260) was created.

The quantitative and qualitative data collected with the ‘move-along’ consisted of the the photographs and the itineraries of the participants’ movement in different colours (*Appendix\_VI*); the recording and transcription of Move-Along casual conversation; and the transcription of the follow-up interview. Three types of information emerged from the itineraries, transcripts and photographs: a) favourite places in the building by users (in quantity), b) experience of the building by users (in quality), c) personal experience of therapeutic environment by the researcher. The method used to analyse my data (Excel for the transcriptions and a graphic programme for superimposition of the traces of all itineraries), allowed me to identify the paths and the environments preferred by people ~~use~~ ~~most~~. In this case, inputs from phenomenological psychology helped me connect ‘affect’ and ‘cognition’. For example, during the Move-along interviews, someone could have said: “I come to Maggie’s, but the best space for me is outside, on the terrace or in the roof garden, because I don’t like being in the kitchen” (Move along Barts no.4) showing that they have developed a particular affect for the terrace and consequently deciding to be asocial. This shows that while everyone likes to visit Maggie’s, everyone will respond to the space individually.

Combining information which emerged from the mobile observation and photographs, I was able to reveal new insights into an area of research where little is known. With the aim of identifying the link between architectural design and the state of psychological flexibility and providing instruction to architects, the results of the data analysis set a useful precedent for architects, academic researchers and stakeholders of future healthcare facilities.

## VIc. Focus Groups with Maggie’s Visitors

The relationship between human behaviour and the built environment changes from person to person. Upon their background, people can have different behaviours in the same space and perceive well-being and support in a totally different way in different spaces. Also, every day is different, and people can find comforting or supporting today something that tomorrow will be felt differently. Despite the best architectural solutions, it is difficult to

predict how people feel in a place or even to understand the level of comfort, so it is better to refer to the bodies to accommodate comfort to be interpreted as “a specific affective resonance” (Bissell, 2008), How does the Maggie’s Centre reassure its users and shape their/our experience of its new spaces to us? In order to assess dynamics within the Maggie’s Centre, participants of the focus groups were selected using ‘facilitated’ groups already existing in Maggie’s Programme such as: Connections (bereavement), Young Persons, Family and Friends, Sibling Support, Men’s Group, Young Women’s, Advanced Cancer Group, General Support Group. Final goal of this third part of the study was to understand the user experience and how interaction between people and place contributes to establishing the therapeutic environment of the centre.

The focus groups lasted about two hours and were facilitated by me as a researcher. It included two phases: 1) Presentation of my project with slide projector 2) Conversation and commentary with audio recording following a track of questions. The questions asked in focus groups with Visitors (*Appendix\_IIIc*), as well as for those asked in interviews with Staff (*Appendix\_III d*), came from making the conceptual framework operational, from the study of the Architectural Brief, from the analysis of the first stage interviews and, in some cases, from the participation in the life of the Maggie’s Centres. In particular, the questions addressed the study objectives using suggestions taken from the citations of the Architecture Brief and the topics of the document ‘dossier A4’ (*Appendix\_IV*) that I prepared following the interviews with the Architects with the aim of extracting individual themes and priorities in the use of the building. Framing the group discussion according to the first three processes (concerning the past and present) of psychological flexibility, ‘acceptance’, ‘defusion’, ‘self as context’ I asked specific questions that included their opinion on the Maggie’s Centre as a therapeutic environment and the possible functional or spatial changes that they would have made to the building. By asking about the “synergy between people and place” as ‘their’ conception of the therapeutic environment, the participants’ discussion was contextualised, with the aim of highlighting memorable experiences.

Focus groups with visitors (people with cancer, friends and relatives) were selected over informal or formal interviews for several reasons. Firstly, focus groups allow participants to collectively explore their own perspective and those of others, with the opportunity to discuss and debate with other group members. Secondly, talking with people with cancer or family members in a group setting is known to encourage open discussions without inhibitions. Furthermore, focus groups are an efficient way to collect data from large numbers of participants within the researcher’s limited capabilities. Since, in this case, the

discussion revolved around the architecture of the building, this conversation made some participants, not very interested at first, more aware of the environment of the Maggie's Centre. A number of 5–7 participants was considered optimal for each focus group, and three focus groups (one for each Maggie's Centre) were considered sufficient to capture a good number of significant experiences for this research. As mentioned, the questions of the focus groups were generated using information from the Architectural Brief and from the architects. Finding feedback on what the architects said and trying to be open to what people were saying to me created a way to spread the voice of users with a broader perspective.

The interview was divided into two parts: 1. The interviewees were encouraged to tell their story; 2). The interviewees answered specific questions in accordance with the three parameters of Psychological Flexibility. The interview ended with a question about their personal opinion on the Maggie's Centre as a therapeutic environment, and the possible functional or spatial changes that they would have liked to make. The interviews were recorded and then transcribed for analysis.

The data was thematically analysed with Excel, with the aim of grouping the main common threads to identify any relationships existing between the focus groups of the three Maggie's Centres. This made it possible to compare any similarities and differences in the results that emerged from the data and themes of the three group discussions, i.e. to understand whether the visitors of the different centres share thoughts and feelings or not, and therefore whether the buildings generate the same effects, despite the different location, etc. Microsoft Excel was used to create a framework for managing and presenting the expected breadth of interview data (*Appendix\_VII*).

## VId. Interviewing Maggie's Staff

Maggie's staff were the first persons I met during my first visits to the centres. Every time I went to a centre, I was surprised to ascertain the staff's involvement in the realisation of Maggie's architecture, in which buildings are intended not as stabilised objects, but as ongoing projects, in a constant process of construction and renovation (Gieryn, 2002). Yet, the staff's interest in architecture is not a natural or immediate process. From the interviews with the Client-expert it had emerged that one of the difficult roles that the Client-expert has is educating the staff about the architecture of the building that will have to support their work as well the visitors. Coming from previous work experience in the healthcare

environment that is very disciplined and organised but usually carried out in limited environments, or where the quality of the space does not matter, new staff members struggle to ‘surrender’ to the building. Inside the Architecture, the role of the staff is fundamental in providing aid that ranges from practical (organisational, financial) to lifestyle (nutrition, creativity, social relations) to the emotional (psychological) level. As Charles Jencks has repeatedly argued, “the building supports the Staff and Staff supports people with cancer” (Jencks, 2015, p. 10), yet “the real and fundamental variable of Maggie’s success is not so much Architecture, but team, spirit and programme” (Jencks, 18.06.2018).

Because of the aim of understanding ‘the level of cooperation’ of the building in supporting the staff in detecting the main psychological changes usually sought in normal therapy, my interviews with the staff were initially limited to the three key staff roles (Centre Head, Psychologist and Cancer Support Specialist). Since they come from various schools of psychology, not all psychologists at the Maggie’s Centre use the processes of psychological flexibility, but without distinction they all count on the flexibility of the space and the programme that encourage flexibility in people.

You don’t have to take somebody into a room, all the different ingredients of that therapeutic change are actually here, within the synergy, by how the people use the space, and the space encourages the people to behave in a particular way. (Howells, 01.11.2017)

What Howells argues is that the same therapeutic changes that occur within psychological therapy can occur in the building space, thanks to the way the building works with both non-psychological and psychological staff. Within the research / discussion this passage anticipates the final goal of this fourth part of the study which was to understand to what extent the work carried out by the building, in co-action with the work carried out by the staff, constitute a ‘synergic power’ that generates psychological flexibility in Maggie’s users.

As mentioned, the questions asked in the semi-structured one-to-one interviews (*Appendix\_ IIIId*) came from making the conceptual framework operational, from the study of the Architectural Brief, from the analysis of the first stage interviews, from my observations made during the construction of my A4 dossier that I made following the interviews with the architects and, in some cases, from the participation in the life of the Maggie’s Centres. They were framed according to the second three processes concerning the present and the future processes of psychological flexibility, ‘here and now (mindfulness)’, ‘values (you know what matters)’, and ‘committed action (do what it takes)’.

By juxtaposing what the architects said with what the users said, I came close to an understanding of the interplay between the intention of the buildings and the user experience. In trying to understand how the building helps the staff to support the visitors to voluntarily focus on the present, encourage them to do what is important to them, and direct their attention towards concrete future actions, it emerges that through the staff's 'generosity' and 'authenticity' an adaptation mechanism of 'reciprocity' arises in visitors that improves their survival. Within healthcare spaces, people with cancer respond with a sense of reciprocity by creating an interdependent environment, in which shared work allows humans to be more efficient (Williams, 2007).

Besides the interviews with the Staff key roles, I ended up interviewing staff members in other roles (such as fundraiser) who have worked at Maggie's for a long time. Interviewees were encouraged to tell their story by trying to follow the order of the questions prepared. The interview was divided into two parts: 1. The interviewees were encouraged to tell their story; 2). The interviewees answered specific questions in accordance with the three parameters of Psychological Flexibility. The interview ended with a question about their personal opinion on the Maggie's Centre as a therapeutic environment, and the possible functional or spatial changes that they would have liked to make. The interviews were recorded and then transcribed for analysis.

An inductive approach to data analysis was undertaken as the themes emerging from the dataset were first coded and then linked and grouped to identify any existing relationships between the themes staff. The data was thematically analysed with the aim of identifying any relationships on the topics that emerged from the Staff and subsequently verifying a validation once associated with those that emerged from the focus groups. I chose the thematic analysis because I wanted to extract the essence of the Maggie's Centre to apply to other facilities. Microsoft Excel was used to create a framework for managing and presenting the expected breadth of interview data (*Appendix\_VIII*).

## VII. Concluding considerations on Fieldwork Stage 2

The first consideration I can draw from the ethnographic fieldwork Stage 2 within the Maggie's Centre is that using the four methods and twelve parameters allowed me to experience a wide range of perspectives from which subsequently to analyse the empirical data. For example, using the agency parameter (5B) in the 'Move-along' method, I detected

the degree of autonomy of people, as well as the areas of the building that evoke this feeling and the actions that demonstrate it, such as entering the building with mastery, sitting together with other people, sitting alone, or moving freely around the rooms with confidence. From applying the framework of the Social interaction parameter (1A) in the 'Participation and Observation' method I came to understand that some of the activities I participated in (physical and psychological) do not allow conversation during the activities themselves, but only before or after. This usually occurs in the kitchen, where people meet before or after the activity and where the level of social interaction is the highest within the building. Within the Values - Do whatever matters most in this moment' parameter (5D), at Maggie's Oldham I discovered that 'the Tree of Life' is taken as an example by the staff to focus visitors' attention on the values that matter to each of them, and the living room with the fireplace represented an important refuge with the infinite view (6B) of the "Pennine horizon and the windmills". Finally, in the first counselling room, a woman said, "I feel very safe here, but what happens when I have to move?"

With these examples what I want to show is, in general, how the parameters were used and how, despite the parameters, the structure of the fieldwork opened my eyes to the experience of the users of the buildings. As already mentioned, in applying the four methods of stage 2 the use of the 12 parameters that emerged from stage 1 was done only as a 'tool', i.e. a frame which, once used, I moved on from - as it is done with the cast after the casting of a plaster sculpture. Gradually moving them to the background as users' perspectives emerged and spoke directly to the building, what remained was the data collected and read within these frames that helped understand what Maggie's buildings do and progressively discover the findings. As for the analysis of stage 1, from the dimensions of stage 2 I have derived the pieces which, as we will see in Chapter 8, have been reassembled in the idea of Maggie's as an emerging paradigm.

Although Butterfield and Martin's research (2016) had already defined Maggie's gardens as "therapeutic landscapes" and stated that following patients in the garden opens the way to monitor people in the building itself (Butterfield and Martin, 2016), my discoveries are new and original. Through the identification of the 'therapeuticity', the 'favourite places', the 'kind of support' and the 'level of cooperation' of the Maggie's Centre, I was able to discover the link between design strategy and psychological flexibility in the definition of its therapeutic environment. The logical progression of methodology and rationale for the two-stage process and the development of the questions and parameters used in the interviews and focus groups can be found in Box 7.

Reconnaissance fieldwork Stage 1	Methods	Goals	Findings	Ethnographic fieldwork Stage 2	Methods	Goals	Findings
<b>Literature Review about:</b>  Past research on Maggie's Centres  Architectural Brief  Psychological Flexibility	Visiting all the centres in Europe  <b>Method 1. Informal conversations</b> with staff and observations of their activities	Understanding the 'essence' of the Maggie's Centre	Confirming my choice to study the role of architecture in therapeutic environments, with confidence to undertake such an emotionally difficult subject.	<b>Literature Review about:</b>  Ethnography  Phenomenology  Performativity	Immersing myself in three centres  <b>Method 1. Participation and Observation</b> (mapping people's use of the space)  <b>3 parameters</b> -Social interaction -Privacy -Counselling	Verifying the level of «therapeuticity»  what are the most therapeutic areas or rooms within the Maggie's Centre  what are the favourite places of people	<b>Level of therapeuticity of the building</b>
<b>Architectural Brief (extract topics for interviews w/ architects)</b>  <b>Past research on Maggie's Centres (extract topics for interviews w/ architects)</b>	<b>Method 2. Semi-structured Interviewing Architects</b> -Scientific vs intuitive knowledge -Architectural Brief -Going beyond -Relationship with the Client-Expert -Relationship with Users --Maggie's influence on other projects	Verifying how architects applied the Architectural Brief to their projects and extract themes, principles and parameters	<b>3 parameters from the interrogation of the Architectural Brief in interviews with architects</b>	<b>Architectural Brief (extract 3 + 3 parameters for Method 1 and Method 2; develop questions within each parameter)</b>	<b>Method 2. Move-Along</b> (mapping individuals' physical movement)  <b>3 parameters</b> -Agency -Identity -Prospect & Refuge	<b>Find the link between Architecture and Therapeutic Environment / Psychological Flexibility</b>	<b>Favourite places of users</b>
	<b>Method 3. Archive research (12) / Studying the projects (12)</b>	Looking for edited material	Unedited material	<b>Psychological Flexibility (extract 3 first parameters from Psychological Flexibility ACT model; develop questions within each parameter)</b>	<b>Method 3. Focus groups</b> with Maggie's Groups (Visitors) (extracting key themes from Architectural Brief on how the building supports people)  <b>3 parameters</b> -Acceptance -Defusion -Self-as-context	Find the key element that define the therapeutic environment of the Maggie's Centre	<b>The 'kind of support' the building gives the visitors</b>
<b>Architectural Brief (extract topics for interviews w/ Client-expert)</b>  <b>Psychological Flexibility</b>	<b>Method 2bis Semi-structured Interviewing Client-expert</b> -Healing vs. Therapeutic -Architectural Brief -Role of the Client-expert -Relationship with the Architect -Relationship with Users -Hybrid Building	Criss-crossing what architects said  Understanding the role of the Client-expert and what makes a building therapeutic	<b>-Therapeutic vs Non-therapeutic -Hybrid -3 parameters from the interrogation of the Architectural Brief in interviews with Clients</b>	<b>Psychological Flexibility (extract second 3 parameters from Psychological Flexibility ACT model; develop questions within each parameter)</b>	<b>Method 4. One-to-one semi-structured interviews</b> with staff key roles (comprehending the level of cooperation of the building)  <b>3 parameters</b> -Contact with the present moment -Values -Committed action	Give a universal definition of therapeutic	<b>The 'level of cooperation' the building gives the staff</b>   <b>'Link btw Design and Psychological Flexibility: Movement'</b>

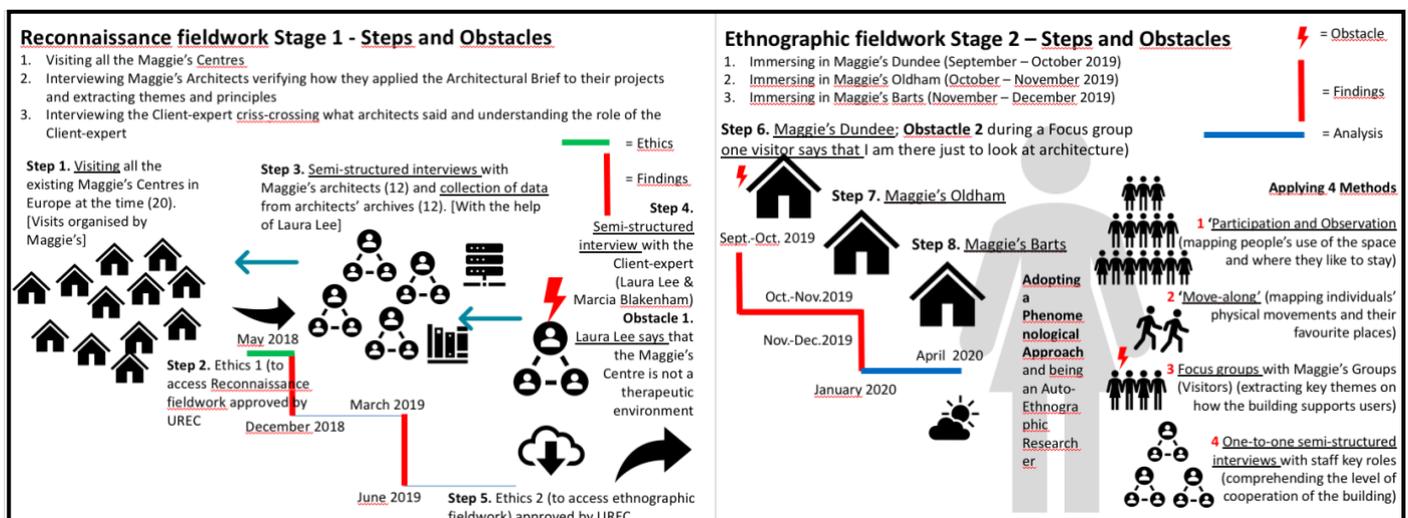
Box 7. Logical progression of methodology and rationale for the two-stage process.

## VIII. Steps and obstacles

Within a doctoral thesis, the methodology chapter is usually centrally positioned to link strategic considerations to data and results. In doing so, it explains how these considerations were made and how any obstacles occurred and were overcome, in order to give future researchers a way to understand where further research is needed to meet user needs. As shown in Box 8, in an attempt to be as clear and logical as possible, I summarise my steps and obstacles and I recall that:

1. Strategic considerations (or hypothesis): a. the Architectural Brief, just like the Benedictine Rule, is a cornerstone of the organisation; b. Maggie's therapeutic must be something more than comfort and restoration (Chapter 1);
2. The role of emotions and feelings that generate a therapeutic environment was inserted and read into the broader interdisciplinary theoretical framework (phenomenology, psychology, geography, sociology, science) (Chapter 2);
3. Consequent research decisions were made: 1. narrowing down the field of investigation (from 25 visits, to 12 architects /buildings interviewed / analysed, to 3 centres of ethnographic fieldwork), 2. Adopting multiple methods and parameters (Chapter 3).

As shown in Box 8, only one major obstacle occurred during my interview with the Client-expert and one minor during one of the Focus Group. As I will explain later, however, both obstacles turned out to be just two different ways of perceiving the reality and actually the solution of the two apparent breakdowns that were overcome through finding a common understanding because more truths are always possible (Swann, 2002).



Box 8. Steps and obstacles during fieldwork stages 1 and 2

## IX. Ethical Considerations

In drafting these ethical notes on research considered sensitive because of the presence of vulnerable people, I have tried to always keep in mind the cardinal principle that governs this thesis, namely that of safeguarding the dignity of people, especially with reference to Maggie's visitors. In this regard, in this thesis, exactly as Maggie's does, I have never used the term 'cancer patient' referring to Maggie's visitors and I have avoided, where possible, defining hundreds of people with completely different pasts and backgrounds under the category "people with cancer". In reference to the main ethical dilemmas that the literature has discussed in research with cancer patients, categorisations do not help. When we talk about people with cancer, classifying them as "vulnerable people" or "survivors" or even "warriors", we are referring to our personal fear or distress about this condition (Wolinsky, 2019). Friends and family, but also organisations and even ethics committees, often take charge of the protection of the person with cancer, deciding for them and thinking of doing them good. In my personal experience, this proved to be a misjudgement when, in my ethical application, I was asked to change my proposal about relying on 'Maggie's psychologists' in case of need with 'family members' instead. As the participants themselves testified, in fact, most likely they do not want to talk to the family, because the family would treat them as sick and instead, they want to have their voice. Telling someone that they are vulnerable, that they have no voice and that they must have a family member to approve of something actually goes totally against the ethical principle. So, 'family' was not the right recommendation to make.

Although a filter must be put between researchers and vulnerable people (it happened to me that some people did not want to be disturbed), a good way to highlight the participants' voice is participatory research. Involving patients, sharing power, giving them respect, exchanging reciprocity and guaranteeing mutual benefit has shown that in the various stages of the research process improves research ethics and its adequacy of methods (Chiu, Mitchell and Fitch, 2013). However, the literature on this topic is generally focused on participatory research on 'cancer' (Wright et al., 2006) and proposes to engage participants in the change process to improve 'integrative cancer services' or to give voice to the patients who are concerned for using complementary and alternative medicine (White and Verhoef, 2005), while in my case the topic was 'architecture'. In the contradictory nature of Maggie's, participatory research that I activated on a topic that is 'other' than cancer, besides making people feel 'normal' and therefore good, has meant that the relationship with

my research participants developed in a way to address dilemmas like that of classifications. So much so that discussing architecture at Maggie's empowers people to the point that often we cannot distinguish people with cancer from those without and enhances them to the point that, in some cases, they no longer wanted to keep the anonymity.

As already stated in this chapter, compared to the category of "architects", that of "people with cancer" is of a broader nature, especially humanly speaking. However, this thesis considers them not so much as the "visitors" component of Maggie's but as the variegated and diverse "people" of Lesley Howells' postulates, whose presence and intersubjectivity allows psychological flexibility and a therapeutic environment as a meeting point between architecture and people. And since "architecture without people becomes sculpture" (Alvaro Siza, quoted in Berger and Gepshtein, 2020, 8:40), without the human component this thesis would not have made sense.

I confirm that the quotes and considerations I reported in this thesis faithfully refer to the experience lived by the interviewees. By this I don't want to unify experiences and to say that all people experience cancer equally, but rather that the experiences and phenomena I speak of in relation to the transition to cancer are elements that most people with cancer experience and decide to address to a greater or lesser extent, and on which their status as a user of the Maggie's Centre depends. While their different pasts naturally affect how they live as 'people with cancer' and how they manage and react to the situation each in their own way, the focus of this thesis is what they have in common. As cancer does not look at anyone when it presents itself, nor at their social, cultural and intellectual origin, and forces people to reset life from a new zero point, taking inspiration from psychological flexibility, this research wants to look at the 'here and now'. In my interviews I have therefore always avoided asking questions about the past of people with cancer, despite the fact that people often told me "how it started" and what their dreams had been and how they suddenly stopped. In fact, each of them has contributed to the research precisely by virtue of their own unique and particular experience, different from that of all the others.

In designing my ethnographic fieldwork Stage 2 (Kiernan, Gormley and MacLachlan 2004, Schubert 2009, Büscher, Urry and Witchger 2011, Fincham, McGuinness and Murray 2010) within such a particular field of research, the approach I adopted was using ethics instead of responding to ethics. So, to the normal requests of divulgation of my study aimed at respecting vulnerable users from all points of view (tranquility, anonymity, freedom), besides making my methods evident and transparent in order to prevent any problems, I tried to make it a human relationship. Accustomed to the hospital exercising power over patients

(Foucault, 1963) even only through instruments of consent and even dissent, the participants could perceive my modules as yet another means of exercising power over them. By stimulating potential participants' interest in my ethnographic work with letters of participation and notifications that clearly and simply explained the purpose of my fieldwork, I made the research participants feel in control of the situation. Graphically, I tried to capture people's attention with posters, notices and participant information sheet of different colours and design used, depending on both the method and the centre selected. Part of the fieldwork 'equipment' was the analytical work done following the interviews with the architects (A4 book). With it, I could explain my work better and arouse the interest of users among whom, later, after seeing it, some volunteered as participants. During the method undertaking, I realised that people at Maggie's were much more relaxed than I was, and, and this was probably due to their flexible minds. I must say that when I said that my brother died of cancer in 2013, unfortunately for him, it made my life easier because I became 'one of them'.

If I can give advice to future researchers, I would suggest adopting two or more methods used flexibly, interchangeably and freely during ethnographic fieldwork, associated with posters and notices of different colours and other eye-catching images; within the space, I recommend always being visible and interacting with people who wish to communicate - and not always dare to do it - and never use the computer or telephone while being in public. Finally, after the end of the fieldwork, I strongly suggest keeping in touch with participants and come back to visit them.

This thesis required three ethical approvals, one for the interviews with architects and Client-expert issued by the Oxford Brookes University Research Ethics Committee (UREC) and two to gain access to the three Maggie's Centres, one from Maggie's Research and Advisory Board and one from the Oxford Brookes University Research Ethics Committee (UREC). Access to participants (architects and Maggie's users) was secured by contacting CEO Laura Lee and the Centre Heads of the three Maggie's Centres. All participant data collected was anonymised prior to transcription and will remain confidential within OBU. Notwithstanding some practical limitations, Maggie's gave me a lot of freedom, and the opportunity for a live learning experience.

## Chapter 4. The Maggie's Centre

This chapter traces the story of Maggie Keswick and the Maggie's Centre and explains the reasons behind the proliferation of its many centres in Great Britain and elsewhere. Thanks to Maggie's foresight, and her husband Charles Jencks and her nurse Laura Lee's determination to make her wish come true, today there is an organisation running a network of centres still offering the same support programme. By way of the interviews with the Client-expert and Maggie's Architects, I will cast light on the 'Client-Architect-User' Triad and the themes of the design instructed in the Architectural Brief. With the Users section, I describe the visitors and staff and the lifestyle of the centre, while with the Building section I give a more systematic description of the architecture of the Maggie's Centre. Even if the Client-expert will always say "we like imperfections and they serve as an asset" (Lee, 09.03.2018), in the 'Issues, Differences and Imperfections' section I show how at Maggie's there are several imperfections with different degrees, depending on the centre. Perfectly aware of the flaws, Maggie's takes them as resources, letting everyone be free to accept them or not. Finding therefore also a positive aspect, Maggie's affirms that there are no good or bad solutions, but two different points of view. Indeed, Maggie's paradoxical continuous dialectic of success/failure, humour/fear, despair/hope (both person and organisation) is reflected in the complex building of opposite qualities that represents the struggle of life – as described by Charles Jencks, a metaphor, hybrid, placebo construction (Jencks, 2015b).

The idea started in a very modest way, a room inside a ward of the Edinburgh hospital to be transformed into a pleasant place "with a view onto nature, where one could sit peacefully between bouts of noxious therapy" (Jencks 2015b, p. 7). Maggie was convinced that "at the moment most hospital environments say to the patient, in effect 'how you feel is unimportant. You are not of value. Fit in with us, not us with you'", while it would be so easy to change that in "Welcome! And don't worry, we are here to reassure you, and your treatment will be good and helpful to you!" (Keswick 1994, p. 21). During the treatments Maggie experienced discouraging moments, like most cancer patients treated in UK hospitals do:

"The NHS is obsessed with cutting waiting time but waiting in itself is not so bad – it's the circumstances in which you have to wait that count. Overhead (sometimes even neon) lighting, interior spaces with no views out and miserable seating against the walls all contribute to extreme mental and physical enervation. Patients who arrive relatively hopeful soon start to wilt" (Keswick 1994, p. 21).

Dissatisfied with the treatment received, Maggie set out to create a comfortable and reassuring place where cancer patients could live moments of normal life. To this end she and her husband Charles commissioned Richard Murphy, architect from Edinburgh, to build the first Maggie's Centre. Highly involved in the design, Maggie Keswick Jencks died in August 1995 at the age of 55 with the design drawings on her bed. Even though Maggie couldn't see it realised, the seed of her future centre had been planted. Directed by Laura Lee, the centre in Edinburgh opened in 1996.

In the next section I illustrate the origins and development of the Maggie's Centre. All the information was derived from the book "The Architecture of Hope", edited by Charles Jencks and Edwin Heathcote in 2010 and by Charles Jencks in 2015 (a third edition is on its way); an interview in June 2018 and many in-person and email conversations I had with Charles Jencks between December 2015 and January 2019.

## I. Maggie Keswick Jencks, Origins and the Development of the Maggie's Centre

Maggie was a fashion designer with a passion for Chinese gardens. When she met Charles in London at the Architectural Association in the 1970s, she was a student and he was a lecturer, with a background in architecture and a passion for landscape. From the day they met, they spent their time travelling, researching and planning, filling their lives with experiences and friends, and expanding their family with their two children, Lily and John. In 1988, in Edinburgh, at the age of 47, Maggie was diagnosed with breast cancer. After dealing with treatment and struggle, Maggie thought that she had recovered, but in 1993 the cancer returned. After waiting in this "awful interior space with neon light and sad people sitting exhausted on these chairs" (Jencks and Heathcote, 2010, p. 11), she was given the bad news that she only had two or three months to live. Then, the nurse approached her and said, "I'm very sorry dear, but we'll have to move you out into the corridor, we have so many people waiting". Charles sat in the corridor thinking: "There must be a better place in a hospital to deal with a death sentence, a new place in the NHS set apart to face last things, away from the happy-clappy world" (Jencks, 2015b, p. 18).

Traumatised by this negative experience with the National Health Service (NHS), Maggie was adamant that "people affected by cancer could not bear to enter a tunnel without return" (Jencks and Heathcote, 2010, p. 11). After a hard moment of despair and with little

time left, she decided to react and spend her remaining life designing an ideal place to help cancer patients. As mentioned in the Introduction of this thesis, together with her nurse Laura Lee, Maggie visited the Wellness Foundation in Santa Monica, California to investigate the *hospice* and gather information on this type of institution, cultivating a strong belief in the benefits of good nutrition, yoga and a pleasant environment. Back in Edinburgh, Maggie managed to raise £70,000 to start building the centre, and persuaded doctors to support her pilot idea. The hospital contributed by donating an abandoned stable on the edge of its grounds to be transformed into the ‘CCC Cancer Care Centre’. After interviewing four architectural firms, Maggie and Charles chose, as mentioned above, the Scottish architect Richard Murphy, who was able to incorporate into the small building all the activities that Maggie wanted to offer to people with cancer. What was absolutely clear from the start was the fact that the centre was to be complementary to the hospital, but not institutional: no corridors, signage nor information desks. If the centre doesn’t look like a hospital, Charles wondered, then what was it? The answer was that it had to be like a home, where the kitchen was the heart for socialising over a cup of tea.

Starting from the design idea of a double-height space with a single entrance and four rooms, Murphy positioned the kitchen near the entrance, and the living room that had to accommodate various activities on the ground floor, while two consulting rooms sat on the first floor. As Maggie had requested, an aquarium was placed in the centre of the wooden staircase that doubles up as a bookshelf, inviting us to sit and read or continue toward the mezzanine. With the exception of the toilet, which was completely closed to allow people to cry without being heard, in the centre there were no doors but sliding panels, so that the space could be divided into rooms or left open with absolute flexibility. Outside, a rose garden had to be the horizon that Maggie would have liked to see “amid attacks of harmful therapies”. Thanks to her determination to complete the project, Maggie survived another eighteen months, saying that her last year was “the best year of my life” (Jencks, 2015b, p. 13).

Although Maggie could not see it finished, the first Maggie’s Centre was the fulfilment of all her wishes and ideas that were soon collected in what was to become the Architectural Brief, the essence of Maggie’s philosophy. With no expectation that there would be more than one centre, Maggie’s project began to grow. Between 2001 and 2005, Murphy doubled the size of Maggie’s Edinburgh with two expansions, and three more centres were opened in Glasgow (2002), Dundee (2003) and Highlands (2005). While Glasgow’s new centre was another conversion of an existing building, the Maggie’s Centre

designed by Frank Gehry in Dundee was a new construction that became a milestone in the charity's story. Larger and unconventional, yet still homely, the white cottage-like volume with the aluminium roof was the first building built in Britain by Frank Gehry. This attracted the media, who started talking about the psychological impact that high quality architecture had on people with cancer. This fact reminded visitors that "good architecture has the role, as T.S. Eliot said of poetry, of becoming 'a superior form of distraction', a superior type of visual music" (Jencks and Heathcote, 2010, p. 29). Playing a double role, 'architectural presence' suddenly became a significant contribution to the organisation, demonstrating that the demand for unconventional architectural design in the Maggie's Centre programme would be a key component of the institution's future success. Moving fast, the "Maggie's Centres cancer movement", as Charles Jencks called it at the time (Jencks, 2005), with the simple question "could things be different?" was effectively challenging the traditional mechanistic and anti-beautiful view of public health to promote instead a human-centred approach and its basic need for aesthetics.

After Gehry, several other world-renowned architects were invited to design a Maggie's Centre, including Zaha Hadid with Maggie's Fife (2006) and Richard Rogers with Maggie's West London (2008). Even though, as Jencks used to explain, -Maggie's did not aim to hire famous architects, most of them were already well-known or became so after they designed their centres. Notably, most of the architects were either old friends of Maggie and Charles, such as Frank Gehry, or former students of Charles who attended the Architectural Association in London. Many of them, such as Zaha Hadid, Rem Koolhaas, and Piers Gough, emerged around this time, adding a very distinctive and unconventional building to their architectural portfolios. Since 2009, growth has been exponential and Charles Jencks and Laura Lee have been instrumental in building Maggie's Centres for more and more hospitals, always using the same essential Brief. As Jencks argues: "If you think of Maggie's as an experiment in a Petri dish, where you put in different ingredients, the same programme, but out-pop all these completely different buildings, and they are all good solutions! In mathematics you know you can't have twenty different answers and all be correct, in most professions, can you? But with Architecture, it's interesting, that you can have that pluralism of response" (BBC, 2016). Today there is a total of twenty-six Maggie's Centres in the world, mainly in Great Britain, many of which have received major architectural awards. In addition to the existing centres, others are under construction or in the planning phase, since more and more hospitals are requesting one, and more and more architects are offering to join the Maggie's architects' community.

## II. Maggie's Legacy

With the premise that all the information in this section comes directly from Maggie's (<https://www.maggies.org/> 2021), the establishment of the Maggie Keswick Jencks Cancer Caring Trust in 1995 and the rapid expansion of the charity in the UK and overseas demonstrated the strength of Maggie's original concept and the demand from local communities for this new type of health facility. Backed by private sponsors, today Maggie's (having first dropped the suffix 'Cancer Care', and later 'Centre') is an independent organisation of which ex-nurse Laura Lee is the CEO. Maggie's is chaired by Her Royal Highness Camilla the Duchess of Cornwall, governed by the Board of Directors (chaired by Stuart Gulliver), advised by the Research and Advisory Board (led by Robert Leonard, Maggie's oncologist and key partner in the creation of the Maggie's Centre), and carried out by the Executive Group and the Architecture Co-Clients. Called 'Client-expert' in this thesis, the Architecture Co-Clients Laura Lee and Maggie's best friend Marcia Blakenham are responsible for commissioning projects, following those in progress, and creating future ones, still based on the Architectural Brief.

The organisation has two offices, a larger one in London, which the centres of England and Wales relate to, and a smaller one in Glasgow, which those of Scotland refer to. The latter is based in the former Maggie's Centre, "the Gatehouse" or "Infirmery" (2001) in Glasgow. In total, between administrative and executive, the organisation had, in 2020, 235 members of staff in the UK and an international network of 24 people. In addition to its structured staff and external figures such as architects, builders, and experts, Maggie's relies on a number of volunteers which is significant if we include those fundraising. Maggie's does not receive government funding but relies on the generosity of local communities and different kinds of donors. In terms of managing funds, what Maggie's does differently from other healthcare facilities is letting its donors know, in total transparency, how money is used. This is very important for the visitors, because knowing where the money goes helps them to feel protected.

Two years ago, when Sue died, we wanted to make a donation, but someone said "whatever you do, don't sign the check to just the Marie Curie, make it out to that Marie Curie Hampstead Hospice, because if it goes to the head office, Hampstead won't see it. This is what happens with the big charities. And this is what is so nice about Maggie's, because you know that if you donate anything here, it will go here. I think that's important too, because with a lot of these big charities you don't know where that money goes. Here, it's for management or management and staff and offices. (*Focus group Barts*)

As for Maggie's relationship with the hospital, lately, it has evolved. At the beginning there was the firm idea that the centre (and the organisation) was complementary but opposite to the hospital – therefore non-institutional – in order to distinguish it as an environment specially designed for this supportive use.

At the time of the planning application, it was very important to them that we didn't put a lift in the building. You know, it's this problem about being institutional. Anything that seems institutional is an anathema to them, and I can understand that. So, they would say 'we wouldn't have a lift in a house, we will never have a lift'. But, of course, in legal terms you have to provide a lift, otherwise you are not meeting the requirements. But the bureaucracy is like that. The most difficult things were that and ensuring they didn't have a means of escape sign, saying 'escape out of the back'. They are small things, but they are actually, bureaucratically massive, and they mean a huge amount to what, the perception of the building not being an institution but actually just being a lovely place to feel, help you feel good. (*Harbour, 20.07.2018*)

Today, trying to avoid opposing the hospital, Maggie's says "We work closely with local NHS trusts to bring our support to as many parts of the UK as possible. Our ambition is to be at 50% of all major NHS hospitals in the UK by 2022" (Maggie's Professionals, 2021). Although it might seem a step backwards from the original philosophy, this new position of complementarity of Maggie's with the hospital demonstrates a sign of maturity in line with the future model of cooperation I will discuss in Chapter 8.

### III. Maggie's Support Programme

The support programme currently offered by Maggie's is the result of many years of improvements. As mentioned, after visiting the *hospice* in California, Maggie had adopted the same orientation of creating the conditions of physical and psychological well-being for and around her ideas and wishes that she would have liked to bring to her future centre. As reported by her husband Charles Jencks in his book "The Architecture of Hope" (2015), among the strategies named "guerrilla tactics" (Keswick 1994, p. 21) that Maggie took in order to react to the 'death sentence' she received a year and a half before she died, there were ten actions: yoga, tai chi and qigong exercises, relaxation, and Ayurvedic therapy to lower her level of stress; counselling with psychologists and Vipassana meditation to deal with her family problems; Chinese herbs, capsules of mushrooms, and vitamins for her physical benefit. Maggie's interest in Asian and complementary/natural therapies certainly

came from her family background (she was the daughter of an influential Scottish trader who brought his family with him to Hong Kong and Shanghai), but also from researching on her book “The Chinese Garden” (1978).

Of all the actions, the most effective strategy Maggie took was to change her diet. The beneficial effect of this empowering ‘tactic’ did not come so much from the new low-fat regimen, but from its psychological impact. Acting immediately, taking control in a situation beyond her control, and obtaining something rewarding for herself was what ultimately made her strengthen her willingness to fight by any reasonable possible means and understand the power of self-help. In trying to put all these feelings in the latest of several versions of her “A View from the Front Line” (1994), Maggie became her own spokesperson for her cancer experience, hoping to help others fight their own battles. Urged by Charles to use the statement ‘empowering the patient’ in the conclusion, Maggie realised that the real secret for a cancer patient, in order to “navigate through many choices down here in the war zone”, was *self-help* (Jencks 2015, p. 20), an active involvement in one's own therapy. Besides the ‘self-help’ strategy, in her ‘war’ Maggie won the final battle against cancer leaving another fundamental aspect that gave life to her programme: the paradox of “the liberating therapy of struggle and humour evident in the already quoted sentence about her last year that she defined ‘the best year of my life’” (Jencks 2015, p. 13).

Today, the original ten ‘guerrilla tactics’ have become the basis for Maggie’s more extended support programme. With seven goals each, the three cores of the programme offer practical (financial, information, prevention), lifestyle (physical, nutritional, creative), and emotional (psychological, social, architectural) support. In the last of these, the ‘Warm & Welcoming Spaces’ category that establishes Maggie’s as a place of art, architecture, landscape, and flowers is perhaps the most immediate. The friendly, convivial atmosphere better known, as mentioned, as ‘kitchenism’ (with a cup of tea offered as visitors come in the door or once they are seated around the kitchen table), along with the unconventional architecture accommodating welcoming areas for sitting and viewing art and nature are of primary value and importance. Unconventionality usually makes people aware and, in this case, helps regular visitors to know and appreciate the value of architecture. Also, over time, people with cancer become familiar with the space and begin to feel at home. From my fieldwork I came to realise that users understand the relationship between their experience and the building, they know why they feel well, and what architectural characteristics makes them feel so.

The design of this building is so relaxing, it's like the Scandinavian. I mean, you haven't got a brick wall they're happy with; they want you to have a nice view. And the way it's built on sticks also means it's not imposing. And the greenhouse there as well. (*Focus group Oldham*)

From this quote it is clear that Maggie's users, in an articulate way, know how to talk about architecture and recognise the characteristics of a therapeutic environment. This fact is also facilitated by the presence of many architectural books which, on the shelves of Maggie's libraries, sit next to those on cancer. Within the practical support, in fact, another important action of the program is 'Information for visitors and families', which Maggie defined as 'power' - but only if supported by the knowledge of 'what it means'. Always with a view to "empowering the patient", in addition to books, computer desks help visitors to deepen their research on cancer.

In Charles Jencks' opinion, it's the programme along with the contribution of the professional staff, the spirit and the architecture, that makes up the real, fundamental element of success.

If the building supports the carers, the carers will support the patients. A big factor in our buildings is the way they liberate the imagination of those who come to think again, and feel again, from a new position: an imaginative jump. The magic of the architecture is to make patients suddenly see their situation in a new way. It acts as a transformative experience where a medical diagnosis becomes a positive existential challenge. (*Jencks, 18.06.2018*)

From this quote the fact and importance that the building has in supporting the Staff in order to help Maggie's Visitors begins to emerge. As we will see later, staff members often rely on the building to help them with their work.

#### IV. The 'Client-Architect-User' Triad

The Triad concept is one of the key features of the architecture system and it is made up of 'client', 'architect', and 'user'. The briefing process consists in communicating the client's ideas to the architect through the Brief, in order to make efforts that converge towards the common goal represented by the user (Salisbury, 1998). This triple system provides for a close collaboration between the three parties. The lack of a systematic approach to this is the main obstacle to the success of the project (Yu et al., 2007). This misstep occurs when, for example, the link between the client and the architect becomes a very close relationship,

while that with the users is kept minor or neglected, highlighting a discrepancy between the values of the clients and those of the users. Although, as mentioned, the research conducted today to improve briefing practices has shown that clients are the main providers of information (Barrett and Stanley, 1999), users can be considered a valid source of knowledge on specific requirements which frequently the client struggle to capture. Therefore, engaging them should improve the value of the briefing process and design team, not only with clients but also with the architect (Zwemmer and den Otter, 2008).

In Maggie's case, through the Architectural Brief the Client-expert collaborates closely with the architects, by guiding them; in return, with their architecture, the architect influences on the one hand the Client-expert and on the other the users of the building. Finally, users (visitors and staff) are influenced by the Client-expert through the support programme the building was designed for and the lifestyle of the centre. However, despite constituting the main objective of the project as recipients of the final product of the Triad (the building), following the principle of Zwemmer and den Otter (2008), within the Triad Maggie's users do not have the same weight in the design process of the building, if not through the Client-expert acting as their advocate.

In the study of the built environment, the gap between users and architects is still a profound problem (Kamara et al., 2001). To counter it, environmental psychologists propose to put users in contact with architects and clients and train them through the participatory study of the built environment (Churchman & Sadan, 2004). Participatory design started in the 1960s along with increased democracy in society and implied to give power to users. In the last thirty years, this task has moved from power-based to a knowledge-based process (Granath, 2001) and, in this sense, through the "Warm & Welcoming Spaces" category in the 'Emotional chore' of Maggie's support programme in which users discuss about architecture, we can say that at Maggie's users have knowledge of design. But, despite having a representative in the Client-expert, especially in reference to the past, users do not have an active involvement in the building project, as in many of the previous design processes the link between architects and users was largely missing or very weak. However, over time, this bond has strengthened, and circumstances have made Maggie's architects more willing to interact with users when, during the design stage, they go to see the built centres. But because there is still a weak link and a need to fill that gap, my research has gathered information from users of these environments to provide to Maggie's architects.

Within the Triad design team, always with the clear objective of satisfying the needs and desires of Users, the Client and the Architect collaborate on an equal and complementary

basis to guarantee the final product to the Users. In reality, as the title of Salisbury's book "Briefing your architect" (1998) suggests, the primary responsibility lies with the Client. In addressing his lesson on the not-so-simple art of communicating one's needs to the designer to obtain the desired product, Salisbury implies that the competence of the architect does not in itself guarantee the result. Furthermore, by using the adjective "your", Salisbury implies a certain dependence of the latter on the former. History demonstrates that the architect cannot achieve anything without a client (De Carlo, 2004). Therefore, far from leaving the architect the role of sole actor in the design team, inserting them in a project team process that involves other operators, the Client-expert constantly guides the Architects in responding to the apparently simple but difficult to interpret needs of the Architectural Brief. Precisely because of this difficult reading and the challenge required of the architect who, subtly, is pushed to go beyond the brief, the Client is not, as it may seem, excluded from the design team, but rather has a guiding role in the teamwork which is the basis of the construction of the building. As part of a project team process that also involves other operators with whom it is necessary to establish relationships - which in turn require a system of rules of conduct (Fontana, 2007) - the Client-expert guarantees balance between the parties as evidenced by the various interviews with the three members of the Triad that the reader can read in this thesis and some of which I anticipate here.

As Users' advocate, the Client-expert asks the Architect to investigate the cancer challenge which is a very difficult job to do. "Architects have to do this hard work on their own. Of course, we are by their side" (*Lee, 18.05.2019*). And thanks to the Client's continuous assistance will the Architects say: "they were able to bring out the best from me" (*Aado, 1.11.2018*). In this challenging relationship, the architect occasionally complains that it is not so true that they were free to do whatever they want. "We enjoyed working with them, not because it was open and free and you could do anything, that's really not true" (*de Rijke, 17.12.2018*). At the same time, the work of the Client-expert, which in recent years has become exponentially complicated due to the growing number of centres and the difficulty of raising funds, is to not lose sight of the final goal which is to satisfy the user needs. Indeed, the visitor would like to let the architect know that "it's not an insult to say this to the architect. It's just that when he does the next building, or she does the next one, or when the next one is built, they need to just take that into account. That's all". (*Focus group Barts*)

In an unusual position of a repetitive Client, compared to those clients who will hire an architect only once and therefore will not be able to learn from him or her, Maggie's

continuously learns by commissioning similar buildings to different architects, thus gaining more and more experience. Also facilitated by being a Client-expert open to listen, besides confirming that the Client-Expert is appropriate as an advocate for users, this type of active learning becomes a real wealth of knowledge underlying the art of the ‘Commission of Architecture’. Within the ‘Commissioning of Architecture’ theory, otherwise known as ‘Design Brief Management and Procurement’, the definition of a procurement system is: “method of obtaining and organising the external resources necessary to carry out an intervention” (Construction Industry Board 1997, p. 4), which in the Anglo-Saxon context includes a wide range of options for the implementation of building interventions (Masterman, 1992). Within this practice, as we will see better in Chapter 8, Maggie’s makes a new contribution precisely for the repetitive act of commissioning. In fact, in this ongoing learning process, not only the client learns, but the architects also learn. When asked what unites the architects of Maggie’s and whether they can be considered a community, according to one architect, the community of Maggie’s Architects is “a bit like an architecture school”, where everyone has made a mark and learned. “And they left clear ideas and thoughts and maybe they will come back as a tutor. And you stand on their backs and then the next batches stand on their backs and everyone learns from the previous one and, in this way, they are a community” (*Gough, 16.05.2018*).

To understand the degree of success of the Maggie’s Centre it is necessary to analyse the individual figures of the Triad, whose relationship occurs through the Architectural Brief and its emotional requirements.

#### IVa. The Client-expert

As already mentioned, traditionally the role of the client is the one who commissions an architect to realise a building with the request of meeting a certain number of requirements in the interest of the users. At Maggie’s, since 1996, Charles Jencks, Laura Lee and Marcia Blakenham have adopted this role not as a way to ‘dictate’ the architecture but instead, through the Architectural Brief, to influence people’s ‘feeling’ generated by the final building. At this juncture, the Client-expert proves to be very appropriate as a spokesperson of the users. We must not forget that Laura Lee was Maggie’s cancer nurse. Coming from an NHS nursing background, with the taken-for-granted opinion that windows are not important in hospital spaces (Marsh, 2018), and without an architectural knowledge, Laura

Lee had to educate herself by surprising many people, including her staff and other clients who didn't really believe that architecture could help.

The client's task thus is to keep the architects focused on architecture, and their ultimate focus is "how to make people feel". If the Client-expert were to assign a technical Brief, the architect would respond with a technical solution; instead, by asking the architect to think thoroughly what the purpose of the building is, they get a result which prioritises the feelings that the building generates.

I think that when we look at plans or drawings or whichever it is, the basic question underneath anything we ask is: what is going to feel like for someone who is going to use it? So, we try not to talk about aesthetics, but it's what is going to feel like to be used by somebody who is in a horrible moment psychologically. (*Blakenham, 18.05.2019*)

From this quote it emerges that feelings and emotions generated by the building in Maggie's users are of priority importance. As we shall see, within my research this has helped judge buildings to a new way.

Following Charles's death on 7 October 2019, Laura and Marcia have continued their mission alone. Not having a technical perspective, in delivering the Architectural Brief, the Client-expert instructs the architect in an unusual way. So, the two women do not tell the designers what they want, but rather what they do not want. For example, Laura and Marcia do not want people to feel 'manipulated', nor that there are secrets in the building.

So, we work from another point of view, of things we don't want people to hear. We don't want people to feel processed; we don't want to make people feel like they are in a factory. So, we have that kind of conversation, rather than just telling the architect what it is. Because what you are saying to the architect is already limiting his or her creativity and freedom to find the solution for what it is. Because we want them to come out with what it is, we have to tell them we don't want to have secrets, we want to be 'homely', we want you to 'feel like you want to let it go' and 'be yourself'. (*Lee, 18.05.2019*)

From this quote it starts to emerge the contradictory nature of Maggie's. By instructing the architect in these terms, the Client-expert obtains what they are seeking thanks to a paradoxical and enigmatic action that would not normally seem obvious: asking for nothing to obtain the most. One more thing that could sound unusual for a client in relation to an architect is not expecting perfection.

We don't worry too much about imperfections, as long as the feelings are right. We keep coming back to this 'feeling thing'. If the feeling is right, you can take the general. (*Blakenham, 18.05.2019*)

Finally, thanks to the fact that Maggie's is a private organisation, architects don't even have pressing deadlines. The Client-expert has time, they are never in a hurry, because they know that if they hurry the architect, they can make mistakes.

And these mistakes are always the client's mistakes, never of the architects. Beauty comes first. Only if you have a mind free from concepts you can reach the magic that Maggie wanted. *(Lee, 09.03.2018)*

What the Client-expert shares with the architects is their goal: to obtain from them the ability to stimulate people with cancer to react, and to pull out something they had inside and did not know they had.

In the most vulnerable moment of their life, we want visitors to be able to enter a space and feel stimulated, explore their spirituality and sexuality that they may not dare to seek in another environment. *(Lee, 18.05.2019)*

Urging the architects to go beyond the Architectural Brief, the Client-expert asks them to investigate and interpret the social challenge with cancer of the Maggie's Centre, which is not an easy step.

Architects have to do this hard work on their own. Of course, we are by their side, we work with them to explore their imaginations, if they have it, and when needed, we try to lift them hard. *(Lee, 18.05.2019)*

By investigating the social problem facing cancer patients and their families, architects help change the way care is normally delivered along with the behaviours and culture of the way staff operate (Lee, 2021). As mentioned, much of the Client-expert's thought concerns the way in which the building is conceived to help the staff to support the visitors. Indeed, the most substantial challenge facing the Client-expert is how to tell the staff to "consign" themselves to the building, as coming from very bureaucratic, disciplined and organised jobs, the staff initially do not like open and indefinite spaces like those of Maggie's buildings. Considering that among the staff there are also many volunteers (who rotate often but who have a primary role because they are the ones who serve the cup of tea), it is important that this adaptation process takes place. Fortunately, time helps to familiarise, and staff begin to appreciate the space. In a sort of dual process, the space that, as we know, combines architecture and people supports the staff who in turn support the visitors in the way they need.

Part of the learning process that the Client-expert asks the architect who has just been commissioned a new Maggie's Centre is to visit and analyse the existing centres. In reality,

this is another challenge that the Client-expert launches. Since there are now so many buildings, there could be a risk that the new architect will be influenced, or on the other hand, they could be stimulated to make a project different from the previous ones. Of course, every architect will look at what has been done previously and try to do better. In the past, some architects deliberately worked on their own design before visiting the other buildings. For example, Ivan Harbour (Rogers Stirk Harbour + Partners) developed his own design idea before visiting Maggie's Edinburgh, the real matrix of everything. As already mentioned, as part of the investigation process, the architects in charge are now visiting previously built centres and consequently spend time in the space with visitors and staff. While this isn't an in-depth collection of data from all users, there is a connection that is becoming stronger over time. However, because it is difficult for an architect to interact with all users, knowing the needs of the user through the Client is still the best way to obtain all the necessary information.

## IVb. The Architects

An architect, by definition, is someone who cares. There is no question about that. There is no financial remuneration that will ever pay a care of an architect, it's just not. So, in a way, Maggie's philosophy was 'let's get all these architects who care to do it'. (Page, 01.10.2018)

Despite this quote, Architects are usually known to be more interested in their design of a building than in those who will use it. On the other hand, there are cases, including the architects I interviewed, who show a strong interest in users and in establishing a relationship with them. Indeed, it is very important for users to find a way to facilitate their needs and wishes and for the architects a way to respond to those needs. Yet, for an architect having a relationship with users is not always easy, it depends on the type of users. Among Maggie's architects, there were individual situations where the architect was more connected with users than others. For example, Alex de Rijke (dRMM) spent six months at Maggie's Manchester while his girl-friend was hospitalised at Christie's. While there, he spoke with visitors and staff and he gained a lot of information on how to design his Maggie's in Oldham.

As seen, Maggie's architects have something in common. In addition to sharing the experience of having contributed to Maggie's mission, what unites them most is the emotional involvement they invested during the development of their project and,

consequently, the ability to include the human dimension in the project. It is true that each of us, even from a distance, may have been involved with a history of cancer, but for an Architect, taking on a theme that has to do with the struggle between life and death situations is not an easy task to carry out and complete successfully. “It is a serious project, and it brought out the best of architects, of our wonderful profession, which is obviously [like medicine] ideal and utopian in every way” (Jencks, 2019, 5:20). As already mentioned in the Introduction, the relationship between Architecture and Health is an ancient theme that Maggie’s architects are faced with and to which their emotional involvement is central (Jencks, 2018). This means that their contribution pushes them beyond the conventional response to the Client’s call.

In response to the client’s briefing, the architect starts to work on the design. In the dialogue that the architect has with the Client-expert, the Client-expert constantly and intensely maintains a high level of revision for each of the spaces, as well as for the general project. Among the spectrum of reactions to this process evident in the interviews I conducted with twelve Maggie’s architects (see questions in *Appendix IIIa*) a very high level of collaboration and respect was always clear.

They want you to think grandly. They remind me of the De’ Medici family. They are the sponsors of excellence and beauty, what more can you ask for? So, they make you perform beyond yourself. (*Page, 01.10.2018*)

Confirming what has already been said, the relationship is centred on freedom.

What is amazing about this client is giving architects freedom. This is the easiest project I ever did. (*von Loon, 15.05.2018*)

What is fascinating is that ‘what you think we ought to do’ and they are very open to that. If anything pushes you to be more like yourself and less like them. They are always very open to ideas. (*Gough, 16.05.2018*)

During my interviews with Maggie’s architects aiming at finding out how and to what extent they applied the Architectural Brief to their project, many themes arose. The first theme concerned the level of *scientific knowledge of healing architecture* they had in order to design a Maggie’s Centre. About the former Maggie’s Glasgow, ‘the Gatehouse’ or ‘Infirmary’ (2001), David Page said: “I struggle with the notion of scientific proof. I think if we would have waited for scientific knowledge nothing would have happened” (*Page, 01.10.2018*). About Maggie’s Dundee (2003), Frank Gehry, a dear friend of Maggie, said that the building needs humanity, respect, and generosity towards patients. So, “the building

shouldn't be about capital 'A' architecture, but it should be about the people" (Gehry, 18.06.2018). Still on the *healing/therapeutic environment*, speaking of her Maggie's Kávida Barcelona (2019) which is located near the Hospital de la Santa Creu I Sant Pau (1902–1930) – a masterpiece of Catalan Modernism – Benedetta Tagliabue said that she was inspired by the sense of beauty that the Spanish architect Domènec y Montaner used in the design of the old hospital (Tagliabue, 19.11.2018). About the *interpretation of the Architectural Brief*, while designing Maggie's West London (2008), Ivan Harbour said that the Brief was open and flexible to any interpretation. What he understood from the client was that "the building, whatever it was said, was not really a collection of rooms, but an evolving space and this manifested itself in specific things the client said, like 'we don't like doors that close, but sliding doors, because they can be left a little open'" (Harbour, 20.07.2018). According to Piers Gough (15.05.2018), as mentioned, the Architectural Brief is apparently very simple and "very British", however the precedent centres constitute and contain, each in a different way, the essence of the Brief. About the *feelings the building generates in people*, most architects said they used light and space as materials. About Maggie's Aberdeen (2013), Bjørg Aabø said that upon entering the building "our eyes are drawn to the ceiling, where colourful skylights radiate vital energy". Effectively, this space conveys a peaceful atmosphere and a sense of embrace; that is why they call the building 'Hug'. Still in Maggie's Aberdeen, the 'Pelican chairs' that wrap around those who sit in them seem to welcome people, too (Aabø, 02.11.2018). For Maggie's, the chair is an object of primary importance. At Maggie's Forth Valley (2017), Wendy James said that the fixed seating arranged at the edge of the space generates "a sense of order" which, in turn, transfers calm and tranquillity. At the same time, the scattered chairs and moving furniture bring variety and movement to the space (James, 13.06.2018). About the comfort of Maggie's Nottingham (2011), Piers Gough said that "it's traditional with a twist. Hence, it has exaggerated schemes compared to traditional notions of comfort" (Gough, 16.05.2018). Another feeling discussed during the interviews came from the activation of the "prospect & refuge" effect. Speaking of Maggie's Manchester (2016), Darron Haylock of Foster + Partners said that the idea of having an American porch as a veranda at the entrance of the building where people could sit, "pause", meditate and enjoy nature while sheltered from the typical rain of Manchester was a priority (Haylock, 12.06.2018).

Regarding the question of *designing a therapeutic environment*, it turned out that materiality is of paramount importance. Jasmin Sohi and Alex de Rijke of dRMM stated that Maggie's Oldham (2017), the first permanent building constructed from sustainable

tulipwood CLT (cross-laminated timber), also has a therapeutic nature evident in the Silver Birch tree located at its centre (de Rijke, 17.12.2018). In Maggie's Glasgow (2011), for Ellen von Loon (OMA) the most important material was the garden, so she said: "The big idea was to bring nature into the building made of concrete and glass". When designing a therapeutic environment, it is difficult to predict how people feel, especially those with cancer. "Since every day is different, it is important providing a 'menu' of spaces that adapt to different feelings, so that everyone can find the right place for the mood of the moment. And the architecture will accompany those feelings" (von Loon, 15.06.2018). Speaking of Maggie's Barts (2017), Chris McVoy SHA, partner of Steven Holl, highlighted *the psychological impact that architecture has on us* and said: "It's all absorbed through the senses and in the way the mind, soul and the body work together". As Chris explained, architecture is an art that deals entirely with how space, material and light influence our sense of curiosity and our moods. "The beauty of light is its energy. So, when you work with light, that energy always becomes material, spatial and visible" (McVoy, 26.05.2018). Finally, Richard Murphy who in 2018 completed the third major extension of Maggie's Edinburgh (after those of 1996, 2001, 2015) said he is much more interested in people than symbols, and what he pursues is a "sense of humanity in architecture, how people interact with spaces and with each other and how buildings can make that possible or not, or even stop it" (Murphy, 11.06.2018).

If before, being friends of Charles and Maggie, Maggie's architects were established names - and perhaps for this very reason not inclined to communicate with users - today there is a new generation of younger / less known architects who seem to be more willing to meet the users than in turn they are interested in talking to architects. Through the visit of the buildings, to which the Clients invite them to do, the new architects have the opportunity to dialogue with the users, establishing a new potential way of approaching design.

#### IVc. The Users: Visitors and Staff

Maggie's users are the third party in the Triad. Being those who physically and psychologically experience the building every day (staff) or during their visits (visitors), they are the key component of the Triad. In the architecture system, usually, the user is the tip of the balance, the one who establishes the success of the building on the basis of the level of satisfaction (Salisbury, 1998). Usually, in healthcare architecture, staff and patients

use the building in an antithetical way, receiving an opposite experience and perception, very often both of dissatisfaction. In the case of Maggie's, since staff and visitors use the building equally, benefiting from the sense of familiarity of the kitchen and the multisensory nature of the space, and sharing stories and daily events, they can all be considered users in the same way. Very often on entering a Maggie's Centre it is difficult to recognise who staff and who visitor, because everyone is busy contributing to the community. Although being a person with cancer or a caregiver makes a difference, the visitors say that for them Maggie's is a big family and, beyond the roles, there are no differences with the staff (*Focus group Oldham*). For this reason, towards the Architect – who in turn collaborates with the Client-expert – Maggie's staff and visitors are indiscriminately the users of the building, the primary objective that inspires the work of the design. In this regard, as in past research (Annemans et al. 2012) the objection has already been raised, in general there is not enough knowledge transfer directly from users to designers so as to implement healing environments. However, as mentioned, Maggie's users have a voice through the Client-expert who is the advocate for them. By acting as interpreter, the experienced Client-expert will transfer users' information to the architects with the aim to ensure the best result.

Like her, Centre Heads and all the staff are aware of architecture. In particular, Centre Heads prove capable of interacting with the users on the two levels (architectural and healthcare), just as Laura Lee. And this probably happens because, in many cases, at the time of the construction of the building centre heads were already appointed and could interact with the architects and still today they deal with them during the occasional visits. Despite their clinical background, focusing not so much on how architecture works, but rather on how architecture brings people from different backgrounds together, Maggie's Centre Heads who initially didn't believe in architecture eventually begin to believe in it more. And during my visits to the centres in the reconnaissance fieldwork stage 1, in many ways, this was a recurring element of surprise to discover.

Towards the Client-expert, the staff has a role within the structured programme and the responsibility of receiving in foster care the building that will have to support the visitors. Though visitors are the primary recipient of the design of the building, as mentioned, the Client-expert holds the staff in high regard, while working with the architect. "Very much part of the thought is about how the building came to help staff behave better" (*Lee, 09.03.2018*). In the act of learning how to use it, both staff and visitors are surprised to become aware, for example, that they can greet each other from one side of the open space

to the other or of a different way of waiting, compared to the hospital or Macmillan. As Maggie noted during her doctor's appointments and dreamed about her centre visitors:

Waiting time could be used positively. Sitting in a pleasant, but by no means expensive room, with thoughtful lighting, a view out to trees, birds and sky, and chairs and sofas arranged in various groupings could be an opportunity for patients to relax and talk, away from home cares. (Keswick 1994, p. 21).

At Maggie's, in freedom and guilt-free, visitors can sit on the sofa for two hours, without talking to anyone else or just chatting with the others. Through the ceremonial of greeting, visitors are greeted by all staff members regardless of their precise role. Depending on the size of the Centre, the number of staff members varies. There are three basic clinical figures: Centre Head, Psychologist and CCS (Cancer Support Specialist). Among the non-clinical ones, there are other two fundamental ones, Benefit Advisor and Fundraiser. Added to these are a large number of full-time and part-time volunteers, who raise funds or work at the centres offering visitors a warm welcome and a cup of tea as they experience life-changing events. It is that, together with the architecture and the support programme, which makes Maggie's different from all the other organisations. All of Maggie's staff have a hospital background from the National Health Service (NHS), and all healthcare professionals have a thorough understanding of cancer and its treatment. All cancer support specialists have backgrounds as oncology or radiology nurses. Despite the professional background, a strong sense of hospitality is required from all members of Maggie's staff, which together with generosity and discretion, could be seen as recalling ideals typical of East Asian culture. Perhaps Maggie's past re-emerges in the hospitality of today's staff, which finds its apex in the ritual of offering a 'cup of tea'. From 9am to 5pm – or often even later, until 9pm – the staff members are constantly engaged in their work and in the supervision and entertainment of visitors. "The staff is open, committed, attentive to people's comfort, empathetic, present, silently scanned, ready to interact. It is a genuine presence" (Howells, 2019) Working in line with Maggie's support programme, each member of the Staff assist visitors doing what is necessary for them, from debt management to helping them with sleep, anxiety or allowing them to think about how to get back to work. But to help visitors, first you need to help the staff. As Maggie's argues, adding culture to the regular staff work, putting the right skills in people and giving them freedom and responsibility can achieve a lot in terms of improving healthcare and outcomes (Lee, 2021).

The community of the centre visitors (people with cancer, family and friends) is of different kinds, with many backgrounds and stories. From the moment of receiving a

diagnosis, it is usually a matter of days before the first visit to the centre (in which neither the issue of names nor registration fees are required) – or sometimes just hours, depending on who suggested going to Maggie’s. This may be doctors or nurses in the hospital, but also nurses or secretaries from other cancer centres like Macmillan or friends who have had the same experience with cancer.

Being in the hospital ground, the proximity to the clinical setting creates a great contrast between the large hospital and the small Maggie’s Centre. As the staff say, most of whom having a background in that environment, when patients enter a hospital, they have to prepare for a battle to overcome something they know is probably quite traumatic. These moments, in which a diagnosis of a life-limiting illness, which will affect work, hopes and dreams, or the ability to have a family is received, represent for people ‘traumatic transitions’ that manifest themselves in a transformation of the way the mind and brain organise perceptions.

Trauma, by definition, is unbearable and intolerable. (...) While all of us would like to ‘go beyond’ trauma, the part of our brain responsible for ensuring survival (located well below the rational brain) is not so good as to deny. (...) Feeling that they are not in control of themselves, traumatised people live in a state of persistent fear. (Van der Kolk 2015, pp. 3–4)

With the aim of focusing the attention of the new comer on having arrived in a safe place, Maggie’s staff try to convey to visitors, when they enter for the first time, that they will be cared for and supported as they choose. In this delicate moment, the building, considered as another staff member, collaborates with the staff and offers psychological, practical and lifestyle support, helping the staff to ‘welcome’ and ‘entertain’ the visitors. The spacious, inviting and homely kitchen, often overlooking lush nature through high floor-to-ceiling windows or enveloped in filtered light, natural or artificial, is clearly where the building joins the staff. As mentioned, the first space that visitors see when they arrive at Maggie's, unusual for a healthcare centre, is the kitchen with a large table in the centre, which, even on the darkest days, is always bright, joyful, active with visitors and volunteers preparing food and drinks for anyone who enters. If there is a yoga, nutrition or art therapy course scheduled at 10am, visitors begin arriving around 9:45am to make coffee and tea for themselves and their carers. Laughter is often heard emerging from the background buzz. Suddenly, the crowded kitchen will be quiet as soon as the course starts, and, conversely, a couple of people can be heard sobbing as they stand alone in the calm and peaceful space. The group has just moved into the activity room, a warm sitting room large enough to hold at least twelve mats. Group activities, which also include tai chi, relaxation, sleep sound classes and more, will continue

until the centre closes at 5pm. At the end of each activity, the kitchen fills up again, especially during the lunch break, when the staff have lunch sharing the the kitchen table or counter with the visitors. After a quiet moment of coffee and chat, new visitors arrive around 3pm for afternoon activities. Visitors who have booked a one-to-one psychological meeting, which usually takes place in one of the two consultation rooms, will spend their time before or after the meeting waiting in the welcome area, socialising or alone. For those who, between one treatment and another or after a visit at the hospital, do not come to attend a lesson but only for a 'cup of tea and biscuits', arrive at any time of the day from 9am to 5pm, and their stay can last one to two hours or even longer. Last visitors arrive between 4pm and 5pm or later if some courses such as choir, dance or special support groups are scheduled between 5pm and 9pm. In general, alone or in company, immersed in a reading or chatting and drinking a cup of tea, for most visitors, visiting hours are mainly based on hospital hours and chemotherapy times.

About three to five new visitors come to Maggie's every day. As already explained, they could arrive directly from the hospital, immediately after receiving the bad news, or a few days later at the suggestion of someone else. "It was quite hard to walk through the door. But it was like a whole feeling of calm coming over to me, totally" (*Follow-up Dundee*). As soon as they enter, visitors are greeted by staff who are always ready at the door with a smile to offer their help and care. Usually accompanied by their families, new visitors are hosted in the library or in the welcome area to feel reassured that they can leave at any time. Being in a mutual view of everyone else, people's empathy along with building empathy helps offset the pessimism of the moment, and Maggie's offers newcomers a community where they immediately emerge from isolation and can think of imagining again. By naming the building with the same adjectives that could be used for humans, the staff rely on it. After an initial conversation, moving from the library to the kitchen, the staff invites new visitors to self-help by making their own cup of tea as they would do at home. While showing the centre to newcomers, the staff gives them the freedom to access any part of the building whose open and flexible space encourages them to feel free to explore, but also to open up and look forward. Working as a 'member' of the staff, the physical-spatial characteristics of a Maggie's Centre come to the aid of people with cancer. The Maggie's Centre with the staff constitutes a kind of 'building event', a hybrid between building and human (Jacobs, 2006).

## V. The Building (Architecture, Art, Furniture)

As already explained in the Introduction of this thesis, the non-clinical Maggie's Centre is always located on hospital grounds, complementing the clinical work while maintaining its distinctive identity. The sites offered by the hospitals are former parking lots or brownfields usually near the Oncology Unit within diversified contexts. As a consequence of this morphological variety, but also thanks to the open and flexible interpretation of the Architectural Brief left to the architects, both the landscapes and the buildings of Maggie's Centres are very different from each other, although, as Maggie's claims (Howells, 2017), each centre contributes to its mission by obtaining the same psychological effects on people. "The Maggie's Centres represent an ongoing experiment in architecture and a powerful investigation of effects of space and form on patients, their families, friends and staff. (...) Sculptural and inspiring pieces of architecture, unique yet identical in their way of offering safety and welcome, as well as atmospheric effects that are 'surprising and inspiring' within them" (Jencks and Heathcote, 2010, p.91).

With an average total area of 280 square meters (3,000 square foot) , now upgraded to 300-450 square meters depending on the cancer population depending on the cancer population within the hospital reference area, the Maggie's Centre is a small building that stands out for its great visual impact or is hidden inside a luxuriant garden. As mentioned, from the outside the way to enter the building is visible, inviting and not intimidating. Inside, the absence of typical hospital corridors and encouragement of the principle of 'spatial interaction rather than walls' allows an immediate understanding of the arrangement of the rooms (Jencks and Heathcote, 2010). The opening of the spaces implies the proximity of the different conversations made possible by the relaxed attitude of the users. The distance and some differences in level inside the building guarantee intimacy. "At Maggie's there is very little that goes on behind closed doors" (Howells, 2017). The doors do not close, rather they are designed to be deliberately large, sliding or rotating, which helps people forget to close them and not worry about privacy.

Unlike other healthcare facilities, each centre offers a series of informal common spaces that give visitors the opportunity to socialise with others or be alone in privacy or in confidential conversation with the staff. As mentioned, 'social interaction, privacy and counselling' are, in fact, the three fundamental objectives of the Maggie's organisation. The limited number of functional spaces that the building provides can be adapted very flexibly to the three different types of support: welcome area/library (practical support),

kitchen/activity room (lifestyle support), kitchen/consulting/living rooms (psychological support). As Maggie Keswick had asked, the toilets are not “lined up with openings under the doors” like we can find in the hospital but closed like at home. “They should be private enough to cry” (Maggie’s Brief, 2015, p. 8).

## *Architecture*

### Entrance/‘pause’

The moment of "pause" is when visitors hesitate a few seconds before entering the main door that tries to give them the courage to enter or when once inside they stop in disbelief to look at the space and then take a deep breath. In the beginning, this entrance space was not called a "pause", but simply an entrance. Although in the current Architectural Brief (2015) its description corresponds to an internal space (entrance / welcome area), during my ethnographic doctoral work my perception was also that of an external space which still gives you the freedom to choose whether to enter or try again next time. Some visitors told me they made several attempts before they could enter the building. Once inside, however, visitors always take a "deep breath" upon their first arrival, as a sign of acceptance but also of having arrived at their destination. As described in the Architectural Brief, “the entrance should be obvious, welcoming, and not intimidating, with a place to hang your coat and leave your brolly. The door should not be draughty, so perhaps there should be a lobby” (2015, p.7).

### Welcome area/library

Upon arrival at Maggie's, visitors enter a welcome / library area. “The first impression must be encouraging. There should be somewhere for you and a friend or relative to sit, a shelf with some books and an ability to assess, more or less, the layout of the rest of the building” (2015, p.7). As for the books, the contiguity of the spaces has changed slightly over time. The library was once located near the entrance; today it is sometimes far away. Including books on cancer, art, poetry, fiction and children’s literature, visitors can isolate themselves by staying in sonar contact with the rest of the centre. In the welcome area there are no reception desks, but coloured armchairs or sofas placed in large bright halls adjacent to the kitchen. The lack of signage typical of institutionalised health facilities (there are no labels on doors and cabinets, staff badges, orientation signs) evokes a familiar atmosphere. The activity board is usually found here or in the kitchen. At the beginning, the office was not

included among the functions of the centre, but over time it has acquired a precise description for practical reasons.

### Kitchen

As mentioned, the kitchen area is typically the first space a visitor sees when entering a Maggie's Centre. Full of light, it is large and cheerful and often noisy when full of visitors and volunteers serving drinks to those who enter.-Unique to all Maggie's Centres, the large kitchen table inevitably draws people into difficult situations. By placing a domestic piece of furniture near the entrance, Maggie's wants to facilitate the opening process and since "everyone knows what to do in a kitchen" (Howells, 2016, 7:16), after making a cup of tea or coffee, the new visitors sit down and start conversing with old visitors, sharing tips and experiences around the kitchen table. Feeling at home, in a familiar atmosphere, new visitors will receive, without knowing it, psychological support from this very moment that will begin to generate flexibility and openness.

### Large sitting room or activity room

Warm and welcoming, the large sitting room is used for group activities ranging from physical ones (relaxation, tai chi, yoga), to psychological ones (mindfulness, cancer groups), to social ones (choir, beauty, conferences, fundraising meetings). Depending on the activity, it could be a place of relaxation but also of anxiety. As requested by the Architectural Brief, it offers enough space to accommodate 12 people lying down and a storage room for folding chairs and yoga mats. Visitors I met associated this room with 'work' and 'action', while the kitchen meant 'share' and 'release'.

### Consultation rooms

Consultation rooms are of two sizes, larger for small group conversations and smaller for one-to-one counselling. In them, confidential discussions take place with psychologists, oncologists and professional staff or external financial experts. These rooms always have windows that look outside, towards nature or the sky, comfortable chairs that can be moved, and warm blankets and colourful cushions.

### *Art*

At Maggie's, art is as important as architecture because it helps visitors and staff see the world from a different point of view. "Hanging a work of art is like opening a window: it

gives you a view. And you look at it and you are enchanted. It's not decoration; we hope it's not decoration" (*Blakenham, 18.05.2019*). Maggie's art collection includes paintings, sculptures, glass, photography and outdoor land art. The inclusion of these works was made possible thanks to the donation of artists such as Edoardo Paolozzi, the Scottish artist and old friend of Maggie and Charles, and many others. This important feature of the Maggie's Centre is quite unique. It is rare, in fact, for a healthcare building to own or hold works of art of value, as people designing spaces in this sector usually do not think that art's ability to distract and surprise the people with cancer is of primary importance. As it holds a large number of works of art, part of the MAG (Maggie's Art Group), the Maggie's Centre can be described as 'a place of art', reinforcing Charles Jencks' vision of the Maggie's Centre as a hybrid building: "We are 'homely', but we are not a home; we are religious, but we are not a church; we love art, but we are not a museum; we help patients, but we are not a hospital. The work is essentially gripping" (*Jencks, 18.06.2018*).

### *Furniture*

The Maggie's Centre is designed to feel homely, with the types of furniture we would find in a home: a carpet, a lamp, an old sofa which, combined with ordinary objects such as a kettle, a coffee pot, a fruit bowl, cushions and blankets, create a comfortable and domestic atmosphere. Yet, being contemporary buildings "each in their own style and approach versus the Modern" (*Jencks, 18.06.2018*), the addition of industrial design pieces such as famous chairs, lamps, and coffee tables alongside the traditional furniture brings a sophisticated touch. In particular, to have confidential and emotionally charged conversations, people need to sit comfortably. For Maggie's, as already mentioned, the act of sitting down and the chair as an object are fundamental because they are the basis of the social act and interaction with others. Compared to a traditional healthcare facility, whose furniture cannot be moved within a space, at Maggie's the furniture is constantly in movement, bringing variety and action to the space. Together with art, furniture plays a fundamental role in enriching spaces and making people feel cared for, with the same care with which the building is well-kept.

## VI. Gardens and Landscape

Within the project of a Maggie's Centre, the landscape plays a significant role not only for its therapeutic characteristics but also because it goes back to Maggie Keswick and her

research and book on 'The Chinese Garden' (1978), of which she was an expert. As Laura Lee says, and as confirmed by Angie Butterfield (2014), if the Maggie's Centre has therapeutic power, that power is in the garden. "I think the only healing way is with the garden" (Lee, 18.05.2019). In reality, Maggie's gardens do more than the normal mental restoration that comes from nature, and its colours, scents, shapes and seasonal changes. As Lily Jencks explains in her text "Maggie's Cancer Centre Gardens: Herbs, Habitat and a Search for Deep Meaning" (Lily Jencks, 2021), the original concept of her mother Maggie and evident in her book, was that small gardens could represent the macrocosm of the world in the microcosm of a garden. This is evident in *Gongshi* (scholar's rocks) representing miniature mountains, or in the soft edged and angular-shaped ponds representing endless seas and planting which frames the space to imply that the garden extends beyond the walls. Capturing the panorama of the world in a miniature garden means making a garden connect us to something greater than ourselves (Lily Jencks, 2021). At Maggie's, this connection is fostered through a garden that encourages socialising, interacting, and thinking. And from my meeting with Maggie's users, the effectiveness and strength that nature transmits emerged: from the Oldham tree of life to the fragrant roses of Dundee, all Maggie's gardens increase the sense of well-being and stimulate the senses of users so much that, as Lily Jencks says, at Maggie's "the 'joy of living' is palpable" (Lily Jencks, 2021, p. 21).

While in the past, the garden was thought of as the final act of the project, with the latest update of the Architectural Brief (that consequently took the name of Architectural and Landscape Brief), Maggie's understood the importance of the landscape designed together with the building and not subsequently. Considering that no Maggie's Centre has ever been born without a garden, since then all the new projects have been conceived as an integration between building and landscape; therefore, in addition to the architects, Maggie's has also commissioned landscape architects. In the name of "integration", for example, Dan Pearson designed the landscape for Maggie's West London (2008) together with Ivan Harbour. Built not on a former car park (as is often the case for a Maggie's Centre), but on a green public area just outside the hospital, the landscape of Maggie's West London integrates not only with the architecture, but also with the nature outside. Connected to it through the window open in the orange wall, the herb court offers users the ability to modify the design by adding new herbs such as lavender and verbena. By suggesting to the landscape architect what to put inside the scented garden, it also becomes a way to generate ways to communicate the user experience to the designers. With their project, Ivan Harbour and Dan

Pearson showed what can be achieved if this relationship exists from the beginning: seeing something green from every single corner of the building is what makes the centre unique.

Although landscapes are key to Maggie's concept, initially my choice not to interview any of the landscape architects arose from the fact that most of the architects I interviewed talked to me at length about their garden or landscape design when I asked them: "What role does nature play in your project". During my fieldwork at Maggie's Barts, however, I had the opportunity to speak with Darren Hawkes, the landscape architect in charge of the new ground floor garden design. As the third floor of Maggie's Barts, as mentioned, is not widely used, it was considered necessary to expand the garden at the rear of the building to involve visitors who mainly use the ground floor and the general public. Maggie's Barts is the most urban centre of Maggie's. In the heart of London, the building develops vertically rather than horizontally, and the landscape is made up only of the roof garden.

I think the facade of the building is stunning, but it is isolated and does not reach any old buildings. Then, a large opening with a direct line view will help connect the building to the site and creating an extension with the plants will immediately show who the user is. So, maybe you sat next to a Smithfield market porter or someone at church or a hospital staff member. But you still want to go upstairs, because as you go up, things get calmer, softer and quieter and that top roof with a view is a calming device (*Hawkes, 04.12.2019*)

Although it is essential to have 'a view onto nature' (Keswick, 1994) and to be connected to the natural environment while being inside the centre, it is also very important to enjoy the external landscape that offers moments of 'pause' or rest on the way to the centre or on the way out. "And the landscape, as we know, is so important from a therapeutic point of view, it is the interface, the thing that transforms the building into a 'therapeutic' sensation" (*Lee, 18.05.2019*) Acting as a buffer between the stressful experience of the hospital and the acceptance process at Maggie's, or between the time spent at the centre and returning home, the landscape offers a useful moment of reflection that can filter the minds of its users. Thanks to sculptures that attract attention, fragrant herbs that capture the sense of smell, structures such as greenhouses where flowers and fruits require care and dedication, in addition to the building, gardens and landscape too give their contribution to the staff in supporting visitors. Keeping them busy and bringing produce grown in the garden into the centre, the staff says that for visitors using the garden "is a good way to lower their defences and open up to others" (*Haylock, 12.06.2018*). By substituting the staff, the garden can be a place of reflection with meditative spaces whose design can tell a story that metaphorically

connects to living with cancer. This is particularly evident in the landscape created by Charles Jencks in collaboration with David Page (Page\Park) for Maggie's Highlands (2002), in which the conceptually and formally intertwined landscape and building design is inspired by the theme of cell division (mitosis): an overturned mound (the building) and a void (the garden). The basis of life, if cell division loses control it becomes cancer in a rapid process of reproduction that spreads throughout the body. "Here the landscape and building together form a meaningful narrative that connects visitors not just to views of nature, but the biological forces that create nature as well, while also conveying meaning to Maggie's Centres' specific programme" (Lily Jencks, 2021, p. 22). In the overall design of the landscape, a flow of cells features two single cells represented by two mounds, which with their spiral paths encourage movement and remind visitors of the pleasure of being alive. Inviting them to enjoy nature, by placing seating at the top, the mounds solicit the visitor to linger longer in a place to contemplate the truths of nature, the beauties and struggles of life (Jencks and Heathcote, 2010).

## VII. Architectures and the 'Full Panoply of Meaning and Aesthetics'

This section will accompany the reader near and inside the three Maggie's Centres that I have analysed through my fieldwork. In the Appendix of this thesis, the reader will find an illustration of how the architect responded to the emotional requirements of the Architectural Brief about the feelings that the architects tried to enable in the users (*Appendix\_IV*). In order to provide a more systematic description, I will report here the feelings and emotions that I felt at the moment of my experience and the meanings and aesthetic impressions that remained within my memory. Beyond the phenomenological approach of those theorists and architects who have substituted the ocularcentric perception of architecture in favour of an embodied experience of the built environment (Mallgrave, 2017) – although ocular experience still holds the authority within a phenomenological reading of the place (Norberg-Schulz 1996) – in line with my idea that phenomenology does not need sight to experience an embodied immersive experience, as in a novel, this narrative aims to capture the reader's mind through the written description. By substituting the use of images in favour of a narrative of feelings and meanings experienced in a Maggie's Centre, this story aspires to accompany the reader in letting their subjective imagination reconstruct the architectural settings. As Charles Jencks emailed me: "The full panoply of meaning and aesthetics:

atmosphere, emotion, senses conveyed through the usual architectural means of space, light, rhythm, material, but also meaning and relation to place” (email by Charles Jencks, 11.06.2018).

*Coming to Maggie’s Dundee: the beginning of a life learning experience,*  
16.9.2019

On a late summer day, still warm and bright, across a labyrinth carved into a large green plain against a white Scottish sky, I found myself under the watchful eye of *Another Time*, the sculpture by Antony Gormley exploring the relation of the human body. In front of me, the white volume of a strange cottage that stands out on the grassy slope with a beautiful façade that, seeming almost to smile, overlooks the hospital behind me. It looks like a lighthouse with a white tower and a corrugated stainless-steel roof reminiscent of the woman’s pleated shawl from Vermeer’s *Young Woman with a Water Pitcher*. I walk to the building, and quite emotionally I look through the glass door. I know it can be difficult for visitors to enter this door. I finally enter.

Inside, the welcome area opens into a large, bright and calming space under a tall skylight. As I look across this space towards the view, I realise that the only exit gives access to a narrow and long pier that projects you into nature, the reed bushes in the foreground slowly moving in the wind, giving a sense of vitality. On my right side, next to the two counselling rooms and behind a low counter of a hidden office space, some members of staff loudly greet and welcome me. My attention, however, is still drawn to the architecture and, in particular, to the timber of the intricate structural ceiling, reminiscent of the overturned hull of an old ship which runs through the entire building.

In perfect balance between open and closed plan, the space opens up, letting me glimpse various rooms. The kitchen, separated by a glass door left open, is bright, large and welcoming, filled with people chatting and making drinks. They call me to offer me a cup of tea and a great sense of comfort and warmth catches me. Returning to the main entrance, on the right side next to Gehry’s *Wiggle Side Chair* I find the door to the toilet where, in a frame, I discover Maggie’s Dundee stamps. Next to the toilet, a wide double timber glass door screened by a green curtain provides access to the activity room, where yoga, tai chi and relaxation classes are usually held. It is a welcoming space with a single window looking towards the sky. Here I can feel the presence of many masterpieces of art and design.

On the other side of the welcome area, I can see the library, a calming space full of books and toys. Since it is the ground floor of the round tower, I realise that the staircase

going up to the first floor of the tower from the library is a spiral. Once upstairs, a single space with a fireplace and large tapestry by Eduardo Paolozzi, illuminated by a skylight and a single window that opens onto the silent horizon, surprises me. This tower, with its breathtaking view of the natural landscape and the River Tay, is the lighthouse that Gehry dedicated to Maggie and all the users of the centre who find in this space the ideal environment for one-to-one meetings. Returning to the ground floor, with a general farewell greeting, I leave the building and walk towards the parking lot. Walking along the white path that detaches from the building in the green Scottish plain I can smell a strong scent coming from the rose garden, which surrounds a lawn where visitors can practice yoga during the summer. Almost a reminder and an invitation to return, the landscape further prolongs the time of the experience by adding meaning and relationship to the place.

*Coming to Maggie's Oldham: entering into a different world, 21.10.2019*

On a rainy day, I arrived in Manchester by train and struggled to find the right bus to take me to Royal Oldham Hospital. When I got off at the bus stop, it was easy to spot Maggie's Oldham, albeit a little camouflaged by the dark wood of its outer skin. Conceived as a raised box with a large hole in the centre, the wood and glass building stands on tall, slender legs, allowing the space below to become a garden for the entire hospital. Unused for many years, the original site, at a lower level than the street, was an abandoned mortuary. Despite this, it was chosen because it was located in a quieter area of the hospital grounds, with an endless view of the Pennine hills. Walking towards the building along its right side I see the entrance over a pedestrian bridge. Still on this side of the bridge, I can already glimpse a very bright space inside that attracts me. I decide to cross the bridge and open the glass door and, dazzled by a bright yellow floor that transmits joy, I stop. In front of me there is a curved glass case that surrounds me while, incredulous, I look at the silver birch contained within it that conveys a strong sense of life. Through the wet panes of the curved case I can see the garden below and the rainy sky above. The curved glass encourages the movement of my body, pushing me to the left. I walk towards the kitchen, where I see people sitting around the table and along the counter. A staff member comes up to me, smiling, and offers me a cup of tea.

Thanks to the open space all on one level, it is easy for me to understand the organisation of the building with the counselling rooms all on the entrance side, and the open kitchen and shelving on the opposite side. From the hospital side, the view is mediated by the deep south-facing terrace which, together with the niches and comfortable armchairs, reinforces the domestic atmosphere of the kitchen. Here, another curve of the glass case

embraces the round kitchen table and pushes me back towards the last curve that encloses a small corner where I can finally sit. From here I can observe the open space that offers a complete sensory experience: the bright yellow floor transfers energy; the wooden walls and ceiling – even the door handles – transmit warmth to the touch and a good scent. I turn towards the hills and the infinite view of the horizon lends me self-control, being able to look away from a safe place. The strange silver curtain running on a curved track placed on the ceiling transforms the living room with minimal furniture and an isolated fireplace into the activity room; once closed by the curtain, the circular space is dark enough to take a nap during group relaxation or alone, as well as having good privacy.

Returning to the kitchen area, I observe people through the glass case. There is a great coming and going, and when they see each other through the transparencies people greet each other. I approach the kitchen countertop and, touching it, I realise that it is a wooden plank cut from a very large natural trunk. Looking further at the cross-laminated timber (CLT) and the natural materials that surround me, such as the walls, ceiling, door handles and terrace balustrades, I realise that this is a healthy building. Its therapeutic nature, in addition to being symbolised by the tree in the centre, continues in the greenhouse and garden with flowers and vegetables that visitors collect and consume inside the centre in summer. Connected to the terrace by a staircase, the garden invites me to go down and enjoy its peaceful atmosphere sheltered from the building above and, as it is pouring with rain, to watch the water fall into a reflective basin that collects rain from the roof.

*Coming to Maggie's Barts: a glowing lantern in the darkness, 22.11.2019*

On a cold but clear day I found myself inside the main courtyard of the historic Bartholomew Hospital, where Maggie's London Barts attaches to James Gibbs' North Wing (18th century), which contains the Hogarth Stair and the Great Hall. Looking at the recent postmodern building, so different from the surrounding context in terms of material (glass), shape (curved) and absence of plastic elements, I realise that its new dynamic presence has certainly shaken the static historic buildings. Although different, the large, frosted glass case with curved corners is placed with elegance and discretion in the corner of the historic courtyard, providing a new fundamental function. In fact, if during the day the translucent glass volume that looks like solid alabaster is impenetrable apart from vaguely seeing coloured fragments, in the evening the same volume becomes an incandescent white lantern dotted with strong and bright colours that works as a reference for the whole hospital. A real phenomenon that leaves me enchanted. Inspired by the coloured notations of thirteenth-

century medieval music found in the nearby church of Saint Bartholomew the Great (12th century), to give continuity to the score of the horizontal stave, the façade has rounded corners on all four edges, including the two in which the new building meets the old one, so as to reveal the historic angular ashlars.

The centre has two entrances, one facing the Chapel of St Bartholomew-the-Less and the other, the main entrance, facing the historic courtyard. Although the door merges with the façade, I recognise it and enter. Standing in the ‘pause’ / entry space, Maggie’s Barts already takes my breath away. In the double-height space, the translucent white glass façade punctuated by various colours which, unlike the outside, inside come alive in daylight, diffuses an enveloping light that transmits energy. Inside the curvilinear layer of glass, two other curved layers reveal themselves: that of the structure conceived as a concrete frame which, in addition to curving, tilts together with the inclination of the musical score that rises upwards and the bamboo staircase, which curves on itself, spiralling two floors. The grandiose space, enveloping and warmed by bamboo wood, encloses me in a warm hug. Once my brain has absorbed this total embodied immersion of my body, I slowly move towards the kitchen area where the staff greets me joyfully, offering me a cup of tea.

Together with the Centre Head we sit at the kitchen table, where I find a great sense of homeliness. Designed in the shape of an hourglass, depending on where and how we sit, the table can accommodate multiple single conversations or a group discussion. Going up one floor and looking from top to bottom, the view is total and the table, in the centre of the ground floor and the staircase, becomes a reference point for the entire building. If I look towards the outside, however, I realise that the translucent glass prevents me from seeing outside, but along the way I discover a transparent window overlooking the chapel at the back. When I finally get to the top, all the windows overlooking the terrace are transparent, putting me in touch with nature and the large tree behind the apse of the chapel making my view extend beyond the building. The view over the rooftops of the surrounding buildings makes me feel elevated above the city, away from the noise, nearest the sky almost in an English village. And if I look beyond the hospital, the infinite view of the horizon also makes me feel optimistic about the future and about life.

## VIII. Issues, Differences and Imperfections

As described so far, Maggie's experience seems to be always and only wonderful and positive while, during the ethnographic fieldwork stage 2, I collected comments on some issues from users for whom, for example, it was not easy to enter or see or adapt to the environment. One man, for example, said to me:

When I arrived at Maggie's Dundee, I didn't even see the building. I didn't see the architecture. For me it was just my problem and the people standing in front of me there to help me; only later, I understood what the building was like (*Focus group no.1 Dundee*).

In general, men are more critical and difficult than women. They often do not understand the Art (for example, Grayson Perry's drawing about war and suffer, hanging in the big living room in Maggie's Dundee was "quite disturbing" to them) or the choice of certain colours (Maggie's Oldham's yellow floor was incomprehensible or more expensive to men, while women saw it as a message of energy and joy) and they find flaws in the construction (Maggie's Barts's bamboo staircase was, according to one male participant, badly crafted like were the concrete and the doors).

In their criticism, some women at Oldham were less critical and more practical. "The only problem with this building, like any other hospital, is the path. We had to go through half of the hospital to get there. But other than that, it's lovely". In addition to saying that concrete floors are not suitable for dancing, some women at Barts criticised the staircase.

I feel like that the architect did not necessarily consult the users. So, it's very architectural, but I sometimes find it very impractical. I wouldn't have had stairs, expecting cancer patients to walk up two flights of stairs it's rather hard. (*Follow-up Barts*)

In general, the idea of the three floors at Maggie's Barts is not very popular and although there is a lift and it allows for good light and a sense of openness, the central high ceiling does not make people feel comfortable and safe and, therefore, it is not suitable for 'everyone.

This building has rather high ceilings. so, that means not cosy, but it is open and spacious and natural light is always good. So, this has a lot of translucent light as well as transparent light, which is pretty good. I mean, London isn't known for its light, but what can we do. (*Follow-up Barts*)

By highlighting serious problems, some women at Dundee became truly critical when, for example, they disagreed with basic principles such as uncritical acceptance of anticancer therapies or an unsuitable diet due to excess sugar.

The reality has been more conventional at the moment. What would be good for Maggie's as a whole is to take on board and be willing to take on board some of the natural therapies. And I think they don't because they're right next to a hospital. (...) It's about this, that it is a therapeutic environment if you put together the way you eat, the way you sleep, etc. (*Move[Sit]-along Dundee*)

Both Staff and Visitors told me of people who said: 'I don't think this is for me' or 'I don't think I'll stop for a chat, but I might come to a particular event'. These aspects, that not everyone knows, surely give the reader a more realistic version of the facts and a more objective way to judge Maggie's experience. However, the reasons for this reaction could be of different kinds, from personal to social (especially for men) or because of the architecture. There have been occasions during my visits to the centres (e.g. Maggie's Aberdeen and Maggie's Swansea) where I have come to realise that due to the overwhelming size and challenging spaces, some visitors felt alienated from the place. But, although we may think that not all of users are prepared to understand unconventional architecture or a sophisticated environment, as Laura Lee explains, beauty helps to familiarise.

Oh, there have been days at Maggie's when we had people saying: 'You cannot get people in Richard Murphy's building, in that fancy kitchen, because they come from a mountain community and that's not the kitchen they are used to'. But, of course, they want to be in that kitchen, because they love it! And in Rem Koolhaas' building, working class soil and earth men come in and enjoy the feeling which is coming from the concrete and glass interplay. They don't say 'oh we love Rem Koolhaas', but they are enjoying the quality of the building and space. And I think as all humans, we have the capacity to feel beauty. (*Lee, 18.05.2019*)

In terms of differences, as explained, while sharing the same synthetic functional programme required by the Architectural Brief (entry/pause, library/welcome area, kitchen, two counselling rooms, one big living room, office space and toilets), all Maggie's Centres are different. In particular, due to the different number of floors (1 floor for Maggie's Oldham, 1.5 floors for Maggie's Dundee and 3 floors for Maggie's London Barts), the three buildings of my fieldwork have further differences in the characteristics of each function and in their sequence. For example, within the 'entry / pause' area where the first psychological act of 'acceptance' takes place, the entry door is described by the Architectural Brief as 'obvious'. While Maggie's Dundee's front door literally draws people inside and at Maggie's Oldham

the door gives time to think, at Maggie's Barts the main entrance door blends in with the glazed facade and is almost invisible. Furthermore, positioned on the curved facade, the MAGGIE's sign is impossible to read in its entirety, from a distance. Another difference is in the use of the fireplace, a request from the Brief that lately is no longer a priority due to some technical problems that some centres have had, although in many old centres it works well, representing one more interactive social space (Cumming and Poncelet, 2018). While at Maggie's Oldham it is in the sitting room so very accessible, and at Maggie's Dundee the fireplace is on the first floor and has ceased to be used, at Maggie's Barts, being on the third floor, it has only been used once appearing to people like 'a decorative thing'. In terms of sequence, at Barts the library is not adjacent to the welcome area as requested by the Architectural Brief, but on the first floor where there is also the bathroom which everyone says should be on the ground floor. Here, the lift takes you to other toilets in the basement, but this doesn't seem to please the visitors and sometimes the lift is out of order. Speaking of the relationship between health and therapeutic through materiality and nature, at Maggie's Dundee, besides the view and the surrounding nature, the timber used generously throughout the building, along with the natural light and the rose gardens, strike a good balance. At Maggie's Oldham, the central theme is precisely the representation of this relationship, achieved through the timber, as the raw material used for the construction, in addition to the tree in the centre of the building, and the light and the views on opposite sides of the space. However, the fact that the building and the garden are not on the same level makes the relationship with nature more difficult for people with cancer. Finally, at Maggie's Barts this relationship is expressed by another materiality, light, which, as the architect says, is energy. The roof garden is seen as a nice outlet but criticised by many for not having enough greenery and an outdoor shelter to allow people to sit outside in the shade. Also, the door leading to the roof terrace is incorrectly positioned so it prevents people from going out when yoga or other classes are held in the room.

In terms of imperfections, at Maggie's acoustics represents a problem in all centres, but this stems from the architectural choice of having "spatial interaction rather than walls", which Maggie's interprets as a way to connect people to each other. It is difficult to find silence when we enter a Maggie's Centre; on the other hand, the feeling is certainly that "we are not alone" (Lee, 18.05.2019) and that we can experience the joy of living. In addition to the technical imperfection, the proof that acoustics isn't a real problem is that ultimately the most private conversations happen in the kitchen, perhaps in secluded areas, but for all to see. Even the lack of signage, which makes difficult for the people arriving at Maggie's for

the first time to find the entrance, does not prevent people to enter after all: even if they may think it is a restaurant or café, at the end, just out of curiosity, they come in (*CCS Barts no.1*).

Considering the issues raised by users as a more realistic account of Maggie's experience, ultimately the technical differences and imperfections seem to be acceptable across the broad spectrum of twenty-six architectural solutions, with the freedom for each person to interpret the building in the way they want.

## IX. Charles Jencks: Icons, Metaphors, Hybrid and Placebo Effect

Charles Jencks described the Maggie's Centres as "mini icons" containing "multiple metaphors".

They all imply various metaphors that connect us with nature, some even with cosmos, but they also allow for different readings. They all give presence to the basic questions of 'living well, suffering and dying'. (Jencks, 2012, p. 37)

As Jencks explains, in the past the iconic was that of the monument based on symbols that people knew well, such as the shape of the temple and the Christian cross. Today the iconic building is much louder than individual symbols. When we are faced with cancer, in a continuous oscillation between preparing to die and the struggle for life, the unconscious solution is, like in the past, to orient ourselves to nature.

'Take your pain to the cosmos' is a Christian nostrum dating back to prehistoric times; only nature is large enough to contain it. (Jencks, 2017, p. 69).

The Maggie's Centre implies various metaphors that connect us with nature and the horizon. This is why it has both the gorgeous sky view and the small contained nook, which overlooks tiny gardens. It is to these complex, opposite, and contradictory human emotions that the minimalist and sober or highly expressive 'architecture of hope' of the different Maggie's Centres can respond. The context of the hospital grounds is usually dark and melancholy. By contrast, the Maggie's Centre has a 'cheerful' and non-institutional feel. The reason behind the 'iconicity' of some of the buildings finds its answer here. Yet, others are very quiet, almost "hidden in the forest" (*von Loon, 15.05.2018*). As already mentioned, an ideal and utopian project, as Charles Jencks considers it, the Maggie's Centre combines four different types of buildings into one. "A hospital that is not an institution, a house that is not

a home, a non-confessional religious retreat, a place of art that is not a museum” (Jencks, 2015, p. 7).

All the buildings taken as a group are colourful and basically upbeat: the war on cancer is not the primary note they strike. Their domesticity and slightly unusual shape suggest that they might be the friendly clubhouse of an obscure religious sect dedicated to golf. However, the metaphor of ‘normality’ (which some people may have problems seeing as a rhetorical trope) is also very strong. Tea and cushions – ‘kitchenism’ – is the recurrent keynote. It displaces the fact of cancer from the exotic and horrific into the everyday and accepted. (Jencks and Heathcote, 2010, p. 34)

Informal as a home, the typical Maggie’s Centre is designed to be cosy, domestic, small in size for socialising, sharing experiences at the kitchen table or while making a coffee or tea at the counter, to learn relaxation and how to eat well. At the same time, as we know, the Maggie’s Centre is also a place of art, where people can enjoy art-therapy courses, or a place where one can look for information on cancer care, depending on people’s needs. To be alone, dealing with some final questions and even crying, people can find privacy even inside the large common areas in secluded corners overlooking the outside. The “power of the hybrid”, as Charles Jencks calls it, is inherent in the Maggie’s Centre, which enhances architectural richness and human values. As he has stated since 1983:

The hybrid is difficult to achieve, certainly more demanding than single-minded attention to aesthetics and technology that the brilliant Mies van der Rohe followed. It is also as a language richer in scope, making full use of the architectural means including ornament, symbolism, craftsmanship, polychromies and metaphor. (Jencks, 1985, p. 8)

Another attribute that Charles Jencks gives to the Maggie’s Centre is that of the ‘placebo effect’. Its discovery was marked by the famous quote by the American philosopher William James. “The greatest revolution in our generation is the discovery that human beings, by changing the inner attitudes of their minds, can change the outer aspects of their lives” (James, 1890, quoted in Jencks, 2012, p. 31). As is well known, a placebo is a ‘fake’ cure that works because it acts on the patients’ belief. Since 1950s and the work of Henry K. Beecher (1955) the scientific community has taken placebo results seriously, as placebos have been shown to work well as conventional medications in some cases, especially those dealing with psychogenic problems (Jencks, 2012). Consequently, Charles wondered:

How can phoney things work? [And, moving the discussion to Architecture] “how do we gauge the effect of a building on health if, like the placebo effect, it is partly in the mind? Or, is there an architectural placebo? (Jencks, 2012, p. 31)

Because in the placebo effect, blue pills work statistically better than red ones, especially for diligent patients (Moerman, 2002), translated into architectural language, Jencks argued: “style does not matter if patients who go to Maggie’s diligently may do better than those who do not” (Jencks, 2012, p. 33). Since the placebo effect in medicine is scientifically proven, Charles explained to me that in the case of the Maggie’s Centre, this fact is amplified by the quality of the building, by the style and, above all, from the feelings and activity provided by the staff. However, not wanting to give too much weight to the question ‘can architecture affect health?’ he argued that the architecture and arts of Maggie’s have an indirect effect on people with cancer, but first passing through the staff. As already mentioned, “the Architecture supports the Staff which in turn supports the patients” (Jencks 2012, p. 37). Even if the architectural effect on people with cancer is not direct, it is still significant because it is transmitted by staff that work in a friendly and reassuring atmosphere. And this is confirmed by the history of humanity, which has always used architecture (with art and landscape) as an overcoming of great suffering.

Architecture gives a perspective, a message of hope, at least in a religious or faith context: monuments, sanctuaries and temples that man built in the history to celebrate or thank divinities after survival through epidemic times witness the deep connection between architecture, religion and health. The ritual monumental setting, from Stonehenge (3000–2000BC) to the Lourdes Sanctuary (1858) – in a way, early examples of architectural placebo – constitute the spiritual landscape of healing environments. (Jencks, 2012, p. 37)

As in ancient Greece Asclepius’ healing resides in suffering, what Maggie’s Centre does is to convey to people with cancer the message that ‘suffering’ is a normal part of life and, as such, it is best accepted.

## X. Conclusions

What is the style of an architect? The Maggie’s Centres are all different, but to Charles Jencks it doesn’t matter what look the building has; it is really the effect that the architecture has on us. So, the architect can come from any background and the building can be different, but because of the Architectural Brief, they all will achieve the same result: the experience they generate in users will always be the same. According to Charles Jencks, what defines

them is therefore not an architectural style, but rather their healing side. However, therapeutic architecture has no technical rules, only the strength of its spirit, the hardness of its challenge, the sense of provocation.

Zaha's architecture is, in its way, an antidote to the institutional neutrality of healthcare architecture. It suggests a visceral shock, a dark shadow which initially knocks the visitor, of course. It is the most effective example of questioning of that orthodoxy of blandness, that fear of the sharp-edged and the visually arresting. Yet its apparent aggression is all bluster. This is an extraordinary envelope containing within it a surprising and rewarding series of spaces. It poses the question: what else can an architecture of health do apart from accommodate? Does it have to soothe or just work? Can it infuriate? Surprise? Refresh? Delight? Can it do all of these, and if it does, what effect can it have? This is not an architecture of healing, but it is an architecture of provocation and perhaps that is what we need. (Jencks, 2015b, p. 138)

Maggie's buildings are defined not so much by beauty, but by aesthetics which include the provocative and brutalist. Reinforcing the sensory is the overarching style of each building. "We are a Postmodern project where twenty buildings are each in their own style and approach, versus the Modern idea that there is one best solution for each problem" (Jencks, 18.06.2021). As with the Benedictine Rule, the Brief may be similar, but just as there are 75,000 solutions in the world, Maggie's programme seeks and supports the particular solution for each building. What counts is that with the same goal of "empowering the patient" the Architectural Brief contextually informs the architecture, the centre values, and the support programme.

## Chapter 5. The Participants' Voice

In this Chapter, I aim to describe the experiences of Maggie's staff's and visitors'—and highlight their voices. Supported by Lesley Howells' postulate stating that Maggie's users have positive experiences, from recent but very limited literature on Maggie's design and from what emerged from my focus groups and interviews, the methodology adopted in my fieldwork was not aimed at interacting with users to understand what kind of experience they have at Maggie's and if it is positive or negative, but to find out what it is about the architecture (together with the good attitude that the staff has towards people) that allows for well-being in users.

Gaining my inspiration from Lesley Howells (01.11.2017), as mentioned, the first purpose of my ethnographic fieldwork at the three centres (Maggie's Dundee, Maggie's Oldham and Maggie's Barts) was to discover the link between design and psychological flexibility, and, more precisely, how this link enables an effective therapeutic environment as the result of the 'synergy between people and place'. Therefore, this chapter takes equally into account the notions of *people* and *place*. In terms of *people*, borrowing the terms used by Maggie's in brochures and on the website (<https://www.maggies.org/> 2021) for titling the five-steps healing process – how it begins and develops in a Maggie's Centre – I start by giving voice to the staff who witness the shocked condition of the visitors when they come in. After explaining how they help them to move toward psychological stabilisation, I pass the word to the visitors who are the best spokespeople of their own experiences. As already mentioned, although the condition of health between staff and visitors is opposite, at Maggie's, users (staff and visitors) perceive the space and feel affection for the building equally, feeling the same sense of familiarity and warmth around the kitchen table while sharing stories and daily events. What emerged from the interviews and group discussion is how the new element of 'empathy' helps to create a strong mental connection between *people* and *place* and make the two different user types appear as one category.

In terms of *place*, in describing the architectural elements in common to the three centres, what emerges – and it is surprising to witness it – is that users too have a great deal in common. In unfolding the communal five-step process of psychological healing that staff adopt to lead visitors to be 'stable', the terms and expressions used by staff and visitors of the different centres are revealed to be the same. Though this is perhaps to be expected among members of staff, as they all receive the same type of training, it is not explicable that visitors say the same things using the same terms and behave in the same way by making

the same gestures even though they are very distant from each other. In realising that there is a 'red thread' that connects the three Maggie's Centres and that makes people speak and act in the same way (what Maggie's claims is that, despite the differences of the buildings, the psychological effects are the same), I understand that this common denominator resides in the architecture and its spatiality, which was originated by the Architectural Brief.

This fact got me thinking. As we know, Maggie's users are aware of architecture, some are more interested than others, and sometimes they know more than architects. They certainly knew more than I did when I arrived, because they had been there for longer than I have, but also because architecture is a topic that is discussed in the support programme and therefore known and domain of Maggie's users. Once learned, Architecture can become a passion and a feeling common to all. The fact that the Maggie's Centre is the result of teamwork and not just an architect (it often begins with a community fundraising) explains the sense of ownership that users have for the building and how much architecture brings people and their different thoughts together. Far from being a faith-based organisation (Howells, 2018), coming from all sorts of backgrounds, stories, experiences, Maggie's users, after some time spent at the centre, start thinking, speaking and moving in the same way, sharing an interest, an attitude, a unifying way of living and understanding life.

Despite this common interest between users and me, once I entered the 'field' and ethnographic work, architecture was no longer so prominent, nor did I set it as my objective of investigation towards users, indeed it was used like a *basso continuo* in an orchestra - constant but never emerging. With this premise, while continuously verifying the possible biases caused by my background, trying to maintain the objectivity of a researcher, and aware of what I was facing while doing it, I began to focus on the experiences of people enabled by the space but also by subtle details. For example, speaking of the connection between 'nature', 'material' and 'therapeutic' suggested by two architects - Alex de Rijke, who used only timber as a material and placed a Silver Birch tree in the centre of his building and Benedetta Tagliabue, who spoke of beauty and the fact that in the old hospital in Barcelona nature is represented by the flowers painted on ceramics, which she placed in her Maggie's Kálida - allowed me to speak not of architecture, but of materials as metaphors of nature and therapeutic.

The second part of this chapter analyses the individual sentences and gives an in-depth explanation to this finding. Through the analysis of similar terms and concepts pronounced by visitors and staff upon their experience, framed by the established search parameters, I was able to verify the effects that the building generates on users. In particular,

during my ‘Participation and Observation’ method through the parameters of social interaction, privacy and counselling, I was able to measure the level of ‘therapeuticity’ of the building found in the areas where visitors prefer to stay, while, through ‘identity’, ‘agency’, and ‘perspective & refuge’, I was able to access participants’ immediate ‘feel’ for the centre (Rose, Degen, and Basdas, 2010). With the study of what Maggie’s (place) represents for users (people), the presence of the therapeutic environment began to emerge.

## I. Timetable of Activities: The Life of the Centre

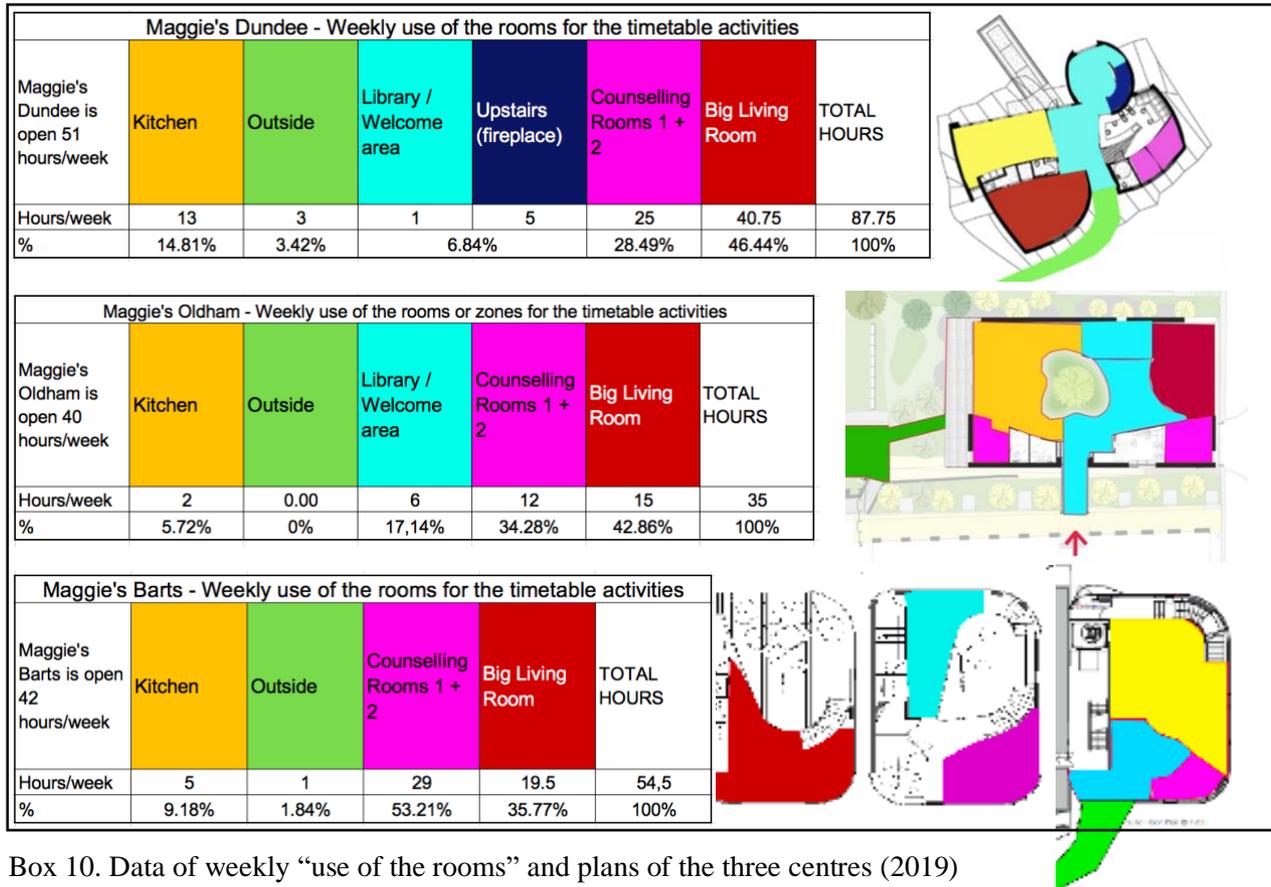
As soon as I arrived at each Maggie’s Centre, I was given the timetable of the weekly programme, so as to understand the activities offered there and adjust the schedule of my methods to the life of the centre. Furthermore, together with some numerical data provided to me by Maggie’s, the use of the spaces was explained to me both for the number of hours per day and for the type of activity carried out there. By reporting this data in diagrams and related building plans (Box 10, 11, 12, 13, 14, 15), in this section I aim to explain how each room was used and for how long. In this way the reader is able to understand where and when I was investigating the action of the building on the users.

From a first collection of data, such as attendance and opening times of the centres and comparing the sets of opening and activities hours (Box 9) and how activities are distributed in the three centres, I realised that Maggie’s Dundee (2003) is open later in the day and that it offers double the hours of activity offered by Maggie’s Oldham (2017), which is a very young centre. Being in London, Maggie’s Barts (2017), also very young, collects more than twice the visitors of Maggie’s Dundee, even if it offers two-thirds of Maggie’s Dundee’s hours. As one of the main goals of my fieldwork was to understand the use of building space, I found that the density (the ratio of the building surface to the number of visitors) is quite similar among the three centres, and that this was a good premise in trying to verify that despite the different sizes, the three centres perform in the same way.

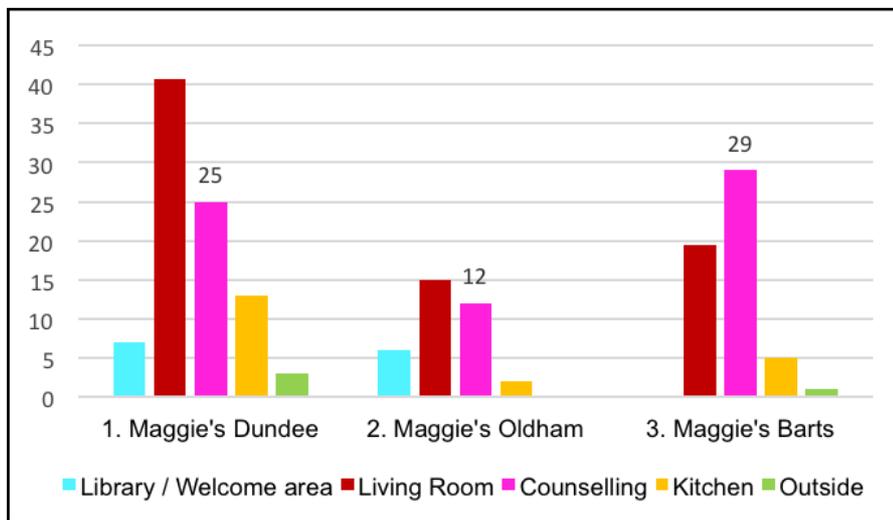
	Year open	Surface Sqm.	Staff number	Visitors/day	Hours open/week	Hours for activities/week	Density visitor/sqm
Maggie’s Dundee	2003	214.00	9	48.23	51.00	87.75	4.44v/sqm
Maggie’s Oldham	2017	260.00	6	49.05	40.00	35	5.30 v/sqm
Maggie’s Barts	2017	607.03	8	120.00 ca.	42.00	54,5	5.06 v/sqm

Box 9. Comparison of data of the three centres of fieldwork (2019)

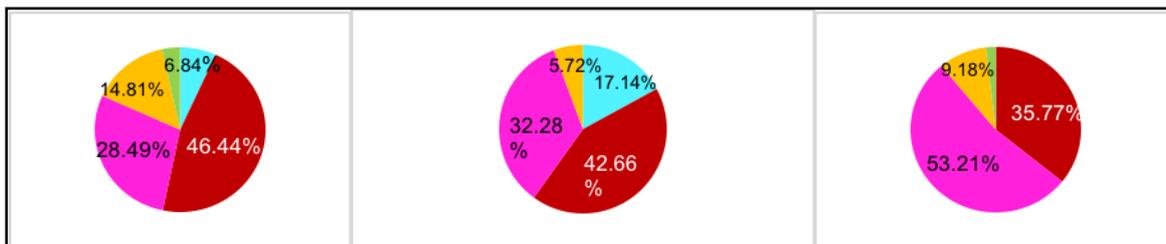
Analysing the timetables of the three centres through the framework of the ‘Use of the Space in regards to the timetable activities’, I found that the use of the large living room, also called the activity room, in Maggie’s Dundee and Maggie’s Oldham is relatively higher than that of the counselling rooms, while in Maggie’s Barts the counselling rooms are the most used and the living room is quite underused. The kitchen and the welcome area/library are hardly used for activities, but are essential for immediate support, ‘social interaction’ and ‘privacy’ (Box 10).



Box 10. Data of weekly “use of the rooms” and plans of the three centres (2019)



Box 11. Histograms of comparison by weekly “use of rooms” by number of hours (2019)



Box 12. Maggie’s Dundee, Maggie’s Oldham, Maggie’s Barts (left to right). Pie charts of comparison by weekly “use of rooms” by percentage (2019)

Histograms (Box 11) show the number of hours and pie charts (Box 12) show the percentage of time users spend in each room of each centre. The reason for the difference in the use of the large living room (in red), derives also from the number of floors of the building. In this case, the third floor of Maggie’s Barts is rather daunting for visitors who have to climb stairs; hence the living room is not used as in the other centres.

In terms of the number of hours devoted to each activity, the different types of support offered are best balanced in the Maggie’s Dundee and Maggie’s Oldham timetables and worst balanced in Maggie’s Barts, which notably lacks relaxation group activity (Box 13). Compared to physical and mental activities, at Maggie’s Dundee, Art and creativity are not very strong. At Oldham’s, in general, activities are almost the half compared to Maggie’s Dundee, but there is a lot of emphasis on creativity and mental restoration courses. Lastly, at Barts’, I understood that cancer groups and cancer courses were definitely the priority in the programme, as evident in the Box 13 although the Creative Art Therapy, along with few physical activities, were very popular among the visitors.

Maggie's Dundee - Weekly time of the activities						
	Physical, Creative, Choir, Nutrition, Choir, Feel good Look beautiful, Haedwrapper GROUP	Walking, Running, Gardening, GROUP OUTSIDE	Relaxation, Sleep Soundly, Mindfulness, Fatigue Management GROUP	CANCER NETWORK Groups	Will, Wigs, Individual relaxation INDIVIDUAL	TOTAL
Hours/week	18,5	3	11,75	29,5	25	87,75
%	21.09%	3.42%	13.39%	33.61%	28.49%	100%

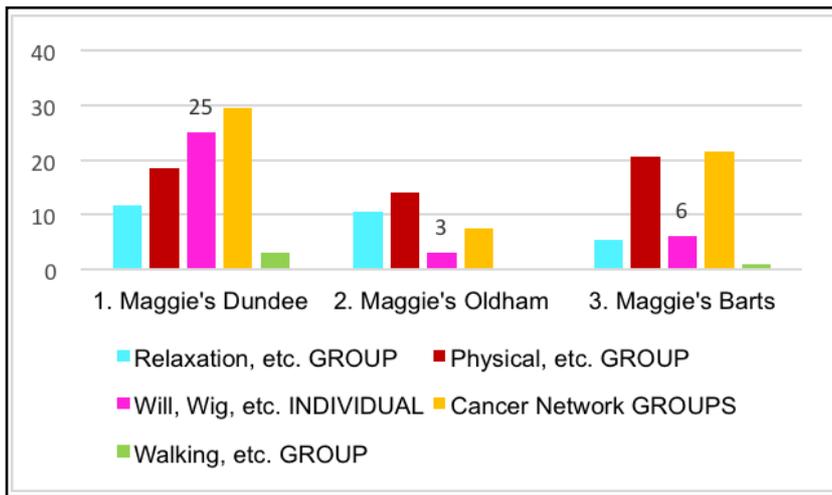
  

Maggie's Oldham - Weekly time of the activities						
	Physical, Creative, Choir, Nutrition, Choir, Feel good Look beautiful, Haedwrapper GROUP	Walking, Running, Gardening, GROUP OUTSIDE	Relaxation, Sleep Soundly, Mindfulness, Fatigue Management GROUP	CANCER NETWORK Groups	Will, Wigs, Individual relaxation INDIVIDUAL	TOTAL HOURS
Hours/week	14	0	10,5	7,5	3	35
%	40%	0%	30%	21.43%	8.57%	100%

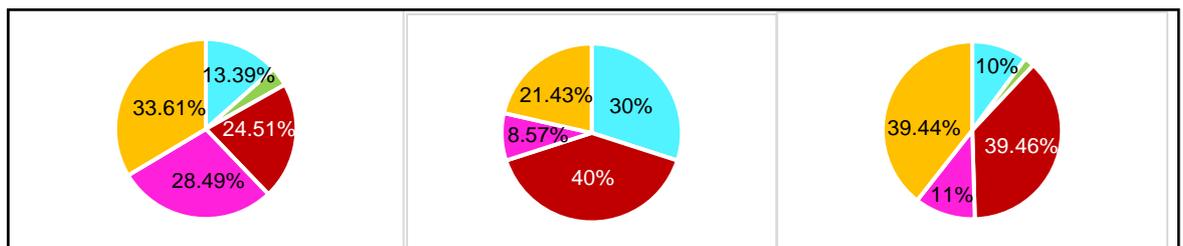
Maggie's Barts - Weekly time of the activities						
	Physical, Creative, Choir, Nutrition, Choir, Feel good Look beautiful, Haedwrapper GROUP	Walking, Running, Gardening, GROUP OUTSIDE	Relaxation, Sleep Soundly, Mindfulness, Fatigue Management GROUP	CANCER NETWORK Groups	Will, Wigs, Individual relaxation INDIVIDUAL	TOTAL HOURS
Hours/week	20,5	1	5,5	21,5	6	54,5
%	37.62%	1.84%	10.1%	39.44%	11.0%	100%

Box 13. Data of “activities offered” at the three centres (2019)



Box 14. Histograms of comparison by “activities offered” weekly by number of hours (2019)

The diagrams (Box 14 and 15) help to visualise what people like to do and how they use the space. In this analysis I began to include the use of the kitchen which has not yet emerged because it is not used for activities except for nutrition, but which, as we will see, is fundamental.



Box 15. Maggie’s Dundee, Maggie’s Oldham, Maggie’s Barts (left to right). Pie charts of comparison by “activities offered” weekly by percentage (2019)

## II. The Healing Process Seen from the Perspective of Maggie’s Users

The pathway of a cancer patient starts in an NHS Oncology Department where they receive the shocking news. Unfortunately, since it happened to Maggie in 1994, the place and the modality of this kind of communication has not changed; an “awful interior space with neon light and sad people sitting exhausted on these chairs” (Jencks 2015b, p. 11) is still the norm. As reported by Maggie’s staff, formerly working for the NHS, the hospital is very limited in terms of space and the only area where specialist nurses can bring people to talk is the waiting area. In addition, these areas usually lack natural light or soft furnishings where people can sit comfortably, especially if they are about to get bad news. The atmosphere is always impersonal and engaging and very noisy “The clinical space is always very busy in

alarm bells going off, call bells, emergency bells. And everybody rushes” (*Centre Head Barts*).

Many Maggie’s CCS (Cancer Support Specialists) hailing from other cancer facilities such as Macmillan have told me that these facilities are a little better equipped than the hospital, but still they are clinical, noisy and very limited in space as well, thus reducing the possibility of helping people from an emotional point of view.

Yes, it was possible to assist people, although we literally had a sofa this size, so you could only see one person at a time. And you didn’t have a programme. So, you were there to listen and to give information and support. And that was really important, because we were actually within the Oncology department, and so you often got people that would just come out of clinics being given news or just finished treatments, but when I worked there, I didn’t feel I was able to deliver support as the one I can give at Maggie’s. So, it was within my duty to be able to say: ‘Unfortunately, this is what we’ve got at this hospital’. (*CCS Barts no.2*)

From this quote from an interview with the Staff it emerges that other cancer facilities such as Macmillan are unable to support patients due to their confined spaces in the building. Within the research/discussion this shows that the experience of receiving the bad news in the wrong environmental conditions can cause extra stress to the patients. Given the importance that Maggie’s gives to the built environment, even if a Maggie’s building is not yet completed, Maggie’s recreates the same conditions of comfort by adopting (usually in mobile homes) the intermediate solution of ‘Maggie’s Interim’.

I have the past experience of working for Maggie’s but just in a portable cabin, where you have the same Maggie’s philosophy, but you don’t have the ‘different’ architecture. So, you’re running the same programme, you’re still offering what Maggie’s is going to offer but in a very, very different space. (*Psychologist Barts*)

The finding that the Maggie’s Interim works very well gave me the great dilemma of whether or not the unconventional architecture of the real building is fundamental to the Maggie’s mission and, in general, whether it is necessary to create a therapeutic environment. Did the absence of architecture affect the work of the staff?

Well, I did wonder about it, at the time. I think we, obviously, made great attempts to make it very habitable and cosy and the Centre Head there worked hard to do that, and we just aimed to make it comfortable and ‘Maggie’s like’. I don’t think it took away from the work. I don’t think I was in there or the visitors were in there, thinking ‘I wish we had the building’ because the focus at the time was on health and being well, and they were answered to the questions that they’re facing, so all the resources were there. Also, that’s not for them a priority, at the time. So, it’s not a noticeable loss, I don’t think, but that doesn’t mean anything. I’m trying to think about it, now.

Because, I think what it gives isn't always understood by the person. So, they may not be aware, because their focus is on their problems. They're not aware of what they're receiving from the building. So, they won't be aware also of what they're missing. And I think they're very aware when they're in the hospital of the, what that does to them, and what that hospital building does to them, but I don't think they're aware of the opposite. Definitely the delivery was still the same aiming to the calming reception, greeting them and being with them. I guess we would try to offer what the building gave in ourselves. I mean, we still do that here, but building adds, doesn't it, in doing so, whereas there was still received that sense of calm and being held. The building is a good step forward. (*Psychologist Barts*)

From this quote from an interview with a Psychologist Staff member it emerges that Maggie's Interim constitutes the prelude to the final building, although it cannot replace it. Within the research/discussion this also shows that the work of the staff alone, although valuable, is not sufficient to achieve the results which occur when it is combined with the architecture of the building. This condition came by force in 2020 with COVID, when Maggie's Online took the place of the other two support conditions by offering the use of digital channels as the only means of providing assistance. This time the question that arose spontaneously was: do we still need the physical environment and the ability of people to be together, enhancing the human dimension? After seeing what hospitals did to relatives of patients who were not admitted for keeping a safe distance and were, essentially, excluded from the power to take care of their partner or loved ones, it finally became clear that the human social interaction is vital (Lee, 2021).

Indeed, without any degree of support, there would be no result. The staff hence conclude:

I think if I had a desk and a chair somewhere, people might come to me with a specific question, but I don't think they would build the same relationship. My work would not be as effective, I don't think it would at all, because I think people just wouldn't be there so long to start with. And I relate to the space as part of the help or in order to help them. I think my support would be much harder. (*CCS Barts no.1*)

From this quote from the interview with a Cancer Care Specialist it emerges that it would be more difficult for the Staff to support patients if they could not relate to the building. Within the research / discussion this shows that the built environment helps to make people stay longer in a space.

In the following sections I will illustrate the 5-steps healing process seen from both staff and visitors' points of view, summarised here below in Box 16.

5-STEPS HEALING PROCESS	THE VISITOR ENTERS	THE BUILDING	MEETS THE STAFF	RECEIVES or PRACTICES
1. <i>Just come in</i> (Permission) (Staff's voice)	Be emotional	Entry/Pause, Welcome area	Centre Head, CCS, Volunteer	Empathy of the Staff
	Be here	Welcome area Kitchen area	Centre Head, CCS, Volunteer	Empathy of the Staff
	Go anywhere	Kitchen area Open space	Centre Head, CCS, Volunteer	Empathy, Encouragement
2. <i>Here with you</i> (Stabilisation) (Staff's voice)	Walk through door (scared or shocked)	Welcome area Counselling room	CCS Psychologist	Counselling
	Stay and continue to come	Open space in secluded zones	CCS Psychologist	Counselling
	Start seeing, makes decisions Accepts choices	Counselling room, Open space	Psychologist CCS Volunteer	Counselling, Social interaction
3. <i>Everyone's home with cancer care</i> (Adaptation) (Visitor's voice)	Do-it-yourself Use the space	Kitchen, Open space	CCS Volunteer	Social interaction
	Share experiences and emotions Being Present	Kitchen table, Open space, Counselling room	Volunteer CCS Psychologist Centre Head	Social interaction (Cup of tea with visitors)
	Participate in activities	Big living room Counselling room	Course teachers Psychologist	(Beauty, care, art therapy) Cancer Support Groups
4. <i>You are not the only one</i> (Normalisation) (Visitor's voice)	Remove cancer	Counselling Room Kitchen table	CCS Psychologist	Cancer Support Group Empathy of other visitors Social Interaction
	Being sociable	Big living room	Course teachers	(Yoga, Tai-Chi, Move-more)
	Being on your own	Your own chair	Volunteer	Privacy
5. Making the biggest difference (Affection) (Visitor's voice)	Re-grounding oneself	Kitchen Open space	All Staff other visitors	Social interaction
	Viewing the book Architecture of Hope	Kitchen table, Open space Own chairs	Empathy of the Building and others	Social interaction
	Making space for others	Welcome area Kitchen	Centre Head All Staff	Event, Choir, Fund raising

Box 16. Progression of steps into Maggie's 5-steps Healing Process

## IIa. *Just Come In* (Permission) (Staff's Voice)

The first meeting with the Maggie's Centre is always quite emotional. The staff say that, when they walk through the door, visitors seem scared and often in shock. People with cancer

usually come with their family, because, unlike the hospital from where they are excluded for privacy reasons, Maggie's includes the family. As the staff say, when they arrive at the centre for the first time, simply from entering the building, finding an environment that is overwhelming, even before anything is said, new visitors often start crying. Staff are there to help and invite them to share their feelings and concerns, telling them "it's okay to cry" and giving them permission 'to be emotional'.

It's the expression we use when we talk to them. We invite them to share what's going on, in a place which is very much in contrast with the atmosphere of the hospital. Over there everybody is so busy, they don't have time, and people don't engage and sometimes there's this reluctance to engage with everyone, because they've got so many tasks that they have to complete. (*CCS Barts no.2*)

Without understanding what is happening to them, once they have calmed down, the new visitors will say: "I don't know why I'm doing this". The staff say that despite receiving an invitation to be emotional, visitors tend to be astonished by their own behaviour. According to them, this invitation mixed with the comforting environment and relaxing atmosphere leads to an emotion that is actually a release of the tension accumulated in the hospital: just walking through the door, almost a return to a home and safe environment, "for some people could mean instant tears" (*CCS Barts no.2*).

I think people are more willing to let their guards down when they come in. They enter here, so that kind of barriers that they might have put up, they let them down. And I think the space helps that, I'm sure the space helps that, because their feelings are a bit more relaxed, more likely to disclose things. (*CCS Barts no.1*)

From these two quotes from interviews with the Staff it emerges that the first meeting is always emotional and that the staff + building conjunction helps visitors to lowering the barriers put in place for self-defence. Within the research / discussion this shows that the experience of being welcome in a warm atmosphere and nice space helps people share what's happening to them. As mentioned in Chapter 4, the new visitors arrive to Maggie's (on average a few days after their diagnosis) on the advice of the nurses at the hospital (although they tend to send cancer patients to Macmillan, instead) or, in a second moment, by the nurses or secretaries at Macmillan's. In other cases, friends who had the same experience with cancer or other cancer patients at the hospital may pass the information. In any case, they are not required to pay for anything nor to give their data. Once they arrive, according to the staff, visitors often feel the need to explain why they came to Maggie's. In the hospital, if a patient is told to go to a clinic, they must have a reason, and so even though Maggie's is

so different to the clinical world of cancer, when they arrive visitors feel the need to justify themselves.

It's almost like they need permission to be here. That's probably one of the first things they want to explain, why or what brought them in. (*CCS Barts no.2*)

The staff noted that all of these troubled emotions occur in the entry space – which the Architectural Brief calls 'pause' space because it is where visitors take a moment to stop and think – and in the welcome area where the newcomers 'meet' the space. The staff also noted that visitors always take a 'deep breath' upon arriving, as a sign of acceptance.

What I've noticed is that people, because there is the space, which is nice, they always take a breath. It's a chance for them to take a breath. And people do actually get quite emotional sometimes. And they say: 'I don't know why', you know, they might cry a little bit and they'll say 'I don't know why I'm doing it'. And I haven't really said or it's anything that we've said or done particularly, but it's just this chance, maybe that's *acceptance*. (*CCS no.1 Barts*)

In more relaxed situations, people will walk into the building and ask for information or advice, but if it is not directly for them, they often stop at the door and don't walk inside. For those who decide to enter, as reported by the staff, an almost personalised explanation is given.

By their nature, when they come into a new space, people act a little bit gropingly until they feel accustomed and, once they've been introduced to where the basics are, they're given permission to go anywhere. 'Next time you come in, make yourself a home in the space, and if a door is open, feel free to go in', and people do feel able to do that. (*Centre Head Barts*)

From these quotes taken from interviews with the Staff it emerges that in addition to being emotional at the beginning, the mental state of people is confused, almost out of breath and control, but that the invitation from the Staff helps them to feel at home, putting them at ease. Within the research / discussion this begins to show that encouraging people to feel free to move can improve mental conditions. The staff warmly welcomes visitors by explaining that at Maggie's everyone is free to do what they want, so if they don't want to talk to anyone they don't have to, but if they want to socialise, they just have to ask. The staff explains, however, that despite telling visitors to 'act as if they were at home', at the beginning they are still too shy or respectful and do not necessarily want to do something without being asked to do so. "It's okay to have a drink". "Yes, really?" "Yes, please help yourself". The CCS (Cancer Support Specialist) says that, in this way, people gradually gain the confidence

to have a drink, although staff still have to stand by their side in this process of *opening*, which will make the visitor feel free to be a host or hostess in their new home.

## **I**ib.** *Here With You* (Stabilisation) (Staff's Voice)**

After the CCS has helped new visitors lower their level of fear in the entry or welcome area, psychologists explain that when they come to them, they may still be scared. During the counselling sessions, psychologists notice that for the new visitors there is much more to go through than they can actually do at the moment, and they realise that the visitors will not be able to do it alone. The new visitors are under tremendous pressure; they know that, in the midst of fear, they have to make decisions about a new experience that they often don't understand. However, in order to make these decisions they must be able to think about what is happening to them. And they cannot. "So, how do you voluntarily direct people's attention, focusing on the present?" (Box 6. Method 4, Parameter 4D) (*Appendix\_III*d, Be Here Now, Question no. 3)

And so, *I am with them* from that point of feeling scared, scared because they're about to face something that they're not going to be able to cope with, if not supported. And I am with them from that point through, helping them, enabling them, and that's my task, to stabilise slightly, to start to scope the task of it. (*Psychologist Barts*)

Using the cognitive abilities of people with cancer as much as possible to start making decisions, psychologists say that the stabilisation process begins to occur almost immediately and opens up to flexibility. It must be said here that during my interviews I discovered that few psychologists at Maggie's use 'Psychological Flexibility' therapy, because every psychologist comes from a different school and because it is a relatively new approach, which began as a development of ACT (Acceptance Commitment Therapy). Despite this, some of the psychologists stated that they are interested in it and that they would work in the direction of psychological flexibility. Lesley Howells asked me to ask psychologists, what they thought of the idea that the "synergy between place and people" creates a flexible state of mind (and therefore that people with cancer are able to tolerate what they previously could not tolerate), where flexibility is given by the building and the staff together and probably by other subjects such as the community itself. "How does the building help you to open people up to the concept of not struggling and working with reality

while feeling free to make the choices they are offered?” (Box 6. Method 4, Parameter 4D)  
(*Appendix\_IIIId*, Be Here Now, Question no. 4)

Flexibility, for me, would be something I would be working with. I might use a different language, I might use *adapting*, but I might also use the word ‘acceptance’. And it’s surprising how – and I see it again and again and again – people face a situation they don’t know how to cope or survive with and they do. Often what seemed insurmountable becomes possible for them. And I see it again and again.  
(*Psychologist Barts*)

Once they’re a little firmer on their feet, thanks to Maggie’s psychological support and other types of support that people with cancer may find elsewhere, psychologists say that they can work towards flexibility. People with cancer and their family are now in a better position to start seeing what is happening to them, and the psychologists facilitate this very slow process by helping them see reality and allowing them to understand their own feelings. “When is the moment that visitors start to feel part of Maggie’s”? (Box 6. Method 4, Parameter 4D)  
(*Appendix\_IIIId*, Be Here Now, Question no. 5)

It can be a slow process. I wouldn’t go any faster than the pace at which it’s appropriate to work to understand what their paces are. So, I’ve got to be careful because we need to keep it slow. (*Psychologist Barts*)

From these quotes taken from the interviews with the psychologist at Maggie’s Barts, it emerges that once the first emotional moment is over, visitors (both people with cancer and their caregivers) must take the hardest step to cope with the disease and all that can come along it, and that the search for stability offered to them by psychologists is the starting point for finding flexibility. Within the research / discussion this shows that by offering and placing “freedom of choice” in the hands of people, it helps them to cope with something that was previously unthinkable. But when exactly does the building enter into this relationship? At the beginning, often people do not realise that these are special buildings, because they are concentrated on themselves and their problems. But when they are no longer frightened and can see the people and the space around them, after the contribution of the CCS in the entrance, and of the psychologist in the consultation room, it will be the building that intervenes by helping the new visitors to stay and telling them to keep coming. The Architectural Brief (2015) requires the building to be self-confident and safe, to have zest and calm. “How do you feel supported by the building in helping the visitors to see values, despite their illness?” (Box 6. Method 4, Parameter 5D) (*Appendix\_IIIId*, Values - Know what matters, Question no.1)

I think it allows people to stay. If this were an awful building, and I was seeing people just as individual appointments and people would not stay, since they don't have the space and time around the appointment, which is very important, and I might or may talk to people about that. I may say, you know, 'take your time afterwards, just sit on a bench here and look at the space and think what we've discussed', because that's part of it, you know, that does further work. I remember I saw somebody who came out and just stopped. (*Psychologist Barts*)

If, at the end of the session, people with cancer move from the counselling room to the open kitchen area and stay to have a cup of tea or, vice-versa, if they wait for their appointment in the reception area before entering the consultation room, that extra time spent in the space prepares visitors to have a better frame of mind or extends the benefit of the psychological therapy to be an extremely beneficial time. Before or after the session, the building therefore offers visitors a welcoming space to sit and drink a cup of hot tea for a sufficient period of time that will help them prepare to be more responsive or better willing to receive therapy. The Architectural Brief requires that the building should look as if it is acknowledging what people are going through. "How useful do you think your support would be if the building wasn't here? Do you think it helps focus visitors' attention on concrete actions?" (Box 6. Method 4, Parameter 6D) (*Appendix III d*, Committed action - Do what it takes, Question no. 1)

I do, I think it provides time and space and allows them to be with what they're going to discuss with me before they come in. Yes, because I noticed when they come in, if they've been sitting for a while – I have been thinking about it – in a comforting space that it is for them. Yes, the building is for them, and I think the people do really feel that. I mean, no doubt about it, an extraordinary difference between that and being in a corridor or in lined up seats. I mean, the difference is beyond the description, really. (*Psychologist Barts*)

And what work exactly does the building do with them? Does it make them open up? One of the parameters of psychological flexibility is 'defusion'. Does the building help in this?

Yes, it does. And I think it allows people to be with others and be with themselves and their problems and stay with them in a place where they feel safe. I mean, it provides such *safety*. (*Psychologist Barts*)

From these last quotes taken from the interviews with the psychologist at Maggie's Barts, it emerges that space and atmosphere help people to be alone with themselves and their thoughts (and with the others), because they feel safe. Within the research / discussion this shows that the space, and the arrangement of the furnishings in it, affect people's behaviour and their feelings.

## IIc. *Everyone's Home of Cancer Care (Adaptation) (Visitors' Voice)*

During the traumatic transition (see also Chapter 4, section 'The Users: Staff and Visitors'), there is a huge process of adjustment that is needed, a total recovery for both brain and body. For a real change to occur, however, the brain and body need to learn that the worst is past and that to overcome it we must live in the present or, if the danger is still ongoing, that the place where it is lived is there for us and to protect us (Van der Kolk, 2015). This is where architecture comes into play, and in particular in a Maggie's Centre.

After the first meeting with Maggie's CCS and psychologist, while people with cancer are still going to the hospital for treatments, new visitors do not yet or may still not have much control. During the treatments, they have to listen very carefully to what is happening, in an attempt to grasp what is being said to them or to regulate themselves around that information. Not only does it change what or the way that they think, but also the actual ability to think.

When you're over the hospital, a lot of times you feel panicking. Whereas when you come in here, you can control the level of whatever you want. (*Follow-up Oldham*)

And only when they leave the hospital and arrive in a safe environment can they regain control. If they return to Maggie's, the next step for people with cancer is to meet other visitors and start a conversation. The easiest place to talk to other people is by the kitchen counter over a simple "pass me the milk". To trigger the opening process in the new visitor, in fact, the building offers, in the kitchen and its large table, the place to recognise a familiar environment and a sense of well-being. A sense of control begins to arise in the new visitors, simply by preparing their drinks themselves, no longer as a 'permission' but with the freedom to help themselves.

The first thing I do is making myself a cup of tea, and I like the fact that you do it yourself. Some people come in and may order, because they don't realise it's a 'do-it-yourself' thing, they think that they've been ordering a drink. It's not a café. (*Follow-up Barts*)

If they want to let their emotions out, they can now do it and they will feel safe in doing it, because they know it's their choice.

If I want to go and sit in a chair downstairs and just let it all come out, I can do that as well. That's freedom. You know, you have control. (*Follow-up Dundee*)

From these quotes taken from the Follow-up conversations I had with the visitors at the end of each of the three ethnographic fieldworks, their sense of self-confidence in moving and acting emerges. Within the research / discussion this shows that once this state of mastery is achieved, people are self-sufficient and also able to help newcomers. For all the visitors I have met, Maggie's is a 'safe place' and they have described it as a 'sanctuary of peace' or a 'cocoon' and a 'welcoming and comforting space'.

If I really want to be recharged, I come here. And It's a combination of the people and what we do here, but without a shadow of a doubt, it's definitely the sanctuary of peace. (*Follow-up Dundee*)

And, although I was very upset at the time, because of the diagnosis and the treatment, I thought 'this is safe' and I said 'this is the place to come'. (*Move-along Barts no.1*)

I couldn't survive without Maggie's; I wouldn't know where to go if I weren't here. (*Focus group Barts*)

I couldn't believe my cancer diagnosis. But then I thought 'I can come here every day! I can sit in a corner and cry some time, yeah! I swear to God, if I didn't have it, I don't think I would be ok as I am. (*Focus group Barts*)

From these quotes from various conversations and focus groups, it emerges, as already seen, that Maggie's visitors feel safe. Within the research / discussion this shows that visitors perceive their sense of protection as something coming interchangeably from the building as well as from the support programme. This concept of a safe space, a space that allows visitors to work on their priorities according to their own time frame, is left to the individual: from sitting in a corner without talking to anyone to being in a peer support group that speaks of a particular type of cancer or need. So, someone can choose an isolated room or an open space and still feel safe.

I often sit here. I use a lot less downstairs, actually. I think it's a very, very good space, the curve that surrounds it and the individual space. When I did the 'Where Now' course and that was upstairs too. I liked the group. I don't want it to be just the person. People only talk about themselves. So, I'm going over there, but I feel better up here. (*Focus group Barts*)

One of the parameters I used in the 'move-along' method was to figure out which room or area the participants considered safe as a 'refuge' from which they could have a view or a 'prospect'. As illustrated in the second part of this chapter, I soon realised from my data that individuals have different perceptions of what 'prospect & refuge' can represent and that it

does not necessarily mean a 'safe haven with a view'. One of my participants at Maggie's Barts found that just sitting upstairs overlooking the double-height space made her feel safe from "too much socialising" while still maintaining perspective and control. Another participant found the library the safest place in the building, with a 'prospect' on a book representing a 'refuge', the door of which opens onto "different worlds". One last participant found 'refuge' in a comfortable room where she could hide and isolate herself with a small view of the street. On the contrary, other participants found it essential to be able to look outside.

And the fact that you can see outside. So, I started to look outside, which is very beautiful, and in fact I sat down and laid back and my shoulders got stuck there. And it makes you applaud. When I walked up for the first time and I saw the roof garden I would say it was just so calming. And I noticed the plants. Lovely. (*Focus group Barts*)

Anyone appreciates the view of nature and being able to sit inside and look out and far. Having experienced and understood the beneficial power of this effect from Maggie's, one of my participants told me that she wanted to replicate the same window in her home.

We've got a lovely cottage with a lovely garden but it's quite dark, very Scottish. I sit in the house in the evening when it's darker anyway. But when there's daylight I would need to get more light, so we are about to sign an alteration in the upstairs room so to get a window like this, because when I am not well, I would need to sit inside and have a view. I've never thought that was a priority. (*Follow-up Dundee*)

From these latest quotes from various conversations and focus groups, it emerges that by staying at Maggie's, visitors realise that the view from above or outwards provides a sense of pleasure and control. Within the research / discussion this shows that visitors slowly appreciate the psychological effects released by the building generating different feelings in people.

## ***IId. You are Not the Only One (Normalisation) (Visitors' Voice)***

When they go to the hospital, people become patients by taking on a patient's personality and behaving as a patient. When they walk into Maggie's, they stop acting like passive patients and suddenly become active themselves, and staff say they can tell the difference. The staff remind visitors who they are, just as the building reminds them who they are. In

this, the family often sees people with cancer as people who are no longer ‘normal’, given their vulnerability.

And at Maggie’s I just don’t have to pretend like I have to do with my family. And my brother wants to share things so, sometimes, I have to tell him. And I told him more before than I am doing now, because he was asking what I did here, and I had to tell him. It’s one of those things that you say to your family, but they were like: ‘So somebody else got the same thing, because we all have to support things’, which is a nightmare. I just find that it is so easy that I don’t have to pretend here or hide, at all. (*Focus group Barts*)

Being exposed to a ‘normal’ environment (not clinical, imposing and restricting), with normal people, and behaving normally around people helps people with cancer feel normal again. This daily practice of ‘normalisation’ is evident in several aspects of the programme, from offering to participate in physical activities, to sitting down and sharing stories and emotions or secluding oneself quietly with a book, just like at home. It must be said that physical activities such as yoga, tai-chi or gentle movement can be quite difficult for some people, which is why instructors always advise not to do some exercises if they had a recent operation. What I have observed while participating in the activities is that people with cancer often take courses as a way to feel normal again and sometimes even challenge themselves while knowing that they are in a safe environment.

Doing a physical activity, yoga or dance or whatever else, may be challenging you physically in ways that you realise are going to be beneficial in the long term. But in that challenge, you know that you’re in a safe space because you’re in this building and anything happens in this building will be for your own, for your holistic benefit, not for somebody else. (*Move-along Barts no. 2*)

In the process of challenging themselves, a chain of reactions allows visitors to help and share with others.

Sometimes, I see people crying so I ask: ‘Would you like a cup of tea?’ I’m not a volunteer but I know what it’s like to feel sad and uncomfortable and just being offered something by someone: it’s a peer to peer exchange, it’s a peer kind of support. I think that once you’ve been here for a while you think ‘Yeah, I can share my experience’ because it’s not just about taking, it’s about giving experience. I remember a bunch of us sat and talked to someone who was worried about radiotherapy and organics radiotherapy and we’re trying to explain to her. I think that’s a thing too; sometimes you feel you need support, other times you feel you can, because you’ve got the energy, give support to other people. And that makes you feel good as well because you think ‘Okay, I’ve had a shitty experience but at least I can pass on my wisdom to someone else’. (*Follow-up Barts*)

In the normalisation process, not being worried for ‘confidentiality’ seems to be a good strategy. But if confidentiality is so important at the NHS, what is it at Maggie’s that makes visitors relaxed and not worried that what is said will be taken away? What is the difference with NHS confidentiality?

I don’t know what the difference is, but it’s true, I personally don’t tell people I go to Maggie’s. I have talked about it from time to time, but I never talk about it, I think it’s because I don’t need to say I’m coming here. I never thought about it before. I really don’t know what the reason is, I don’t know”. “I don’t talk about it, either. I could refer vaguely”. “I don’t know what it is, I think it’s so separate from the outside, they are two different worlds”. “I think so. I don’t know if you’ve ever been to a festival, I mean for two or three days, you’re in a festival away from everything, from another reality, in another world. You never think it works with slightly different rules like leaving your stuff in a tent and you think it will be fine. Nobody will steal anything, and you trust it. You trust the people of that world. (*Focus group Barts*)

From these quotes from various conversations and focus groups, it emerges that at this point visitors feel they no longer want to share their Maggie’s experience with their family or outside the centre. Within the research / discussion this shows that for visitors entering Maggie’s is like entering a different world that belongs to them, at the base of which is empathy, trust and respect.

## *Iie. Making the Biggest Difference (Affection) (Visitors’ Voice)*

As we saw in Chapter 2, architectural phenomenology and phenomenological psychology tell us the built environment has an impact on us. And at Maggie’s visitors are well aware of that.

But life comes from this interaction, I think life comes from everybody who comes here. Everyone who comes to Maggie’s – I’m trying to choose the right word – is affected by it. And now, you can compute strengths on the ones affected, and you can go down lots of different routes. But I think every single person that comes into this building is affected by it, by the building. (*Follow-up Dundee*)

Also, as we saw, people perceive their environment in their own way. In this process in which we are ‘personally influenced’ by the events of life and the environment, we become able to evaluate the significance of these events or places in terms of cognition, planning and adaptation (Iurato, 2020).

For me, Maggie's is a place where to reground myself away from what's going on out there. I know it will never go away. You need strategies to deal with your cancer, you need strategies to deal with the people that surround you when you have cancer, all different kinds of strategy. My strategy to cope is to come to Maggie's. (*Follow-up Dundee*)

Since all cognitive and sensory experiences are to some extent infused with affect, visitors who are aware of the architecture, develop a strong affection for Maggie's. In return, the building never disappoints them in any season or weather conditions and makes them feel special.

It can't be disappointing. I am very aware of my environment and so when I look around the colours, you know, the glass, the coloured glass. (*Focus group Barts*)

Once immersed in space, without realising it, Maggie's individuals develop a cognitive process on a personal level stimulated by affective thoughts that allow the openness and flexibility at various levels.

After I have been sitting there for a while, I was looking around and I felt really contained. And then I started to feel a bit safe. I don't know, it was the environment with huge light downstairs in glass that have made it to make me feel at home (...) And then suddenly someone was talking to me and it was like waking up and... It just felt it was ok to speak about it. And it just made me feel safe. I'd say it calmed me, in a way, to make me see. (*Focus group Barts*)

In each centre, on a coffee table or on a bookcase shelf, there are always at least 2–3 copies of Charles Jencks' book "The Architecture of Hope", which tells the story of the Maggie's Centres. During my fieldwork, I found myself several times indicating the volume to visitors as I was explaining my research. Both the staff and the visitors feel very proud of their centre, showing a bit of a competitive spirit towards other centres. Each centre has a different story, often very touching due to the efforts behind it.

I can't say I would have the same feeling if I went to Kirkcaldy or Edinburgh, because I've never been to any other Maggie's. I think, due to the ethics behind what she (Maggie) was trying to create, getting to know people that have been behind the centre, it helps. (*Follow-up Dundee*).

Once visitors learn about Maggie's story and the buildings' background, they begin to develop more affection for the building they are in.-Sometimes, especially in older visitors, attachment to Maggie's could turn into addiction, in the sense that 'I could come every day because I have a particular attachment'.

Besides architecture that I love, I will be as attached, but it is when that attachment maybe becomes a dependency as well, which I'm way off. I don't want to be dependent. So, actually leaving here might be quite difficult, if you can't control at what point you say, '*I'm leaving*'. Because the philosophy of Maggie's is actually not depending on the movement the ball to move. (*Move-along Dundee no. 2*)

From these quotes from various conversations and focus groups, it emerges that in this last step visitors are able to recognise the impact of the building on people and what architecture now represents for them. Within the research / discussion this last stage of the healing process demonstrates that the affection that visitors feel for Maggie's organisation and building leads them to a different level of feelings (those that 'normal' people experience and share) which also includes awareness, pride and even addiction.

### III. Maggie's Users: A Shared Mind

In the constantly vigilant presence of the staff, in synergy with the psycho-social support programme provided by Maggie's, the unconventional architecture of the buildings stimulates the senses and arouses feelings of psychological flexibility in people so as to be 'more present', 'open to new perspectives' and 'oriented towards one's own values'.

It could be anything. What happens is that the therapy and the synergy together create a therapeutic space that makes them become more able to move with the reality. And for moving through this, it means they might have a meaningful life, regardless of whatever they are against. (*Howells, 01.11.2017*)

From this quote it emerges that, within the Maggie's Centre, it does not matter what situation a person is in; they may have six months to live or may have just lost their partner or may be about to start their treatment. Within the research / discussion this leads to saying that the reached flexible mental state helps visitors to overcome the suffering of a life that is about to end, in the name of the awareness of a perspective shared by the Maggie's community.

In general, during my fieldwork, women were much more enthusiastic than men, more receptive to my research. For example, during my last week at Maggie's Dundee, when I thought I had already collected enough data from the men's group, a group of three women asked me to talk to me about the building. Likewise, at Maggie's Oldham I was quite surprised when on the very first day of my fieldwork, a group of six women from the tai chi

class asked me to hold a group discussion on my research. They wanted to know all about my research and, at the same time, wanted to let me know their opinion on the architecture of the Maggie's Centre. On this precedent, as soon as possible, when I arrived at Maggie's Barts, I invited a group of women from the art therapy class to attend a focus group. In all three cases, by soliciting the discussion with specific questions about the architecture of the building, I was able to collect individual views on their Maggie's Centres and understand the themes I was looking for. The most surprising aspect of the three discussions was that, despite the three centres being in different places, very far from each other, not only were the themes that emerged the same, but also the terms used by the participants were practically the same. This would be obvious from the staff, considering the fact that they are trained by Maggie's using a particular terminology, but it was surprising to me to hear the same concepts from the three different groups with visitors from such diverse social and cultural backgrounds (*Focus group no.2 Dundee, 14.10.2019 / Focus group Oldham, 21.10.2019 / Focus group Barts, 04.12.2019*). For example, from a question such as:

1. What do you remember of your first visit? (*Appendix\_IIIc*, Schedule of Interview, Opening, Question no. 1)

Question	Maggie's Dundee	Maggie's Oldham	Maggie's Barts
<b>What do you remember of your first visit?</b>	Somebody met us, just as we came in and looked a bit lost and so he came over and asked. And that was a nice welcoming and he took us in and gave us tea and that was the first day; and even the second day everybody seemed to have a place you know, everybody was talking and they seemed to know what to do. I never felt like that.	The first day I came in I was apprehensive on that side of the door, but as soon as I walked in, I thought, I just felt like somebody had just gone 'you're okay'.	I was bit apprehensive in coming in, where to start, I didn't know quite where to go, but immediately while I was coming in the Staff came to say hello, you know. So that was my first encounter. Like, I couldn't believe it. Astonished by everything.

I heard mentioning terms such as *welcome*, *calm* ('it's very calming', 'relaxing'), *safe* ('shelter', 'cocoon', 'sanctuary') that emerged from the three different focus groups with the same expressions and terms. What was also striking was the feelings that centre visitors receives from the building, again described in a very similar way. For example, from the question:

2. What is your experience of this building? (*Appendix\_IIIc*, Schedule of Interview, Defusion - Watch your thinking, Question no. 1)

Question	Maggie's Dundee	Maggie's Oldham	Maggie's Barts
<b>What is the experience of this building?</b>	This place makes me realise that I'm just like everybody else and is liable to get cancer as standing next to me at the bus. You know it doesn't discriminate.	The Maggie's Centre gives you a sense of worth because you're not a patient in here. In that	I suppose, in my mind, I think 'Wow, I am valuable. I have got a creepy disease, I have it, I have been cured, I hope,

	But it means of why I have cancer, I'm not expected to deal with other people. That makes a great deal of difference to me, again it's that having somebody like the Staff, there's no pressure on the patient.	building over there [hospital], you are a patient, but in here you are you, you've got your identity back, perhaps.	whatever cancer, but I am valued'. So, this building says: 'you are valued, we care about you', you know, really very basic things. 'Hey, we love you, we want you'.
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I heard such as terms *worth* ('you value', 'I feel valued') *normality* ('be yourself', 'I don't need to pretend'). Finally, asking about the relationship that centre visitors have with the building with a question such as:

3. What does the Maggie's Centre represent for you? (*Appendix IIIc*, Schedule of Interview, Defusion - Watch your thinking, Question no. 3)

Question	Maggie's Dundee	Maggie's Oldham	Maggie's Barts
<b>What does Maggie's represent for you?</b>	A place of sanctuary, because it's away from the hospital, but connected to life. At the beginning I thought this was a place where you go at the end, and I didn't realise it was about living rather than dying. There is a feeling of total tranquility, a church quality about it, and safety.	And that's why you see Maggie's is like a 'home from home' you're always with people, anything that someone proposes in the building, you're always trying to participate.	It's just like being at home. And it's very, like, you know, you have towels, you have chairs that are comfortable. So, it's this kind of touches that make you feel like you're home.

I heard terms such as *familiarity* ('home away from home, 'another home') and *freedom* ('don't hide anymore', 'don't feel guilty', 'don't feel judged') and phrases such as "It's a lovely place and the building is just perfect", "It's a comforting blanket", "I don't know where to go if I weren't here", "the building doesn't force you to do anything in particular" (*Focus group Dundee no.2*); "This is lovely, it's modern, it was built for you", "It makes you embrace life", "It's an injection of energy", "Light up your mood when you come here", "You come home refreshed, completely relaxed" (*Focus group Oldham*); "I swear, if I didn't have it, I don't think I would be as fine as I am", "This is the place I want to be", "It's a psychological massage from head to toe", "I couldn't survive without Maggie's" (*Focus group Barts*). All these sentences were expressions of true comfort and relief that only a 'therapeutic landscape' can enable (Butterfield and Martin, 2016).

As already mentioned in the introduction of this chapter, the empirical data that I was able to collect during my fieldwork research were analysed through the lens of the two aspects (and related key themes) of the Maggie's Centre that this project intended to explore: 1. Maggie's ability to establish a therapeutic environment (Security, Authenticity, Trust; Normality, Sense of Value / Identity, Affection; Agency, Freedom, Control / Self-Confidence); 2. The paradigmatic nature of Maggie in becoming "exemplary" for the architects of future architectural projects of other healthcare facilities (Predictability, Flexibility, Stimulus). (*Appendix VII, VIII*)

### IIIa. Building and Visitors: Safety, Normality, Agency

In this and the next section I will highlight the themes that emerged indifferently from the three focus groups of women (*Appendix\_VII*) representing the mental conditions enabled by the architecture of the building to support its users with a ‘symbiotic’ empathy. Despite the uniqueness and different geographic location of each centre, they demonstrate that the three Maggie’s Centres contribute to their mission equally. As already explained in the methodology chapter, the questions asked in the focus groups (*Appendix\_IIIc*) came from studying the Architectural Brief, from the analysis of the first stage interviews and, in some cases, from the participation in the life of the Maggie’s Centres. The way the questions were selected was to find out how the building supports the users and also to test the architects’ intention, that is the architecture.

From the group discussions, what mostly emerged was the sense of safety, normality and agency that Maggie’s visitors feel. Looking for a relationship between the physical conditions that facilitate this synergy, which in turn generates psychological flexibility, and framing the three group discussions around the first three parameters of psychological flexibility, the following groups of themes have emerged:

#### *SAFETY: Acceptance (Open Up)*

From the moment they enter the building, simply sitting and looking at the space while sipping a cup of tea will help visitors be more responsive and more willing to meet the psychologist. For example, in his design of Maggie’s Dundee, Frank Gehry was influenced by the Yiddish concept of ‘heymish’: familiarity, intimacy, safety. The design, with its different spaces and levels, allows for different conversations, constituting a subtle example of synergy. Through the synergy of spaces, people open gently to reality, feeling safe. This means opening up to difficulties, finding the meaning of things, discovering the choices and possibilities offered by Maggie’s. In short, it enables somebody to turn towards reality rather than struggling against it”. (Howells, 2016, 0:45)

#### *Safety*

I think this is a safe environment, where you can talk to people. You speak to experts on the site. And you don’t feel like you’re taking them away from the jobs. And it’s so relaxing, and it’s the design of it is so warm. (*Focus group Oldham*)

The word safe is what comes to mind to describe the Maggie's Centre. You are safe to talk about cancer or not. When you're in the world, and you have cancer, you can't talk to your friends and family because they're stressed out for you. And besides, nobody understands if they're not going through it. But, when you come here, everybody's in the same boat, everybody just talks openly about it, and there is a sense of relief. (*Move[sit]-along Barts no.6*)

From these two quotes it emerges that, within the Maggie's Centre, people feel safe in a place where they do not have to worry about the consequences if they talk about their cancer to other visitors, because they are all in their same condition. Within the research / discussion this leads us to say that an environment made up of 'people' and 'place' whose 'design is so warm', helps to allow a sense of relief, to overcome fears and to regain self-confidence.

### *Authenticity*

The Maggie's Centre is absolutely beautiful and authentic. A lot of time and effort has gone into it. (*Focus group Oldham*)

And in here you don't have to pretend to value, like I had to pretend within my family. You can be yourself, here. So, I decided not to tell them anymore. (*Focus group Barts*)

As mentioned, at Maggie's adjectives can be indiscriminately associated with the building and people, both staff and visitors, and this is especially true of the term 'authentic'. Within the research / discussion this shows that the non-human component can interchange with the human one not so much when its architecture is sophisticated, but rather when it has something to say, e.g. revealing the effort people have made in creating it.

### *Trust*

And, you know, you see the openness and you think 'oh, there's no confidentiality' and I was looking for that, but I could see only those two seats there by the veranda and, really, we had a good chat there, totally in the open space, which was nice. It wrapped around you; you could feel secured even in a big space. (*Focus group Dundee no.2*)

You trust the building and you trust the people. Yes. There's an inherent kindness I think that runs through its core. A kind of school, you, and for yourself and for others, I mean it's really powerful. Yeah, very contagious. (*Focus group Barts*)

From these quotes it emerges that, inside the Maggie's Centre, people trust both 'people' and 'place' despite the apparent lack of confidentiality due to the openness of the space. Within the research / discussion this leads us to say that privacy does not necessarily coincide

with an enclosed space and that, on the contrary, thanks to the open space, this sense of trust is transmitted from one person to another.

### *NORMALITY: Defusion (Watch our Thinking)*

After 'acceptance', the second step in psychological flexibility is 'defusion', which is the opposite of merging, so visitors 'de-fuse' flexibly from their thoughts. In his design of Maggie's Barts, Steven Holl was inspired by the music notations that were used to perform in the nearby church. Giving meaning to the building, through a positive atmosphere of light and colour, the open space defined by a frosted glass dotted with coloured notes envelops people who detach themselves from their thoughts, making them feel free, valuable and normal again. And the atmosphere enables trust.

### *Normality*

I can't remember the last time anybody spoke about cancer or illnesses. It's more about life. It wouldn't suit me if it was everybody talking about their experiences and their illnesses. It doesn't happen here. (*Focus group Oldham*)

I think we are all normal people you know; all things are happening and there is not a single being on this planet that has not been affected by something. (*Focus group Barts*)

From these quotes it emerges that, inside the Maggie's Centre, people feel 'normal' as they no longer feel passive patients but active people because they are asked to participate. Within the research / discussion this shows that the physical environment designed to engage people (space open and accessible to all) in combination with a stimulating programme has an impact on helping the individual to regain objectivity in judging themselves.

### *Freedom*

And I like that, you could either sit and just talk to nobody or you can chat to people. And if someone will come and speak to you and if you don't want to speak to anybody, I get the feeling that if you say to them 'I'm just looking for some quiet time', don't feel like you've got to talk. (*Focus group Dundee no.2*)

I don't know how to describe it; I just feel at home. I can be wherever I choose to be in this building. There is a freedom that you have, except when there are courses or workshops running, but then there are alternate spaces that you can use. So, there is that freedom, that sense of freedom that there's always space for you to do whatever you. (*Focus group Oldham*)

### *Familiarity*

And that's why you see Maggie's like a 'home from home' you know and you're always with people, anything that someone proposes in the building, you're always

trying to participate. (*Focus group Oldham*)

And it's just like being at home. And it's very, like, you know, you have towels, you have chairs that are comfortable. So, it's this kind of touches that make you feel like you're at home. (*Focus group Dundee no.2*)

From these quotes it emerges that at Maggie's people feel at home and therefore free to act. Within the research / discussion this shows that Maggie Keswick's original idea of creating a centre with a strong sense of domesticity (a concept that has never changed in twenty-five years) represents a very important point of reference for human beings and, in particular, for vulnerable people.

### *Sense of worth/identity*

I suppose, in my mind, I think 'wow, I am valuable. I have got a creepy disease, I have it, I have been cured, I hope, whatever cancer, but I am valued'. So, this building says: you are valued, we care about you, you know, really very basic things. Really basic things, this is what this building says. 'Hey, we love you'. Yeah, there we go! (*Focus group Barts*)

It is a beautiful space and that's the first thing you notice how amazing it is and then, as you walk through, you're just amazed at how beautiful it is, but there is a sense of worth, because it's built, it's designed with this sense of serenity in it, so you can see how you the first time you walk through, you're just amazed at the architecture and how beautiful and brand new is, but also you can see within that that there are places that you can just be quiet. You can see that immediately even if it's a busy day you can see that immediately. (*Move[sit]-along Barts no.6*)

In these two quotes we find observations already made for the other themes, in particular how the Maggie's Centre is considered as a human being and how its architecture generates in people values that matter such as beauty and serenity. Within the research / discussion this shows that the physical environment helps people to increase the individual's sense of self-worth.

### *AGENCY: Self-As-Context (Observing the Self)*

Within the 'self as context', the third process of psychological flexibility, a sense of control begins to arise in visitors, no longer as permission but with the confidence of 'do it yourself'. To make that change possible, the building supports the visitor by allowing a sense of agency. For example, in his design of Maggie's Oldham, Alex de Rijke used the 'hole' idea as the heart of the building, place the silver birch there as the 'tree of life' which indicates the connection between heaven and earth and the underworld. At Maggie's Oldham, the tree

brings together all the values of life which individuals recognise and in accordance with which they live.

### *Agency*

Yes, I can do that. If I want to go and sit in a chair downstairs and just let it all come out, I can do that as well. That's freedom. You know, you have control. (*Focus group Dundee no.2*)

I have cancer therefore I belong. This is not my living room, but this is my space, and I can use it out. So, for instance I'm here doing exercises on my own to get my body back into shape for dance. I come up here, almost every day and do that. And I'm allowed to. Nobody's stopping me from, as long as I don't interrupt anybody else or disturb anybody else, go ahead and use the space so I'm using it how I want to. And I think that's what's so great about this space is that you use it as it needs to be it works for you as you need it to. (*Move[sit]-along Barts no.6*)

From these two quotes it emerges that inside the Maggie's Centre, people feel they are agents of acting and moving thanks to a strong sense of belonging to the place. Within the research / discussion this leads us to say that an unconventional environment in combination with a stimulating programme which engage people by giving them a role helps to grow their self-esteem which is a set of evaluative judgments that the individual gives of himself (Battistelli, 1994).

### *Control / self-confidence*

After you come to one of the classes you feel quite comfortable just going up and having a cup of tea and helping yourself, but I wondered about that to begin with because everyone seemed to know what they were doing and you could just go. How do you get to be that familiar with the surroundings, so you don't have to ask questions? (*Focus group Dundee no.2*)

I feel self-confident because of the building, the staff, the design a bit with all the little nooks and crannies of the rooms that, you know, that look open but then there's a door that you don't see and things like that. (*Move[sit]-along Barts no.6*)

While one might wonder how it is possible to become familiar with an environment intuitively. Inside the Maggie's Centre people move confidently thanks to a design that invites. Within the research / discussion this shows that a built environment that unfolds over time and continues to surprise helps stimulate people to develop attention and curiosity and therefore self-confidence to keep coming.

## *Affectivity*

This is my favourite part of the building. But it's not someplace I've come, or very often, but it's like somebody's house, it's like being in your front room. Yeah, with the fire and the seats by the window looking around, it's calm and quiet. I always feel it's yours. (*Move-along Dundee no.3*)

I don't think I could live without it. And Maggie's has been fantastic, not an immediate thing, but I never left it, and it's never left me. And so, little by little I felt better and better. (*Focus group Barts*)

So, I came here and took the courage and they haven't gotten rid of me since. And I joined so many different things, creative writing, lovely. (...) And it's something, I don't get many hugs in life. Up here, always getting a hug from someone you know and that's great. (*Focus group Dundee no.2*)

From these quotes it emerges that people develop affection at various levels towards the Maggie's Centre, to the point that many visitors could no longer live without it. Within the research / discussion this demonstrates once again that the physical environment in combination with the support programme can elicit feelings that fill emotional gaps left by human beings.

## **IIIb. Building and Staff: Predictability, Flexibility and Stimulus**

The themes that emerged from the interviews with the members of Staff confirm what I had noticed with the visitors, and represent the mental conditions enabled by the architecture of the building to support its users. By offering predictability, flexibility and stimulus, staff and building generate safety, normality and agency in users. As mentioned, the ultimate goal of the semi-structured interviews was to understand how the premise that the building contributes 'in tandem' with the work the Staff does, constitutes a 'synergic power' that generates Psychological Flexibility in Maggie's users. While not all psychologists at Maggie's use psychological flexibility therapy, 'flexibility' is a widely used term in psychology, so the questions were well received and generated consistent answers. By framing, the one-to-one interviews around the second three parameters of Psychological flexibility, juxtaposing what the architects said with what the users said, my questions aimed to come closer to an understanding of the interaction between the intention of the buildings and the user experience and the following groups of themes have emerged:

### *PREDICTABILITY: Contacting the Present Moment (Be Here Now)*

With the aim of focusing the visitor's attention on 'being here now', Maggie's staff say that they feel supported by the architecture of the building, as well as by art, design, and furniture. Maggie's motto "Don't lose the joy of living in the fear of dying" explains to visitors that, despite their anxiety, both the building and the people within it are there for them and offer safety, authenticity and trust in a predictable and consistent way.

Crossing that threshold, there is anxiety because people don't know what to expect. But I think often there's a sort of wonderment, of pausing and people are looking, because they don't know what to expect when they walk through the door. Then, as soon as somebody will welcome them to Maggie's – can I get you a cup of tea? – there's this exhaling, and a feeling of relief, so they know they are in the right place. (*Psychologist Dundee*).

The softness of the building, given by the wood and the felt on the doors, allows time to think, because they feel comfortable and safe. (*Psychologist Oldham*)

And the motto is an individual thing, because as a psychologist it's important not only to work with what's not going well, but to work with what is, and what can be enhanced. So, there's very much attention to where you can make choices, accepting that change and working with what I can, and the building is here to represent 'this will' to stay stable and standing for you at a time where other things will shift and change, often quite radically. But there's a predictability here that's important when life has become unpredictable. And that's part of my job, too. I have to be as predictable as possible, as consistent. The building is consistent. Yes, it's consistency and people are consistent, and I want to make sure that we are consistent and committed. (*Psychologist Dundee*).

When it comes to privacy, Maggie's psychologists know that people seek solitude, intimacy, anonymity, confidentiality, but most of all the freedom of choice to be in such conditions. As previously mentioned, the Staff reassures visitors by explaining that they can trust as the building will support them by always offering a way to respect their privacy.

This is what I say to my visitors 'Nobody in this space is going to do anything to you that you don't want to happen. So, if you want to come in and just quietly go and sit down somewhere. Somebody will always say hello. They'll respect your privacy'. (*Centre Head Barts*)

From these quotes it emerges that as perceived by the visitors, the staff notice a sense of relief in the newcomers when they arrive to Maggie's. The staff say that the feelings of safety and authenticity come from the people and the building that convey a sense of stability and trust. Within the research / discussion this reaffirms that the physical environment in

combination with the stimulating programme makes people feel reassured and therefore ready to react.

### *FLEXIBILITY: Values, Now What Matters*

By recognising what is important to them, visitors accept their illness and understand that they have the freedom to choose various options in an attempt to react and empower themselves. In making the best use of the building, in addition to immediate benefits, comfortable spaces, beautiful features, in their conversations, the Staff will refer to Maggie's architecture and comfort ensuring flexibility, normality and identity in offering, for example, different seating options and freedom of interpretation.

I guess at Maggie's in general, there is that sense of choice. And partly because we're not imposing, they don't have to come here anyway, it is their choice to walk through the door, there's no expectation. If they miss a session with me, they're not going to be punished, or to be kept away from the building. It's different than having appointment at the hospital they must attend. There is a lot of freedom of choice here. And again, that extends into that they choose where to sit. They can leave if they like. (*Psychologist Dundee*).

In other therapy rooms, perhaps, you might have two or three chairs and there is a sort of distance and this is an expectation of where I will sit and look at. In Maggie's and many of the spaces, I could sit directly next to somebody, so I am not facing them. And what that does, and I can think of one person in particular who just happened to be here today, it enabled her to cry, she wasn't able to cry when I sat frontally. But given that we could sit side by side and something about the space was flexible, it really helped the way the room was set up, but also, you know, there's a window, there's natural light, but we couldn't see anything. You can see any buildings from where we were sitting, we had natural light in the room and things like that, I think, are quite unique. And the window upstairs frames a really incredible view. (*Psychologist Dundee*).

I hear more than I tell or encourage people to find out for themselves. Maybe by coming to our cancer groups and workshops, they can build their interpretation to find out a little bit more. Because, I think, you have to choose your words very carefully and something could sound quite clever using an analogy, but it will really have to be sincere and pertinent to that situation. (*CCS Dundee no. 2*).

To bring about change, the building substitutes the staff by allowing in the visitor a sense of identity. Feeling normal, visitors, through the furniture, can recognise values such as the community or family environment in which they feel at home and self-confident, even without the help of the staff.

Ironically, over time, the conversation about cancer becomes less and less frequent and, in this sense, Maggie's is a therapeutic space. To some extent it removes that,

and it is a really important part of helping people normalise what's going on in them. (*Centre Head Royal Marsden*)

I think the kitchen table is a good example of that. People feel part of a community. Visitors come in and sit down and immediately start talking and interacting one another, which is a great value. (...) And if they have been here a few times, they come in and go to make themselves a cup of tea and they don't even acknowledge the members of staff. (*CCS Dundee no. 3*)

People will directly say "Maggie's saved me". That's what they say, and it's often that phrase "being in this place" contributes to this sense of change, and people are in the process of change when they come here, and they're stuck. Usually, people are stuck. And so being here in this environment, very much it contributes to a new sense of identity in a lot of people, particularly I think the people who come here for a long time. (...) And this happens in the kitchen, because it's a combination of spaces: it's got two distinct areas to sit, it's got tea and coffee making, it's got lovely big windows that just occur under the trees, it's got comfortable seating around the edge, and it feels homely, it feels like a lovely home. And, there, people understand what a kitchen table is. (*Psychologist Dundee*)

From an architectural point of view, the open plan of the building helps the Staff to "be with them" and show visitors the surrounding context and encourage them to act.

As Centre Head I like to know what's going on everywhere. So, normally I'll even pick where I sit to see everything that's going on. (*Centre Head Oldham*)

From these quotes it emerges that at Maggie's the flexible support programme and the open space help to make people feel free and normal. Within the research / discussion this shows that empowering people by giving them freedom of choice and value nurtures a sense of identity in them.

### *STIMULUS: Committed Action, Do What it Takes*

To focus visitors' attention on concrete actions, staff refer to beauty which at Maggie's is considered a priority human value and the psychologists say the building helps stimulate people with cancer despite their illness. Indeed, the building offers stimulus as wherever they look, visitors will always find something pleasant: a softly lit lamp, a beautiful frame, a velvet cushion, a comfortable chair. And staff feel comfortable giving them, especially when they are emotional or upset, space and time to think. Through the eyes of the visitors, the CCS can see the ongoing dialogue between the visitors and the building and feel that the building comes to meet and supports them in generating in them agency, self-confidence and affection. All these feelings make the visitors committed to return.

There's something about this building, there is this sort of stimulus there, different kinds of art, the furniture, the soft furnishings. (*Psychologist Dundee*,)

It would be beauty. I'm not sure if that's quite the right word, but there's something about, when people are sitting in this space, in this building, something is generating in them, despite their illness, they get in touch with the feeling of safety, the feeling of space, art, there is this sort of stimulus there, and there are different kinds of stimuli given the fact that we have different kinds of art, the furniture, the soft furnishings. The views, the windows even, you know, the details like the blinds for example that move up instead of traditionally down. I think a lot of people they are affected by that, it does, it taps into. I guess what it does sometimes. I think it takes a person further than their illness and their physical self, and it reminds them that there are a whole lot of other things in the world and about who they are, to some extent. (*Psychologist Dundee*).

No matter where people look, they're always seeing something that is pleasing. And I think that helps, and I think maybe in a more unconscious way. And even today, after 16 years I have been coming here every day, no matter where I am in this building, I always look and see something that's different, you are always surprised. I don't think when people are coming in, they take the building for granted, they are warmed by it and welcomed by it. I am a professional nurse and I probably don't know how to speak about architecture, but I think that is the beauty of architecture, it's the fact that someone can actually design something that increases feelings. It's soothing, it's pleasing and uplifting and quirky and gay. (*CCS Dundee no. 2*)

The building supports the staff in being there allowing for a sense of agency, self-confidence and even pride in the visitors. At this point, the staff can tell them to focus on moving forward reassuring them that the building will always be there and open for them.

If somebody has finished the treatment, and gone through the 'Where now' programme, and now thinking about going back to work, you do see people drift off. And it's really good because they're moving on. (...) you get some people that haven't been in for six months and they come in and they say 'oh I've not been in. I'm doing this, I'm doing that' and that's fantastic to see. Because most of time, all I know is these people's first names. I might not know where they live, because we don't take any records, but in a way that's the beauty of it, as well. (*Centre Head Oldham*)

What happens here, the building entirely supports because the building is holding in everything; in the views to the horizon, in the light, in the space, and the furniture. It's saying: 'I'm going to make this as nice as possible for you at a time where that's probably as horrible as possible for you'. (...) And this also encourages a sense of pride, even if you look at the number of people who fundraise. (*Psychologist Dundee*)

As the focus groups have shown, however, for some of the older visitors the ‘affection’ for the building can turn into ‘addiction’ and it is sometimes difficult for the staff to tell them to move on.

But we’ve got a couple of people that would normally come in every day, and they become a family. For them it’s like being a member of a club that you would never want to be part of, but that you become part of, and they do. They end up being part of your lives, and you have to have boundaries from that sort of working relationship. They know they’re always welcome although they should try something different. And although it’s encouraging, it is a difficult conversation to have. (*Centre Head Oldham*)

Although at Maggie’s ‘time’ is a difficult conversation subject, the fact that there are no clocks in the building helps the staff not to rush and to always be available, and visitors to relax about how much time is dedicated to them commit and return in the future.

By keeping my eye on the front door, I am able to see who is coming in. And it’s just that glance. And if somebody goes and scoops that person up that’s ok, if not, I would then say: ‘Excuse me for a minute’. And people can have as long as they want, but we can’t fix everything in that one visit. So, it also encourages them to commit and return the next time. (*Centre Head Oldham*)

Finally, within the dilemma of whether it is the ‘building’ or the ‘people’ who support the visitors and allow the change, or ‘both’ is not in doubt - everyone has opted for – ‘both’.

Often people might see it’s not about the building, it’s about what happens in the building and people in the building. I think it’s both actually, I think we could have a beautiful building which would do an awful lot anyway. But I think the right people are important.(...) I think there is something, I can’t explain it but there is something about having a conversation in this building, which is different from having that even in another nice building, not necessarily in a dark space, but I think there’s something very unique about this building. I think it allows you to pause or even allows you to stop talking and look at something and think, whatever I’m doing was whatever the visual is doing to our brains that is soothing and comforting. I think it’s quite special, but I don’t know if it’s because we love it so much. (*CCS Dundee no.2*)

All the interviewees confirmed that the building is ‘with them’ (*Psychologist Barts*) and supports them in the therapeutic process: the calming atmosphere of the building, the relaxed environment (*CCS no.2 Dundee*) is so much in contrast with “the clinical rooms and spaces, fairly blind to the surroundings. And, for me, the Architecture is a big part of what I love about working here” (*Psychologist Oldham*). However, although, as mention in the introduction of this chapter, the Maggie’s Centre is one step further than Maggie’s Interim, all psychologists felt similar to the former nurse visitor who stated that the basic work she

used to do in a clinical setting must be the same despite the surrounding conditions, she admitted that the building (and the team mix) adds a lot to that.

I was a nurse, and you go into it because that's what you want to do, you want to help people. So, I don't think that the building will make it different, maybe it makes it pleasant to both the Staff and the people who attend. I think also that there's an ethos here. That is, maybe, very helpful to them to carry out certain helpful tools to the Staff. But it doesn't matter. If you are in a war area, and you're a nurse, you go and you help, do what you can for the patient, you do the same job under different circumstances. But the conditions, the spatial conditions are not there to help you. (*Focus group Dundee no.2*)

Have I been helpful to people, when I've worked in an NHS room? I hope so, I don't think they've had a different psychologist. I think this helps, and I think this is nice for me and it's nice for them. And this is ideal that this is the therapy that people get, whether it's here or whether it's at the NHS; I hope it wouldn't impact on the work I do. But it just makes sense if you're in a nicer space and, you know, we are here and it's a nice place, it puts people at ease, it is going to be hopefully helpful for the work we're going to do. It's hard to tell if I can see the difference, because I should take the same person to two different places. But this is nicer, it's more therapeutic. And I think it's the team here, really. I think it's beautiful being in this building, but if you had an awful team to work with, I think that wouldn't be enough to keep me here. I think it's probably the type of people that want to work for Maggie's and everybody is very warm. (*Psychologist Oldham*)

This comparison is useful to see how the visitors' point of view coincides with that of the staff also in thinking that the environment is not always a priority even if it obviously helps. By associating the information from the focus groups with that emerging from the interviews with the staff (of which a summary of the data and topics are in *Appendix\_VII, VIII*) and using the different colours for the different categories, it is shown that the two validate each other.

#### IV. What Buildings Do to People

During my fieldwork, aimed at 'scanning' the architecture of the building, in addition to better understanding how it was used and where people liked to be, I tried to recognise the action of architectural forms and understand the 'push' that buildings give to the practices of those who use them (Kraftl and Adey, 2008). In more phenomenological terms, I was trying to find the experiential dimension of the spaces of the three Maggie's Centres. The idea that buildings 'act' on us and can 'push' our bodies in space was already highlighted by Gieryn (2002), who stated that we should move away from and look beyond the static notions

of artefacts that appear to be compartmentalised in their final stages (2000). As seen, “human participation in buildings is complex and involves many processes of making” (Rose, Degen, and Basdas 2010, p. 347), since buildings are evolving projects in a constant process of making and re-making (Gieryn 2002; Ingold 2013). According to Gieryn, buildings can do many things (contain, protect, hide, represent, entertain, prevent, and much more), but above all they stabilise social life, giving solidity, identity, and durability to society against the forces of change. With all their imperfections, “buildings don’t just sit and impose themselves” (Gieryn 2002, p. 1), rather they interact. Buildings live thanks to the people who use them and take care of them and associate them with meanings; in exchange the buildings protect, support, and arouse affection and emotions. According to Winston Churchill’s famous quote, which has become the motto of the recent biological trend of niche design and construction, “we shape our buildings and then our buildings shape us” (1943). As mentioned in Chapter 2, this entailed a change of perspective from the oculocentric or symbolic appreciation of buildings to that of the embodied event, lived as a sensory, emotional, cognitive experience, but also conjoined and not disjointed to the others (Marchesini, 2013). Consequently, “we can no longer consider the design of a building or a city outside of how people engage with them” (Mallgrave, 2017, para.8).

In order to evaluate the findings of my fieldwork, which was not aimed at understanding whether the user experience of interacting with the building was positive or negative, but to discover what is it about the architecture (together with the support offered by the staff) that allows for well-being in users, I conclude the chapter by making these first observations:

1. Regarding the understanding of how spaces are used and in which rooms people like to stay, sought through the ‘Participation and Observation’ method and framed by the three parameters adopted, the data showed that ‘social interaction’ and ‘privacy’ are the parameters in balance with each other because, as already pointed out by Annemans et al. (2012), people perceive the building social and private at the same time. In terms of ‘social interaction’, as we have seen, the opening of the building encourages people to socialise, observe and imitate others in order to help themselves, thus gaining power and control. Visitors agreed that the kitchen is the most therapeutic room when considering ‘social interaction’, where they are free and not dependent on the staff. However, Maggie’s Barts’ first-floor consultation room, despite not being heavily used, is said to be where visitors benefit the most from the building. In the ‘privacy’ parameter, the building invites people to the peripheral

spaces of the social areas; in this case visitors find the highest level of ‘therapeuticity’ perched in niches or single chairs (yet, in eye contact with the others) or even sitting at the kitchen table alone in quiet moments. In the ‘counselling’ parameter, the areas near the entry / ‘pause’ and welcome area are very therapeutic, because the person in difficulty, especially if a newcomer, can during the consultation with the staff observe the other users as they move in space and understand the lifestyle of the centre in order to decide if they want to return or not, yet feeling free to leave at any time. (*Appendix\_V*)

2. Regarding the understanding of what are the favourite places of people in the buildings, researched through the ‘Move-along’ method framed by the three parameters adopted, the data showed that ‘agency’ and ‘identity’ are the parameters in balance with each other. Unlike ‘prospect & refuge’, the two mental conditions are not instinctive and immediate and require more work to develop, but once developed they stay in the person. Despite the uplifting and empowering entrance space and the sense of encouragement offered by the staff, the first meeting for a newcomer is not easy. For example, during the Move-along Barts no.1, the participant admitted that due to her diagnosis and treatment, she was very frightened when she first entered Maggie’s Barts; however, thanks to the “incredible warmth” of the Staff, today she feels a sense of agency and a firm identity. Since each individual responds to the space differently, based on their personal life experience, I realised that unlike the first two parameters, within ‘prospect & refuge’ it is not only totally subjective which room represents a place of ‘refuge’ and what exact constitutes a ‘prospect’ (a view or a book), but it’s likely the case that the entire Maggie’s Centre represents a ‘sanctuary’ or a ‘cocoon’. (*Appendix\_VI*)
3. Regarding the understanding of how buildings support the users, visitors and staff (which will be analysed in depth in the next chapter), sought through the methods of ‘focus groups’ and ‘interviews’ and framed by the 3 + 3 parameters adopted, the data showed that the 6 parameters/steps of the ACT model of psychological flexibility parallel the progression of Maggie’s 5-steps healing process (Box 16). A summary of the themes and data emerged from the focus groups and interviews can be found in *Appendix\_VII* and *VIII*.

During my fieldwork I observed that the users of the three centres, Maggie’s Dundee, Maggie’s Oldham, Maggie’s Barts, very distant from each other, behaved in the same way,

making the same gestures and speaking with the same terms and expressions. And this was quite surprising. The testimonies of the visitors of the three centres have, in fact, reported the same beneficial effects deriving from the open and hybrid space (place) combined with the informality and warmth of Maggie's users (people), despite being in a different location. While speaking or acting in the same way for the staff receiving the same kind of training is normal, it is almost unbelievable for visitors who don't know each other, who have different backgrounds and live in different places. With this awareness and from the experiential dimension described above, I realised that the common denominator, the 'red thread' that connects the users of the three centres and makes them speak and act in the same way is the spatiality created by the architecture, confirming Maggie's claim that despite the differences, buildings contribute to their mission by producing the same psychological effects in people.

If as per the premise of this section, a building acts and 'pushes' only in the presence of people, just as its therapeutic action is implemented only if people use and get engaged by the building – and as per my observations, spatiality is what triggers people's flexibility and it is what links all the centres – the conclusion is that it is the coexistence of people and place which makes people flexible. Furthermore, only with the presence of people can a building, environment or place be therapeutic. Understood as a psychological state, being therapeutic or non-therapeutic is not a condition of the space, but rather a subjective condition and, therefore, only in the presence of people can this property be attributed to the environment. Also aware of the fact that at Maggie's, the spatiality created by the architecture joins Maggie's support programme that invites people to accept the reality of the disease and choose to react, triggering people's flexibility, I can also conclude that Howells' postulate - the synergy between people and place allows psychological flexibility in users - derived from her observation made for over fifteen years from a psychological point of view as explained in the introduction to Chapter 3, finds also confirms from an architectural point of view.

## Chapter 6. My Reflections on the Data

What exactly is a Maggie's Centre? Why is it so important to people? How does its architecture initiate a process of change? These were the questions I asked myself every day while doing my fieldwork. In the previous chapter, I gave voice to the participants and organised the data by 1) the 5-step healing process (Box 16); 2) the level of 'therapeuticity' through the charts (*Appendix\_V*) and the 'favourite places' through the itineraries (*Appendix\_VI*); 3) the themes and categories identified thanks to focus groups with visitors seeking the 'kind of support' and semi-structured interviews with the staff searching for the 'level of cooperation' (*Appendix\_VII* and *VIII*). This has allowed me to see Maggie's under a new light and paved the way for extracting the undisclosed elements. I can thus confirm that the Maggie's Centre is a therapeutic environment. Starting from the premise that 'the synergy between people and place allows for psychological flexibility' (Howells, 2016), with the aim of discovering the link between design methodology and psychological flexibility, in this chapter, I return to the theoretical discussion of Chapter 2 and cross it with the empirical data of the fieldwork. After being defined as a 'vicinity' between people and the surrounding spatial field, revealing it to be a 'fusion' due to the *intersubjectivity* of people *immersed in an experiential field*, the synergy between *people* and *place* becomes a 'phenomenological synergy'. Synergy is a concept acquired from the Gestalt approach according to which the perception of reality allows the individual to perceive something more than the totality of the parts of the object (Bratton, 2015). Within the context of phenomenology, that same totality is called 'structure' (Merleau-Ponty, 1963 [1942]), which is not the reductionist sum of isolated elements. At Maggie's this totality comes from the 'many things' that the Maggie's Centre's hybrid space, characterised by "spatial interaction rather than walls", offers. Encapsulated in the continuous stimulus coming from a 'structured' field or the 'totality' of the open space, people with cancer are called upon to 'act' and access the 'many things' that the hybrid space of the Maggie's Centre represents.

As mentioned in Chapter 2, despite the success of the discovery of mirror neurons (Di Pellegrino et al., 1992) - probably also due to the simplicity of the theoretical explanation (Bloom, 2019) - in the end, Heyes and Catmur (2020) recognise a limited role of mirror neurons in reference to the understanding of the actions of others, of which the various studies conducted lead to the conclusion that mirror neurons are involved in the low-level processing of the observed actions (e.g. distinguish grip types), but, in reference to "emotional imitation" (Gallese 2006, p. 305), there is clear evidence of a greater response of

the mirror neuron areas during the reproduction of observed movements (Heyes and Catmur, 2020). In particular, if, as Gallese (2006) explains, for a patient such an action takes place outside the hospital, in a warm and domestic environment, the empathy that is generated reaches higher rates. In the quiet and open environment of the Maggie's Centre, people begin to imitate themselves in a process of chain reactions by extending good humour and joy of living to the others (Jencks 2015b, p. 13) and triggering the psychological healing process. As mentioned in Chapter 2, in this research neuroscience has served as an inspiration rather than an approach, but I have found it useful to engage with the ways in which neuroscience improves our understanding of how the built environment impacts on our sensory experience.

Before I continue, I would like to recall what I have already said in in Chapter 3 in reference to critically evaluate how my position and experiences as a researcher have influenced and guided the analysis of the findings and what this meant for the results. Since doing qualitative research means putting yourself in others' position and seeing the world from their point of view (Austin and Sutton, 2015) I can say that I have been faithful to what the participants in data collection told me. I have reported their voices as I have heard them and as others will read them. In analysing the data, I looked at feminist theory both for how it encourages the co-production of knowledge and how it focuses on marginalised groups in society, helping me to understand people like those with cancer's perspective. Given these premises, it was important in my research to avoid interpreting the participants' narratives from my point of view, rather than that of the participants. In the interpretation of the data, being an architect-storyteller, I can say that it consisted mainly in the organisational modality of the data, which also means selection. The way in which I chose and presented the data had different strategies: by tables, by drawings, by images, by texts and, within those modalities, it had different readings: by parameters (social interaction, privacy, etc.), by themes (safety, freedom, identity, action, etc.), by stages (5-step healing process or 3-step therapy processes). As with data collection, I adopted a phenomenological approach to data analysis because I wanted to understand how the participant experienced the building and I wanted to try to see the experience from that person's point of view. In particular, the data analysis very much reflected the experience I had with my brother. This personal story of mine therefore constitutes the lens through which I have examined the data. Without spoiling the results of the analysis, this lens is meant to explain how I see the Maggie's Centre. Having heard many stories that ended well thanks to Maggie's, unlike my brother's that

ended badly, by exposing my lens, I explain my point of view to the reader and contextualise my work better.

Having myself experienced the same feelings as my participants, by bringing my own experience I introduce the description of the therapeutic process that connects *cancer*, *experiential field*, and *psychological flexibility*. Before doing so, I need to explain to the reader that during my fieldwork I never encountered any real difficulty, except for the time during my first week at Maggie's Dundee, when in the focus group with the men's group, a visitor blamed me for being there "just to look at the architecture and not to understand the real content (i.e. cancer)" (*Focus group Dundee no.1*). I tried to explain that, in truth, my ethnographic fieldwork aimed at incorporating me into Maggie's environment, and becoming a temporary member of the community through my physical presence in the activities and daily life. Also, to demonstrate that I was familiar with the reality of cancer, I decided to tell about my brother who died from brain cancer in 2013. My own past experience with cancer, which lasted almost two years in distressing conditions, immediately made visitors accept my presence and myself as 'one of them' and understand my role as an ethnographic researcher.

With a focus on illustrating Maggie's experiential field, which, phenomenologically speaking, is a charged and changing space shared by the observer and the environment, by way of the narration of my direct embodied experiences as a means of knowing and absorbing space, the chapter continues by explaining the 'body with space' connection, albeit still uncertain about the "I don't know what it is", "I don't know how to explain it". Based on this uncertainty, I therefore address the 'cancer reality' and provide a concrete account of how phenomenology is an indispensable condition for triggering the process of psychological flexibility. Seen as the development from *cancer* through *experiential field* to *psychological flexibility*, the healing process explained by the interviewees in Chapter 5 will ultimately become 'therapeutic'.

To understand the phenomenology of space I have decided to return to the Architectural Brief. We know that in order for the stimulus of the experiential field to be continuous, it needs a more active form of vision, which Merleau-Ponty suggests depends on maintaining bodily movement (2012 [1945], p. 249). Aware of the fact that all the requests of the Architectural Brief lead to 'movement', I understand movement to be the link between design methodology and psychological flexibility, and why all Maggie's Centres generate the same feelings: they all share and are connected by 'movement' which induces the flexibility of spatiality that represents the 'common thread' that unites all the buildings.

To confirm this finding, in the second part of the chapter, I return to the Greeks and link the ‘fluid dance’ generated by the healing Temples of Asclepius with the revised flexibility, analysing the architecture of the three centres through the three-processes model of the ACT (Acceptance Commitment Therapy). With the theoretical references of flexibility, reflexivity, performativity, I then continue by reflecting on the voice of my participants and discover that flexibility, the intrinsic movement of Maggie’s triggered by the Architectural Brief and enabled by the Triad (Maggie’s-Architect-Users), becomes the generating principle that encourages people to be ‘active’ and not ‘passive’. Understood as ‘versatility’ and ‘adaptability’, flexibility should therefore be seen not as a passive change of scene, but rather as an active sequence of experiences.

Since movement is the key element that enables flexibility and links architecture to psychological flexibility, in order to make people with cancer more aware of their environment, only by incorporating a motile dimension in perception as Merleau-Ponty (2012 [1945]) will Maggie’s ‘phenomenological synergy between people and place’ be effective in the constitution of a therapeutic environment.

## I. A Phenomenological Synergy

At the still point of the turning world. Neither flesh nor fleshless;  
Neither from nor towards; at the still point, there the dance is,  
But neither arrest nor movement. And do not call it fixity,  
Where past and future are gathered. Neither movement from nor towards,  
Neither ascent nor decline. Except for the point, the still point,  
There would be no dance, and there is only the dance.

*T.S Eliot, Burnt Norton, Four Quartets, 1936*

As concluded in Chapter 2 supported by the theoretical framework and based on the considerations expressed by the participants outlined in Chapter 5, in an attempt to decode the therapeutic process, I needed to unravel the phenomenological nature of Maggie’s space. With the idea of diving into the space of Maggie’s Centre, to explore the three connected passages of the synergistic phenomenological value of “cancer-experiential field-psychological flexibility”, I had to understand the true nature of the synergy advanced by Lesley Howells.

As Lesley Howells explains in her TedxDundee Talk (2016), it is the synergy between the bespoke architecture of the Maggie’s Centre combined in a vibrant ‘fluid dance’

with the people within that enables and creates the concept of Psychological Flexibility. By creating a ‘vicinity’ between people and the surrounding spatial field, the synergy allows Maggie’s visitors to be present and open to reality. This means that people open up to the concept of not fighting, finding freedom in the choice that is offered to them.

By interviewing Maggie’s psychologists, I discovered that the feelings of agency and mastery that are evidently aroused in visitors certainly derive from the stimulating physical space enhanced by the warm atmosphere, but only in combination with an apparently informal way of conversing, a more subconscious way the staff frame conversations and interactions. By telling them that it is okay to be emotional and encouraging them to feel free and act normally, people will start to react. As mentioned previously, in Maggie’s Centres conversations are widely visible from afar because the open space allows people to observe with a wide optical range. This is key for human beings in helping them to believe that “if others do it, we can do it, too”, and in feeling reassured in thinking that, of course, “we are not the only ones” (Howells, 2016, 8:53). This synergy of thoughts and feelings that is exchanged between people is called, as mentioned, *empathy* and it is one of the basic concepts of phenomenology. Understood as a sort of emotional imitation, as explained in Chapter 2, empathy is “the ability to understand the others as intentional agents” (Gallese, 2006, quoted in Di Fazio, 2015, p. 9). Being able to recognise the intentions and emotions of others, the experience of empathy is essential to the phenomenological account of *intersubjectivity*. Within intersubjectivity, one experiences oneself as being a subject among other subjects, or as existing objectively for others, or as the subject of another’s empathic experience (Zahavi, 2001). “If human beings can see somebody else, they can identify a way of doing something, they are unbearably doing it themselves. The subtlety of the design, the openness of the design works with it, in this respect” (Howells, 2016, 8:30).

Perceived differently by each individual, depending on their background and personal life aspirations, Maggie’s is a place that is open and flexible to any interpretation with respect to the flexibility and adaptability that Maggie Keswick would have desired in telling people that her centre is ‘many things’ (*Murphy, 11.06.2018*). This synergistic coexistence of things recalls the Gestalt motto “The whole is greater than the sum of the parts” (Bratton, 2015, p.191). This is ultimately the unallocated definition of synergy, in which Merleau-Ponty identified his concept of structure. As explained in “The Structure of Behaviour” (1963 [1942]), space is like a football field that “is pervaded with lines of forces (...) and articulated in sectors” which will offer opportunities for action “as if the player were unaware of it”. Hence, the field becomes a ‘structured arena’ and “the player becomes

one with it and feels the direction of the goal” (1963 [1942], p.168). As Merleau-Ponty suggests, it is only through habit that we acquire the ability to ‘in-habit’ space, since familiarity allows us to navigate easily. However, at the sensory perception level, familiarity is the body’s ability to dampen responses to a continuous stimulus by gradually causing us to lose attention and ignore details (or exclude distractions such as noise) (Hale, 2017); that is why every act of focusing must be renewed (Merleau-Ponty 2012 [1945], p. 249).

Being in synergy with the place or the ‘structure’, Maggie’s visitors are stimulated to understand the intentionality of others and move and explore the ‘many things’ linked together in a ‘whole’ and surrounding them. If it is true that the fieldwork proved that phenomenology – which in its methodological principles is an investigation of relationship – was the correct methodology to adopt in this research, it also revealed that the synergy between people and places that Maggie’s Centres create is a phenomenological synergy. In this story of mine, I bring evidence that the stimulating social context that aspires to “spatial interaction rather than walls” helps to create the experiential field.

Today is a beautiful day, the kitchen is quiet and sunny. After sitting and sketching at the kitchen table for a while, I decide to go over to the oval counter to introduce myself and my research to Alice (an invented name) who is there reading a newspaper. She is happy to meet me and speak with me. After listening briefly to her, I understand that she is an ‘out of the ordinary’ woman, for several reasons. First, a long time ago, she refused treatment for her first bout of breast cancer and managed to treat herself with alternative methods. Because she refused chemical treatment and was ‘different’ from everyone else, she was one of the few Maggie’s visitors who did not like coming to Maggie’s, although she liked the building. She felt she did not fit in, so she walked away. Last winter, though, the cancer came back, and she was going to die. So she had to accept the traditional protocol. Despite this, and her thin body, her skin and her hair are still beautiful. In any case, this time she decided to return to Maggie’s where she continues to appreciate the architecture and the people.

Totally taken by these stories and fascinated by the way she is telling them, I haven’t noticed that, in the meantime, the kitchen has filled up and 3 or 4 other people are sitting at the oval counter with us, conversing with each other. In the rest of the room there are 3 or 4 other groups of people conversing. One of the volunteers goes around the groups to collect empty teacups and serve new ones. While all of this is happening, I find myself in tears because of Alice’s stories, but also because of my current unstable psychological condition. The volunteer comes over to offer her help, and all it takes is for her to smile for things to go back to normal right away, and Alice and I continue talking about the building. (*Fieldnotes Dundee, 17 September 2019, 12-1:30pm*)

One aspect of the building’s ‘magic’ has actually just happened and revealed itself. Testing this experience first-hand with my body and mind, I cried unreservedly despite the surrounding crowds. The different areas of the open kitchen contained under each one of the

complicated truss ceiling structures allowed for the creation of ‘bubbles’ of privacy, yet the open space allowed other people to see me and maybe do the same. The empathy of the building supports people by isolating them from other conversations, however voices, sounds, and movements are still audible and visible. In the experiential field intimacy and openness can coexist.

## Ia. Body and Space. Premise to the Therapeutic Process

During my fieldwork, my bodily presence in the three centres was certainly an alien element, because of my role as a researcher as well as because of my physical presence. However, my participation in the centre’s activities served to take the pressure off both myself and the visitors, who acted naturally without seeming to feel they were being observed.

In a Maggie’s Centre, the person’s body blends naturally and harmoniously with the surrounding space, and is constantly moving through physical activities, in particular, ones such as ‘Move more’, Tai-Chi, or Yoga. For example:

Tai-chi is a Chinese practice based on physical exercise whose movements express what is inside someone’s (mind). Since it is physical (body and breath), and not meditational (soul), concentration goes onto the body, and the movement is like a dance, that moves in a fluid way. The mind is at the centre, controlling movement and balance. You never stop, even within a single movement, hands, arms and body move making curves and circles almost like a long ribbon could move in the wind. This magic movement sets the body in the centre, like a point, around which all the fluids spin. The room, in its 50% soft darkness is the third layer that wraps around the fluid-ribbon-movements of the body, arms, hands and head and the still mind. The 50% lightness of the room comes from the window framing the sky and the Scottish pine trees. The light is suspended, and it helps to reveal the structural ceiling. All the exercises refer to objects (ball), nature (horizon), or universe (stars, sky, moon). It is like bringing sky and horizon within us. everything starts from Tai chi. (*Fieldnotes Dundee, 23 September 2019, 12:15-1:15pm*)

As Maggie’s yoga instructor stated, in yoga the awareness of the physical force transmitted to the brain makes people feel stronger both physically and psychologically. Physical activity and body movement are therefore important in stressful or depressive situations. In addition, our body constitutes a welcoming home that we use as a means to create comforting places in the surrounding space. So, body and space are necessary to establish deep and regenerating relationships with others (D’Avenia, 2018), a good premise for generating the therapeutic process.

We know from Merleau-Ponty that the body is the key means to learning in human experience. Once immersed in space, the skin of the body is the only limit between us and the world which is nothing but a continuation of us. “And the subject is inseparable from the world, but from a world which the subject itself projects” (Merleau-Ponty 2012 [1945], p. 454).

## Ib. Embodying the Cancer Reality

But what is it exactly that connects the body and space? Maggie’s community shares a common trait – cancer – and thanks to the particular architecture and professional support of the staff, people are in control. The staff say that old visitors “almost erase it” and cancer is no longer a topic of conversation. And because they no longer need to talk about their cancer, even though they still have it, people can actually start talking about something else. Although visitors develop strength and positivity, because they have a life limiting disease, sometimes when they have a bad day or feel tired, knowing that going to Maggie’s they will feel better, they make an effort because they are aware that it is worth it. A cheerful atmosphere that makes you forget about cancer is normally the case but there are days at Maggie’s Centres when you see people who are tired, and often forget that some of them may be gone soon. At the same time, it is quite common (it happened to me and I know I am not the only one) to enter a Maggie’s Centre and not be able to distinguish visitors who are sick from those who are well. This derives from the constant invitation addressed to the visitors to feel normal. As described in Chapter 3 (Methodology), inputs from phenomenological psychology helped me to connect ‘affect’ and ‘cognition’. When in exhausting situations yet enhanced by affect, particularly in reference to ‘decision making’, people were able to react. Hence phenomenological psychology was key to understand how in a favourable environment people become aware, receptive and proactive.

In this normalisation practice, the kitchen table is a very important tool, representing the visitors’ travel companion from day one. Regardless of the shape, which is different in each centre (in Dundee it is rectangular, in Oldham round, in London Barts oblong), the table constitutes a ‘pedal’ to start the day by inviting people to sit around it and encourage them to talk. What emerged from my data is that the kitchen table has the largest number of people visiting it, and therefore the highest level of social interaction. This means that along with the activity room the kitchen is one of the two most therapeutic social rooms at the Maggie’s

centre. At the same time, during my fieldwork, I observed that around the kitchen table there could be different types of conversations among visitors, in small groups, in large groups, or with the staff. At the same table, there are also visitors, oblivious, who sit in silence and listen to the others, and who maybe, suddenly, one day, open up and start talking. “When you have cancer, you don’t want to be part of the group, quite the contrary” (*Murphy, 11.06.2018*). What is very difficult with cancer is the sense of isolation. People choose to remain in isolation to protect themselves but also to maintain control over the personal information given to others. Considering privacy as “personal autonomy”, as already defined by Westin (1967), privacy is “the claim of an individual to determine what information about himself or herself should be known to others” (Westin 2003, p.431). Although asocial, at Maggie’s single visitors like to be present, in eye contact with the others, watching and listening. As already mentioned, there is a certain comfort for people to be together, even if secluded. This is important to make visitors feel free to isolate themselves, yet not feel ‘alone’. Feeling that one is a part of Maggie’s community ultimately develops a sense of identity. Linked to the ability of individuals to defend their identity, ‘privacy’ is also a selective control of access to oneself or to one’s group by others (Altman, 1976). In this, Altman suggests using privacy control defence mechanisms such as ‘personal space’, hence the control over personal information against others. ‘Personal space’ is the closest layer of the self or the invisible boundary surrounding the self (Hall 1966, Sommer 1969). The concepts of privacy and personal space are fundamental for the individual to be in balance with the environment. To maintain this balance, as we know, Maggie’s offers openness and freedom of interpretation and that’s why during my fieldwork, visitors said “it’s unthreatening, a place that’s neither medical nor home, so kind of halfway between the hospital and personal space” (*Follow-up Barts*).

Along the journey with cancer, from the diagnosis to the recovery (which luckily still happens), the building accompanies visitors by offering its spaces and all the conditions of warmth and peace necessary for people to identify the Maggie’s Centre with a ‘hug’. At Maggie’s, this metaphor is often used to define both the staff and the building. When people cry, because “here it is okay to cry” (*Move-along Dundee no.2*), Maggie’s brings back memories of times when emotions were allowed. Feeling like children again, especially when they were sick and cared for by their mother, participants say they feel ‘hugged’, which is more than just feeling protected. In the process of ‘surrendering’ themselves to the building, people begin to look back at their lives and wonder why and what caused them to be ill and maybe dying. Thinking back to the best time they can remember, they say “It was

when they were in their mother's arms" (*James, 13.06.2018*). The maternal metaphor (Butterfield and Martin, 2016) of Maggie's Aberdeen (2013) described as a "hug" by Bjørg Aabø (*02.11.2018*) is thus confirmed. Hence, the Maggie's Centre itself is not just a member of the staff, it is much more. It is a place of "unconditional and indefinite hugs for devastated and demolished people who no longer know how to behave or live" (*James, 13.06.2018*).

At Maggie's, people with cancer share a clear understanding of what cancer is and how it affects their lives. This has an impact not only on the individual, but also on the people living around them, especially their friends at the centre. Since the Maggie's Centre is not the place where cancer patients receive the bad news, but, rather, the place where they can recover from it or, when they are lucky, even share the good news, we can luckily witness, alongside the crying, the complete opposite emotion of joy. Visitors say it is common to hear a great deal of laughter in the building. Older visitors are not ashamed to laugh in the presence of newcomers in tears, because they know that very soon, the new visitors will be in the same position as them. Within this ambivalent scene, the open space allows people to witness all kinds of emotions and actions which, through empathy, will activate a chain of positive reactions. As I observed during my fieldwork, seeing the other visitors laughing, the people who had been crying up to that moment reacted by stopping their crying and starting to smile; newcomers who observed the staff busy in the kitchen felt encouraged to help; visitors interested in participating in a group activity but were too shy to try, but they told me the next time they were able to. This unassuming but psychologically sophisticated way of interacting solidly between staff and old visitors that benefits newcomers is facilitated by the openness and flexibility of the building. "One of the things that architecture has been able to offer at Maggie's is providing a unique way of helping people relate to each other" (Lee, 2020).

When undergoing radiation treatments, visitors go to the hospital every day for 4-5 weeks, for a total of 25 treatments, and often stop by Maggie's before returning home. Many people say that 'the reason I do this is because it bridges the gap between the clinic and home'. Sitting in a quiet space while having a hot drink contemplating what is happening to them, visitors can rid themselves of clinical stress out, and ponder the idea that once they leave, they will feel better (*Centre Head Barts*). For people with cancer, the Maggie's Centre represents the interface between home and hospital, although psychologically it is 'the space between' where they can stop and reflect to find the very essence of who they are when everything around them is falling to pieces. Using the quote attributed to Viktor Frankl, which says that we cannot control what is happening to us in life, and that the only space we

can control is our mind and how we respond to it, Howells (2019) explains that Maggie's psychologists enable a flexible state of mind in visitors.

Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our freedom and growth. (Viktor Frankl, quoted in Covey, 1989, p. 70)

Between the trigger and the response, the Maggie's Centre is a 'still point', a space where people are free to choose how to respond rather than react. A free, open, flexible space to be interpreted and taken in a different way by each of us.

## Ic. Maggie's Experiential Field

The link between our body and the surrounding space, which, in "The Structure of Behaviour" (1963 [1942]), Merleau-Ponty refers to with the ethological concept of Umwelt (the surrounding world) is a tenacious one. If the external environment influences and induces the movements of our body, it is equally true that the action of our bodies affects the surrounding environment. In this process of interaction with the place, the body imposes its habits as well as grasping the challenges of the context. As we have seen, in Maggie's Centres the synergy between *people* and *place* is facilitated by an open and continuous space, a 'whole' that improves psychological flexibility while stimulating people's senses. This multisensory and 'interactive' space, shared by the body and the environment, becomes charged and changing. The space changes and moves, harmoniously accompanying the movement of the body of those who use it. The space is therefore dynamic and enabled by a variety of solutions that create movement, which is seen is the key element that enables flexibility and links architecture to psychological flexibility. But where does the movement come from? And how is it inherent in all of Maggie's buildings? Knowing that the projects for the Maggie's Centres are the result of the application of the Architectural Brief (2007) (*Appendix\_I*), if we carefully examine the document, we discover that the request for 'movement' is already implicit in the first requirement. The continuous space visible from the reception area invites us to walk.

*Entrance*: clear, welcoming, not intimidating. Small coat-hanging / broly space. A welcome / sitting / information / library area from which the layout of the rest of the building should be clear. There should be as much light as possible. There should be views of grass / trees / sky. You should be able to see where the kitchen area is,

equally the sitting room and fireplace-area (hearth & home). Maggie suggested a fish tank. (Maggie's Brief, 2007, p. 2)

Once inside, the space invites people to move into the building. Thanks to the seamless spatial sequence, depending on the mood of the individual, people looking for social interaction will let themselves be attracted by the noise coming from the kitchen; if, on the other hand, they want a more peaceful environment, they will be called from a secluded and quiet space such as the library or the garden. If we continue to analyse the entire Architectural Brief, we realise that 'movement' is a constant reminder.

"The kitchen should be relaxed and inviting enough for anybody to feel welcome (...)  
A large room for relaxation groups / lectures / meetings (... ) you should be able to  
open and shut walls (perhaps between this and welcome area / kitchen area) to have  
flexi-space, (...) small rooms for counselling or therapy (...) have sliding doors that  
can be left open and be inviting when not in use. Furthermore, it is important to be  
able to look outside - and even get out (...) We want visitors to have an idea of what  
is going on in the whole building when they come in. (Maggie's Brief, 2007, pp.2-5)

The sequence of spaces divides or joins flexibly through sliding doors and movable walls. The spatial experience is that of an evolving space, which encloses a space within a larger space, thus generating an extended experience. In addition to the continuity of spaces, there is also the continuity of light that strengthens the perception of continuous space. With slants of light or, vice versa, with diffused light surfaces, the space that allows for long perspectives transmits a sense of transparency and control. In this uninterrupted and ever-changing space, if we look up we can see moving ceilings, coloured skylights, and large lanterns that frame the moving clouds in the sky (*Harbour, 20.07.2018*).

Going beyond the Architectural Brief, by way of the curved glass, bending walls, and round spiral stairs, Maggie's architects are able to move people's bodies within a charged and changing space that surrounds the body. The set of these forces form a sensory field, previously referred to by Gestalt Psychology as the psychological field. But the sensory experience involves perception beyond the five senses. With a more active form of vision, which Merleau-Ponty suggests depending on maintaining bodily movement (2012 [1945], p. 249), the sensory field becomes an experiential field, awakening sensations in the moving body such as orientation, gravity, balance, duration, and stability. The experiential field, by its very nature, feeds the movement of the body, inviting exploration by the observer whose perception is constantly evolving. The body, in fact, by moving in space and changing position continuously, feels a new experience each time in a sequence of always different positions (Gepshtein and Berger, 2020). Recalling Merleau-Ponty's (1963 [1942]) example

of the football field may help to illustrate what Maggie's users feel in the centres' experiential field. Terms often used by Maggie's users, 'atmosphere', 'aura', 'ambience', are generated by the action of forces acting on the human body and brain that processes experience as an embodied perception of the phenomenological space, which is very often difficult to describe ("I don't know how to explain it", "I don't know what it is"). The 'structured arena' and "the player becomes 'one with it' and feels the direction of the goal" (1963 [1942]).

In the phenomenological design process, space, the rhythm of light, and materiality play an important role in the generation of movement. As previously described, Maggie's Dundee's intricate structural wood ceiling, Maggie's Oldham's curved glass case containing the silver birch and light source, and the double-height space defined by the dazzling white glass facade containing the Maggie's Barts sculptural staircase generate the experiential field which, engaging beyond the sensory experience, allows people's psychological flexibility in accepting the changes that Maggie's offers. Hence, phenomenology is essential to trigger the process of psychological flexibility in the constitution of a therapeutic environment. Within the ever-changing experiential field, visitors gain space and time at their own pace and can always rely on the predictability of the staff and the building. All of the values that are offered (beauty, freedom, community, identity, pride) are fundamental for each individual who therefore responds to the space in an individual way. In offering 'many things', and leaving openness and freedom up to interpretation, the hybrid nature of Maggie's 'whole' re-emerges. "This is not the business of healthcare, but it is the business of the spirit. And it really is a very spiritual place, in a non-religious way" (*Move[Sit]-along Oldham no.5*).

## II. Psychological Flexibility: The Fundamental Role of Architecture

In the search for the connection between architecture and psychological flexibility generated by the synergy between people and place, the movement of our body generated by the surrounding space was offered by Ancient Greek healthcare. As explained in the introduction, Kearney (2009) talks of how Asclepius healing is about a fluid synergy between places and people. Moving between the library, theatre, the baths, in places of great natural beauty, rich in vegetation and spectacular views, professional carers and sick worked

together around a way of healing in suffering, by turning towards ‘emotions, intuitions and somatic awareness’, rather than fighting against their experience (Kearney, 2009).

In the Maggie’s Centre the synergy between architecture and the people who move within it constitutes a holistic environment where people learn, by imitating others, to participate and to help themselves and creates a psychological space in which people move with reality rather than struggling against it (Howells, 2016, 0:45). In this empathic process, the ‘spatial interaction rather than walls’ is a fundamental design request of the Architectural Brief for the architect to allow the opening of the visual field and the encapsulation of the people in it, the ‘fusion’ between people and place. Since the first step of the therapeutic process starts from facing the *cancer* reality, the application of psychological processes within the *experiential field* of Maggie’s architecture helps people to achieve a state of *psychological flexibility*.

What happens in the Maggie’s Centre, because of the synergy between the architecture and the people in it, is that Staff can enable people to turn towards that difficulty and actually see what choices they can have, in terms of having lived their life as meaningfully as possible. Without knowing they are having a psychological therapy; the architecture creates the conditions; it happens very, very subtly. (Howells, 01.11.2017)

In order to understand whether the space of the Maggie’s Centre enables the therapeutic process that goes from *cancer* through *experiential field* to *psychological flexibility*, I will apply the *triplex* model here to assess the Maggie’s Centres built environment. As mentioned previously, in fact, the six processes of the *hexaflex* model of psychological flexibility that I used as the parameters of two interviewing methods (focus groups with visitors and one-on-one with staff) for my fieldwork, can be summed up in the simplified three-processes model of the ACT *triplex* of ‘open up’, ‘be present’, and ‘do what matters’ (Harris, 2009).

1. ‘*Opening up*’ to reality means accepting the choices we are offered: the open and continuous space of a sunny kitchen overlooking the River Tay at Maggie’s Dundee, for instance, helps to open up to conversations and social interactions. In a domestic environment everyone knows what to do in a kitchen, and this is facilitated if the space was conceived to experience familiarity and achieve openness. By repeating the same familiar script, Maggie’s buildings work in synergy with the staff to create conversations. The language adopted by the staff plays an important role in framing the care, the ‘hug’, as it is the Centres’ practice to not refer to visitors as ‘patients’. Therefore, part of the ‘opening’ comes with the construction of a language that the

staff will teach its visitors to use. By opening up to conversation with the idea of not hiding and with the ability to accept talking to others, it allows people to open up to a new narrative of their life and to rewrite it (Howells, 2018)

2. *'Being present'* with life as it is, means anchoring oneself in a building that naturally invites people to fully engage with all of their senses, rather than being captured by thoughts about the future or memories of the past. For example, the moment of 'pause' offered by the entrance asks people to dwell on the present, as well as the movement achieved by the double-height space and swirling sculptural staircase at Maggie's Barts puts people in touch with reality by moving their bodies with it, absorbing space through their skin and brain, and making them appreciate the present moment.
3. *'Do what matters'* means acting according to one's own values. The curved glass case located at Maggie's Oldham makes the body move around it – maintaining a view with the rest of the open floor through the transparency of the case – while people are connected. With light, sky, and nature at its core the building creates and shares the experiential field with the visitor. In adding such a strong symbol to the architecture, the 'Tree of Life' inside the glass case allows the observer to connect with both the ground and the sky, moving thoughts and priorities to the 'value of life'. And there is a value that people find not only in the environment they are in, but also in the way they think about themselves or how they can be valuable to others. And in this, the kitchen table intervenes again and helps to share values.

What begins as a process of normalisation, in a space where people with cancer are free to choose how to respond rather than react, the therapeutic process of the Maggie's Centre goes through a 'still point', between stimulus and response. We know that in order for the stimulus of the experiential field to be continuous, it needs a more active form of vision, which Merleau-Ponty suggests depends on maintaining bodily movement (2012 [1945], p. 249). Like in Ancient Greece, the healing of Asclepius enables dance, that synergy between the place, but also between people, professional caregivers and the person in terms of "attunement" (Pérez Gómez, 2016) to "using the inner senses of emotion, instinct, intuition, and somatic awareness" (Kearney 2009, p.46), to find a turning point to work with the fight

against the disease rather than against it. Users (*people*) and Maggie's (*place*) now embodies psychological flexibility.

## IIa. Maggie's Flexibility

As previously explained, of the three supports offered by Maggie's, lifestyle (physical, nutritional, creative) is the one that includes all the activities going on at the centre. Since my research focuses on architecture and people's well-being, the activities I participated in during my fieldwork were mainly those aimed at 'distracting from cancer' (yoga, Tai-Chi, art therapy, nutrition, relaxation) and not those dealing 'with cancer' (cancer support groups). At Maggie's the activities take place in a flexible way inside the centre's different rooms. The Staff are constantly moving the furniture and the rooms are continuously changing setting to become a new space each time. As already mentioned, in this regard Lesley Howells says:

We constantly roll up the carpet and then unroll it as we change the background for each of our courses and workshops. And that flexibility, that 'bending' with our environment is what we hope will shape those around us. (Howells, 2016, 15:50)

In pursuit of psychological flexibility among Maggie's visitors, I realised that by offering adaptability and flexibility, the building helps people to adapt easily and thus become flexible. This included me when, in adapting my methods to the centre's timetable of activities, I found myself to be greatly flexible in facilitating visitors and participants at all costs. This was of essential importance to developing involvement and a sense of well-being especially on their part. This led, as already mentioned, to two groups of enthusiastic women, in two different centres, immediately asking me to be interviewed. As mentioned in Chapter 4, one of the most criticised topics, in all three centres, was that of acoustics. As Laura Lee says, in a mentality of adaptability and flexibility, the problem of acoustics must be taken as an asset rather than an imperfection, as, indeed, all imperfections should be taken. The transmission of sound, in fact, helps visitors feel they are a part of the community, so that, "if you still hear voices behind the walls, it means that you are not alone in the building, but that there is a community out there, of which you are a fundamental part" (Lee, 09.03.2018). To justify and compensate for the inconvenience, the staff will then say: "We must learn to live with the building".

At Maggie's Dundee, although there are rooms with doors, during the relaxation class some visitors complained of noise coming from the welcome area just outside the large living room. Sound transmission travels through the wooden ceiling and voices can be heard and become a distraction. When I arrived at Maggie's Oldham, the problem was even greater. The Centre is essentially a loft space with a few rooms located on one side; moreover, there are no walls dividing the living room from the rest of the open floor, just a heavy, non-soundproof double curtain that once pulled creates the activity room. Hence, if the visitors in the kitchen area are loud, during the relaxation course it is quite difficult for those inside the curtain to relax. On the other hand, the curtain works very well to make the room totally dark during the 'sleep soundly' course or for taking a nap. If until then I had thought acoustics was a problem for the first two centres, when I arrived at London Barts, I realised what the real problem is with the acoustics. As explained in Chapter 4, the main vertical structure of the building is composed of three layers, three stories high: an external glass facade, a supporting concrete grid structure, and a large internal self-supporting spiral staircase with bamboo finish, all of which are about 20 cm apart from each other. Therefore, the room above is acoustically, even visually, connected with the room below through a wide gap that runs along the entire edge of the floor. Going back to what Laura Lee says about taking acoustics as a resource rather than an imperfection, some visitors are happy not to be 'locked up' in a room and always connected.

So, hearing other people's voices is not wrong because it makes visitors feel the presence of other people in the building. - But is it the noise that bothers you? - No, it is not the noise. It is the fact that when you are talking about something very personal with a member of the staff, someone else can hear you. (*Focus group Barts*)

While some people are happy to be connected and positive about acoustics, others experience it in the opposite way. The staff are aware of the problem but, as visitors are all different and not everyone sees or hears it the same, it is left to people to judge whether or not it is a problem, and whether to accept it as a compromise, as they often do. However, as proof of Maggie's flexibility, the technical problem is overcome by the fact that even the most private conversations take place in the open and visible space, in the welcome area or at the kitchen table. As mentioned previously, the building has no secrets, and nothing happens behind doors. That's why at Maggie's we find large doors that open and don't lock, slide and don't close, or even curtains that people rarely pull. Thus, it is the flexibility of the building inherent in the way it was designed that makes people feel comfortable about opening up in conversations and sharing experiences and emotions, without worrying that

what was said inside the building will not remain within the building. As reported by the focus group participants, there is trust in the community, and visitors trust the building and the people.

## IIb. Maggie's Reflexivity

As seen in Chapter 2, in the field of sociology reflexivity means self-awareness (i.e. reflecting on oneself) (Harvey, 1985). This awareness helps improve subject-agent competence which consequently improves the reflexivity of the architecture seen as an active agent rather than a passive context (Hensel, 2010). This concept is evident in the performance of the Maggie's Centre, where reflexivity is expressed in the continuously changing environment that shapes the people around it. Within the scenography of the domestic atmosphere, there is a very careful and sophisticated way of choosing furniture and lamps, pillows and blankets, colours and patterns, ceramics and kitchen utensils. Based on this, the 'reflexivity' created by Maggie's is not just part of a daily performance but becomes real. The environment, therefore, shapes people for real, who 'bend' and change around it. To confirm this, within a framework of reflexivity, in line with Maggie's mission and philosophy (which we discovered to have a rather rigid 'non-institutional-institutional dimension'), Maggie's organisation and the Architectural Brief are self-referential, leaving the staff very little freedom to decide on different solutions for the environment of a room, or to change the position of things inside the building. If they transform anything, in fact, it will have an impact on how the building should function. This explains what makes Maggie's so different from other healthcare environments. Nothing is left up to chance, despite the (apparent) informality of the environment. At Maggie's there are precise rules that I only learned about after staying in three of the centres. In fact, what is and is not allowed is not so obvious. For example, only a certain type of kettle can be used, microwaves and clocks are forbidden, air conditioning is not allowed, towels can only be terry cloth and coloured, and furnishings are both traditional and highly sophisticated in design. "Really? How strange?" Actually, it's not strange at all, because it means that Maggie's cares a lot and that's why they hire "only a certain type of person" (*Focus group Barts*). Despite the psychological pressure coming from people with cancer, visitors think that the staff members, who work in a beautiful environment, are happy. In fact, they think that the little freedom left to the staff, the fact that they are contained and directed with precise indications

from above, is a good way to make visitors feel content and guided. They are encouraged knowing that they are in good hands. Like a child who expects his or her parent to behave calmly, visitors expect the same from the staff. This enables in them a strong sense of control.

As a further consequence, a strong sense of agency is activated in people even in the absence of staff, because visitors know that the building, also seen as an active agent, can replace them at any time. As mentioned, the staff often state that the warm, enveloping, and welcoming structure facilitates the pleasure of the place by giving them time and space. Although present, they rely on it to take care of the visitors. In this regard, the quote from Butterfield and Martin (2017), “the non-human, designed environment assumes a form of agency, acting as a calm presence or ‘silent carer’”, is clearly asserted here. From a formal point of view as well, the round shape of the glass case in Oldham, the curved walls in Dundee, the spiral staircases in Barts make visitors feel embraced and accompanied. “Yes. As I said, the shape of the stairs just makes you slow down, it forces you to slow down those stairs. It’s a subtle imposition on you, but it’s positive” (*Move-along Barts no.4*).

## IIc. Maggie’s Performativity

As discussed in the theoretical section of Chapter 2 concerning performativity, performance theory analyses the performative nature of society and how it becomes a reason for human understanding to adopt a performance code that guides events in our daily life (Hensel, 2010). Over time, performance that has become an expression of the way individuals situate themselves in the world has been studied in the related area known as performativity. According to her concept of performativity, American feminist and gender theorist and philosopher Judith Butler explains that people come to perform to believe that a script has been rehearsed, realising a reality through repetition just like actors playing a script (Butler 1993, pp. XII). Inside the theatrical space of the Maggie’s Centre, through the repetition of words and acts such as ‘make a cup of tea’, staff and visitors become actors who recite the script that celebrates the ceremony of life. This family script, the ritual and daily routine performed by way of phrases such as ‘would you like a cup of tea?’ and actions such as sitting around the kitchen table, surprisingly encourage people to open up to confidential conversations. In conversing and performing the holding of a cup of tea, perhaps with two hands, Maggie’s users not only experience the pleasure of sharing, but also embrace a socialisation process on an individual and group level. By way of such acts (performances),

emphasis shifts from ‘reality’ to ‘events’ that imply involving the recipients, listeners, and spectators (Fischer-Lichte, 2008). At Maggie’s, the ‘cup of tea’ is a constant ritual that involves the space and the people, the stage and the actors.

Butler’s notion of the ‘performative’ is not only applicable to corporeal acts but can also be applied to words and speech. The words we use exclude and include, form and shape, and they are a means of performance for ourselves and others (Butler 1997, p.8).

Human beings have language. We have this unique ability to have dialogue with each other, but also with ourselves, internally. And if we can ‘honour’ that ability then we can work, create and help people to ‘honour’ Psychological Flexibility. This helps them to converse with their minds as friends rather than as enemies and their wiliness to discuss intimate things within an open environment. (Howells, 2016, 6:20)

To remind visitors that the centre is like a house – where one would not hang signs on the doors – at Maggie’s there is no signage. When visitors enter the building there are no words anywhere; the staff are responsible for explaining how the building works. This strategic lack of written words – from signage to flyers – leaves room for action and openness as to how to interpret the Maggie’s Centre. This freedom to any interpretation, this vagueness encourages people to position themselves and communicate in Maggie’s world without declaring who they are and what they believe in. The choice of not collecting visitors’ data, nor keeping written records of visitors is another way of performing. The less that is said or acted and the more that is left up to the imagination and space of action.

As concerns the ‘stage’, by moving furniture throughout the day to adapt the programme’s different activities and by modifying the environment to become a new space each time, the staff builds the background to Maggie’s performativity. During its daily performance, Maggie’s engages spectators, and everyone feels valued.

The Maggie’s Centre gives you a sense of worth because you’re not a patient in here. In that building over there (hospital), you are a patient, but in here you are you, you’ve got your identity back, perhaps. (*Focus group Oldham*)

As explained by Umberto Eco (1989) in his approach to Semiology, an ‘open work’ is a work that engages the spectator. Deliberately characterised by ambiguity, the ‘open work’ must leave to the public or up to chance the disposition of some of its components on display, conferring to this work a field of possible settings rather than one defined and conventional one, where the subject is free to move about by choosing among a range of possibilities. Yet, this must not be thought of as a totally free and unstructured field; rather, it needs the guidance of a designer who will create the ‘structure’ of the field for the subject (Eco, 1989).

As suggested by Hensel (2010), this is an important insight for architecture, and in particular for the Maggie's Centre. The 'open work' of a Maggie's can take on different forms of performance. Through design, the performance can be charged with meaning and the subject can become an 'active agent'; however, no performance will occur until action is taken by the subject (Hensel, 2010).

During my interviews, the participants seemed to be in control. The concepts of control, agency, and identity are of essential importance if the individual is to be in balance with the place. In the past, within the Maggie's Centre performing control and agency was different for men and women, and architecture has since played a role. As we saw in Chapter 2, although it might seem contradictory for performativity, the concept of agency has been re-evaluated by Butler (1990) and McNay (2000). Butler clarifies the fact that the body is not a fact of nature, but, like gender and sex, it can be performatively re-inscribed in ways that accentuate its 'constructed-ness' rather than its existence. By eliminating sex/gender distinction, Butler argues that there is no sex that is not always already gender, and that the new 'subject', the one that is built, is characterised by subversive possibilities and agency. Lois McNay (1999) argues that we should overcome the negative connotation of agency suggested by current thinking that does not take into consideration the creative dimension of the subjects and explains the ways in which women and men negotiate changes within gender relations.

Although there has never been a sex/gender distinction in the way the design of a Maggie's Centre performs, both in terms of who produced it (Architect) and who uses it (User), the neutrality of the Architectural Brief is what guarantees this negotiation. The intricate structure of Maggie's Dundee's (2003) wooden ceiling reveals a hint of masculinity that solicits interest in men and balances out the emotional experience of the bright and warm kitchen traditionally found at those Maggie's Centres that are deemed to be feminine. The reasons behind this relate to objective facts (breast cancer was the earliest and most widespread type of cancer) and social and cultural conditions (women are more likely to be willing to open up and share). With the increasing amount of attention being paid to the 'men's group', the previous connotation has been, if not eliminated, at least assigned a more neutral nature, proving that interests are no longer connotated, as per this feminine testimony.

While I observe I realise that the many small beam do not run transversally to the main beams. I am also intrigued by the animal figures that appear in the wooden structure of the ceiling. (Fieldnotes Dundee, 24 September 2019, 2:30-3:30pm)

Regardless of the sex/gender distinction, at least in terms of the way a Maggie's Centre performs, two male participants said that the kitchen is the place where they feel they are the most in control. "And I just have some indulgency to that table. This kitchen, the oval counter, is 'our' table" (*Move-along Dundee no.2*). Indeed, in evoking atmospheres and feelings, the smell of food coming from the kitchen table does not make distinctions in sex/gender. "Architecture is not about form, it is about many other things. The light and the use, and the structure, and the shadow, the smell and so on" (Zumthor, 2013, para.2).

### III. Psychological Flexibility and Movement

In a Maggie's Centre, the movement is therefore the key element that allows for flexibility and connects architecture with psychological flexibility. In this continuous changing of backgrounds, in describing Maggie's flexibility, more important than the 'temporary' attribute is the 'motile' component that the theatrical scene of Maggie's Centre sets in motion on a daily basis. Everything inside the Maggie's Centre contributes to creating movement: the programme with the dynamic change of activities and the encouragement to 'do-it-yourself', the architecture with its forms and materiality that shape space and light, and the staff that, with the 'continuous rolling and unrolling of the carpet', modifies the space and keeps the visitors in action. In short, all three subjects of the Triad (Maggie's-Architect-Users) contribute to generating movement that fosters flexibility. Within the dynamic space, the continuous fluctuations represent for both the 'subject' (*people*) and the 'structure' (*place*) a series of physical and mental, conscious and unconscious perceptions which are what keep the human senses reactive and ready for the changes that Maggie's offers visitors. Overcoming the senses, the experiential field focuses on the body-brain link, but in order to maintain bodily movement, a more active form of vision is required (Merleau-Ponty 2012 [1945], p. 249). The dynamics enabled by spatiality must therefore provide that, in order to merge with space, the observer continuously changes perception according to the position of the body. The phenomenological space that facilitates movement and emotion, placing the individual at the centre of the experience, is key to understanding the link between the Maggie's Centre architecture and psychological flexibility.

No two peoples' cancer is the same. Everyone is different. Look to people's experiences the same, every experience is different, and we all handle them in different ways. But the Maggie's Centre, wherever that centre maybe, provides a

sanctuary. (...) If I just want to come in here, come upstairs or sit here and look outside the window, I can do that. (*Follow-up Dundee*)

Movement is not just a component of the spatial experience, but rather it becomes a generating principle. By engaging the individual in a dynamic built environment, the flexibility of Maggie's 'bodily connection with architecture' enables a personalised experience and a sense of identity, the exact opposite of the clinical, static, and passive condition of the cancer patient which manifests itself at the hospital. As Lesley Howells puts it:

What I have been observing, during my years of my talking, being in a Maggie's Centre, is that the same therapeutic changes can happen because of the way the building works. (*Howells, 01.11.2017*)

Understood as 'versatility' and 'adaptability', flexibility should be seen not as a passive movement of the scene, but rather as an active sequence of experiences. At Maggie's, everything contributes to feeling in control and empowering, and that's why the person with cancer says: "At Maggie's people are accepted at different stages of treatment. No embarrassment or expectations are needed". (*Focus group Oldham*)

## Chapter 7 - The Three Elements of a Therapeutic Environment

In the previous two chapters, I focused on the participants in my fieldwork and finally discovered the connection between design methodology and psychological flexibility as movement. With the ultimate goal of defining the Maggie's Centre as a therapeutic environment, in this chapter I will shift the focus from participants (*people*) to space (*place*) in order to explore the dynamic, multiple, and contradictory nature of Maggie's spatiality. Convinced by now that 'movement' is the key element that enables flexibility and links architecture to psychological flexibility, I want to find out what other possible clues I can use to define the Maggie's Centre as a therapeutic environment. In order to have a complete understanding, I begin by reviewing 'movement' as a form of externalising the concerns of the mind through body motility against a narrow frame of reference that looks at crucial moments in history, from Greek 'fluid' dance' to modern 'dance therapy'. On closer inspection I realise that these references all embody a multifaceted nature. Based on this, I return to the 'hybrid' in the form that was used by Charles Jencks to define the Maggie's Centre: "a hybrid of four types of buildings: a house that is not a house, a church that is not religious, a hospital that is not an institution, a place of art that is not a museum" (Jencks 2015b, p.7). By examining the 'ambiguity' and the 'transformation' of the hybrid, as well as the 'multiplicity' that characterises it, I discover that these attributes lead to psychological well-being. I can therefore confirm that the 'hybrid' is my second element in enabling the therapeutic environment of the Maggie's Centre.

But, as Maggie's therapeutic nature gradually finds an explanation, other questions arise. If the fact that the 'movement' helps to be 'flexible' and 'hybrid' is what defines the 'whole' in architecture, and if the Maggie's Centre as a 'flexible whole' is a 'therapeutic environment', then the latter should be the result of applying some kind of knowledge in this field. But what do Maggie's architects know about healing architecture? Were they chosen because they were all specialised in the design of a sanitary building? The answer is no. As we saw in the Introduction to this thesis, no architect of the twelve interviewed had any experience or knowledge of healing architecture. In fact, as Ivan Harbour says: "For an architect, the idea of being a specialist is really anathema: specialists know the answer, while architects don't want to know the answer but want to look for it together with the client" (Harbour, 20.7.2018). And not only does the architect refuse to think that this is a healing

architecture, but as we saw in Chapter 3 with the ‘breakdown’ that occurred during the interview with Laura Lee and Marcia Blakenham, even the Client-expert does not accept this interpretation. When she turns to an architect, Laura Lee certainly does not ask them to design a ‘therapeutic environment’, because she says “that would be awful and assumptive that ‘you need to be healed’ and ‘we are going to heal you in this environment’. I think that’s an arrogant concept” (*Lee, 18.05.2019*). And of course, even Charles Jencks never wanted to define this building as a place of healing, but rather, as already seen, as ‘many things’ together, a hybrid, in fact. By closing the circle, the paradoxical and enigmatic ‘non-therapeutic/therapeutic’ nature reveals itself as the third element that identifies the Maggie’s Centre as an effective therapeutic environment.

This chapter investigates the three concepts that define the properties of the therapeutic environment of the Maggie’s Centre: the ‘movement’ that links the architecture of the Maggie’s Centre to the psychological flexibility enabled in its users; the ‘hybrid’ characterised by multiplicity, ambiguity, and transformability; and the paradoxical ‘non-therapeutic/therapeutic’ condition, which generates therapeutic effects precisely because it is defined as non-therapeutic. Returning to the concepts of ‘flexibility’ and ‘normality’ discussed in Chapter 5, I show that the absence of the elements of healing architecture is the catalyst that makes people react to being inclined to a new condition of life and, as such, can be overhauled and reset. The claim of the absence of therapeutic qualities, in addition to being rightly invoked by Laura Lee, on the grounds that there is no scientific evidence that the Maggie’s Centre is a therapeutic environment, is part of well-calibrated tactics implemented simply by not placing “expectations on how people entering the door should feel” (*Lee, 18.05.2019*), and not cataloguing the organisation as a healing environment. However, the declaration of absence does not necessarily mean non-presence. As we saw in Chapter 5 in the section ‘What Buildings Do to People’, being therapeutic or non-therapeutic, understood as a psychological state, is not a condition that has recognisable signs in space, but is, rather, a condition that arises in each one of us. This chapter demonstrates how the dynamic, multifaceted – a house despite its ‘architecture of provocation’ (Jencks, 2015b) - and contradictory nature of the Maggie’s Centre can generate a therapeutic environment.

## I. Movement

As mentioned, what binds architecture to psychological flexibility is the ‘movement’ stimulated by the *flexibility* of the physical space (resulting from the application of the Architectural Brief to the architects’ design) together with Maggie’s support programme (based on the principles of psychological flexibility, openness, presence, and orientation).

One time, I came in to do the move-dance-feel class and I knew that I needed to do that class because, by the end of the class, my mood would have improved so much because I was doing that class, but in the process of doing it, I had to unwind my negativeness as it were. And everybody else could see that I wasn't in my normally cheerful mood; they just gave me the space to unwind myself and didn't force me to talk, didn't force me to do anything I didn't want to. So, they all understood. And it's the same in any activity or space in this building. Everybody understands that cancer is not straightforward, you can go forward, you can go backwards, you can go sideways. We all understand that, so we all are empathetic to the situation, whatever it is. And that's what's special about this building. It helps you to keep your balance in this dance. (*Move-along Barts no.5*).

This move-dance-feel experience at Maggie’s Barts that I also participated in, is what made me open my eyes to the fact that movement is what connects architecture to psychological flexibility. During this experience, by releasing thoughts and tensions that had until then been imprisoned in my body, my brain transmitted a state of flexibility to my body, making me relive the process of mental opening that takes place in a person with cancer. The dance movement performed in a favourable environment generates well-being by placing the internal world in continuity with the external world (Palumbo, 2011). In addition to recalling the individual body-mind unity, movement and dance tend towards a collective ritual and, in transmitting it to others, help to release the tension of the group simply by way of a chain reaction. Through this awareness, people, in addition to being able to communicate, become more receptive and mentally present, developing a greater interaction with themselves and with the environment surrounding them. In this passage, the mind undergoes a mutation that makes it possible not only to relate to the outside, but to feel the presence of others, to become empathic, leading people to have a strong sense of community (Cerruto, 2018). This fact demonstrates that the external environment affects people’s health and that body and mind are inextricably connected (Sternberg, 2009).

At this point in my research, the discovery of ‘movement’ as a form of the externalisation of the mind’s concerns via the motility of the body requires, or makes necessary, an integration of a historical-theoretical kind. In search of references in other

disciplines and historical eras, the following sections will examine cases of psychological flexibility triggered by body movement such as Greek mythological medicine, eurhythmics, choreutics and dance therapy. These disciplines, whose fulcrum is the human body, representing the embodied practice of movement, have shown that dance generates a state of psychological well-being with therapeutic effects on the mind and the spirit.

## Ia. Movement as a Therapeutic Practice, from the Greeks to Dance Therapy

Introduced in Chapter 2, and often returned to it in this thesis, the Greek Asclepius healing practice (V B.C. - IV A.D) constitutes a solid reference in the search for examples of psychological flexibility. As we have seen, Michael Kearney (2009) implies a ‘fluid’ dance that is generated by the experience enabled in the *Asclepion* that created a vibrant synergy between people and places. The term therapy, from the Greek *therapeia* (= service, attendance; healing cure), indicated for the Greek worshipers of Asclepius, not so much the medical treatment as an end in itself, but above all the participation in healing from suffering within a favourable environment. This combination of people and place generated a flexible psychological state in patients who in the struggle found harmony, balance, and personal development (Kearney, 2009). The adjective ‘therapeutic’ (Lexico, 2021a) thus designates a process of transformation and dance itself that, being vital energy, is therapeutic (Cerruto, 1994). As already evident in the synergy of movements performed around the Temple of Asclepius in pleasant and harmonious spaces by *therapeutes* and *invalids* (Kearney, 2009), the Greeks thought that through dance – which they considered a gift from the Gods – they could forget their pains and worries (Raso, 2004). For them, the rhythmic movement of the dance had a therapeutic power over the body and mind, because it awakened the life force that was in tune with the rhythms of the heart and breathing (Schott-Billman 2011).

Considered the rediscovery of “one of the secrets of Greek education” (Sadler, 1913, p. 11), at the beginning of the last century at the Hellerau Academy (which paved the way for the Bauhaus), Dalcroze’s ‘eurhythmics’ – a technique for teaching music through the rhythmic movement of the body – were considered particularly revolutionary. ‘Rhythmic gymnastics’, also called ‘eurhythmic’, emphasised the body and its movements by listening to the biological rhythm of one’s body. To help students be happier and more creative, Dalcroze explained that music is “coordination between the mind which conceives, the brain

which orders, the nerve which transmits and the muscle which executes” (Jaques-Dalcroze, 1913, p. 18). In this holistic process where the creative mind and emotional and nervous systems align, the key is to refer to the body’s natural rhythm. As Dalcroze also noted “the body can become a marvellous instrument of beauty and harmony when it vibrates in tune with the artistic imagination and collaborates with creative thought” (Jaques-Dalcroze, 1913, p.21). Thanks to Dalcroze and his artistic programme based on dance and music, today we can appreciate the role that body movements have in generating emotions and well-being. With the aim of creating a new and harmonious society through a careful education of the individual, the Hellerau experiment pioneered the application of the psychological and physiological knowledge of the time thanks to which we now know that our biological ‘rhythms’ can be triggered in generating human cooperation and individual happiness, and that the brain and nervous system are “a veritable symphony of varying rhythms that communicating through its frequencies” (Mallgrave, 2008, p.8).

The idea of the therapeutic value of dance was revised in America at the end of World War II, when it was introduced into psychiatric facilities. Together with doctors, psychologists, and psychiatrists, the dancers Trudi Schoop and Marian Chace (Cerruto, 2018) were devoted to helping people with mental disorders, demonstrating that dance could be an efficient means of communication for those who were unable to express themselves through verbal language. Through movement, the subject was able to overcome psychophysical blocks, giving free expression to imagination and thought, rediscovering contact with the outside world. Since then, movement has been considered essential for the development of communication and for a state of well-being. By moving out of isolation, movement also becomes more spontaneous and creative, and by way of improvisation, emotional and unconscious states emerge (Garcia, Plevin and Macagno, 2006).

## Ib. Choreutics, or Movement as Architecture

Physical movement is what gives meaning to architecture, because only through the motile experience of a built space can we establish spatial relationships with ourselves, with others, and with the objects that surround us (Samuel, 2010). Already defined by Le Corbusier as a *promenade architecturale*, the path in which the observer moves through the built space is central to the design of an architecture. Seen as the sequence of images that unfolds before the eyes of the observer, the *promenade* also creates a hierarchy among architectural events,

“a set of instructions for reading the work, the ‘internal circulatory system’ of architecture” (Samuel, 2010, p. 6).

Movement is, so to speak, living architecture – living in the sense of changing positions and changing cohesion. This architecture is created by human movements and is made up of paths that trace shapes in space, which we can call trace forms. A building can only stick together if its parts have definite proportions that provide a certain balance in the midst of the continuous vibrations and movements that occur in the material of which it is built (...) The living building of spatial forms that creates a body in motion it is related to certain spatial relationships. Such relationships exist between the individual parts of the sequence. Without a natural order within the sequence, the movement becomes unreal and dreamlike. (Laban, 1966 quoted in Foster, 1977, p.65)

This passage, taken from the book “The Influence of Rudolf Laban” by John Foster (1977) is an extract of the book “Choreutics” (1966) by Rudolf Laban (1879-1958), a Hungarian dancer and choreographer and an important modern dance theorist, establishes the analogy between human movement and architecture. For Laban, each movement creates a ‘trace form’, and each shape is created by the artificial separation of space generated by movement (Laban, 1966). Starting from this principle, space is never “empty space”, but it is what highlights the movement created and modified through a body in motion. The body thus becomes living architecture, created by human movement that develops a sequence of traces of ‘spatial forms’ (trace forms), which are those forms that are left in space by the movement itself. Space can only be understood if, in movement, the experience is always sequential (Sala, 2017).

Introduced in 1926 together with the more general meaning of choreology, choreutics investigates the interaction of the body with space and the harmony that is established between them. This harmony of movement is based on the golden rule that Laban refers to when he speaks of definite proportions. This perfect relationship that we find in nature is very important in the experience of architectural space. The idea that our eye compares height with width in a given body, automatically creating a relationship, has always been the greatest ambition in architecture. Hence, if space is in harmony, the body must also participate in this harmony. Laban considered the golden section as the dominant proportion between the different parts of a perfectly constructed human body, the same that over the centuries has coincided with the canon of beauty in man as well as in architecture (Foster, 1977).

According to the golden rule, Laban was strongly influenced by the ideas of balance and laws of forces. To think in terms of movement rather than in terms of body mechanics,

Laban uses terminology based on architectural principles. Referring to the three views of the representation of architectural drawing – plan and two elevations of a building – Laban imagines three possible perceptual experiences of movement in space: that of the person who moves immersed in the immaterial world of emotions and ideas (plan); that of the objective observer, from the outside (elevation 1); and that of the person who enjoys movement as a bodily experience and observes and explains it from this perspective (elevation 2) (Foster, 1977).

In the relationship between movement and architectural space, Laban shows a great interest in “discovering the unity of movement”, a fact “that existed in ancient times” (Laban and Ullmann 1960, p. 13). To arrive at this discovery, Laban refers to Gestalt psychology and, in particular, to Kurt Koffa (1886-1941) and Max Wertheimer (1880-1943) working in Germany in the 1920s. As Merleau-Ponty had already done for his concept of structure (1963 [1942]), Laban (1966) also refers to “the whole is greater than the sum of the parts” Gestalt motto (Bratton, 2015, p.191) to describe the overall vision of actions of a movement including the intellectual and physical components that constitute a unitary motor experience (Foster, 1977).

## Ic. The Body in Motion in Phenomenology

Man is alone in motion. Likewise, the world does not hold up. Being is only in motion, only in this way can all things be together. (Merleau-Ponty, 1960, p. 45).

According to Merleau-Ponty, in order for the body to perceive, it must move, because if it does not move, it cannot experience, and the world cannot appear. For a subject, which Husserl previously defined as ‘volitional’ and indistinguishable from his body, thought follows action, external stimulus follows movement. What drives the subject to move is the desire to cancel the distance between oneself and the world and the harmony between the different parts of the body – that is, the connection between desire and movement – is what allows the subject to move in space (Di Fazio, 2015). Hence, the body in motion is the basis for phenomenological thought. Exactly as for Laban’s space, in which movement generates ‘trace forms’, the movement of the body that moves in phenomenological space defines space. Motility, spatiality, and corporeality are aspects of a single action: space allows the movement of the body which in turn highlights the space. In particular, it is the ‘body scheme’, also defined as ‘postural scheme’, which makes evident the fusion between body,

spatiality, and motor skills (Hale, 2017). Only by considering the body in motion, therefore, can we understand how the body is in space, because “it is clearly in action that the spatiality of the body is brought about, and the analysis of movement itself should allow us to understand spatiality better” (Merleau-Ponty 2012 [1945], p.105). The perception we have of our body is the one with us, hence, the experience, even the motor one, is immediate: there is no mediation between us and our body. We move with our body, but we don’t see the movement. Yet, our perception of the world comes from the body in motion, particularly from our eyes. (Merleau-Ponty 2012 [1945], p.147). The body in motion, inseparable from mind and soul, before being a natural modality of relationship with the world, is configured as an experiential communication modality. The movements of the body project their meaning outside, forming a continuous correspondence with it (Di Fazio, 2015).

By moving, the body explores itself and at the same time explores the *extreme de hors* (Husserl, 2012 [1901]), projecting its interior towards the outside. In movement, the body registers itself in the world and interacts with others, giving meaning to its existence through which it communicates will and desires. Movement is thus enriched with emotional expressions and allows the transmission and reception of intentional messages that the subject is able to emit and perceive (Di Fazio, 2015).

Our body, rather, is the origin of all the others, it is the very movement of expression, it projects significations on the outside by giving them a place and sees to it that they begin to exist as things, beneath our hands and before our eyes. (...) The body is our general means of having the world. (Merleau-Ponty 2012 [1945], p.147)

For a long time the “dance of the people in the world” (Mugerauer 1994, p.10) was not a real dance, rather it was a “march” of the “reason” that had marched triumphantly and that, over time, through evolution and progress, led to today’s scientific, technological, cybernetic, and logistic movement. As Mugerauer (1994) states, this violent and forced march had suppressed “the dance that was being danced” (1994, p.10). From the Greeks onwards, the dance composed of ‘people’ and ‘world’ has been forgotten, and if a new dance is able to move it will be a revitalised form of the old rhythm. A crucial part of the dance is in fact its movement, its reaction against the opposite: against a ‘reason’ that has tried to stop it and continually tries to do so. From within the movement of this old dance, the opposite can still be seen as a passing partner or challenge, challenging and provoking us. This dance now takes place in our landscapes, buildings, and poems. Or, as said, in the ‘architecture of provocation’ of the Maggie’s Centre (Jencks, 2015b). A movement that could last or run out (Mugerauer, 1994). It is a challenge that we should take up.

## II. Hybrid

As already mentioned, Charles Jencks identifies the Maggie's Centre as a hybrid made up of the opposite of four types (hospital, home, museum, and church). In Jencks's opinion, this nature gives the building a power, a 'hybrid' one, which enhances its architectural richness and human values. In scientific and social disciplines (biology, sociology, anthropology), from Mendel (1822-1884) onwards, the meaning of hybrid was almost always negative because it was linked to the idea of "something that is a mixture of two very different things" (Cambridge Dictionary, 2021f), hence as a "crossing, mixing, interbreeding", often with a monstrous connotation, of beings hardly compatible with each other. In the architectural field, the combination of multiple functions within a single structure is a strategy that has been repeated throughout history. The house above the shop, the apartment above the bridge, and the Roman baths, which include many functions, are all examples of the tradition of combining two or more uses within the walls of a single building (Avitabile, 2013). Unlike multifunctional buildings (airports, shopping malls, etc.), hybrid buildings present an interaction between functions necessary for the life of the other that cultivates a mutual alliance (Fenton, 1985). Indeed, the hybrid is mixture, contamination, and ambiguity. Introducing these concepts, but also those of instability and heterogeneity, starting from the 1960s, Venturi stated as follows:

I love elements that are hybrid rather than pure, those of compromise rather than clean ones, twisted rather than straight, ambiguous rather than articulated, corrupted rather than anonymous, boring rather than interesting, conventional rather than designed, accommodating rather than exclusive, redundant rather than simple, traditional as well as innovative, inconsistent and equivocal rather than clear and direct. (...) I am for the richness rather than for the clarity of meaning (...) I prefer this and the other to this or the other. (Venturi 1980, p. 84)

Although Fenton wrote, in 1985, that the hybrid building had never been catalogued before since it remained hidden in the body of historical, chronological, formal, and stylistic inquiries, in that same year, Charles Jencks argued that, despite being difficult to reach, the hybrid has always been evident in the past and linked to ornament, symbolism, craftsmanship, polychromies, and metaphor (Jencks, 1985). The postmodern experience of the 1980s used the hybrid to work by contamination, promoting new ways of interpreting space and architectural language (Calanca, 1991). The hybrid has always tried to re-emerge in the various artistic, literary, musical, and architectural disciplines, depending on the cultural wave of the moment, assuming a positive meaning and a sense of openness towards

a multiple, necessary, intriguing horizon (Avitabile, 2013). Nowadays, reproposing the hybrid would mean “a return to architecture as a balanced and pleasant art” (Jencks 1985, p. 8).

## IIa. Ambiguity and Transformation

One of the fundamental conditions of hybrid power is ambiguity. The hybrid, revealing its multiple nature, allows a simultaneity of different realities which are sometimes hard to classify, categorise, and describe (Avitabile, 2013). The term ‘ambiguity’ (from the Latin *ambiguus*) indicates a lack of clarity that derives from the potential double meaning of an element (Cambridge Dictionary, 2021g). In the artistic field, ambiguity is an intrinsic and innate characteristic of the aesthetic representation itself. In the *Poetics* (334-330 B.C., Chap.1) Aristotle tells us that every art is mimetic and makes use of other arts, separately or in combination. No work of art releases aesthetic information if it does not associate unknown and unexpected elements. Ambiguity, therefore, is identified with the very concept of art and, as such becomes not only a function but also a condition of aesthetic production hence of enjoyment (Calanca, 1991, p. 35). It can therefore be said that the word ‘ambiguity’ refers to ‘imprecise’, ‘indefinite’, ‘vague’, which in itself is intricate and stimulates curiosity. In fact, the adjective ‘vague’ (from the Latin *vagus* = to wander, stroll) implies and pushes towards movement, wandering, the interchangeability of continuous space. From the interview with Ivan Harbour (Rogers, Stirck, Harbour + Partners), it emerged that by asking for an indefinite and vague space, the Architectural Brief and the Client-expert ask for movement.

What I got from Laura and Marcia Blakenham was the spatial experience. They wanted the ability to find space within a larger space, which in itself also an extended experience. (...) Actually, I can say all of the decisions that we took were based upon having an idea of continuity undispersed with a sort of evolving experience. (*Harbour, 20.07.2018*)

The concept of hybrid is also linked to the term transformation, within which dynamic relationships and balances are recognised that readjust each time (Calanca, 1991). At Maggie’s Centres, these dynamic processes are related to the flexibility of space and the adaptation of functions to it. The four “non-types” (Jencks 2015b, p.28), or rather the four faces of the hybrid of Maggie’s Centres intervene simultaneously or one at a time,

transforming themselves, manifesting themselves more or less evidently to people, depending on the moment experienced by the individual, and the adaptation to one's feelings.

In the case of the transformation processes, Arnheim (1977) refers to "enharmonic modulation", which in music is:

the almost imperceptible shift from one key to another, in the course of which certain tones act as bridges by fulfilling different functions in the two keys and thereby display a double allegiance. The transitional moment generates a slight sensation of seasickness, unwelcome or exhilarating depending on the listener's disposition, because the frame of reference is temporarily lost. (Arnheim 1977, pp. 167-168)

Indeed, in music, particularly in Richard Wagner, this device (including the transitional phase of disorientation) is considered an effective stylistic means of expressing liberation from absolute standards. Although the comparison with music may be questionable because a building is configured as an architectural entity as a whole, and not a sequential event such as a sonata, the spatial experience is undoubtedly a sequential perception, to be considered also as a spatial metaphor for the relativistic view of the world (Calanca, 1991).

After a moment of bewilderment, due to the indefinite, changing, compelling space, Maggie's visitors find their balance in the new context, surprising themselves by the standards to which they adapted in the past, for example in the hospital. Although initially they can create confusion and disorientation, the spaces of the hybrid induce, in the following moment, a feeling of well-being and the start of the therapeutic process. Ambiguity, integration, transformation, and exchange of the parts that come into contact give sensations of spatiality, increasing the taxonomy of feelings. In a world where today's technologies dominate and control us, it is interesting to observe how the approximation and non-definition of the boundaries of spaces are unconsciously appreciated by people, becoming a way to choose, stand out, and be free.

Sometimes, it's kind of scary when you come in, I never saw a building like this before. But, after a while, you feel proud of it, it is so special." "When I first came in, I did not know where to go or what to do. After sitting there for a while, I was looking around and felt really contained. I don't know, it was the environment with bright light coming through a huge glass downstairs and then they made me feel at home in certain areas like the table, the kitchen area. And you could sit in different places where you felt like it; if you wanted to be on your own, you could go by the door - which I did - or talk to someone. And it just made me feel safe. (*Focus group Barts*)

Using the concept of 'hybrid' to define the holistic and all-encompassing nature of the Maggie's Centre, confirming once and for all Charles Jencks's definition, means first of all underlining the non-defining nature of the space. It is complex and contradictory, because it must have open and closed spaces, be welcoming and informal like a home, but clear and discreet in order not to impose itself or, in some points, even provocative. This skilful interweaving of open and semi-open spaces has the important function for Maggie's staff of maintaining direct contact with the visitors (Jencks, 2018). Thanks to this spatial condition, in fact, Maggie's staff can do their job and at the same time control everything that happens in the building. The use of the concept of 'hybrid' is also appropriate for the staff who, coming from different worlds and with multiple tasks assigned, have different skills. When they were nurses, the staff members could not perform other roles; at Maggie's the first thing they learn to do is offer 'a cup of tea'. Finally, the use of the concept of 'hybrid' strengthens the support programme, equally hybrid but tailored for 'normal' people which, ambiguously, triggers the therapeutic process. Maggie's Centres reveal a new polysemic architectural identity, in continuous evolution, never completed, in which the new functions are articulated, and which should enter the world of healthcare by right.

## I**b**. Hybrids that Evolve

The concept of the evolution of a model in architecture can be compared to the musical technique of the "variation on a theme" dating back to Ancient Greece. Often extended to literary and figurative works as well, the meaning of variation on a theme oscillates from digression to wandering on a topic, while in architecture it coincides with the reworking of a model that changes to adapt to new situations. In the book "The Variations of Identity-Type in Architecture", Carlos Martí Aris, in considering variation a typological procedure, legitimises the transformation and development of a given theme as a fundamental principle of configuration. Without repetition it is difficult to speak of type, but this cannot generate repetitions without difference (Martí Aris, 1996). Yago Bonet states that "every place is sacred because it is unique in relation to the universe" (2000, p. 53). Hence, architecture, when it undertakes the construction of a place, deduces its specific characteristics from it. For example, the monastery complex, in particular the Benedictine one, a hybrid of many functions, developed multiple formal solutions to propagate religion on the basis of the same typological structure of the courtyard (the cloister) and the 'Rule' (the programme). These

multiple formal solutions have been the expression of the necessary adaptations of the building to the geographical, social, and cultural conditions of the place, as well as of the changes and traditions acquired over time. A famous example of the adaptation of the monastic typology is the convent of La Tourette (1960) designed by Le Corbusier. By adopting the Brutalist language, the French-Swiss architect was able to embody and reinterpret the essence of the original spiritual precedent. What, in this centennial transfer process of the convent has never changed, and has been a constant until today, is the ‘void’ inside the building, the squared cloister (Zucchi, 1989). Inside the convent, the cloister represents the heart, the meeting point for prayer and socialisation to which the various functions (library, church, refectory, rooms) surrounding it all converge. The fact that the square cloister has remained unchanged since its origins is proof of the strength of the type. By being a paradigm, the cloister represents, in the transformation of the typology, the matrix, the constant element around which the type transforms. In particular, in its transformation, the convent represents an example that embodies both the hybrid nature of the religious building and the evolution of the courtyard type, which not only generated hundreds of convents, abbeys, and monasteries for charitable, artistic, social, and religious purposes, but also influenced other categories of buildings, such as the Renaissance palace, the hospital, the prison, and modern social housing.

Other examples of hybrid buildings that have evolved over time to become paradigms are the house-workshop of the medieval lot of the European city and the inhabited bridge. The first is an example that crosses the course of history and reaches, through various transformations, up to the present day; the second combines the structure of the intersection with the domestic typology, becoming a space for relations between public and private (Murray 1996, p. 22). Typologies thus intersect with each other, favouring the proliferation of variants and combinations in which different realities come to terms with one another and intertwine. I am not referring so much to the form here, but rather to the functional, cultural, and social programme. To grasp the true meaning of typology it is therefore necessary to take the broadest possible vision, considering the term ‘type’ as a ‘paradigm’, or rather as a model or framework that creates a world-view favouring indeterminacy and heterogeneity (Avitabile, 2013).

### III. Non-Therapeutic / Therapeutic

If we think of the healing architecture of Greek temples, Maggie's Centres contain all the ingredients of a therapeutic space: the splendid architecture, the glimpses of nature, the presence of professionals who provide care in synergy with the building, the multiple functions, the openness to family members, the message that the 'mind is as important as the body'. Despite containing all the ingredients of the *therapeutikós* space, Maggie's Centres show no signs of the therapeutic environment typical of modern healthcare. Non-clinical, small in size, with a quiet, pleasant, calming atmosphere, Maggie's Centres release very different feelings from those of the hospital environment. In fact, the first thing visitors notice at Maggie's is the absence of signs of sanitary architecture to the point that the curious passing by enter the building, attracted by the kitchen often visible from the outside, as already mentioned, thinking it is a restaurant or a cafe.

From the moment they walk in, simply by sitting down and looking at the space while having a cup of tea, patients say they feel better and cannot explain why. Immersed in an atmosphere that completely envelops them and makes them feel part of a whole, one of my participants said:

What I like about the building, when you first come in, is that it just wraps you around. I like the space and the way people can be stimulated through their senses and mind. (*Move-along Barts no.4*)

In addition to the absence of signs of any kind reminding visitors that the centre is like a home, even in the dissemination of the programme there is a very limited use of the written word. For example, as we have seen, the brochure that simply says "Just come in" is a way to let people enter the centre where they will receive information only by voice, directly from the staff. As I mentioned in the Introduction, having already abandoned the suffix "Cancer Care", the organisation has also eliminated that of "Centre". Consequently, when they say they go to "Maggie's", visitors are often misinterpreted, and those who are not familiar with the place might think they are referring to a nightclub or a gym. Yet, rather strangely, ambiguity helps people to feel normal.

As for its hybrid nature, the Maggie's Centre releases the contradictory and enigmatic character of a therapeutic and at the same time non-therapeutic environment. Could this contradiction constitute the third element that enables therapeutic well-being in people? And to whom does the therapeutic condition belong, to the building or to the people?

Sometimes, like today, we are the only ones in here and nobody else. And it's a nice space to be in, in a holistic sense. It's a nice building to be in and the people who are in it bring it to life. So, without people this building doesn't mean much". Is it true that nice buildings make nice people? "I would say a nasty building doesn't help, it's an extra challenge to cope with, while a nice building enables better things to happen, or things to happen in better ways if you're in a better building. Especially if that better building is well designed or thought through, and not jarring. (*Move-along Barts no.5*)

"Architecture without people becomes sculpture" (Alvaro Siza, quoted in Berger and Gepshtein, 2020, 8:40). Understood as a psychological state, being therapeutic or non-therapeutic is not a condition of the space, but rather a subjective condition and, therefore, only in the presence of people can this property be attributed to the environment. The experience of a therapeutic environment is inscribed and persists in people in various ways. To generate this experience, paradoxically, Maggie's uses psychological tactics and devices using the concept of 'absence' rather than 'presence'. In addition to the lack, as already seen, of words and signs written in the building, the absence of the term 'therapeutic' in the language of both the building and the people helps divert attention from the cancer. Paradoxically, by not using the term therapeutic a therapeutic effect is generated.

### IIIa. Absence of Signs of Sanitary Architecture

As already explained in the Introduction (p. 17), in this thesis the term 'sanitary' is used to refer to conditions affecting hygiene and health, finding its roots in the Latin term *sanus* (healthy) (Glosbe Dictionary, 2021). In this perspective, the sanitary architecture is that which deals with the health of the body; however, as Foucault (1969) observed, the 'clinic', as it was conceived from the end of the eighteenth century to the end of the twentieth century, is based on the relationship with the patient's body, but not with his/her person. Although Merleau-Ponty (2012 [1945]) predicted long ago that the body and the mind are one and work together in the perception of reality, when the disease occurs, the perception we have of our body as the incarnation of the mind changes. Recognising a weakness of the flesh towards the mind (and conscience), the sick go back to seeing their body as an aggregate of organs which, referring to the old division between body and soul, splits from their own conscience (Di Fazio, 2015). In a hospital, this condition places the patient in an inferior condition. The process of change that takes place in a Maggie's Centre begins at this stage: the patient is invited to feel that they are no longer a patient but rather a 'normal' person.

As mentioned, in a warm, domestic environment, neuroscientists (Gallese, 2006) also explain how empathy achieves higher rates of outcomes when implemented outside the hospital, in a normal setting. At Maggie's, during this "emotional imitation" practice, by imitating others, people begin to feel normal. The scenography made up of bright colours, soft chairs, good smells combined with the choreography or better yet the 'choreutics' of Maggie's created by the slow movement of people walking quietly and talking calmly, all together contribute to generating comfort and well-being. Within this sensory environment, art and objects of design play a decisive role in distracting and offering normality. Within normality, the presence of beauty combined with the absence of the sign of sanitary architecture make a fundamental contribution to the psychological support of people. As the staff say, at Maggie's, wherever they look, visitors will always find something beautiful they see that can generate pleasure and will also help them to open up even in difficult conversations.

### IIIb. The Enigma of the Obvious

Borrowing the title from Armezzani (2019), this section highlights how Maggie's visitors, as mentioned above, have full freedom of choice, action, and speech. As Laura Lee says of the 'non-therapeutic' space, one of the things that architecture has been able to offer at Maggie's is to provide the opposite things that cancer patients in the hospital setting often talk about, to feel helpless and hopeless, feeling lonely and isolated and feeling out of control. The building is designed to make people feel responsible by telling them that "this is their place", a unique way of helping people connect with each other.

When they cross the threshold, people with cancer can decide whether or not to accept the help of the staff. Within a space that instils safety, normality and control, visitors are able to face the change process at their own pace. Unregistered, visitors are free to act as if they were at home: they can access any part of the building, participate or not participate in group activities, decide to be alone in a corner without talking to anyone, or stay in the company of other visitors. Given its hybrid nature, everyone is free to consider the Maggie's Centre as they wish: a 'home away from home', a spiritual place, a place to receive psychological, practical, or lifestyle support, a pleasant place where they can meet new friends and laugh or cry together with them. By doing the opposite of the obvious, allowing people to choose, to move freely, and open up without hesitation, Maggie's strategically

offers freedom and gives people a sense of identity and belonging to that place as well as a strong sense of value.

The flexibility of the physical space coincides with that of the support programme offered by Maggie's. To satisfy all the activities foreseen in the programme, during the day the staff constantly move the furniture and the space adapts to the new provisions to allow for a different use each time. By offering flexibility and versatility, Maggie's buildings urge people to adapt easily and thus become more flexible as well. The flexibility of the space also lies in the fact that the building, as mentioned, has no secrets, and nothing hidden happens behind the doors which, instead of closing, slide or rotate because, in this way, they can always "be left a little open" (*Harbour, 20.07.2018*). Thanks to the way the building is designed, many confidential conversations can take place comfortably in the same room and people feel comfortable that what they say will remain within Maggie's. By doing the opposite of the obvious, which is that the building is versatile, and the staff is always available, this strategic flexibility earns the trust of people who become willing to share experiences and emotions.

At the basis of everything, there is the invitation to normality, that is, to no longer feel like a patient in a hospital, to feel like a normal person instead. When they enter the hospital as people who are sick, they are patients and behave accordingly. Moreover, given the new vulnerable condition, the family very often sees the person with cancer as someone who is no longer 'normal'. When they arrive at Maggie's, people stop acting like patients and suddenly go back to normal. This happens because both the staff and the building remind them who they are (*Centre Head Barts*). As we saw in Chapter 5, this practice of 'normalisation' is evident in several aspects of Maggie's programme: from sitting in isolation to reading a book, just like at home, to sharing touching stories around the kitchen table, participating in physical activities that for people with cancer are sometimes difficult, a challenge to being able to feel normal. By doing the opposite of the obvious, that is, by treating people not as though they were sick, but encouraging them to behave normally, this strategic normality practiced in a normal environment helps cancer patients feel normal again.

The technique of the opposite of the obvious can be found in psychology under the name of Reverse Psychology. This strategy is used to get people to do or say something by telling them the opposite of what you want them to achieve. In today's healthcare, freedom, flexibility, and normality certainly do not characterise a therapeutic environment; on the contrary, since all of these characteristics are inherent to Maggie's, users claim to experience

beneficial effects typical of a therapeutic environment. Whether or not intentionally, with her intuition to declare that the Maggie's Centre is not a therapeutic environment, leaving openness and freedom to any interpretation, Laura Lee applies one of the most effective persuasion techniques and cognitive modalities. In phenomenology, intuition is considered a knowledge methodology that involves openness, questioning, and taking nothing for granted. In fact, one cannot speak of a true reality and a false one, it is simply a matter of comparing two points of view, two perspectives. This methodology has no certainties and knowledge must always be questioned and always renewed (Armezzani, 2019, pp. 2-3).

But, in a sense, because we are not trying to theorise and to put assumptions on how the person coming into the door must feel, it means there is freedom in our Brief and how we work with the architect to allow for the person to find their own way; in a way it is a bit like our programme gives support, is about the best way for them, because everybody has a different set of stuff going on. For some people seeing the sky might be too overwhelming or too much sky. (*Lee 18.05.2019*)

Not only does Laura Lee have the attitude that says “one cannot speak of a true and a false reality” (Armezzani, 2019, p. 20), denoting phenomenological knowledge, but the Maggie's Centre also takes nothing for granted. The phenomena that occur in a Maggie's Centre are based on evidence: they are not facts that arise, but facts that are experienced and always subjectively so. If we substitute the criterion of evidence for objectivity, we can accept that anything appears differently to different subjects. Starting from this assumption, obviousness cannot be taken for granted and the obvious can therefore be enigmatic. This way of looking at the world undermines what we have always been used to (Armezzani, 2019, p. 7).

The soothing, encouraging, uplifting, and poor communication conditions themselves are the expression of an effective healing action of the building that induces people with cancer to tolerate what was previously intolerable. The hybrid, paradoxical, and contradictory nature of the Maggie's Centre is revealed within the scenography of the Maggie's Centre, and the continuous changing of the backdrops. The non-home house, the non-institutional collective hospital, the non-religious church, the non-museum art gallery are combinations of functions that make Maggie's enigmatic nature an effective therapeutic tool.

## IV. How Flexibility Enables the Therapeutic. A ‘Universal’ Definition

This chapter has revealed the three elements inherent in the environment of the Maggie’s Centre concluding that ‘movement’, ‘hybrid’, and ‘non-therapeutic-therapeutic’ condition are essential components of the spatial experience in order to produce therapeutic effects in Maggie’s users. Ultimately discovered in the coexistence of the three elements, the concept of ‘therapeutic’ is what characterises the phenomenological field or the space of experience that makes us say “I don’t know what it is”. As we have seen, according to Merleau-Ponty (2012[1945]), the space of experience is one in which we are not disembodied subjects from the objects that surround us, but rather beings who dwell in space, from which our experience is generated. At Maggie’s the spatial experience, positive and placed in a holistic context devoid of signs of sanitary architecture, generates a synergy between people and place, a ‘fluid dance’, that enables psychological flexibility to give rise to an engaging environment that we could define as therapeutic. As we have seen, since ‘therapeutic’ is not an attribute inherent in space, but a condition that arises in each of us, ‘therapeutic’ is the ‘flexibility’ of our mental condition.

As already explained by Lesley Howells (2016, 2017, 2018) and as I have shown in this thesis, the psychological support offered by Maggie’s invites people with cancer, family and friends to move with whatever is happening in their life, to actually find the peace of mind in terms of who they are. Since as Viktor Frankl says, we cannot control what happens in our life, we just have to control our mind and how we respond to it. By creating the architectural and social conditions to “shake” (Howells, 2018) people’s minds and move with reality rather than fight against it, Maggie’s offers to choose something that humans don’t normally do, that is inviting people to live their lives with the idea of impermanence, uncertainty and not knowing what the future holds. Accompanying the three steps of Psychological Flexibility therapy (Be-present, Open-up, Find-your-Values), the architecture of the Maggie’s Centre provides a common background that brings people who face their struggle together. Between the architectural stimulus and the life uncertainty, a moment of ‘pause’ is needed and at the entry door, the building asks people to pause and dwell on the present, and to consider the choices that Maggie’s presents to them. By regaining control, people can access the ‘many things’ that Maggie’s hybrid space offers and help people to choose. Opening up to the conversation with the idea of not hiding and with the ability to accept to share with others and to face the challenge of cancer, the kitchen table allows

individuals to share their values and rethink the narrative of life, each to their own, and to rewrite it by cultivating the idea a common future. Linked to psychological concepts such as choice, control, responding to individual differences, Maggie's synergy between people and place, enables Psychological Flexibility in people.

After the ramification of the concepts that this thesis has explored, this chapter comes to an end by bringing together the three elements (movement, hybrid, non-therapeutic) in a single concept. Inherent in all of them, *flexibility* is what 'universally' defines the therapeutic environment.

*Flexibility* can be illustrated, as for the Greeks, as a 'fluid dance'. In connection with the space, through flows, releases and round lines the flexibility of the dancer, made up of thought, expression and action, externally joins that of the others forming a harmony of movements (Cerruto, 2018). Within Maggie's *flexibility*, people's minds flex together like reeds moved by the wind. In architecture the feeling of mental flexibility is described with the concept of 'aura'. The *Aura*, a nymph from Greek mythology that means 'breeze of wind', transmits the impact of a person, thing, or place from a distance (Lexico, 2021b). As described by Walter Benjamin in his essay "The Work of Art in the Age of Mechanical Reproduction" (1935), 'aura' or "uniqueness of an object of art" is "its presence in time and space (...) the unique phenomenon of a distance, however close it may be" (Benjamin, 1935, pp. 3, 5).

What was not evident in the basic study of my research (Chapter 4) was that 'movement', the first of the three elements that generate a therapeutic environment, was central to Maggie's architectural space. Analysing the spatiality of the three Maggie's Centres of my fieldwork, and returning to the Architectural Brief, I realised that 'movement' was implicit in every request of the Brief and was the key element that binds architecture to psychological flexibility. What becomes clear from the analysis of the fieldwork data is that since they are all designed according to the Architectural Brief, all centres have 'movement' in common, so they release the same feelings. By framing the data through my theoretical references of flexibility, reflexivity, and performativity, I then verified that flexibility, the intrinsic movement of Maggie's triggered by the Architectural Brief and enabled by the Triad (Maggie's-Architect-Users), becomes the generating principle that encourages people to be 'active' and not 'passive'. Only by incorporating the motile dimension of the space, Maggie's phenomenological 'synergy between people and place' can be effective in the constitution of a therapeutic environment.

Inherent in the Maggie's Centre, enhancing its architectural richness and human values, the second element that generates a therapeutic environment, the 'hybrid' was already evident in the basic study (Chapter 4), but not much appreciated by Maggie's, with the exception of Charles Jencks. In fact, the 'power of the hybrid' has been theorised by Charles Jencks since 1985, while it is very little considered by Laura Lee, and during my interview with the Client-expert I realised that it was overlooked by Marcia Blakenham who was not aware of this concept. This fact made me more curious to investigate. Implying "complexity and contradiction" - which is the title of the book by Robert Venturi (1980) who also theorised the hybrid - the Maggie's Centre allows for open interpretation. By being multiple, open, flexible, the hybrid proved to be fundamental to support the spatial experience generated by Maggie's experiential field in which people will always find the most suitable space for them. Finally, the hybrid also turned out to be transformative. This new dimension has led me to see the hybrid as a type that proliferates and evolves, as in music, in the 'variation on a theme', a tradition that dates back to ancient Greece. In this regard, the historical reference to the Asclepius healing holistic complex, already evident in the basic study (Chapter 4), turned out to be a new significant example of proliferation and evolution also in terms of flexibility.

Not so evident in the basic study (Chapter 4), contained somehow in the concept of 'normality' and in those qualities that define the Architectural Brief as contradictory and enigmatic, finally, the third element that generates a therapeutic environment, the 'therapeutic / non-therapeutic' constituted for me a real discovery that was added to the basic study. Born from what I considered a 'breakdown' occurred during the interview with the Client-expert - i.e. Laura Lee does not consider Maggie's a therapeutic environment - which at first discouraged me, this breakdown then prompted me to use it to my advantage, discovering it as the proper interpretation of the Maggie's Centre. By telling people that they are not in a healing place, people do not feel like a patient and react accordingly. Within healthcare, as the extreme opposite of the passive conditions of the cancer patient and aseptic conditions of the hospital environment, Maggie's stands out for everything that can be the opposite: its unconventional architecture with a dynamic space, a hybrid nature, free of clinical signs, and with a domestic atmosphere at the same time provocative. By engaging visitors in a moving, multiple and enigmatic space, the architecture allows for an embodied experience, and it all contributes to feeling in control and normal which is why the person with cancer says: "When I am at Maggie's I don't feel in the hospital, I don't feel like a patient" (*Focus group Oldham*).

## Chapter 8 - Maggie's as a Paradigm and the Future of the Architecture of Care

The physical context that surrounds us plays an important role in the way we experience our life. In particular, when disease occurs, we realise how important architecture is in order to facilitate the physical and psychological well-being of people, especially those who are experiencing traumatic transitions and need a therapeutic environment (Howells, 2018). Supported by the theoretical sources that emerged along the way, the chapters of this thesis progressively investigate the concept of 'therapeutic' in the case study of Maggie's Centres in order to identify the conditions that define an example of architecture as a therapeutic environment, and afford the term 'therapeutic' a 'universal' definition. Initially taken for granted based on the fact that a Maggie's Centre is a healthcare facility, and later researched in three centres where, according to Howells, a therapeutic space is enabled by the "synergy between people and place" that improves a person's psychological flexibility, the concept of 'therapeutic' was finally found in the coexistence of the three elements of 'movement' of spatiality, 'hybrid' of functionality and, above all, 'non-therapeutic' which generates therapeutic effects precisely because of the paradoxical contradiction. After widening the ramifications, the previous chapter of this thesis narrowed the 'universal' definition of the term 'therapeutic' into the single and summarising concept of *Flexibility*.

Having concluded that the Maggie's Centre is a therapeutic space of which its essence is *flexibility* – and having seen what generates it, what it consists of, and where it occurs – when we say we want to affect people's well-being, questions arise about what exactly this means outside the Maggie's Centre. What is the therapeutic space for users who attend other healthcare facilities? Is there a non-sanitary architectural modality that architects can adopt in order to design other healing structures? Should the large number of centres (and the fact that they have proliferated so quickly) remind the clients of other healthcare realities to look at Maggie's as a model? Can the *flexibility* of a therapeutic environment be applied to other types of facilities and architecture in general? In short, can the Maggie's Centre become a paradigm, an example to be imitated?

In asking myself how to conclude my research and think about a new paradigm based on Maggie's, in order to pursue Charles Jencks's will or some architects' suggestions, I propose to extend Maggie's model to the context of other chronic healthcare facilities such as dementia centres, small psychiatric wards, multiple sclerosis centres, and also, as

suggested by one Maggie's architect, in specific units within large hospitals in which to plant the seed of the Maggie's Centre. However, I propose that we consider other facilities as well, such as care homes for elderly people, nursery schools and kindergartens, and some types of educational facilities for people with special needs where offering flexibility would help to respond effectively to the variegated conformation of these particular social environments.

In healthcare, as mentioned in the Introduction, nowadays, in Great Britain, the cancer diagnosis rate has increased significantly; at the same time, however, science has made great progress that allows for a longer disease course and a higher survival rate. "With new diagnoses rising by 3% each year there is a growing need for Maggie's Centres and evidence-based support they offer people during diagnosis, treatment and survivorship" (Maggie's Evidence, 2015, p.1). In addition to the fact that every hospital should have a Maggie's Centre, Charles Jencks, who also died of cancer on 7.10.2019, would have wanted all chronic diseases (dementia, diabetes, heart disease, obesity, strokes, and multiple sclerosis) (Jencks, 2017) to have a structure similar to the Maggie's Centre, while remaining independent from the hospital.

My hope is that hospitals will evolve in a direction that incorporates these kinds of centres but doesn't swallow them - they should be administratively and culturally separate. We hope to have a Maggie's Centre at every single big cancer hospital, developing them one by one. We are complementary to them -yin and yang. (Jencks, 2015a, para. 23)

Within the National Health Service (NHS), this process has started to be influential as concerns the cancer environment, finally focusing more on the patient. Because many other diseases are now becoming chronic, and people are surviving through their illness, the NHS and other key stakeholders have understood that the new generations of hospitals and supportive structures will need more structures to host chronic or semi-chronic patients. By interviewing Maggie's architects, I also found out that the experience of designing a Maggie's Centre has been helpful to other projects going on in their office (either medical or non-medical structures), with two goals in mind: making their Maggie's Centre so they benefit the NHS, and making other projects, hence, benefiting other buildings; and, ultimately, benefiting the clients who will encourage other projects or other clients in the future.

So, our projects through the office have influenced the clients and the clients then start to say: let's improve things. This is a remarkable model of influence. And all she did was to say 'we'll build this tiny little thing, this tiny... little seed. And that

little seed, which has already influenced the architects and the clients, will grow and change the world (*Page, 01.10.2018*)

Based on this premise, as a key building, can we safely say that the Maggie's Centre is becoming a new paradigm?

Even though it may not have been intended as an archetype, as a model that others would later follow, the Edinburgh Maggie's Centre represented a pivotal moment. The result was a building that has deeply affected and influenced every architect of every subsequent centre, which set the tone and the fundamental conception of the buildings that came in its wake. (Jencks and Heathcote, 2010, p. 31)

By analysing the definition of 'paradigm' and its components, the first section of this chapter seeks to provide a reference to my attempt to elect the Maggie's Centre as a paradigm. Going back and listening again to the interviews with architects, client-experts, and users, the central section of the chapter puts forward the idea for a new paradigm of the 'Commissioning of Architecture'. Based on a) Maggie's Therapeutic environment as a unique product of the 'Client-Expert-Architect-Users' Triad, and b) the concept of archetype contemplated by Healthcare Architecture to be reiterated within the hospital environment, what I wish to promote here is the sustainability of the proposal, addressing Maggie's model to potential interested parties, each from their own point of view (Clients, Architects, Users). The section continues by reporting: a) the suggestions put forward by the Client-Expert for potential new Clients; b) the emotional involvement of Maggie's Architects; c) User' information and suggestions extracted from the focus groups and interviews and in particular from the concluding question I asked them "what would you add or change in the building?". If so far, there has been a difficulty in Maggie's organisation in involving users in the design process, now Users, knowers and owners of the building, become User-experts and will communicate with the Architects through the visits that the designers will make to the centres during their design stage.

In considering proposing a new paradigm of the 'Commissioning of Architecture', since the Triad is based on the Architectural Brief, after analysing each component of the triple relationship, I return one last time to the Architectural Brief from which I extract the psychological effects that the building generates, and construct a scheme of feelings that users experience at Maggie's. Raising the bar over the standard level of Architecture of Care and looking to the future, the chapter closes by delineating the principles of Maggie's paradigm for a new 'Commissioning of Architecture'. With the aim of stimulating new ideas and guiding clients, architects and builders towards the goal of meeting user expectations, I

finally propose to extend them to other healthcare facilities, as well as to non-healthcare facilities or other types of community centres.

## I. Definition and Components of a Paradigm

The late Latin *paradigma*, from the Greek παράδειγμα (*paradeigma*), from *paradeiknynai* = to show side by side, from *para* + *deiknynai*, to show beside (Merriam-Webster, 2021f), was used by the Greek philosopher Anaximenes (6<sup>th</sup> century B.C.) as “actions that have occurred previously and are similar to, or the opposite of, those which we are now discussing” (Sampley 2003, pp. 228–229). In the 1913 edition of the Merriam-Webster Dictionary (1913), the term had the meaning of a standard or typical example. Currently, the online Merriam-Webster’s definition is “example, pattern; especially an outstandingly clear or typical example or archetype” (Midgley, 1997).

The most frequently cited definition of the word paradigm is provided by Thomas Kuhn (1962) in “The Structure of Scientific Revolutions” (1962), in which he says it signifies “universally recognised scientific achievements that, for a time, provide model problems and solutions for a community of practitioners, i.e., what is to be observed and scrutinized” (Kuhn 1962, p. 10). In short, a scheme or model for understanding and explaining aspects of reality (Rosenberg, 1996). Paradigms are dynamic states rather than final responses, and as research continues, anomalies appear that ultimately lead to new understandings of reality and new paradigms (Kuhn, 1962). Kuhn argued that the possession of a paradigm is a sign of maturity in the development of a discipline. It provides an organisational principle that allows the discipline to solve problems that, before then, would have been unsolvable without it (Rosenberg, 1986).

When, after the result of a long process, a particular discipline transits from one paradigm to another, in Kuhn’s terminology this passage is called ‘scientific revolution’ or ‘paradigm shift’. The reason why Kuhn came up with this concept (and named it a ‘revolution’) was that he realised that for a long time science had looked at some specific phenomena in a certain way, but that suddenly that system of representation turned out to be false. Kuhn argued that scientific progress is not an evolution, but rather a series of peaceful interludes interrupted by violent intellectual revolutions, and that in these revolutions one conceptual worldview is replaced by another (Kuhn, 1962).

Beyond its use in the physical and social sciences, Kuhn’s concept of paradigm implies a shift in the worldview at specific points in history. In research, the worldview is

the perspective or way of thinking, a lens through which the researcher looks at the world (Kivunja and Kuyini, 2017). For Guba and Lincoln (1994), a paradigm is a set of core beliefs and their metaphysical assumptions can only be believed, not proven. As they are all inventions of the human mind, hence subject to human error, they are human constructions (1994). In terms of health-care architecture, a paradigm implies a change in the worldview of the human relationship with the ‘construction of health’. Even today, hospital architecture is considered the field of action of specialists with a very narrow view of the world, and since specialists do not like new ideas, they are little inclined to modify it.

The people who get all of the hospital projects are in a business and they are called specialists, and specialists don’t like ideas, they don’t like changes. They like doing things in their own special way. I think the problem is that we wouldn’t be invited to do a hospital, because architecture is considered by the people who procure hospitals to be too particular, or too extreme, or whatever, too unconventional. But I think if we were to get to do a hospital, we could make a very significant change to what health-care architecture looks like. I don’t think it would be that difficult. (*de Rijke, 17.12.2018*)

In order to propose a change, it is important to identify the components that form a paradigm capable of enabling it and in particular those that would constitute Maggie’s paradigm.

According to Guba and Lincoln (1994), a paradigm includes three main components: epistemology, ontology, methodology, plus a fourth one, axiology. If we exclude the latter, which refers to the ethical principles that could be different for each future healthcare facility, the other three should coincide with the components of Maggie’s paradigm. Since from my previous analysis the ‘Client-Expert-Architect-Users’ Triad regulated by the Architectural Brief has been of primary importance in achieving the enabling of a Maggie’s therapeutic environment, in order to identify what would map the emergence process of Maggie’s paradigm, I will examine the apparently simple triangular relationship between the three components. From commissioning the project to obtaining the finished product, with the “very clear message that the agenda is Care” (*de Rijke, 17.12.2018*), the Client-expert and the Architect relate to each other through the Architectural Brief which, with its request for emotional requirements, causes the finished building to release in its users a taxonomy of feelings characterising a therapeutic environment.

In reference to the above set of components (Guba and Lincoln, 1994), if we see the definition of *Epistemology* as being “how we come to know something” (Kivunja and Kuyini, 2017), since Maggie’s is a place of experience, the subjects interested in ontology are the *Users*: they are the depository component of the apprehended knowledge. *Ontology*, according to Scott and Usher (2004), is essential to a paradigm because it helps to give

directions or foundations for a defining of the nature of reality, in Maggie's case, the cancer reality. In this sense the *Client-expert* is the theoretical component that orients the thinking, the meaning, the understanding of the problem, and the approach to the solution of Maggie's philosophy (Kivunja and Kuyini, 2017). Finally, if the broad term of *Methodology* refers to research design aimed to find something out (Keeves, 1997), in producing the unconventional architectural model devoid of signs of sanitary architecture that defines the therapeutic environment of the Maggie's Centre, the *Architects* are the practical component of the paradigm.

## Ia. Maggie's as an Emerging Paradigm

Speaking about the NHS system, from the interviews I had with Maggie's architects and staff during my fieldwork, I came to know from rather close up the current reality of the hospital environment and other healthcare facilities such as Macmillan. Despite Maggie Keswick's experience that led to the twenty-five-years' long Maggie's legacy, as mentioned in the Introduction to this thesis, the idea that 'Design is a form of Care' has still not impacted the architecture of the hospital environment.

The clinical environment is always very busy. I have worked in the NHS for 30 years as a cancer nurse with different positions, but for the last 20 years I have worked in oncology. And before I retired, I saw a lot of changes in the role of nurses, and for the past 17 years of my career I have worked as a Macmillan clinical nurse specialist. But in the last four years it's just got exceptionally busy with a lot of stress, very, very busy. And this was probably one of the reasons why I decided to retire rather than continue. So, it's quite a different environment to work in comparison with Maggie's. There is always a lot of noise and hustle and bustle. There is never enough space to sit and talk to people, in privacy. Sometimes you have to sit in the waiting room and it's just not appropriate. And there is a lot of space used for meetings in the consultation rooms and taken away that privacy you could use to talk to patients in. You can still help, but it is very difficult to do so when you are in a busy clinical environment with grey walls and hard chairs, and a lot of noise surrounding you. (*CCS Dundee no.3*)

Not many hospitals you enter talk about design; they talk about being a machine and the process yes, it's procedural. The message you understand is organisational, procedural, medical, surgical, chemical, you don't understand it as a three-dimensional expression of care and that's what Maggie's does. They say design matters don't they, that's what Maggie's do, as well as human contact and human care matters. Those are two areas that hospitals struggle with, you know they have care, but it's disguised as a process. The nurses really care and lots of people in hospitals really care a lot, but it's sometimes difficult to see it, to be honest. Well,

it's hidden by a process and institutionalised problems wearing uniforms, so you can't see the care of them, because it's disguised, it's disguised as a machine. (*de Rijke, 17.12.2018*)

The evident fact that distinguishes and contrasts a hospital from a Maggie's Centre the most is *design*. While it is true that, in general, *design* is not a priority in hospitals, and that the idea of *care* is masked by a mechanistic system, in Maggie's Centres *design* and *care* are concepts that overlap. People who enter Centres immediately understand that Maggie's goal is *care*, highlighted by the way in which the staff express total dedication to people. This is the salient aspect that distinguishes Maggie's.

I think people who visit Maggie's get a very clear message that the agenda is care and that care is about the staff and the obvious human care and love, but there is also the message that design is a form of care and people care about designing and the design itself is very clear in Maggie's. It's there for you, it's there to make you feel better, so I would say to your question about does it translate to other hospitals or healthcare facilities, I would say yes, because it's really about letting architecture speak about care and that's design. (*de Rijke, 17.12.2018*)

Hence, what Maggie's as an emerging paradigm could offer and extend to other healthcare facilities is, indeed, *design*. But where does the process towards which Maggie's could become an emerging paradigm begin?

Having started in a poorly defined area of care, not originally addressed by the NHS system, neither within medicine nor within social care, and reason that prompted Maggie Keswick to carry out her pilot project of offering emotions and feelings, the Maggie's Centre takes an active role of helping individuals left alone to process their cancer diagnosis, in the limbo of time and space that follows a diagnosis (Lee, 2021).

A lot was being asked of them as patients and carers to be active and to involve themselves in their role in self-management. And I think that's the first thing that is still very pertinent today (...) that your life may be shortened and, yet people are asked to take an active role in sort of helping themselves, but are very rarely given the support and the tools and the guidance within which to do that. (Lee, 2021, 44:15)

With the intent of bringing a new contribution to the 'construction of health', Maggie's paradigm proposes the cooperation between hospital and healthcare structures for other chronic diseases within an integral and integrated system. Maggie's emerging paradigm would therefore require a commitment on the part of hospitals and other organisations to take physical and psychological care of people as it relates to Maggie's belief that dignity is the human value that underlies the Architecture of Care. As per Charles Jencks's will, for

Maggie's model to be proposed to the facilities of other diseases, this would be integrated in the *continuum* of an extended healthcare environment that should include non-health facilities or other types of community centres as well, albeit maintaining a distinct identity. Although the notion of integrating care networks is not new, it is proving to be very slow in absorption, and we need to think about ways to accelerate it (Salus, 2021). In the next section, the attempt is to illustrate the gap between the old and new model of healthcare (hospital and Maggie's) and how this exchange could take place.

## Ib. Architecture of Care. A Paradigm Shift

Establishing a paradigm requires a system in which a body of work is accepted by a community on the basis of something already present, which has already been put into practice in all the different phases of the process and which accepts changes. So, a paradigm can only be applied to a system that is constantly evolving (Kuhn, 1962). Today, Maggie's constant growth means a substantial number of Centres constituting an existing *corpus*, a field of action shared by a community. Moreover, due to the fact that within a public healthcare environment the convention of commissioning the project for a hospital is the one commonly named 'design by committee', Maggie's way of commissioning architects through the Architectural Brief could constitute a significant reference. In my interview with Laura Lee and Marcia Blakenham, Marcia told me that she was surprised when an architect once said the following to her:

You know, people need help with their Brief, because, for example, these hospitals say they want to feel like a Maggie's Centre, but they don't know what it really means. The architect, to make a good project, needs a good Brief, he needs hospitals to ask them to do the right things. (Blakenham, 18.05.2019)

'Design by committee' implies that many members are involved, but it has no unifying plan or vision. In addition to agreeing with Marcia about the need to write a good Brief, Laura Lee argues that for as long as hospitals do not filter the relationship between client and architect by electing a committee with a few members, things will never change.

The project commissioned by a committee composed of many members, through a Brief that constantly presents the fractional nature of what each member of the committee requires, means for the architect that, to be able to succeed in his intent, he must respond to many, too many different requests. By keeping the management

in the hands of a maximum of two or three people, using a clear and content Brief like ours, architects cannot ‘distract themselves’ from trying to respond to what is necessary, in an attempt to please everyone. You should keep them away from politics, you should keep them away from ‘what the sponsor wants’. (*Lee, 18.05.2019*)

At the Phil Gusack Talk at AGM 2018, as reported by the ‘Architects for Health’ website, after someone asked him “why are hospitals so horrible”, Henry Marsh replied that “Hospitals are biological hazard areas; they are full of windowless spaces or high windows; multi bed bays are grotesque (...) It is extraordinary how much difference can be made by windows with views and natural light” (Marsh, 2018, para. 12, 19). Author of two best-sellers, “Do not harm. Stories of Life, Death, and Brain Surgery” (2014) and “Admissions: A Life in Brain Surgery” (2017), as a staunch supporter of the NHS, during his long career as a neurosurgeon, Henry Marsh had a strong say in influencing the hospital environment on patient health and staff. According to him, there are various factors that do not make patients feel well in NHS hospitals where they “rarely get peace, rest or quiet and never a good night’s sleep” (Marsh, 2018, para. 4). On one side, people have a terrible hunger for health care so much so that in the last year of life they spend 26% of the cost. Expression of our fear of death like pyramids or great cathedrals, as a result, “we have an ideological faith in technology and hospitals are becoming so complex they are no longer humane” (Marsh, 2018, para. 9). Although he doesn’t have a high opinion of healthcare architects, on the other side, clients have their own responsibilities. “So where is the incentive to build a well-designed, sympathetic hospital?” The 7-year struggle that Marsh fought to turn a ward balcony into a garden and put artwork on the waiting room walls proves that the road for an “architecture of care” in a hospital is still uphill.

Such a fate had already been predicted in the book written by Susan Francis in 2000 for the Nuffield Trust, “Building a 2020 Vision: Future Health Care Environments”, which defines a twenty-year development of the NHS (Francis and Glanville, 2001). Summarising the key issues and trends in healthcare and design, what Sue advised against and anticipated in her study for 2020 proved true. As design can be a catalyst for change and noting that the political emphasis on patient-centred care is not particularly evident in healthcare building projects, the study recognises that two key industries, healthcare and construction, have met a phase of accelerated change and modernisation. In a period of too rapid development with rash choices, if politicians and stakeholders had followed her advices, today the healthcare system would have been in better shape (Architects for Health, 2017, para. 3).

Based on Alex de Rijke's personal experience, the hospital paradigm is still recognised by its well-known components: a mechanistic and specialist vision, protocol-orientation, elaborate sensation, and absence of design. However, if the 'constructor of health' were willing to accept criticism and do something about it, not only could the concept of the Maggie's Centre be used as a model for other organisations, but the different Maggie's Centres, in their own independent contexts, could offer local health structures multiple paradigms.

If people are willing to, if hospitals are willing to accept criticism and do something about it, then I think the different Maggie's offer in their own independent ways many paradigms. Yeah, I'm positive about it, because a hospital is a machine typically isn't it? It's time to change it. (*de Rijke, 17.12.2018*)

As an establishing paradigm, Maggie's signals a new worldview, embodying the physical care of hospitals expanding the concept of the 'construction of health' from body to mind. This is a responsibility in which the 'constructor of health', the hospital, rather than standing above it, should work together to become an integral part of a *continuum*. The Maggie's Centre model could make a fundamental contribution to the constantly evolving hospital ground, within an integral and integrated healthcare system that includes support structures for other chronic diseases and non-health facilities or other types of community centres to support special needs as well.

Confirming what Maggie's architects and users told me during my interviews about the current hospital paradigm and the potential future integrated healthcare / non-healthcare *continuum* system, the most recent and up-to-date view on hospitals in the UK is outcomes of the Salus European Healthcare Design Congress which I attended in April 2021. In particular, the opening seminar of the programme, which also included Laura Lee and other leading health professionals, was aimed at analysing the current situation of the hospital, before launching the message of the need for an integrated healthcare network and that for a cultural change. Although we know that a hospital is a care setting, which must provide complex levels of clinical care dictated by clinical practice and safety regulations, the current model, as Marsh (2018) puts it, is still too much based on a mechanistic ideology that believes beyond measure in technology, which in addition to being inhuman is also very expensive. To get out of this situation, one hypothesis would be to transform hospitals into nothing more than a 'repair shop' and, at the same time, the centre of a network, which is a network of knowledge that transmits knowledge as well as providing healthcare. Although the concept of integrated networking is a fairly common term, it is often used without

knowing what it means. As understood in this seminar, and what the debate concluded, was that a hospital network is not composed of ‘hubs’ and ‘spokes’ (like airline networks), but of “networks of nodes”, without centres - of which the ‘node hospital’ is obviously very important and the ‘Maggie’s Centre is a node of “pulsating knowledge and right philosophy” that must be connected to all community hospitals.

And as Benjamin Lee Whorf said, language creates a new reality, we have to create, and you’ve done it, that. The Maggie’s Centre has created a new reality. At the end of life, people need to think of ways to live. How can we “industrialise” Maggie’s philosophy? It’s partly by opening up and giving lectures, but we have to have a system for the last year of life, and people need to be trained how to think. (Gray, 2021, 1:13:45)

This new perspective aims to “domesticate” the services offered and to assist, with self-control and responsibility, more and more people in their homes or communities in which the uneven relationship doctor-patient would completely change in favour of the patient. This means that before an integrated healthcare model, there is a need for a cultural change that is not easy to activate. As already seen by Maggie’s and highlighted in the panel discussion, the fundamental flaw of health systems is that hospitals assume that the patient is passive, placing him/her, as already stated by Foucault (1973 [1963]), in an inferior condition, which is the opposite of giving ownership of health to patients so that they can make their choices.

And that is going to be the biggest cultural shift of all because it means taking power away from doctors and giving it to people who should be most interested in investing in their good health. So, I agree, it’s not about organisations, it’s about culture, and it’s about trying to provide the right incentives for the right outcomes at the moment we’ve got a health system that is where we mostly pay for activity but we don’t pay for outcomes. (Roschnik, 2021, 1:18:01)

Within an integral and integrated network system, a *continuum* of an extended healthcare environment, that should also integrate non-healthcare facilities or other types of community centres as well, only when we have a holistic model of practical, emotional and social support that can be applied to other areas but more importantly, an exemplary model of life in which people, staff and patients look towards the same direction as at Maggie’s, we will be able to change the vision of the world and activate the paradigm shift.

Using the data that I collected from Maggie’s, I was able to derive the themes that characterise the Architecture of Care and compare them with those of the old hospital paradigm. The comparison between the current paradigm of the hospital and that offered by

Maggie’s constitutes a potential shift in the worldview, as well as a new contribution to the ‘construction of health’ (Box 17).

Old Paradigm of the Hospital	New Paradigm of Maggie’s
Mechanistic view of a segregated model of life and programme	Mind-as-important-as-the-body view of an integrated model of life and programme
Machine as a form of care	Design as a form of care
Standardised design of sanitary architecture	Design devoid of sanitary architecture
Large buildings with waste of space	Small buildings where space is well utilised
Non-sensory design (no light and static)	Sensory and cognitive design (light and movement)
Mono-functionality / Hospital Art	Hybrid (Architecture, Art, Spiritual, Healing)
Landscape as decoration	Landscape for therapeutic effects
Disconnection between architecture and therapeutic	Connection between architecture and therapeutic
Procedural (Consent form)	Non-procedural (No registration form)
Doctor-patient hierarchy	‘Empower the Patient’ motto

Box 17. Architecture of Care. A Paradigm Shift in the Construction of Health.

The transitions from one paradigm to the next are not like the swinging back and forth of a pendulum, but rather they embody the old paradigm and overcome it with a new dimension, a new way of ‘seeing’ old knowledge (Ferguson, 1980). For a discipline such as architecture which aims to design the built environment for the human being by acting by stratification and incorporation, this concept of a ‘new way of seeing’ by integrating old knowledge is central to the ‘Client-Architect-Users’ Triad, whose roots lie in the Greek healing temples and in Benedictine Rule.

## II. Maggie’s Triad. Paradigm for a New ‘Commissioning of Architecture’

There are twenty-two [*twenty-six, today*] centres up and running, six more on the horizon mostly in Britain, and architects have played a major role in their success (...). What I’ve found surprising, and gratifying, is that most of these Centres work very well and architecturally they are superb. There must be several reasons for this, but among them is the challenge of the building task itself. Living with cancer, succumbing to it, fighting and laughing it off, seems to motivate architects to outperform themselves. (Jencks, 2018, para.2)

The design of a Maggie’s Centre seems to push architects to go beyond themselves. Maggie’s architects must not just be skilled; given the theme and the very difficult challenge that the Client-expert launches, they must also be very ‘engaged’. Despite being a small building, the project for a Maggie’s Centre requires a lot of care, down to the smallest detail, as well as commitment, dedication, and many hours of work. In both size and visibility, a commission for a Maggie’s Centre might be compared to a commission for a Serpentine

Pavilion in London or a Biennale Pavilion in Venice; the commission will eventually become a highlight in the architect's career (*Tagliabue, 19.11.2018*).

I think architects probably try harder on Maggie's projects, just like you mentioned or Benedetta was saying, I put 50% more time in. I mean, we killed ourselves, but we enjoyed doing it. (*de Rijke and Sohi, 17.12.2018*)

Yet, in the case of the Maggie's Centre, it will not be a highlight for the press or for the architect's architectural ego, but for having managed to produce, through the architecture and a strong sense of humanity, a psychological effect on people with cancer. As Bjørg Aabø (*Snøhetta*) says: "This project is able to pull out the best that is in you as an architect" (*Aabø, 02.11.2018*).

How does Maggie's manage to push architects to do this and go beyond themselves and make users extremely satisfied enhancing well-being in them? As explained in Chapter 4, the 'Client-Architect-Users' Triad is a key feature of the architecture system, a dialogue in which, through the brief, the client instructs the architect, who will produce a building that will benefit the users. This relationship is strictly connected and fails if one of these protagonists fails. To monitor the degree of satisfaction of those involved in the life cycle of the building (Clients, Architects and Users, but also sponsors, builders, maintenance managers and future generations), the POE (Post Occupancy Evaluation) tool, which can be defined as "the process of evaluating buildings in a systematic and rigorous manner after they have been built and occupied for some time" (Preiser et al., 1988) has been used since the 1960s. Outside the Triad and the other subjects involved in the construction of the building, those who carry out the POE are external figures such as psychologists, sociologists or geographers who investigate the work of architects and who collect feedback from the occupants of the building - usually through questionnaires, interviews, focus groups and workshops - to finally issue recommendations based on a full set of stakeholders' comments.

In the UK, the promotion of POE in architecture is the result of a two-year strategy by the RIBA Research and Innovation Group (2017) which addresses architects with a call for evidence in the evaluation of their work allowing third parties to carry out research on the building (RIBA, 2016). Unfortunately, a rift is often created between the two figures, architect and researcher, because for many architects the research on architecture is the building itself, while for those who do research the research on architecture is the users themselves and their degree of satisfaction. This gap is also accentuated by the fact that the POE often turns out to be an insignificant tool from the point of view of the user experience

of a place, because it reports values mostly from the technical, energy and environmental comfort point of view of the building rather than the aspects related to the social and psychological dimensions of living (Hay et al., 2018). But, as seen in Chapter 4, the gap that most worries psychologists is the one between users and architects, which in general is a profound problem in the study of the built environment (Kamara et al., 2001). However, at Maggie's, as already stated, while in the past this relationship was largely absent or very weak, over time this link has strengthened, and Maggie's architects seem to become more empathetic and willing to interact with users. In the hope that in the future architects will engage more with people with cancer who attend Maggie's Centres, obtaining information directly from them, my thesis aims to bring the needs and wishes of users to the attention of all architects.

A Triad implies that the Client-expert commissions and works with the Architect to provide a successful building that constitutes a therapeutic environment for the benefit of the Users. This relationship must be harmonious and balanced, and in theory each of these three protagonists must contribute to ensuring the final success of the building to become a replicable reference model in the future. Aware of the lack of user involvement in the design process of the Maggie's Centre, I propose to closely examine the foundations of Maggie's Triad and understand exactly where I can step in to correct this imbalance. Since the Maggie's Centre project as a unique product of the Triad relies on the Architectural Brief, to correct this imbalance, I revisited Maggie's Brief one last time. Knowing that compared to the current 'Commission of Architecture', that of Maggie's is different for the various reasons already seen (emotional, enigmatic, free), from the A4 dossier (*Appendix\_IV*), which collects the interviews to Architects on the interpretation of the Architectural Brief, I understand that they are emotionally involved, so they are driven to design a building that evokes or allows for emotional and sensory states in the users. It is on this level, therefore, that a dialogue can be established between architects and users that will make the architect aware and give a role to users in giving their own contribution to the design process of the Maggie's Centre through the narration of their feelings.

By carrying out a more in-depth analysis of the process of the emerging paradigm of the Maggie's Centre, highlighting its components tentatively summarised in the following triangular scheme, I show how, under each of the three vertices of the Triad (principal components), a more complex development of the components takes place, giving life to Maggie's paradigm for a new 'Commissioning of Architecture'. In addition to the Architectural Brief connecting the triple system (Box 18), I include:

1. 'Client-expert': Maggie's Support Programme (open and flexible to any interpretation, based on the motto "Empower the patient", characterised by the paradox 'Non-therapeutic / therapeutic');
2. 'Architect': Architecture of the Maggie's Centre (devoid of signs of healthcare architecture, characterised by a sensory space and an experiential field that allows for movement, with a hybrid nature that is open and flexible to any interpretation; designed with freedom and emotional involvement);
3. 'Users': Feelings (stimulated by the support programme offered by the staff-people and by the architecture-place, which when in synergy generate psychological flexibility).



Box 18. 'Maggie's Triad system. Structure of the relationship grid

Maggie's Triad includes the following components:

1. **The Triad**-system (Client-expert-Architect-Users)
2. The Architectural Brief (with reference to the Benedictine 'Rule')
3. The Support Programme (based on the 'Empower the patient' motto, with reference to the Greek healing temples of Asclepius)
4. **Therapeutic / Non-therapeutic** paradox
5. Design as a 'Form of Care'
6. Synergy between people and place
7. **Hybrid** nature
8. Freedom, emotional involvement (Architect) / Sensory Space, Experiential Field (Building)
9. Predictability, Flexibility, Stimulus (Staff), Safety, Normality, Agency (Visitors)
10. **Movement / Flexibility** as a link between non-sanitary Architecture and Psychological Flexibility generated by the synergy between people and place

In the following sections, I examine each of the components of the Triad system. In addition to highlighting the suggestions of the Client-Expert and the emotional involvement of the architects, I will let the users speak out loud about their opinion on the architecture, hence of the feelings and emotions aroused in them by the building. By reporting their suggestions and experiences to the architects, Maggie's users become User-experts. Intervening in Maggie's Triad, I therefore propose that in the future paradigm of a new 'Commissioning of Architecture', we consider a more balanced weight between the three figures and in particular a new way of making users communicate with architects. Since the "Design by Committee" constitutes the old hospital paradigm, standardised, always the same and in need of a change, a paradigm shift of a new "Commissioning of Architecture" seems more appropriate in healthcare than in architecture in general, where it would not be applicable due to the variable and multiple nature of commissioning a project.

## IIa. Client-expert

The way Maggie's Client-expert approaches and appoints an Architect and the relationship that is then established differ from what usually happens in practical terms. Having discussed this topic with the architects I interviewed, and being an architect myself, usually in architecture this relationship is a disconnection that leads to a considerable waste of energy and resources, manifesting a problem in the profession. In this sense, Maggie's is an exception: with a great sense of responsibility and commitment on both sides, in an

atmosphere of collaboration, the relationship is always one of encouragement “to go beyond themselves” with the ultimate goal of benefitting the users.

In regard to the choice of an architect, who must be mature – “which does not mean old” (*Lee, 18.05.2019*) – despite the fact that in recent times many new architects have offered to design a Maggie’s Centre, so far the relationship between the client and the architect has always begun on the initiative of the Client-expert. As I explained before, in the past, many of Maggie’s Architects were friends or former students of Charles Jencks, some of whom were already well-known, or rose to fame later thanks also to their design for Maggie’s. If earlier, perhaps, this was why architects were not keen to communicate with users, as mentioned in Chapter 4, today, the new generation of younger / lesser known architects seem to be more willing to meet users, who in turn they are very interested in talking to architects. As we saw, users know the architecture and the story of their building and they know they live in a famous building in the UK context. In spite of the fact that visibility helped bring many donors to the organisation, notoriety mostly means skill that is evident in the unique architecture. But how is this result achieved? What is the recipe for its success?

According to the Client-experts Laura Lee and Marcia Blakenham (*18.05.2019*), the ingredients for success concern a few albeit crucial points: a good Brief, a good client, clear ideas, and not too many outsiders keeping the architects focused on the project and on the final goal, which is to make people feel well, the ultimate goal of architecture. As mentioned, hospitals usually assemble a committee made up of many members, which plays the role of the client and, by way of a Brief, appoints the architect. This Brief usually presents the fractionality of what each committee member requires; this means that for the architects to succeed in their intent, they must respond to too many diversified requests. “Hence, hospitals must first of all write a good Brief and have it handled by only a couple of people in charge of design” (*Lee, 18.05.2019*). By keeping the commissioning management in the hands of two or three people at most, using a clear and concise Brief, architects cannot “distract themselves” from trying to respond to what is necessary in an attempt to please everyone. This means that the architect must have a certain sensitivity and willingness to listen. In order to make sure that the architect achieves the final goal in a linear way, finally the client should keep the architect away from politics or whatever it is that the sponsor requires. Based on a mutual commitment and on personal engagement, hence the client establishes a very different way of communicating with the architect.

And I think there is another thing that can influence how to educate architects and, consequently, how to be a better client, which is actually hard work. It is not to give people too many assumptions or constraints, because every time we tell someone we want something, we often only want what we already know. There are architects who are also thinkers, or architects who have just had an idea. By saying what you want, you inhibit their creativity. (*Lee, 18.05.2019*)

As mentioned, part of the learning process that the Client-expert asks of the architect who has just been commissioned for a new Maggie's Centre is to visit and analyse the existing centres. Some architects said that they did not read much of the architectural brief, but they went and looked at the other buildings: "That's why I said we should re-write the Architectural Brief, because we should ask them to look at the other buildings" (*Blakenham, 18.05.2019*). Encouraging architects to go and see the built centres, as mentioned, also creates an opportunity to talk to the users. "But I would rather encourage when some of the architects want to go and look at the others, because the right ones want to see what people think works and what doesn't work" (*Blakenham, 18.05.2019*).

The architect will possibly spend the whole day and collect the needs and wishes of the users, and this means that something is changing and that there is a new way to approach the design of the building. Although it is difficult for an architect to interact with all users, also because the data received will be limited to the users of that day, talking with the Client-expert is still the best way to obtain all the necessary information. But, because it is not the client's goal to theorise and "[make] assumptions on how the person entering the door must feel" (*Lee, 18.05.2019*), the way they work with the architect is in the name of a freedom of interpretation. As explained previously, this freedom comes from the concise Architectural Brief which is, on the one hand, a set of rooms, and on the other, a 'very British and inhibited 'not much said'' (*Gough, 16.05.2018*). Yet, the 'not much said' on its own constitutes the way the client achieves their goal: paradoxically, without asking, but with a lot of guidance, the Client-expert will obtain from the Architect the project they want. "Yes, the less you give and the more they think for themselves" (*Lee, 18.05.2019*). According to the Client, this is the best/only way to manage the relationship because, by doing so, the project for the building will reflect both the client's and the architect's aspirations, thus ultimately allowing the users to find their own way. In the 'white space between the lines', the architect will garner a great deal of reference and wisdom that will be transferred to the sensory feelings and emotions that building is supposed to evoke or allow. In its essentiality, the Architectural Brief, open and flexible to any interpretation, is the hidden recipe of Maggie's success.

## Iib. Maggie's Architects and their emotional involvement

From the interviews I had with the twelve Maggie's architects to whom I asked how they interpreted and applied the Architectural Brief to their project, it emerged that for them it was a privilege to work on these projects, because they know they were able to do something very special for people with cancer and, therefore, without hesitation, they agreed to be part of the team and 'go beyond themselves'. This is not only true for the architect, but, in general, for all the people involved, such as the project manager, the contractors, the consultants. Everyone did more than they were asked to do, or certainly paid to do.

Because I think that the whole team is aware that it's for charity, so when you are asked to go the extra mile, to think about different ways of doing things or solutions, and you know sometimes in construction people want to take an easy route, but once you explain why you want to change it, because it's a charity and it's a cancer charity, they are much more willing to collaborate with you. (*de Rijke and Sohi, 17.12. 2018*)

By creating a special environment, which acts on the body and mind by stimulating the senses, the architect guarantees the sense of well-being in people. Even if the architect does not have a direct dialogue with the users, adopting a sensory approach, almost a 'mental transfusion', an 'I in them', the architect manages to convey to the users their message of humanity.

"I mean, we know the background of this building. We know we live in an iconic building. This is famous in the UK context, so we know. Maybe that helps, too" (*Follow-up Dundee*).

With respect to the budget, for example, knowing that funds come from donations often raised by local communities, the architect is the first to be very conscious.

They are very experienced clients and they are critical, but in a way that is constructive. So, we worked really closely with them and they were very critical in a good way. They were quite good at identifying what might be worth spending on and what might not. There isn't enough money and there isn't an opportunity to be indulgent inappropriate in any way with such a project. Yet, there is trust and that's a very special thing to work with, between a client and an architect. So, trust and respect were two ways and that doesn't always happen with projects. Sometimes architects are regarded with a certain amount of suspicion, because typically they can spend a lot of money when it is not necessary (*de Rijke, 17.12.2018*).

On the other hand, with surprise, the architect will take up the Client-Expert's challenge to 'dare'.

And Charlie and Laura came to my office, and they said ‘No, no. We want your signature ‘green tile’! That’s what we want. We want what you did at that lavatories in Westbourne Grove, we want that look, we want that feel of ceramic. So ‘fine, ok!’ And I was ‘Can we afford it?’ “For Goodness’ sake... Don’t worry about it! We don’t want to build a building less good, because we are trying to economise, that’s not the way we work. It’s not our thinking! (*Gough, 16.05.2018*)

This is very unusual in the practice world when dealing with private clients. Generally, architects are obsessed with the idea that the client can ask them to make changes, perhaps distorting the project, while maintaining the same budget. Therefore, within the Client-Architect relationship, trust and respect are fundamental, especially in budget management. Indeed, the architects who were involved in their design and building of a Maggie’s Centre played a key role in their success. As Jencks himself explains, there are several reasons that have led to this success, but among them the fundamental one that encourages architects to be determined is, as mentioned, the challenge of the task of the building itself. Living with cancer, succumbing to it, fighting and laughing about it, seems to motivate architects to go beyond themselves (Jencks, 2018).

In my archival research, viewing the large number of sketches, drawings and photographs of models that I found in the architects’ office, it clearly brought out the architectural passion that every architect has focused on a very small object like a Maggie’s Centre. During the design process, the dedication led the Architects to improve ideas and create solutions so innovative they could be called architectural ‘inventions’. At the same time, the difficult content of the building, which touched many of them personally, led to the danger of their being more involved than they should be. A significant example of this comes from the experience of Norman Foster, which I heard about from Charles Jencks. During the design phase of Maggie’s Manchester, and when the meetings with the Client-Expert took place, the discussion often shifted from architecture to human problems; they were about how people under stress would feel while having lunch in the garden or in the greenhouse surrounded by flowers and plants, or looking at nature and the horizon from a safe place, from a garden window, or from the terrace in the sun. It was Norman Foster’s idea to install a greenhouse.

The glasshouse. This was very much Norman’s idea of creating this transition of space, a greenhouse, which allows the landscape to come into the building. Norman felt the idea of producing flowers that are grown in the garden, of their coming into the centre, to be very important. (*Haylock, 12.06.2018*)

Seen as an appropriate context for healing, Foster's approach oscillated between problem solving and spiritual or aesthetic issues. There is a reason for this, and its existential background is worth explaining.

He and his late wife Wendy, who had succumbed to cancer in 1989, knew Maggie, and the four of us had met socially several times. Moreover, we had given them a brief overview of Chinese architecture when they were competing for the Hong Kong Shanghai Bank in 1979. I mention this and the fact of many personal meetings over the years because, when Norman finally addressed the question of designing a cancer caring centre, he was already highly motivated. (Jencks, 2018, para.4)

Norman and his late wife Wendy, who died of cancer in 1989, knew Maggie and Charles, the four of them meeting many times during their years of friendship. Despite this, nothing had ever emerged from the private life of Norman Foster, a world-renowned designer with a practice of 1,500 people and offices across the world. Yet, at the end of the film "How Much Does Your Building Weigh, Mr. Foster?" – a biopic produced by Spanish director and Foster's wife Elena Ocher (2010) – Norman Foster reveals that he had a heart attack and cancer, and that he managed to fight back thanks to his willpower. This revelation was a surprise for everyone, as well as offering an unedited version of his projected image of someone who was invulnerable.

Perhaps this reaction to a death sentence is an archetype with cancer, but it is one of the few cases where an architect has admitted or presented a personal response, and I have seen a direct connection between existential motivation and architectural commitment. (Jencks, 2018, para.9).

Maybe also because Norman Foster was born in Manchester, from the interview it emerged that the commitment of the entire office to Maggie's Manchester (2016) and the results achieved went beyond expectations: the modification of the masterplan of the hospital, a former car park which has now become a lush garden, a light and airy space reminiscent of an aircraft hangar, the tall and thin wooden ballerina-like structure with outstretched arms, which punctuates the space with skylights shaped like triangular crystals: all this is a real invention.

I think everybody felt that timber should be the right material because of its bio-references, the kind of connection to nature, the quality, the warmth, its scale that all that brings. And that was an idea that then was installed into the design while working with our engineers, using that idea of how we can use timber effectively and efficiently to create the architecture, the building image, using the structure to express that. (Haylock, 12.06.2018)

With Maggie's Manchester, RIBA Awards Winner in 2017, it clearly emerges that the existential motivation of a Maggie's architect – Norman Foster and his team – was the driving force behind the creation of this work, according to many critics “the most beautiful new building in Manchester” (Confidentials, 2016, para.14).

Other architects have been emotionally involved with cancer, not themselves personally, but family members or friends have died of cancer. For example, Alex de Rijke (2018) told me how the design of his Maggie's Oldham (2017) had been modified based on his girlfriend Lucy's terminal cancer, who died shortly after the inauguration and to whom Alex dedicated the building. When Lucy was admitted to Christie's Manchester Hospital, Alex spent a lot of time at Maggie's Manchester so he could be close to her, and he learned a lot from that experience. To overcome the problem of feeling a shock that cancer patients have when they touch metal, in his Maggie's, which had almost been completed at the time, he changed all the door handles from metal to wood. The tragedy of Lucy's illness made Maggie's Oldham – which Alex de Rijke believes is the most beautiful building he has ever designed – an existential motivation that eventually awarded Maggie's and the architect with the RIBA National Award 2018.

Benedetta Tagliabue, who designed Maggie's Kávida Barcelona (2019), and who lost her husband, Enrique Miralles, to brain cancer several years ago, won the 2020 Simon Architecture Prize 2020. During our interview, she told me about the last days she spent with Enrique in a Tibetan centre (very similar in concept to Maggie's philosophy) located in Houston, near the hospital where he was hospitalised. When her name was suggested for the job by a group of energetic women who wanted to build a Maggie's in Barcelona, Benedetta gladly accepted because she felt prepared, not because of any particular scientific knowledge of healing architecture, but because of her husband's personal experience with cancer, which had meant learning in advance all that she needed to know.

So, I remember a big thing, ‘now let's sit here and we don't think for an hour’. It was so important. You just say okay, this hour is okay, because maybe terrible things will happen soon, but now you can stay very well. So, these little exercises are so fundamental and a place like Maggie's can give that and can give you this time, because you don't know how long it will be, but it's a nice time and at a moment like that, this is so fundamental. (*Tagliabue, 19.11.2018*)

As discussed in the Introduction, based on what is stated by Annemans et al. (2012), completing a successful (pseudo) healthcare building “would be impossible without a client who is actually strong enough to resist in order to realise the project the way it was designed” (2012). The client's goal in realising the building as it was designed involves sharing a

mutual interest with the architect. At the same time, concerned with satisfying their users, architects will ‘go beyond themselves’ in the interpretation of the Architectural Brief only because they are personally involved. Since by going beyond themselves, during the interviews, the architects have given useful suggestions, I conclude this section by reporting some of them here. These suggestions, which at first seemed important but isolated, instead, like pieces of a puzzle, turned out to be connected and this is because the flexibility is contained in all of them (Box 19).

Chapter	Architect	Quotes from Maggie’s Architects
4	Piers Gough	“Maggie’s Architectural Brief is so British. When you read a brief, you need to read between the lines”.
	Alex de Rijke	“Maggie’s needs to show the relationship between Architecture and Health. You have to build a health building and express it through materiality”.
	Ivan Harbour	“Maggie’s space is a continuity of space. You have to find the space within a space to obtain an evolving experience”.
5	Wendy James	“Maggie’s is more than a member of Staff. Make the building reveal its soul”.
	Frank Gehry	“Maggie’s generosity thinks about people, not about architecture. Don’t think of Architecture with a Capital A, think of creating emotions in people”.
	Ellen von Loon OMA	“Maggie’s provides a menu of spaces. Everyone is different, you need to accommodate people’s mood”.
6	Steven Holl SHA	“Maggie’s is a multiplicity of perceptions. Materiality is not only matter, use light to transfer energy”.
	Darron Haylock	“Maggie’s Therapeutic is within its transparency. Let your sight go beyond the boundaries”.
7	Björg Aabø (Snøhetta)	“Maggie’s is as a social tool. Let the space engage users in a sensory experience”
	David Page (Page Park)	“Maggie’s is about the experience. Don’t apply scientific knowledge, use your intuit”.
	Richard Murphy	“Maggie’s is about flexibility and freedom. Not everybody wants to be social”.
	Benedetta Tagliabue	“Maggie’s is sense of worth. New centres will make hospitals proud of themselves”.

Box 19. Quotes from Maggie's Architects in search of the Flexibility principle

## IIC. Maggie’s Users or User-experts

A “practicing architecture” is that which, after the architect has designed it and the client has built it, is finally used, and whose protagonist becomes the user (Jacobs and Merriman, 2011). As mentioned, we know that the use of the building is what brings the building to life; without the use and the users who keep it alive, the architecture becomes a ruin (Venezia, 2010). As also seen, living in a building generates different feelings, attachments or affective resonances while we dwell, work, visit it. In the building users, material and immaterial things meet in a myriad of complex, choreographic and unexpected ways. These

practices involve different types of embodied engagements with different sensory understanding of buildings (Rose, Degen, and Basdas, 2010), as well as with different perspectives on the architecture, as already mentioned, different for each person who approaches the same buildings or space (Iurato, 2020). In the case of an over-designed building as the expression of “expert design”, users have no choice but to passively accept it (Thrift, 2006). Usually, unconventional or highly regarded architecture tends to be rigid and uncomfortable. In the case of the Maggie’s Centre, instead, the unconventionality of the building combined with Maggie’s choreography helps people with cancer to be present and retain: the difference with overwhelming buildings lies in the way users are called to contribute. Confirmed by visitors, when you see beautiful buildings you can feel intimidated by their beauty, while at Maggie’s people are called to contribute and feel they have a role.

Also, you put the glass away and put it in the dishwasher. So, you take something and then clean up after yourself, which is important. It’s the freedom, not a just ‘you can do it’. (*Follow-up Dundee*)

Although not involved in the design phase of the centre, Maggie’s users, already endowed with knowledge of architecture and a sense of ownership, feel that they can still provide important information and thus contribute to improving the quality of the experience of the space. As already explained, the POE (Post Occupancy Evaluation) tool, which in addition to evaluating the building is also a user satisfaction survey carried out by a researcher, when done properly, is a good way to provide information to the architects. In addition to releasing data on environmental, social, economic and sustainability factors, the POE document, in fact, also addresses more complex issues such as the sense of identity, atmosphere and belonging as in Maggie’s Nottingham (RIBA et al., 2017). A relationship created in this sense can be of great help in bridging the gap between the designed project and the completed building. As highlighted in the POE of Maggie’s Dundee, for example, there are some technical problems of thermal, acoustic and storage comfort linked to the design choice of having large glass surfaces, open space and small dimensions (problems that are common to all centres), but the reports conclude that building users show a high level of satisfaction, (therefore the financial investment is relevant for long-term positive impacts to the benefit of users). By validating a design approach that emphasises the quality of the interior space, good design also allows for a “forgiveness factor” for the technical problems detected in Maggie’s Dundee (Stevenson and Humphris, 2007). As previously mentioned, the POE can turn out to be an insignificant tool from the point of view of the user experience of a place, if the results are more technical than emotional. In this sense, my ethnographic method of

working in the field is a step forward compared to a POE, because only by living in the building it is possible to detect the experience of the users (Morton, 2005).

From the focus groups, interviews and informal conversations I had with the many visitors and staff members in twenty-five Maggie's Centres (I have not visited Maggie's Southampton), it emerged that users have ideas and the freedom to express them. By suggesting changes to both the building and the reprogramming of the activity plan in the final question of my interviews "what would you add or change in the building", Maggie's users become User-experts. At Maggie's Barts, for example, visitors think, as do the staff, that the toilet on the first floor is impractical and suggest adding another one on the ground floor. During the interview / open conversation I had with the landscape architect and a visitor, the latter proposed adding the new toilet as part of the new garden extension project which would include the ground floor alterations. The Staff, on the other hand, thinks they should make the most of all the spaces, especially on the third floor, so beautiful but so underused. There have been a couple of days, in fact, of overcrowding which has discouraged people from entering or stopping, and this is a potential problem especially if the kitchen is too busy and there is nowhere to sit. As food and drink attract people, a staff member suggested adding a kitchenette on the top floor as well as planning the upstairs activities in a way so that all afternoons are free, and the space is available for people to sit in. This change of use already happens every year, during the Christmas Fair. Since the first two floors are occupied by the Christmas kiosks, the cancer consultation and a kitchenette are moved to the top floor. "I think it would be a good idea; it would restore the balance between activities and space, because sometimes it is quite difficult". (*CCS Barts no.1*)

Visitors at Maggie's Oldham see the lack of parking as a big problem which can sometimes be daunting to visit Maggie's, but sadly this is a whole hospital issue. The Staff, on the other hand, thinks that the ramp to go down to the garden is too steep and equally discouraging, but they could not think of a solution to these problems to suggest.

At Maggie's Dundee, all staff members agreed that both another consultation room and an extra area near the entrance would be useful to allow cancer support specialists to speak with visitors but also to see who enters. In such a formal building it is not easy to make extensions, but speaking to a visitor, he launched the idea of building a room under the long pier. Also, as previously mentioned, while not directly related to the architecture, male visitors dislike Grayson Parry's "Politician", the painting in the large living room they find disturbing and out of place. This reminded me of the sense of provocation that Charles Jencks spoke of about Zaha Hadid's architecture. According to Jencks, this is perhaps how

we have to think of ‘hospital art’ “as a provocation and not as a consolation” (Jencks and Heathcote, 2010, p.29). But visitors at Maggie’s Dundee disagree on the ‘provocation’ aspect and ask to remove the frame.

You could put it in a museum, and I would look at it, but being in this room for the purpose we are in this room is not relevant. We use adjectives like ‘familiar’ and ‘comforting’ and in a supportive and welcoming environment you would expect to apply none of them to a picture like this. It’s challenging, but there are enough challenging things that happen in your life if you’re here; you don’t need them, you don’t even want to see them. Actually, this image is depressing. So, maybe there is something worse in life. Well, this picture is worse than what we have, but is this what we need? No, I don’t think so. (*Focus group Dundee no.1*)

From these quotes it emerges that users can be very articulate about their wishes, their needs, their experiences and tell the architects what works and what doesn’t. It is therefore essential to give users a voice.

## IId. Architectural Brief: Psychological Effects and a Taxonomy of Feelings

In designing their buildings, interpreting the Architectural Brief, Maggie’s architects adopted different design approaches. Using the plans of the eighteen buildings at the time, and analysing them according to the criteria of *entry*, *circulation* and *relationship with the landscape*, in his book “The Architecture of Hope” (2012, pp.32-36) Charles Jencks compared the various typologies derivative in categories ranging from ‘pinwheel’, to ‘spiral pinwheel’, ‘donut’, ‘straight’, ‘blob’, ‘L-shape’.

Based on this precedent, as we will see in Chapter 9, I thought of adding a new criterion to the cataloguing of the buildings: the one of feelings and emotions. In fact, in addition to typology and function, architecture should be measured and classified according to the feelings it arouses in people. For this reason, in an attempt to verify the coherence of the application of the Architectural Brief within the three Maggie’s Centres of my fieldwork through my dossier A4 (*Appendix\_IV*), I have explored a taxonomy of feelings generated in users. To proceed in this direction, however, it was first of all necessary to know the psychological effects released by the buildings. By analysing Maggie’s Brief (2015) I was able to extract three psychological effects released by the building: Impact, Presence, Memory.

### Impact

Maggie's Centres can and should look (and feel) bold and self-confident, as well as inviting and safe. They must look and feel joyous; they must have zest as well as calm. The impression they must give is "I can imagine feeling different here". (p. 3)

### Presence

We ask spaces in our buildings and gardens to allow the people who use them to take charge of how they want to use them. We encourage them to make choices. (p. 3)

### Memory

The job of those who work at Maggie's, is to help people work out how to live with cancer. Each person needs to find the way that is right for him or her, but most people will need some help, at some stage, in finding out what their own way is. (p. 1)

Secondly, speaking with the Client-expert, I received confirmation on the psychological effects released by the building which is based on the Architectural Brief. Finally, In the effort to convey to users of other future healthcare facilities what effects the Maggie's Centre enables and what feelings are released, I have gathered testimonies from the Maggie's users of the three centres in my fieldwork and composed a taxonomy of feelings. In elaborating a table of the feelings generated in the users of the three centres, indifferently, I was able to confirm that, due to the hybrid nature of the building and the flexibility of interpretation of the architects implicit in the Architectural Brief, Maggie's Centres have the same effect whatever their 'look', and regardless of the geographic context or the local culture of the place where they are located The 'look' is therefore irrelevant to the final effect (Box 20).

Impact. As described by the Architectural Brief, the impact, of course, is the most important of the three effects because it must convince the visitor to enter the building from the outside. The 'look' will play a decisive role in encouraging people, especially if they are as vulnerable and scared as Maggie's visitors. On the other hand, as Laura and Marcia state in the quotes below the building should not scare, but rather entertain, stimulate, and intrigue.

It has got to be obvious where the front door is from the beginning. And the building, from the outside, can't frighten you: it can amuse you and *stimulate you and make you feel curious*, but it can never be 'Oh my God. Worship, worship this building', because that's not what can get people to come into the building. It's the invitation that's incredibly important. (*Blakenham, 18.05.2019*)

From this point of view, of the buildings that have been built, some of them are more or less iconic, considering 'iconic' to be a positive term. However, to attract people inside, what matters are the feelings generated in the people.

Iconic or not iconic? Like Piers's I just think it's amusing and light-hearted and it makes you smile and fun. Or Rem Koolhaas's is enticing. There is something about his building that is curious (...) But when you see it in the landscape, you are curious about it. You wonder '*Oh I wonder what it is*'. So, you are still attracted, but in a different way. Neither way is wrong, as long as you have been led in a way. (Lee, 18.05.2019)

As for the impact effect on users, the feelings in front of the Maggie's Centre can be very different depending on the architecture and the person.

When I was in the hospital after the operation, my ward looked at the building. And it was so beautiful. And I could see the roof of the building, and people going and coming, and I knew it had something to do with cancer, but I didn't really know what it was, so I decided to come. (Move-along Dundee no.4)

I came one day, and there was a lot of people, I noticed. I must have arrived at the same time as many others and I thought '*No, I can't deal with this*' so I went home and I did the same thing again, the following day. So, I came back on the following Monday and it was quiet and calm, and I couldn't see people. So, I went in, and somebody, almost grabbed me and said, '*Hello. Come on in and have a look around*'. And I think the entrance, because you can't actually see a lot from the entrance, for me, it seemed calm, you know, rather than when you go into a hospital where there are people at reception. There's none of that here. It's you and the tree. (Focus group Oldham)

So, this door is so invisible. I've never seen it. I've never used it. But even the front door that I use is quite invisible because it's muted, it's got the glass muted and it doesn't look as very inviting even the word Maggie's, even when I walked across it this morning I noticed it says MA-GG-IE's, you can never see the full word from a distance, because it's the grey tone and it's a matt tone, you can't see it so well. (Move-along Barts no.3)

Presence. In the Architectural Brief there are many possible descriptions about presence. The way it is meant here and how I have already called it in this thesis with terms such as *ambience, atmosphere, aura*, is when we know the building, and, despite this, we never get tired of it, we are particularly attracted and we don't know why. When people are familiar with the building, they consider it a sanctuary, a cocoon, a peaceful, quiet, familiar place, but also a spiritual or stimulating place that releases emotions every time we visit it.

There is something about his building that is curious. And we are talking about feelings and what feelings that building engenders. Literally, when you walk through the door, it's extraordinary. What I think is remarkable of Rem's building is you almost don't see or feel the architecture, you just feel '*this is the most lovely place to be in*'. You don't say 'look at that amazing ceiling, it has got wood and concrete.' You just feel it, you don't see it, in a funny way. (Blakenham, 18.05.2019)

As for the presence effect on people, although each project is different as are the relationships between the parties, the feelings among the users start to become more consistent:

A place of sanctuary, because it's away from the hospital, but connected to life. At the beginning I thought this was a place where you go at the end, and I didn't realise it was about living rather than dying. There is a feeling of total tranquility, a church quality about it, and safety. (*Move-along Dundee no.4*)

I think this is a safe environment, where you can talk to people. You speak to experts on the site. And you don't feel like you're taking them away from the jobs. And it's so relaxing, and it's the design of it is so warm. (*Focus group Oldham*)

And that's what's so nice about the place. You know, it's not like when you're out in the world and people are expected to talk about it (cancer), or they're given us stupid quotes. You don't know what you're talking about! Here, you do what you want. That's why it's safe, you don't have to talk about it, we can talk about it, you can talk about a little bit, we can talk about a lot. It's accepted, done. (*Move[sit]-along Barts no.6*)

Memory. The idea that there is a future, therefore, to have memories of a place, is implicit in the notion of learning to live with cancer mentioned in the Architectural Brief. In speaking to the participants, I realised that the psychological effect of just the memory of Maggie's is important on the days they cannot be at the centre. In fact, memory is what architecture uses to make people remember the meanings, impressions and emotions that an environment has helped to provide. From individual memory to collective memory, architecture can influence what we remember.

We now know enough about how memories are stored and retrieved to demolish another long-standing myth: that memories are passive or literal recordings of reality (...) we don't store judgment-free snapshots of our past experiences, but rather we hold on to the meaning, sense and emotions these experiences provided us (Schacter, 1996, para.19).

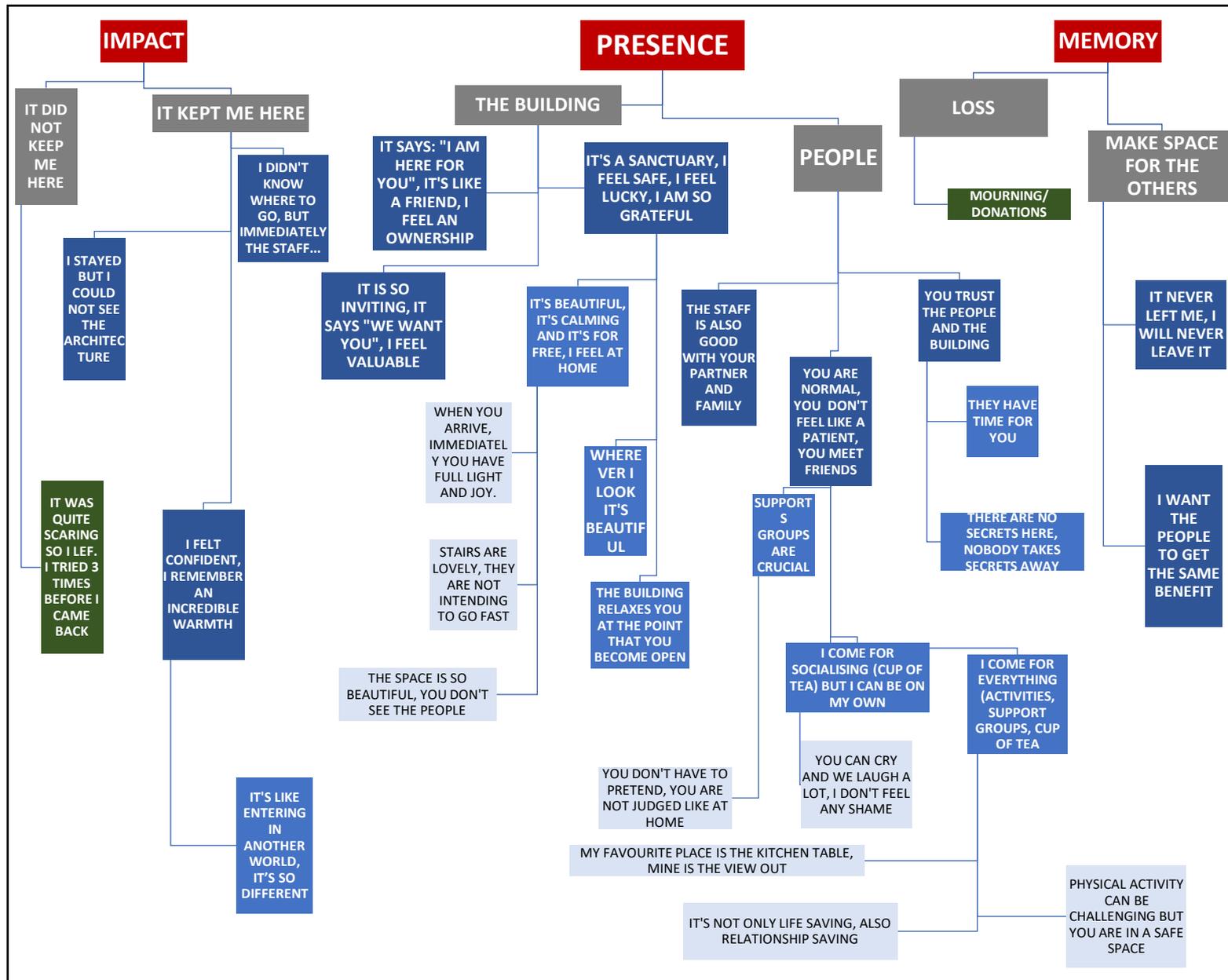
As for the memory effect on people, not having collected many testimonies on the future and on the past as a difficult subject at Maggie's, I report here those on present memory.

So, actually leaving here might be quite difficult, if you can't control at what point you say, '*I'm leaving*'. Because the philosophy of Maggie's is actually not depending on the movement the ball to move. (*Move-along Dundee no.2*).

I've had a couple of days when I felt that I didn't feel good. So, I stayed home but remembering the arts [the art therapy course] made me feel better. (*Follow-up Barts*)

I don't think I could live without it. And Maggie's has been fantastic, not an immediate thing, but I never left it, and it's never left me. (*Focus group Barts*)

In addition to offering some ideas to be able to formulate a new Brief for potential new clients, the Taxonomy of Feelings scheme in Box 20 will help, in the last chapter, to lay the foundations for a “user experience manual” that will teach us a new way of perceiving architecture



Box 20. Psychological effects released by the building and a taxonomy of feelings enabled in Maggie’s users

### III. Looking to the Future: applying Maggie's model

As we already saw in Chapter 4, within the theory of 'Commissioning of Architecture' or Design Brief Management and Procurement (which is the relationship established when a Client entrusts an Architect with a project), the Client has a priority role compared to the Architect (Salisbury, 1997) and, in this, Maggie's makes a new contribution to the way in which the Client-expert instructs the Architects. It must be said that, in the United Kingdom, in addition to the fact that it is not compulsory to use the services of an architect to carry out a building intervention (Mathurin, 1989 cited in Garaventa and Pirovano, 1994), there is no state regulation on the matter and, according to the principles of the Common Law, every contractual aspect must be defined from time to time between the parties according to their particular needs. This implies that, in a mature manner, the freedom of action of the parties is accompanied by a strong sense of personal responsibility (Fontana, 2008). In a humorous form, the relations between the British clients and architect and the various actors in the process, where the architect is always full of ideas that seem bright but turn out to be 'disasters', were already described in the book "The Honeywood File" (Creswell, 1929) and, as Richard Murphy had suggested to watch, in the Monty Python's satires (BBC1, 1969).

Within this context, the RIBA (Royal Institute of British Architects) since 1967 has published an operational model of the building process – the Plan of Work (RIBA, 2020) that is periodically updated and currently used in the definition of contractual documents for the award of professional assignments. While in phase 0 (Strategic Definition) of the Plan of Work, it is about achieving the Client's requirements, in phase 1 (Preparation and Briefing), the briefing process should be less focused on exploring the client's aspirations, to stimulate the designers to respect users' needs (Hirschberg, 1998). Indeed, an effective briefing process involves the client in an interactive process that must consider disparate interests, require the participation of all the parties involved, communicate with all, build adequate relationships between designers, users and developers. Without anyone being discarded or able to dominate others, a creative collaboration between different people can give positive results if one is able to take into account contrasting points of view and cultural disciplines. Peter Barrett and Catherine Stanley, in their book "Better Construction Briefing" (1999) argue that even the best of briefs can result in a modest design solution and, conversely, that the success of a project depends less on a correct check-list system than on an appropriate process. Research in this area has shown that a project is successful when it

derives from a combination of adequate user involvement and the creation of adequate working groups (Blyth and Worthington, 2010).

Based on the literature of management and procurement of the design brief, I report here the data highlighting the conventional approach to the design that still exists today in the UK public sector to respond to building demand. As cited by Clements-Croome (2011), Hilary Cottam, who was appointed as nominee for UK Designer of the Year 2005, wrote that, despite the opposite rhetoric, the public sector persists in choosing short-term cost calculations. The inability to calculate the emotional, social and therefore economic benefits that derive from good design have led to procurement processes that exclude the real experiences and needs of the people who will use the buildings, objects and experiences that are designed.

For example, we are happy to continue building cheap, sub-standard housing to warehouse a population in need, while failing to connect the huge personal and social costs that result. Those responsible for commissioning design in the public sector largely fail to appreciate its potential. Briefs are issued which ask the wrong questions and thereby fail to capitalise on the wealth of design talent within the UK. (Cottam, 2005 quoted in Clements-Croome, 2011, p.255)

In an effort to provide solutions on how to address these problems, Hilary Cottam suggests three basic principles: 1) all briefs are developed in collaboration with those who will work and use the final product whatever it is with a rigorous design process in which a number of professionals collaborate with the users to develop a solution; 2) all projects develop practical and workable solutions for users, but also political guidelines - a set of principles that serve as a reference in the commissions of future projects; 3) all projects are developed within a weighted budget: not more; but differently (Cottam, 2005 cited in Clements-Croome, 2011).

In the study of the theory of 'Commissioning of Architecture', it is important to know that, especially in the past, not all architects have agreed to be governed by an architectural brief. Thinking that it was necessary to learn from practice to write a brief, as already mentioned, Louis Kahn (1901-1974) was adamant that the real brief could only be written once the building was built (Blyth and Worthington, 2010). This is actually what happened with Maggie's Brief, written after the first centre was completed.

At the heart of Maggie's relentless cycling process of 'Commissioning of Architecture' (commissioning one centre, overseeing the construction of another and setting up one that is about to be completed), remaining virtually unchanged over time, the Architectural Brief has enabled Maggie Centres to be "variations on the theme", so that the

act of continuous learning becomes a development of the same knowledge rather than a new experience each time.

With the aim of understanding what will ultimately define the key elements of Maggie's 'Commissioning of Architecture' paradigm to be extended to future healthcare, specific units within large hospitals and non-healthcare facilities or other types of community centres, I list here its contributors and their ties, which make up the iterative and creative process of Maggie's Triad.

- 1) The Architectural Brief – or rather 'the white space between the lines', that is the portion of interpretative freedom given to the architect and left open to any interpretation - which governs the Client-expert / Architect / User-expert relationship. Akin to the concept of the Benedictine 'Rule', the architecture, hybrid functions programme, and life-style values are concentrated in the Architectural Brief.
- 2) The Client-expert (max. 2-3 people) who, over the years, gained a great deal of experience in the construction of buildings dedicated to well-being and who, within the Triad, aims at 'Design as a Form of Care'. Maggie's continues to commission the same building to different architects, gaining knowledge each time. In a sort of active learning, Maggie's is in an unusual position of repetitive client compared to clients who only commission once, and therefore do not learn from that condition. To understand the difference with other healthcare facilities, it is important to explain that, while for Maggie Keswick, fashion designer and landscape design enthusiast, and for Charles Jencks, architecture critic and lecturer, design was always a 'key principle' in their agenda, for Macmillan Cancer Support for instance, architecture is not a priority (*de Rijke, 17.12.2018*). In addition to design, of course, for the Client-expert, there is the more humane and thoughtful approach that is at the base of a new 'Construction of Health.'
- 3) The Architect (not a 'specialist in the sector') who is not required to have any scientific knowledge, but an emotional involvement that comes from having had past experiences with cancer or for being very empathetic in reading the Architectural Brief. This is what encourages architects to commit and do more.
- 4) User-experts who have knowledge and clear ideas about their wishes, needs and experiences and are articulate in telling architects what works and what doesn't. For Maggie's they feel a sense of ownership because they have a transparent image regarding donations and how the money is spent, including architecture costs. In

large charities people never know where and how they are used, while at Maggie's this is very clear.

- 5) Client-expert/Architect/User-expert (Design Team) communication through the Architectural Brief with very few requests. In order not to limit the architect's creativity, the client does not say what they want, but what they do *not* want. The client is never in a hurry. To keep the architect focused, the client does not involve the architect in other issues (politics, donors, etc.).
- 6) Client-Users communication via the support programme and the building. With no assumptions because it is not possible to predict how a visitor will feel when entering the door, the programme and the building are open and flexible. Maggie's users have a say through the role of the Client-expert who is the advocate for them. Acting as an interpreter, the experienced Client-expert will transfer user information to the architects in order to ensure the best result.
- 7) Users-Architect communication (already in progress via Clients-expert and POEs) through the visits to the centres of new generation architects. The newly appointed designer will speak with users during the process of visiting the centres already built while they are designing their new centre-
- 8) Client-expert/ Architect/ User-expert/ Project managers/ Contractors/ Consultants (The Project Team) communication, all the responsible people involved, interested in 'Design as a Form of Care', aware of the fact that the purpose is a charity and that, therefore, when they are asked to do everything possible to find solutions, everyone is willing to cooperate.

Having seen the old hospital paradigm of Architecture of Care, investigated the literature of the 'Commissioning of Architecture' theory and seen the current approach to public sector briefing, and finally outlined the elements that characterise the Maggie Triad briefing process, I propose to compose the Maggie's Brief Model using an example of briefing process that has demonstrated the success of a project (Blyth and Worthington, 2010). Applying its five key elements to my case study I define the "paradigm shift" for a new "Commissioning of Architecture" to extend it to future healthcare and non-healthcare facilities or other types of community centres (Box 21).

	Five key elements (Blyth and Worthington, 2010)	Hospital Brief Model of 'Commissioning of Architecture'	Maggie's Brief Model of 'Commissioning of Architecture'
1	Attribution of responsibility and authority (empowering) to the Client	Design by Committee	Client-expert (2-3 people)
2	Ability to manage the dynamics of the intervention	Briefing process with a fragmented approach and a long functional Brief	Briefing process with a holistic approach and a short emotional Architectural Brief
3	Adequate involvement of users	Users are not involved in design, speak only via POEs	Expert-users (who already speak via Client-expert and POE) will connect with the designers through the process of visiting the centres
4	Use of comprehensible communication / visualisation techniques	Committee-Architect, a relationship with too many requests Client-Users communicate via a limited or non-existent support programme	Client-Architect, a dialogue with very few requests Client-Users communicate by way of an open and flexible support programme
5	Establishment of suitable working groups	Professionals not interested in collaborating with each other because of the fragmented approach	Project Team totally dedicated to the cause, working in close collaboration because of the holistic approach

Box 21. A 'Paradigm Shift' for a new 'Commissioning of Architecture'

As for the architecture and its typology concern, would it be possible for Maggie's, as it was for the monastery, to become an example for the health facilities of other diseases?

No, I don't think it can, because if the cloister, the Benedictine cloister, can become a model for, say, a university, then the scale is roughly equivalent. You can't expect a pavilion model, because the Maggie's are all pavilions. Even when, in miniature, it's a courtyard, or, you know, an object building, they are still pavilions. So, you can't just scale up pavilions. (*de Rijke, 17.12.2018*)

While the Benedictine monastery could become a model for a university or hospital because the scale was more or less equivalent, according to Alex de Rijke, the model of a Maggie's pavilion cannot generate a new typology, which evolves by increasing the number of pavilions or by simply downsizing the pavilion, because it would encounter problems of various kinds. Hence, the only two architectural features that could be drawn from the Maggie's paradigm are:

- 1) Maggie's small size compared to the big hospital. This reminds us of the myth of David and Goliath. Maggie's is David and proves victorious because he is more agile and crafty than the gigantic hospital. Despite its small size, Maggie's succeeds in contrasting the large hospital. This implies that the Maggie's Centre challenges the NHS system and calls for reacting to the accepted *status quo* of the healthcare environment as a whole.

- 2) A design project whose motto is ‘design is a form of care’, but also ‘design is designed with care’. The priorities are then turned upside down: taking the time to think about how people experience the building becomes more important than rushing to build new giant hospitals. These ‘slow’ solutions will also be devoid of signs of sanitary architecture (where the structures of other chronic diseases won’t need it), engaging, flexible, and familiar. This applies, for example, to mental health centres for heart disease, diabetes, strokes, dementia, obesity, or multiple sclerosis (Jencks, 2017).

Some architects have already been asked to build healthcare facilities and even make them look like a Maggie’s Centre. The ability to influence other realities is, in itself, one of the principles that make the Maggie’s Centre a model to be imitated: a small project that first changed the lives of architects, then influenced other projects for other clients, who influenced other clients and users of the centres and hospitals themselves.

### IIIa. Applying Maggie’s Principles in Healthcare

While Laura Lee is working towards the goal of building a Maggie’s Centre for each of the 60 existing oncology units of UK hospitals, Charles Jencks has always talked about applying the Maggie’s model to structures for other chronic diseases, that is, those for which someone does not die, continues to live, albeit with certain limits. As people now survive these diseases, new generations of hospitals will need more and more facilities to accommodate the growing number of chronic or semi-chronic patients. Some of the facilities that might look to Maggie’s as a role model are, for example, those for the care of heart disease, diabetes, strokes, dementia, obesity, and multiple sclerosis (Jencks, 2017). During my fieldwork, I met people with cancer who also had other chronic diseases, such as MS, multiple sclerosis. From these visitors I learned that in the healthcare world, in terms of available funds for research, care and treatment, cancer is at the top of the list, while MS is probably at the bottom.

So, I have cancer this year, unfortunately, but also, I have MS that was diagnosed in 2007. The reason I bring this up is I cannot believe the difference in care and treatment. It’s like different planets, 100%. I have been diagnosed with cancer here, this year, but just in terms of treatment and care, people with cancer are given this. Unbelievable. The thing is, with MS, there are no resources, they don’t do anything.

Also, you know, if you are diagnosed with a chronic disease or Parkinson's, the sense of isolation is huge. (*Focus group Barts*)

This highlights another fact and that is that it is not just a matter of applying the principles of a model to a project for a centre for dementia or other diseases, but that the entire charitable operation must have strong practical basis and be focused and dedicated, for free or almost, to cooperate. The project team of another centre will therefore have to include the managers involved (project managers, contractors, consultants), who will all be interested in the 'Design as a Form of Care' philosophy, aware that the purpose is charity, ready to give their best with the utmost availability.

Within the group of chronic diseases, dementia is the one that requires special care and precautions. Studying the experience of Níall McLaughlin's research on dementia (*Losing myself*, 2015) made in preparation for the exhibition of his Alzheimer's Respite Centre, Dublin (2011) at the 2016 Venice Biennale (*Losing Myself -Venice Biennale Architettura*, 2016), I realised that while Maggie's offers stimulus, involvement, familiarity and more, other facilities are often unable to do so, and this depends on both the organisation and the design of the building. For example, it is a common belief that patients with dementia should always walk on a floor made of the same material as change can be disorienting and that continuing to walk in the same direction in a circle is a good thing. In an interview part of the *Losing myself* website (<http://www.losingmyself.ie/>), however, Sabina Brennan (2015), Psychologist at Trinity College, Dublin who works in neuroscience on a brain health project, explained that walking in a ring only serves to facilitate the work of the staff who will have less difficulty in controlling people, safer if they continue to walk in circles. In addition to implying that, in this type of service, the staff are detached from the patients, what Brennan explains is that the building is designed to facilitate the work of the staff at the expense of the patients. Furthermore, the misinformation delivered to the potential architect as a building requirement for this type of disease, where is dictated by the interest of the organisation, will unintentionally mislead the architectural project. In what form, then, can design intervene in the project of other chronic diseases to generate the appropriate well-being for each of these other centres? In the same interview, Brennan explains that with dementia we fear losing independence and memory, but she argues that we can counter that loss by designing buildings that facilitate our lives, prolonging independence and facilitating memory loss. Within residential care, Brennan denounces the lack of stimuli, and argues that design of a stimulating and engaging environment could be of great benefit to people. Finally, she explains that new residents will always try to recreate their home in an

environment they don't recognise as theirs and don't feel they belong. Thus, in an attempt to adapt to the new situation, they will 'recreate' familiar spaces of the past in the current space. In this case, the design can intervene through the personalisation of the spaces, offering an environment that recalls the comfort of a home (Brennan, 2015, cited in Losing myself, 2015).

In an attempt to apply Maggie's principles to structures of other chronic diseases, what has emerged from my research on dementia care is that, beyond the specific differences between various chronic diseases, basic human needs are always the same: *feel valued, feel at home, feel included*. These principles, which are inherent in Maggie's both through the architecture and the staff and the support programme, are those that emphasise the values underlying human dignity as fundamental to the Architecture of Care. In particular, the last principle, 'Integration', is of primary importance. As we know, at Maggie's the space combines architecture and people in synergy, supporting the staff in their work of assisting visitors in a personalised way. This fact never occurs in institutions offering healthcare services in the UK. There is, in fact, no circumstance in which the "staff room" is deliberately excluded from the Brief, thus limiting the staff from being able to segregate themselves from users. Providing an organisation with a staff's station means characterising it with the 'segregation' of the staff from the patient which, especially in the healthcare sector, means treating residents as something "less" or "other".

It's what I call the 'othering', they are different, so why are you eating somewhere else? Shouldn't we eat together? If you have a caregiver in your house that caregiver has dinner with you, that caregiver prepares dinner and you eat together. (Brennan, 2015, 45:30)

This key factor, which sets Maggie's apart from all other organisations, should be an inspiration for architects of other healthcare facilities. When a community is already constituted at the base of an organisation, it is probably unthinkable that architecture can somehow make up for the shortcomings; it is instead conceivable that the design principles can generate an ideal and caring community, rich in values (Brennan, 2015). As at Maggie's, the request of the large kitchen that unites, as in ancient Greece, *therapeutes* and *invalids* is the generating principle of the synergy between people and place that enables psychological flexibility.

In regards to applying Maggie's approach to specific units within large hospitals, during my interview with Ellen von Loon (2018), architect of Maggie's Glasgow, she told me she knew of examples of hospitals which, unable to afford to build a real Maggie's Centre

on the hospital grounds, created a micro centre inside the oncological ward where they planted the seed of the Maggie's Centre.

Of course, the Maggie's Centre is a separate kind of function in the whole healthcare situation, but I must say, there is a lot of new hospital buildings designed in Denmark, but also in Holland, where they actually try to incorporate this in a normal hospital. One hand you could say, it's nice that it's not incorporated, which I think it is, but of course it's interesting to see. Because of the Maggie's Centres, in fact, architects and people running hospitals are thinking twice of what a perfect healthcare is going to be. So, I think that this kind of project has a big influence on how hospitals think about what the perfect environment would be for patients. (*von Loon, 15.05.2018*)

While I could not find the examples Ellen von Loon was referring to, in my research I found two examples of healthcare buildings in Danmark and Holland that were inspired by Maggie's. The health centre for cancer patients in Copenhagen designed by NORD Architects - who in the past already made a proposal for a Maggie's Centre - is an 1,800 sqm building in the city centre. Using the same ethical and design principles, the large centre provides a relaxed and familiar space where cancer patients and their families can receive counselling and rehabilitation. Much larger in size than a Maggie's Centre, the building also offers sun terraces, indoor gardens, and even a rock-climbing wall while space, natural light, and outdoor gardens encourage a positive mind. An example in the Netherlands, on the other hand, is that of the Verbeeten Institute, a treatment centre for oncological radiotherapy. Alongside the medical aspect, the design of the healing environment is tailor-made and focuses on patients and their experience. Here the patients and employees were directly involved in the design and, thanks to their contribution, the building involves both of them in a community life. Although clinical, the building features spaces full of natural light with views of the surroundings, enabling in users - as explained to me by the architect - similar effects to those that Maggie's users experience. This confirms that what matters is the effect that is generated, and that Maggie's seed can take root and start bringing effects to other environments.

In the hope that Maggie's exemplar can be perpetuated in other forms of health care as well, one of the ways the organisation is currently investing is to also think about how they can influence people by taking care of their own health before they get sick. So, before they are diagnosed with cancer, they teach people to take care of themselves and their family. Speaking of a culture of learning for Maggie's, in fact, does not only mean relying on staff to better support visitors, but above all motivating visitors to lead a healthier life that goes

beyond the care of the simple individual with cancer. And this is another important principle to be extended to other healthcare facilities (Lee, 2021).

### IIIb. Apply Maggie's Essence to Non-Healthcare Facilities or Other Types of Community Centres

Having extended the basic principles of the Maggie's Centre model to other healthcare facilities, knowing by now what the therapeutic environment means and how to improve people's well-being, as well-being goes beyond the healthcare context, I propose to extend what would ideally make any building therapeutic, *flexibility* that is Maggie's essence. As mentioned in the introduction to this chapter, I propose to consider other types of community centres, such as care homes for elderly people, nursery schools and kindergartens, and some types of educational facilities for people with special needs where offering *flexibility* would help to respond effectively to the variegated conformation of these particular social environments.

In an attempt to draw a parallel between the design of a dementia centre and a school, as both cause a rapid change in the structure of the mind, it emerged during the interview mentioned above (Brennan, 2015, cited in *Losing myself*, 2015) that there are some similarities between the two, but that the problem with the design of healthcare environments is that it tends to favour the needs of the staff compared to a school where spaces are designed for the students. As we saw in the previous section, this design choice of facilitating the staff to the detriment of the residents creates the distance between them, lowering the 'sense of community', and in an environment that does not accommodate user needs, it is also difficult 'feeling at home'. As already pointed out by Ellen von Loon (2018) during the interview, the design of a therapeutic environment implies flexibility of spaces. Since today it is difficult to predict how people feel tomorrow, and since every day is different, as mentioned, it is important to provide a 'menu' of spaces that suit different feelings, so that everyone can find the right place that fits the mood of the moment.

We just have to make a shell that fits the best with your state of mind, in that particular moment. So, it needs quite different shades, because nobody can guess how you might feel. (*von Loon, 15.05.2018*)

The same concept was expressed by Sabina Brennan (2015), for whom *flexibility* is an “architectural canvas under which everyone can create their own space” (Brennan, 2015). And since, as we know, people are different from each other, enabling a personalised experience is the key to well-being and happiness.

So, obviously, what makes us happy is entirely different. To answer your question, if happiness is somewhat associated with a personal life aspect, is it that the architect creates a canvas that can be manipulated in segments, not a canvas that is manipulated all the time in all different ways, but a canvas that at least, you're never going to please everybody, but we can still be grouped? Isn't that the architects' job in this instance is to facilitate a personalisation of portions of space, that may have to change over time, depending on the profile of residence? (Brennan, 2015, 40:50)

By offering people, who sometimes want to be very sociable and at other times want to be much more introverted, the flexibility of a “shell” or a “canvas” that adapts to different moods and emotions, we will guarantee them a space that they can customise, which translates into a “feeling at home”, which ultimately means well-being (Brennan, 2015).

## Chapter 9. Conclusions

Up until now, the chapters of this thesis have provided a contribution to the conception of the role that architecture plays in facilitating the physical and emotional well-being of people mainly in the healthcare context. In particular, the discussion is an analysis of the therapeutic space of the Maggie's Cancer Care Centre, in which the built environment in synergy with the psychosocial support programme offered by the Maggie's organisation generates a state of psychological flexibility in people with cancer and those around them, thus allowing them to accept the disease, something that was previously unthinkable. In answering the research questions, this thesis attempted to give a 'universal' definition to the meaning of therapeutic environment and, by the will of Maggie's husband Charles Jencks, to elect the Maggie's Centre as a paradigm for healthcare facilities for other diseases, thus bringing a fundamental contribution to the future 'construction of health'. Having understood the phenomenological nature of the Maggie's Centre as a catalyst for an effective therapeutic environment, with great confidence I encourage the architects of future healthcare facilities to adopt this example in order to make their own contribution to the 'construction of health' as well.

'Therapeutic', as a definition, has had its reference point in the healthcare environment since ancient times. Through the application of a double conceptualisation of the therapeutic environment – on the one hand, in the wake of the tradition of the Ancient Greeks who considered the mind as important as the body and generated a 'fluid' dance in which *therapeutes* and *invalids* moved together that has inspired Maggie's support programme and, on the other, as the unique product of the 'Client-expert-Architect-Users' Triad governed by the Architectural Brief which finds its historical reference in the Benedictine 'Rule' – the Maggie's Centre emerges as an effective therapeutic environment born as a small charity, a 'seed' planted by Maggie, twenty-five years ago, which over time has evolved into an emerging paradigm. Since the relationship between the Client-expert and the Architect aimed at the benefit of the Users is one of the cornerstones of the paradigmatic process, I have explored the design collaboration path that the Client-expert and the Architect carry out together, from the moment of the commissioning of the project along with the assignment of the Architectural Brief, to the delivery of the completed building intended for Users. While not directly involved in the design process, within Maggie's Triad users have a say through the Client-expert who, as their advocate, will report to the architects. Furthermore, users who know of the architecture of the building and feel a sense of ownership, are willing to communicate their ideas to the architects. Especially with

the new generation of architects who are invited by the Client-expert to look at the built centres during the design stage, users can communicate and inform them of any problem they may see and suggestions they may have.

By becoming a unique product, the Maggie's Centre owes its success to the emotional involvement of its designers. With a high level of appreciation by its users, awarded with international prizes, requested by hospitals and new architects who would like to design one, this small charity represents an extraordinary and unparalleled example of the therapeutic environment, and much more. Through the analysis of the different aspects that define the Maggie's Centre as a therapeutic environment – its dynamic spatiality, its hybrid nature, and the enigmatic and paradoxical character of its 'non-therapeutic / therapeutic' condition – this thesis aims to assemble a complex and stratified image of how architecture can have an impact and be 'therapeutic'.

With the intention of opening up the discussion to architecture in general, moving away from the healthcare environment, the second part of the chapter goes further in the attempt to demonstrate the role of design and architecture in creating a built environment capable of generating well-being in people. In addition to the many possible paradigms that Charles Jencks had in mind, I suggest that the Maggie's Centre also becomes a model for the cataloguing of buildings no longer by type or function, but rather by *emotions* and *feelings*. By proposing a 'paradigm shift' between the old way of classifying buildings and that suggested by Maggie's model, this latter section provides the principles for a new paradigm in the way we perceive architecture. To set the parameters we need within a new perception of architecture, I use the scheme of feelings that Maggie's users experience in the buildings designed upon the Architectural Brief and virtually draft with them the foundations for a 'user experience manual' - which will eventually have to be written - a notebook in which to report one's emotions in order to recognise the characteristics of the places that highlights the users' voice to spread with a broader perspective. In doing this I give the users a role and provide some suggestions on how to rebalance the relationship within the Triad.

Finally, since "Architecture without people becomes sculpture" (Alvaro Siza, quoted in Berger and Gepshtein, 2020, 8:40) and since my experience over these past three years will never leave me, after a final reflection on the role of architecture as a 'social tool', I want to close the chapter – and my thesis – by remembering one of the many dear people I met at Maggie's. In the attempt to explain to the reader how answered the original questions, I summarise here the fundamentals of this thesis in the passages in the following section.

## I. Responding to the Research Questions

### Premise

The Maggie's Centre – founded in Edinburgh by Maggie Keswick, who died of cancer in 1995, and by her husband Charles Jencks, who also died of cancer in 2019 – is a charity that offers free cancer support in the UK and abroad, providing both a warm welcome and a cup of tea to its many visitors. Distinguishing itself amongst hospitals for its unconventional design, which is a requirement of the programme and one of the reasons for its success, Maggie's Centres help people with cancer to navigate the complexity of traumatic transition in a unique way. By adopting Maggie's motto, which speaks of 'empowering the patient', the architecture of the building tells users that "Maggie's is their home and that they are in charge" (Lee, 2020). Thanks to the Maggie's Centre and its philosophy, new visitors traumatised by a cancer diagnosis find the immediate strength to react and face the present reality, without fighting against a past that no longer exists nor a future that could never happen. This philosophy is based on the belief that architecture is a form of care that, when combined with the social and psychological support programme offered by Maggie's Staff, generates a flexible state of mind thanks to which people with cancer come to accept the disease, something that was intolerable before.

This phenomenon coming from the synergy between people and place that increases the psychological flexibility of people in a Maggie's Centre (Howells, 2016) was observed for over fifteen years by Maggie's psychology lead Lesley Howells, who suggested and inspired me to verify it from an architectural point of view. To discover the origins of the phenomenon or, as she calls it, the 'magic' that hides behind the Maggie's Centre, I started to analyse the Architectural Brief, the programme that is given to architects when they are commissioned to design their own centre. Only a few pages long, the Brief does not prescribe technical solutions, but rather a variety of emotions that the building should evoke in the user, leaving the designers free to offer their own interpretation. Although many new buildings have been added to the network of centres, the Brief has remained essentially the same; it is both vague and concise.

Question no. 1 (Ethnographic fieldwork stage): identify the link between the adopted architectural design methodology and the positive experiences enhanced in Maggie's Centre's users.

During my interview with twelve Maggie's architects about how they interpreted and applied the Brief to their project, I was able to extract the themes that fuelled my research. These topics provided me with the tools I needed to approach my ethnographic fieldwork in the three centres, Maggie's Dundee, Maggie's Oldham, and Maggie's Barts, so that I no longer observed architecture from the point of view of the architect-researcher, but from that of the user instead.

To understand the point of view of the person with cancer, within an environment where the psychological impact is very high, during my fieldwork I adopted a phenomenological approach. By dynamically participating in the life of the three centres, and combining a perspectival view of the space with an embodied experience – that is, not just observing space but experiencing it personally with my body – I was able to collect the data that allowed me to analyse the use of space both quantitatively and qualitatively. This analysis led me to discover the level of 'therapeuticity' of the building and what exactly 'Maggie's does to people'.

Furthermore, by applying a combined method of mobility with a photo-diary/photo interview compiled by the participants, I was able to collect the data that allowed me to access people's feelings and their flexible mental state. The impressions generated upon my participants by the continuous, changing, and undispersed space that affords the observer an evolving experience, help people to realign their thoughts and, ultimately, feel the therapeutic effects. The dynamic space that pushes people to move enables a series of sensations that first create disorientation, but then gives a sense of liberation: the body that moves in the space of experience (which is the basis of Merleau-Ponty's *Philosophy of Perception*, 2012 [1945]) feels a sense of embodiment with the surrounding environment. Discovering that all the requests of the Architectural Brief invite spaces to 'movement', I understood the reason why all centres release the same sensations despite physical, social and cultural differences. Finding my common thread in the spatiality of the Maggie's Centre, I finally conclude that what links the design methodology adopted by Maggie's Architects and the psychological flexibility generated in the users is 'movement' (question 1, Chapter 6).

*Question no. 2 (Data Analysis):* extract the key elements that identify the Maggie's Centre as an effective therapeutic environment.

Referring to various historical examples, from the Ancient Greeks to dance therapy, while reviewing ‘movement’ as a form of externalising the concerns of the mind through body motility, I realised that these references all embody a multifaceted nature. Based on this, I returned to the ‘hybrid’ in the form that was used by Charles Jencks (2015) to define the Maggie’s Centre (the combination of a house/non-home, an art gallery/non-museum, a spiritual place/non-church, a hospital/non-institution). By analysing the ‘hybrid’ as a type characterised by a paradigmatic nature, I found that in history the hybrid was a source of well-being. Likewise, the paradoxical and enigmatic ‘non-therapeutic / therapeutic’ condition of Maggie’s spatiality – as stated by Laura Lee who disavows that the “Maggie’s Centre can heal people” – generates therapeutic effects precisely because it is defined as ‘non-therapeutic’. Understood as a psychological state, being therapeutic or non-therapeutic is not a condition of space, but rather a subjective condition, and, therefore, only in the presence of people can this property be attributed to space.

Reflecting more deeply on what the coexistence of the three elements ‘movement’, ‘hybrid’, and ‘non-therapeutic/therapeutic paradox’ provoke in the sensory environment, I came to the conclusion that flexibility is what unifies the three concepts. The three components ‘movement’, ‘hybrid’, and ‘non-therapeutic-therapeutic’ condition are essential to generate the spatial experience in order to produce therapeutic effects in Maggie’s users. The spatial experience, if positive and placed in a holistic context and devoid of signs of sanitary architecture, generates a synergy between people and place, a ‘fluid dance’, a flexibility that gives rise to an engaging environment that we could define as therapeutic.

Accompanying the three phases of psychological flexibility therapy (Be Present, Open-Up, Find Your Values), the synergy that the architecture of the Maggie’s Centre offers unites people with the place. Between the uncertainty of life and the architectural stimulus, a moment of “pause” is needed and at the front door the building asks people to be present, and to consider the choices that Maggie’s offers them. By regaining control, the kitchen table helps people open up to conversation, facing the challenge of cancer with others. By sharing their values and thinking back to the narrative of one’s life, each individual, different from the others, can now rewrite it by cultivating the idea of contributing to a common future. Linked to the psychological concepts of choice, control, response to individual differences, Maggie’s synergy between people and place allows Psychological Flexibility in people. Confirming Lesley Howells’ postulate and revealing what was not already evident in the basic study, this chapter comes to an end by bringing together the three elements (movement,

hybrid, non-therapeutic) in the single concept of flexibility that is what ‘universally’ defines a therapeutic environment (question 2, Chapter 7).

Question no. 3 (Final reflections): critically evaluate the Maggie’s Centre as a model to be applied to healthcare facilities for other diseases and other types of community centres.

After discovering the paradigmatic condition of the hybrid, and on the basis of the fact that the substantial number of existing Maggie’s Centres constitutes a *corpus* in evolution, a field of action shared by a community, based on the theories and will of Charles Jencks and the findings of this research, in Chapter 8, I suggest electing the Maggie’s Centre as an emerging paradigm. Since Maggie’s Triad of ‘Client-expert-Architect-User’ governed by the Architectural Brief is what guarantees the unique architecture of the Maggie’s Centre, I have explored this relationship in search of a new brief model of ‘Commissioning Architecture’ to be allocated to other ‘Triads’. To make a contribution to a new ‘construction of health’, based on an integral and integrated system, a *continuum* of an extended healthcare environment, I broadened my horizons and, looking to the future and I highlighted the design principles of the Maggie’s Centre to pass them to other healthcare and non-healthcare facilities or other types of community centres as well. Making designers aware of the design consequences that a project has, I hypothesised applying the Maggie’s model also into specific units within large hospitals (question 3, Chapter 8).

Within the healthcare environment, the now established ‘Commissioning of Architecture’ paradigm always governed by an emotional Architectural Brief will, first, tell Clients how to extract the work from the architects pushing them to ‘go beyond themselves’, and second, tell Architects how to communicate with the users in order to deliver a unique product; finally, following the example of Maggie’s users, it will tell other Users how to become User-experts and judge architecture no longer from an aesthetical or functional point of view, but in terms of emotions and feelings that they will recognise. On the basis of these answers, in the next section I expand my conclusions to a more general reflection.

## II. My Findings as Part of the General Discussion

During the interviews with twelve of Maggie’s current twenty-four architects, as said, none of them claimed to have any scientific knowledge of healing architecture. As confirmed by the Client-expert, while aware of its existence, the current manuals on “healing design” of

hospitals have little value for the design of sensory architectures of ‘health buildings that do not look as such’, in addition to the fact that they are also taken into little consideration in the design of modern regional hospitals (Marsh, 2018). As mentioned in the Introduction, there is a discrepancy between the ideal world of the academy and the functional world of practice dictated by the ‘constructors of health’ that is still tied to a functionalistic logic and non-personalised design of care. As Sabina Brennan (2015) states in the interview about dementia care seen in Chapter 8, the biggest problem in healthcare is the excess of focus in favour of the staff, and the lack of homeliness and the ‘de-personalisation’ of the architectural space for the users.

I think what strikes me is to see these poor individuals constantly trying to find, I would call it home, which in a sense is an architectural space on our home, it is as much about how we personalise it. (...) And it seems to me that buildings like these are designed around the functions that the staff have to partaking, and there’s no consideration about these older people having a life, and frequently, their activities are based around ‘you come, sit down and watch this’. An extremely passive model. (Brennan, 2015, 37:40, 43:50)

Aside from the exception of the Maggie’s Centre and a few other healthcare or wellness facilities, the world of practitioners in the public sector – and much of the built environment – doesn’t place personalisation of user spaces and, therefore, does not consider as a priority moving away from the “standards” of specialists. After forming a caring community, as Brennan (2015) says, only if architects will be asked to build buildings that are addressing the ‘right’ people’s needs and “making these places seem like normal worlds” (2015, 46:54), it will be possible to change the way the Architecture of Care is designed and built to enable the physical, psychological and emotional well-being of people (Francis and Glanville, 2001; Cottam, 2005 cited in Clements-Croome, 2011; Marsh, 2018).

Based on my findings, my thesis develops an understanding about how architecture can create a therapeutic environment. In this regard, thinking that one day the Maggie’s Centre may change its function (as happened with the first Maggie’s Glasgow [2001], which became Maggie’s office for Scotland), from the answers received by the staff it emerged that when people are visiting and the kitchen is working, the way in which the Maggie’s Centre – no longer a healthcare facility – relates to its users does not change and continues to feel a therapeutic environment. Considering ‘therapeutic’ a restorative environment that anyone would benefit from, if the principles extracted from the Maggie’s Centre work and are valid to enable well-being and flexibility in people with cancer, and, if applied, even in users of other healthcare and non-healthcare facilities or other types of community centres, they

would be effective in generating well-being and applying to architecture in general. Having learned the personal stories of many architects, directly or indirectly involved with cancer experiences, and having verified, through the effort made in the design of their Maggie's Centre, that this experience is what prompted them to 'go beyond' themselves, having also learned that this experience has also influenced their way of working, impacting other projects and other clients, made me think that once the ideal conditions are created, a set of valid principles like the ones extracted from the Maggie's Centre could influence the way in which architects work in general. But what are the principles extracted from the Maggie's Centre that can be applied to architecture in general and what exactly can change the design process in it to convey the message in architecture that "design matters" to promote people's well-being?

As already explained, in Kuhnian terms, a new paradigm completely changes the way people think and act. However, as it would not be an easy task to establish a new architectural design paradigm by looking at the beginning of the process, e.g. at the beginning of the design process, in addition to going back to the source (working on improving teaching and learning methods in architecture schools), I rather propose looking at the end of the process, that is, how to judge a building for a sort of 'post occupancy evaluation'. Once the principles extracted from the Maggie's Centre have been applied to architecture in general, to convey the message in architecture that "design matters" to promote people's well-being and influence the design and construction process, users will classify buildings, no longer typologically or functionally, but emotionally, depending on the feelings and emotions the buildings release. But since an effective post-occupation evaluation in architecture has to be repeated several times over a long period of time, the real litmus test is that architecture, even hundreds of years later, despite changing circumstances, continues to arouse in us feelings and emotions that users also of future generations will be able to judge. The new paradigm should therefore be that of a new way of understanding and perceiving architecture of which the best spokespersons are the users. If we raise the level of appreciation and ask the User-experts to teach us not to not take anything for granted, but to instead be very critical in judging spaces of living, work, leisure, etc., architects and builders will begin to change the way they design and build.

## IIa. A New Perception of Architecture

*Emotion tints all human experience.* (Tuan, 1977, p.8)

As we have seen, by offering flexibility and therapeutic space and continuing to arouse feelings and emotions in us, just as the archaeological site of Epidaurus or a quiet cloister of a Benedictine convent still do today, the architecture of the Maggie's Centre is inexhaustible. Inexhaustibility is the principle for which, despite having visited it several times, a place or building continues to arouse feelings and emotions in us, even after hundreds of years and with different circumstances. Almost "elusive", the inexhaustible place or building unfolds itself over time very slowly, revealing a new secret each time, inviting us to return. Surprising us every time we return, the inexhaustible architecture involves us, making us feel committed, arousing in us affection and a sense of attachment. In this regard, I asked some architects what they thought about it. Everyone told me that in fifty years and more, their buildings will live on and could be used as a nice home or transformed into social facilities for small schools or special needs institutions, still giving us the same feeling even if its function has changed. If so, how can we extend this ability to adapt of the building to architecture in general and still arouse feelings and emotions in us? Among the interviewees, Alex De Rijke (17.12.2018) told me that when he visited Maggie's Gartnavel, the new Maggie's Glasgow, he thought the design team led by Rem Koolhaas, had been very skilled in having designed both a 'specific' and 'universal' building: the architectural rules played in the building were very common to other forms of construction; at the same time, the way in which they were assembled generated something new and eternal. This made me think that, being designed according to the principle of flexibility, the Maggie's Centre can be adapted to any social use and, at the same time, this principle of flexibility can be extended to new buildings to release the same psychological effects and achieve the same feelings and emotions even in the distant future.

To promote a new way of understanding and perceiving architecture even in the distant future, I start from the feelings activated in the people at Maggie's, each one different from the other, judging here only the physical (neither social nor ethical) factor of the environment (place) and virtually design with users the basis for a 'user experience manual'. Possibly to be written – this manual is a notebook in which to report one's emotions in order to recognise the characteristics of the places. Using the psychological effects released by the building (Impact, Presence, Memory) and the taxonomy of feelings that users experience at

Maggie's, the User-experts will teach us a new way of perceiving architecture by suggesting some parameters. By cataloging places based on the feelings experienced by Maggie's Users, the effects released by a place can be:

1. Insignificant/ Unattractive
2. Overwhelming/ Intimidating
3. Non-threatening / friendly
4. Reliable / Authentic
5. Comfortable / homely
6. Enticing / Amusing
7. Uplifting / Empowering
8. Unconventional / emotional

Based on the feelings and emotions aroused in Maggie users and the results of this research, I move on to describe the characteristics of a built environment - a building or place where, if the principles are applied correctly, the same feelings that Maggie's users experience, will also be felt in the distant future. Starting from the cardinal principle of flexibility and continuing with a short list of requirements derived from the Focus groups and interviews and the Architectural Brief, this attempt, to be included in the 'user experience manual', aims to extend the principle of the inexhaustibility of Maggie's buildings to architecture in general so that it is perceived and judged positively also by future generations. As seen in the sections Phenomenology of Architecture, Human Geography of Architecture and Synergy between People and Place, topics as place, meaning of place and attachment to a place (Relph, 1976; Seamon and Mugerauer, 1985) are fundamental in the research for well-being. In addition to dealing extensively with space and spatiality in this thesis, as already mentioned, in the email he sent me on 11.6.2018, Charles Jencks reminded me to consider the place. "Remember (...) the atmosphere, the emotion, the sense, yes, conveyed through the usual architectural means of space, light, rhythm, matter, but also meaning and relationship with the place".

1. *Flexibility*. Because individuals differ from each other based on their experiences perceiving the built environment in an individual way, and because it is difficult to predict how people feel, and every day is different, just by creating a 'menu' of spaces that adapt to different people's feelings, a place or a building can be flexible so that everyone can find the right place that fits the mood of the moment (*von Loon*,

15.05.2018). Flexibility of a place or building will transfer flexibility and psychological well-being to people.

2. *Openness*. Being in an open place helps to understand the place (Tuan, 1977). In the openness the observer moves like an explorer, and through open visual cones that change continuously according to the position of the body, the user merges with the space. The “movement” is the essential condition that allows an embodied experience and a sense of freedom in the discovery of a building or a place that leads to a feeling of mastery and control that will arouse emotions of openness towards the others.
3. *Continuity*. A building or a place that offers a continuity of spaces that follow one another or are inside the other, with almost imperceptible passages, will lead to an evolving experience (*Harbour, 20.07.2018*). Within this spatial experience, by crossing large openings that free the sight and by opening doors that, instead of closing, slide or rotate because, in this way, they can always be left 'a little open', users experience a sense of accessibility and agency that lead to both sociability and privacy.
4. *Unconventionality*. Usually, unconventional or highly regarded architecture (*de Rijke, 17.12.2018*) tends to be stiff and uncomfortable. Instead, by drawing attention and stimulating the senses, the unconventionality of a building or a place makes users aware and more present and ready to retain. In this, unconventionality does not exclude familiarity. As happens at Maggie's, far from being conventional, the familiar environment of the kitchen is where, every day, a good mood and a desire to return are released.
5. *Universality*. As in the case of the Maggie's Centre, the architectural rules played in the building are conceived as both a 'specific' and 'universal': they are common to other forms of construction yet, the way in which they were assembled, generate something new and eternal. (*de Rijke, 17.12.2018*). In fifty years, continuing to live with another use, universal places or buildings must give us the 'push' to make the mind travel into the future and arouse the pride of the past.

6. *Personalisation*. While it may seem like a supposed variable, it makes a difference in the world of architecture when it comes to ‘filling’ large depersonalised containers rather than ‘dressing’ humans with a ‘bespoke’ place or building and making these relationships reflect on the construction. Called a “human scale” in architecture, offering a personalised human experience (Brennan, 2015) creates comfort and physical well-being that will lead to a natural exchange between people and the place.
7. *Metaphor and hybrid*. To put it in the language of Charles Jencks (2015), a place or a building should contain the concepts of metaphor and hybrid, enhancing their architectural richness and human values and facilitating their memory. The first, in giving meaning to the content (in the case of the Maggie’s Centre, for example, it is a metaphor for nature and the cosmos, but also for struggle and hope), the second, in maintaining an indefinite and enigmatic character that in Art is an aesthetic canon.
8. *Inexhaustibility*. To be inexhaustible, in the extreme case of the loss of its functionality or its integrity, an architecture must continue to implement over time a charge that architects call *poetics* and continues to arouse emotions in us, albeit different from those it originally caused and despite the passing of time.

## IIb. Architecture and Its Relationships: Remembering a Maggie’s Visitor

Architecture is the space of relationships. The way people move, interact, discover and enter and leave a space will tell us whether it is a work of architecture that generates well-being, telling people how to behave, and making them part of the space. A characteristic of inexhaustible architecture is, in fact, its ability to attract and involve people; in particular, by creating immersive experiences designed to entertain, engage and interact, a sensory environment facilitates these encounters. As a last step in compiling the ‘user experience manual’ - which will eventually have to be written, I suggest to draw up a short list of inexhaustible buildings as examples of which architectures will make us feel sensations and emotions even in the distant future, but above all that they will implement this capacity for involvement on our return. In this sense, the Oslo Opera House (2015) designed by Snøhetta, also the designer of Maggie’s Aberdeen (2013), represents a significant example of user

engagement. In Oslo the sky is very high, and thanks to its Nordic light it never goes out. Together with its clouds it duplicates itself by being reflected in the water of the fjord and becoming the expression of a cosmic order (Norberg-Schulz, 1979). Standing atop the building's glacial roof structure and combining the natural elements of the Norwegian sky, water and earth, the public can observe the city and the sea and experience a strong sense of ownership and embodiment with the place. Through an emotional engagement, experiential architecture has the ability to pinch the strings of our senses, to make us feel emotions to influence our psychological well-being, then open up and push us towards a new sociality.

Everything that is tangible and has immediate access to our senses creates an approach that translates into a feeling of co-ownership with architecture. And when projects are more generous than they should be in their offer – as in this case, with spaces accessible to everyone – the public naturally feels an integral part. (Thorsen, 2016, para.10)

In architecture in general, this building and place are just one example of engaging architecture. Together with this and others, my ethnographic research has shown that architecture and design have played an important role in facilitating my well-being and meeting with the people with whom I have shared and enjoyed the feelings, perceptions and emotions that have created indelible memories. Because during my research experience of the past almost four years, both architecture and people have had an immense impact on my life, in such a way that it will never abandon me, I want to remember a person – one of my first participants at Maggie's Dundee – who, soon after we met, became a close friend. Unfortunately, like another visitor I met, she recently passed away.

In addition to being positive and full of energy, Alice (an invented name) whom we already met in Chapter 6, was also a fighter. That's why she survived for a couple of years despite her diagnosis, thanks to her project of creating an 'Alice's Centre'. Unfortunately, she did not have time to realise her dream, but her soul and the memory of our short friendship will remain forever in the existence of architecture.

The poetic nature of architecture is identified in the presence and the unfolding of time throughout its existence. And in its existence over time, not at a particular moment in history. Temporality, the ability to forge relationships that shape time, moving emotions, is architecture's true secret, its soul. (Venezia, 2010, p. 40)

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The Architecture of Care

The Role of Architecture  
in the Therapeutic Environment.

The Case of the  
Maggie's Cancer Care Centre

Caterina Frisone

APPENDIX

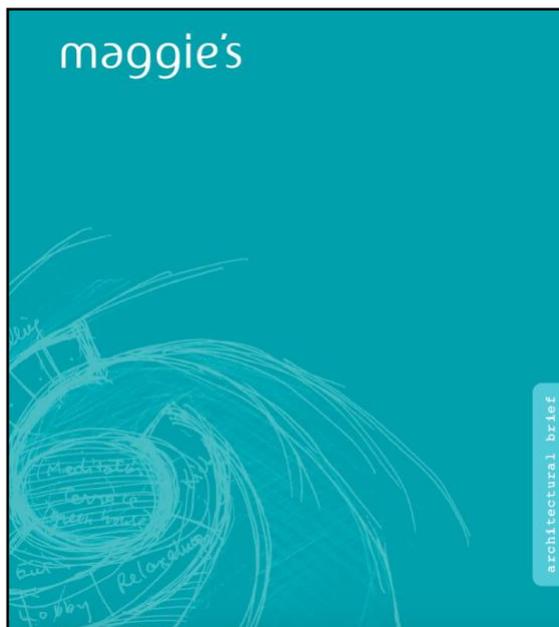
Thesis submitted in fulfilment of the  
requirements of the award of  
Doctor of Philosophy, PhD

Faculty of Technology, Design  
and Environment  
School of Architecture  
OXFORD BROOKES UNIVERSITY

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# I. Architectural Brief (2007)



## MAGGIE'S CANCER CARING CENTRES

Maggie's asks a lot of its buildings and hence of its architects. We expect the physical space to do a significant amount of our work for us.

A Maggie's Centre sets the scene for people going through a traumatic experience. They are places where people draw on strengths they may not have realised they had in order to maximise their own capacity to cope.

We need buildings where people can read themselves differently, as individuals in unusually difficult circumstances, not as patients, let alone cancer victims.

We identify ourselves in different ways and one of them is by our environment. This is why we choose architects who we think will rise to the challenge of making spaces for us which help this transition and also do apparently contradictory things.

We need our buildings to feel safe and welcoming. They need to be small, and domestic in scale. On the other hand these little buildings should not pat you on the head, patronise you by being too cosy. They should rise to the occasion, just as you, the person needing help, is having to rise to the occasion of one of the most difficult challenges any of us is likely to have to face. At the very least they should raise your spirits.

We need our buildings to recognise that the world of the hospital and a cancer diagnosis turn your personal world upside down, and that in deciding to walk through the door of a Maggie's Centre people are saying to themselves and to us: "I am adjusting to a difficult and unknown situation that I am finding hard to cope with on my own."

To a greater or lesser degree, by walking in to a Maggie's Centre people are asking how they can put their lives back together again. They are hoping for transformation.

Giving them a place to turn to which is surprising and thought-provoking – and even inspiring – will give them the setting and the benchmark of qualities they will need in themselves. Knowing there is a place to turn to which is special in itself makes you feel valued.

So we want the architects to think about the person who walks in the door. We also want the buildings to be interesting enough that they are a good reason to come in rather than just "I'm not coping". The first clinical psychologist who worked for Maggie's, Glyn Jarvis, says that working from a Maggie's Centre means that he can start a quantum leap ahead of talking to the same people in a hospital context because people have actively chosen to come in.

Maggie's Centres and the way they are designed increase the sense of connectedness between people: they are not alone in this situation and people can find ways of moving forward from the crisis of a diagnosis. The architects should be thinking about the human relationships and connections, and doing the job of helping that happen.

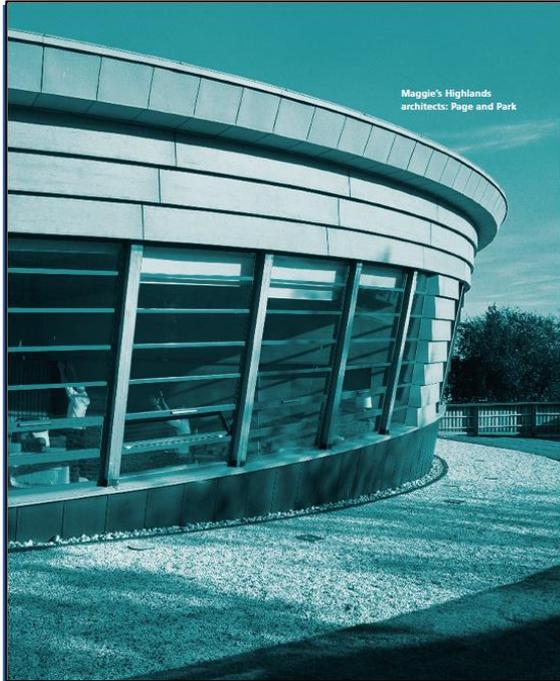
What we're also looking for in our architects is an attitude. We want people to deliver the brief but without preconceived ideas. We don't want to say to them: "This is the way it is done". We want them to open our eyes as well.

Maggie's was lucky in our architect for the first Maggie's, Richard Murphy in Edinburgh, who showed us how much a building can achieve by creating the right atmosphere.

We were also lucky to be able to draw on the close friendships of Maggie and Charles Jencks with some of the most imaginative architects working in the world today, and who have reinforced for us how much a good building can do.

We hadn't realised, until it happened, how powerful a tool it would be that each community feels so proud of its Maggie's. This works on multiple levels. Critical to the success of Maggie's is a strong feeling of ownership by the local community. It makes people feel: "This place is wonderful and it belongs to me, and to other people in the same boat as me". They want to come in. It provides one positive thing to look forward to in their trek to the hospital. It is critical, also, because people talk about their Maggie's. The Centres do our 'marketing' for us. Crucially, these special, unique buildings help us to raise the money we need to build them in the first place, and then to keep them running.

Our buildings are special and we chose special architects, not for some luxury add-on value, but because they are a critical component of what we do.



## THE ARCHITECTURAL BRIEF

### PURPOSE OF MAGGIE'S CENTRES

- To provide non-residential support and information facilities for people with cancer, and for their families and friends.
- The building will offer its users a calm friendly space where each individual can decide what strategy they want to adopt to support their medical treatment and their overall welfare.
- They will be able, if they so wish, to have a private conversation with the programme director or the clinical psychologist about their situation and needs.
- On offer within the building will be a free programme, which will include group support, family and friends support, relaxation sessions, information access and benefits advice. (See Maggie's Centre booklets and website for programme and timetables.)
- People may choose to do any of this programme or none of it. Some will want to use the Centre to have a cup of tea and a quiet pause. Others will be helped by offering volunteer services themselves, such as gardening. And others, again, will want to join support groups and actively participate.
- We do not want to suggest there are better or worse ways of dealing with cancer. Any way that helps anybody going through cancer to feel better is fine, with the important proviso that any service offered in the building will be approved by the Professional Advisory Board and will be complementary and not alternative to orthodox medical treatment.
- Approximate size of a Maggie's Centre is 280m<sup>2</sup>

### REQUIREMENTS FOR MAGGIE'S

- Entrance: obvious, welcoming, not intimidating.
- Small coat-hanging/brolly space.
- A welcome/sitting/information/library area, from which the layout of the rest of the building should be clear. There should be as much light as possible. There should be views out to grass/trees/sky. You should be able to see where the kitchen area is, equally the sitting room and fireplace-area (hearth & home). Maggie suggested a fish tank.
- Office space for a) Centre Head and b) fundraiser/deputy. This should be easily accessible from the welcome area so that either person working at a desk can see somebody come into the Centre, in order to welcome them. Their space should be separate enough that the welcome area does not seem like an office or a reception area. There should be storage space for stationary/pamphlets/bumph accessible to the office space. Space should be allocated for a photocopier, printer, server and other office machinery. Each workstation needs a telephone, computer point and light, shelf and drawer space. As well as the main ones there should be for 5 other workstations, which can be quite small. Can we have this many work stations without it appearing to be like a huge office which dominates the Centre? They don't have to all be in one block. Somewhere for staff to hang coats.
- A video-viewing and computer-link information area or bay for the use of 4 people, probably not all together, but within shouting distance of the programme director's office area, so that he/she can help if necessary.
- A kitchen area, like a 'country' kitchen, with room for a large table to sit 12, which could be used for demonstrations/seminars/discussion groups. The kitchen should be relaxed and inviting enough for anybody to feel welcome to help themselves to coffee or tea. A central 'island' on which cooking demonstrations could take place would be helpful.

- A large room for relaxation groups/lectures/meetings. A space sufficient to take a maximum of 14 people lying down. Storage space for relaxation/folding chairs. As much as possible, you should be able to open and shut walls (perhaps between this and welcome area/kitchen area) to have flexi-space, for more or less privacy, as occasion demands. The relaxation space should be capable of being soundproof when closed off.
- Two smaller sitting/counselling room for 12 people with a fireplace or stove. This doesn't have to be very big – it makes for a friendlier atmosphere if people have to budge up a bit. Perhaps there should be dividing doors to become a second large room, although each one would need to be individually soundproof.
- Two (or one if the large room can sub-divide) small rooms for counselling or therapy, preferably with big windows looking out to grass/trees/sky. They should have a bit of character and perhaps they could have sliding doors that can be left open and be inviting when not in use. They should be soundproof. One should be able to take a treatment bed, preferably facing a window.
- Lavatories (probably 3) with washbasins and mirrors, and at least one that is big enough to take a chair and a bookshelf. They should not be all in a row with gaps under the doors. Private enough to have a cry.
- A very small quiet space to have a rest/lie down.
- Outside: garden areas and 10 parking spaces. If this is unlikely on the site, if possible make a drop-off and pick-up area and perhaps a couple of disabled spaces. We like the idea of a continuous flow between house and garden space there should be somewhere to sit, easily accessed from the kitchen. We want the garden, like the kitchen, to be an easy public space for people to share and feel refreshed by. The relationship between 'inside' and 'outside' is important. A house protects you from the 'outside'. Equally the 'outside' of a garden is a buffer to the real 'outside'. It is a place where you can feel sheltered but enjoy a bit of the kinder sides of nature. There are

practical considerations about privacy, referred to later; we also want to consider how a garden can help invite you in through the door from the street (which is always a key factor) and maybe how to incorporate parking spaces without them being too intrusive.

**PRACTICALITIES**

We have got to run each Maggie's Centre as economically as possible without compromising what we are trying to offer. We know that any kind of complex building costs more to build, but it will have to be borne in mind, at design level, that we have a small building budget and that subsequent building maintenance and cleaning should be as cheap as possible: wood floors/ease of access/6 light fittings preferable to 56.

It might help to think of this as a 'positive' restraint, not an economic constraint, in the sense that the aim of this project is to build a modest, humane building, which will encourage and not intimidate.

**OVERALL**

We want to make spaces that make people feel better rather than worse (most hospitals).

Some things are obvious:

- As much light as possible.
- Important to be able to look out – and even step out – from as many 'rooms' as possible into something like a garden, a courtyard, or 'nature'. At the same time, the sitting/counselling rooms (8) and (9) should have privacy, ie if they do have doors to the outside 'rooms', passers-by shouldn't intrude.
- The interior spaces shouldn't be so open to the outside that people feel naked and unprotected. They should feel safe enough inside that they can look out and even go out if they wanted...this describes a state of mind, doesn't it?

- We want to have the minimum possible 'administration office' type atmosphere. No doors with 'fundraiser' on the outside. We want the ethos and scale to be domestic. We need to think of all the aspects of hospital layouts, which reinforce 'institution' – corridors, signs, secrets, confusion – and then unpick them.

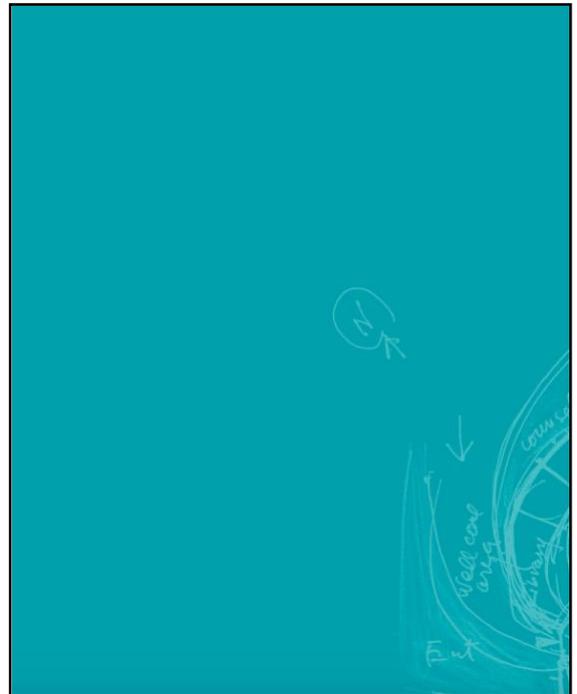
- As a user of the building, we want you to approach the building, and see an obvious and enticing door. When you come in, we want the first impression to be welcoming. People may come to 'have a look', the first time.

- We want Centre users to feel encouraged and not daunted: they are likely to be feeling frightened and very low anyway. We want them to have an idea of what is going on in the whole building when they come in. We want them to feel they have come into a family community in which they can participate, make their own tea or coffee, use a computer, sit down and borrow a book, even find somewhere they might have a sleep for half an hour. Things shouldn't be too perfect.

- The rooms used for counselling should be completely private when they are in use; but it would be no bad thing if they could be opened up when they were not. We want users to know that they can say things in confidence and be quiet, but also be conscious that other things are going on around them that they might be interested in. For instance, they might be able to see what is going on in the kitchen but will not necessarily want to participate in the kitchen chat.

- We want the building to feel like a home people wouldn't have quite dared build themselves, and which makes them feel that there is at least one positive aspect about their visit to the hospital which they may look forward to.

- We want the building to make you feel, as Maggie made you feel when you had spent time with her, more buoyant, more optimistic, that life was more 'interesting' when you left the room than when you walked into. Ambitious but possible?



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# III. Details of interviewees and schedule of interviews

## IIIa. Architects

1. Aabø, B. (2018) Interview with Bjørg Aabø (Snøhetta). Oslo, Norway, 2 November.
2. de Rijke, A. and Sohi, J. (2018) Interview with Alex de Rijke and Jasmine Sohi (dRMM). London, UK, 17 December.
3. Gehry, F. (2018) Interview with Frank Gehry (Gehry + Partners), Los Angeles, USA, 18 June.
4. Gough, P. (2018) Interview with Piers Gough (CZWG). London, UK, 16 May.
5. Harbour, I. (2018) Interview with Ivan Harbour (RSHP). London, UK, 20 July.
6. Haylock, D. (2018) Interview with Darron Haylock (Foster + Partners). London, UK, 12 June.
7. James, Wendy (2018) Interview with Wendy James (James & Garber). London, UK, 13 June.
8. McVoy, C. (2018) Interview with Chris McVoy (SHA). Washington DC, USA, on the phone, 26 May.
9. Murphy, R. (2018) Interview with Richard Murphey (RMA). Edinburgh, UK, 11 June.
10. Page, D. (2018) Interview with David Page (Page/Park). Glasgow, UK, 1 October.
11. Tagliabue, B. (2018) Interview with Benedetta Tagliabue (EMBT). Barcelona, Spain, 19 November.
12. von Loon, E. (2018) Interview with Ellen von Loon (OMA). London, UK, 15 May.

### *Interview schedule*

Body of interview – Key informant interviews were semi-structured and focus of the interview and themes differed depending on the design strategy and focus of the architect participating. Interviewees were encouraged to tell their story. Timeline for the interview (approx. 1.5-2hrs). The following topics/questions are indications of key discussion points:

- Opening:
  - How and when were you approached by the Client-expert?

- Healing / therapeutic environment
  - Background experience in Healing Environment. Scientific or intuitive knowledge and personal experience?
  - Architecture's role. How architecture can contribute to a healing/therapeutic experience?
  - Healing power, from relaxation to stimulation. Feeling better: how? How advanced and beneficial is materiality in the therapeutic environment?
  - Hospital environment, site selection. How did you turn a non-place into a place?
  - Relationship with the Hospital: Detachment and connection. How did you contrast?
  
- Architectural Brief
  - How important was it? How useful was visiting other centres?
  - Visitor's approach to the building. How did you design the entrance route from the hospital?
  - The Brief says that the building has to persuade visitors to enter. Entering the centre is considered a significant moment, as it symbolises the acceptance of the disease and the decision to help oneself. How does the entrance express the invitation? How did you stimulate curiosity?
  - Welcoming effect, engagement and clarity. How did you achieve a clear layout so that visitors can intuitively find their way and not get lost?
  - A building where staff can see people arriving and keep an eye on visitors in other areas as well, but without being too present. What was your strategy, open space or more separate rooms?
  - Domesticity vs. Iconicity, what was your choice? "Feeling at home" by applying only certain aspects of a house (domestic layout in a public building) or symbolism, distracting visitors with visual focuses?
  - The layout of the kitchen should encourage people to help each themselves prepare tea and coffee and facilitate socialisation almost as, in an urban context, a 'piazza', a square or in a convent, the 'cloister' would be the physical heart around which all the subjects gather. How did you obtain that?
  - "Not squared, not too perfect" (Lee, 2018). Furniture, colours, art. How did you integrate them into your architecture?

- Going beyond the Architectural Brief
  - The Brief is apparently very simple, but between the lines it asks a lot (Blakenham, 2007). What was your biggest challenge?
  - It is argued that the experience of a Maggie's Centre is the 'combination' of the spatial experience and the experience of the social atmosphere, e.g. characteristics adopted to describe the architecture as 'welcoming', 'embracing' and 'warm' also apply to users. How did you generate this integration? How did you adapt the different areas to the corresponding privacy levels?
  - People respond differently to stimuli from the same place and feel different levels of comfort in different types of space (Bissel, 2008). Despite the best design, users' comfort cannot be predetermined.' What was your strategy?
  - All designers orientate the centre as much as possible towards nature. What role does Nature play in your project?
    - Inside - outside. Prospect and Refuge. How did you solve, to see out but not to be seen inside? 'Open' inside/'private' from the outside?
- Relationship with the Client-expert
  - A collaboration is a 'collective production' for a 'collective consumption'. How do you judge your experience with the Client?
- Closing
  - Maggie's Architects give the impression of a similar way of working, but, while they share some design themes associated with healing, such as nature, spatial experience, domesticity, privacy, Maggie's architects don't seem to be a community. Are the architects of the Maggie's a community? Is there a common moral or design ethos?
  - How much has this project influenced your work? What have you learned?
  - Further research should be conducted on potential ways to communicate the user experience to designers;

Possibility to access archival material and documents / publications / reports etc. not readily available.

Additional information the attendee would like to add.

Thank you, highlighting the usefulness of the information.

### IIIb. Client-expert

Blackenham, M. (2019) Interview with Laura Lee and Marcia Blakenham. London, UK, 18 May.

Lee, L. (2019) Interview with Laura Lee and Marcia Blakenham. London, UK, 18 May.

#### *Interview schedule*

Body of interview – Key informant interviews were semi-structured and focus of the interview is understand with the Client the conditions for and the moment when a Maggie's acquires its role (tuning). Interviewees were encouraged to tell their story. Timeline for the interview (approx. 1-1.5 hrs). The following topics/questions are indications of key discussion points:

- Introduction
  - I would like to know your story about the work that needs to be done from the moment in which you receive the completed building from the Architects to the actual opening of a Maggie's Centre. Is it always the same 'rite' or is it every time a different experience?
  
- Architectural Brief/ Maggie's Architects
  - The other day a new Maggie's Centre was inaugurated in Barcelona. You have commissioned more than 25 buildings in the past 23 years using the same Architectural Brief and this is one of the strengths of your mission. What was your idea about the role of architecture in people's wellbeing before and how has it changed over the last 23 years?
  - Architects should ask themselves, 'What is it like to be the user of my building?'. At the same time, the architects develop an aesthetic sense. What is more important to you from them, meeting people's expectations or changing their vision?
  - Thanks to the free interpretation derived from the fact that the Architectural Brief asks for emotions and not technical-functional requirements, Maggie's architects have had different approaches in the design of their buildings, and Maggie's states that regardless of the "look" of the buildings they have the same final effect. What do the Maggie's Centres have in common, then?

- Healing Environment/The power of the hybrid/The work of the Staff
  - How do you get a building to behave in a certain way? I have heard that it is partly due to the architecture, partly to the staff, partly to the activities, partly to the careful management etc.
  - Charles Jencks defined the Maggie's Centres 'hybrid buildings' with an 'hybrid' power and that, unlike the multifunctional type (where specific, but unrelated activities coexist), the hybrid nature strengthens Maggie's nature a source of wellbeing. Do you believe in this concept?
  - I would like to know more about the work that the Staff does during the "tuning" process of the building to transform the newborn Centre into an effective therapeutic environment. What is the condition and the exact moment in which this happens and when does a Maggie's Centre acquire its hybrid nature?
  
- Looking to the future
  - By the time the Maggie's Centre stops functioning as a cancer care centre (e.g. Maggie's Glasgow Gatehouse) do you think it will still empower people, for example, as it could do a ruin of a church or a temple, although staff and visitors will no longer interact with the building?
  - By interviewing the architects, I discovered that the design experience of a Maggie's Centre has been useful to their other projects for the benefit of other buildings (medical or not) and to other clients who have encouraged other projects or clients to come. Can we say that Maggie's Centre is becoming a new paradigm?
  - What Maggie's does is create a buffer between the patient and the hospital, the home and the hospital. But the Maggie's Centre is also a challenge for the hospital. A 'David-versus-Goliath' condition, where the smaller and weaker opponent faces a much larger and stronger one and succeeds. Do you think Maggie's will be able to influence hospitals and other health centres in this regard?
  
- Closing
  - Maggie's Architects give the impression of a similar way of working, but, although they share some design themes associated with Healing Environment, such as nature, spatial experience, domesticity, privacy, Maggie's architects don't seem to be a community. Are the architects of the Maggie's a community? Is there a common

moral or design ethos? Do you think that any good architect could design a Maggie's Centre?

- Further research should be conducted on the potential ways to communicate user experience to designers;

Possibility to access archival material and documents / publications / reports etc. not readily available.

Additional information the attendee would like to add.

Thank you, highlighting the usefulness of the information.

### IIIc. Focus groups

Focus group Dundee no.1 (2019) Focus Group with Men's Group Dundee. Maggie's Dundee, 7 October.

Focus group Dundee no.2 (2019) Focus Group with Women's Group Dundee. Maggie's Dundee, 14 October.

Focus group Oldham (2019) Focus Group with Women's Group Oldham. Maggie's Oldham, 21 October.

Focus Group Barts (2019) Focus Group with Women's Group Barts. Maggie's Barts, 4 December.

#### *Interview schedule*

Topic Guide: the Focus group study aimed to extract key themes and help me to understand how the building support users. (Tot.Time: 1,5-2 hours):

- Opening (First Impression/Architecture):
  4. What do you remember of your first visit?
  5. What was that invited you in?
- Acceptance - Open up (neither tolerance nor resignation, but it means to stop investing energy in behaviours that do not work in the long run and turn us away from life as we wanted it):

1. What made you decide to keep coming?
  2. How did the building contribute?
  3. When did you start feeling like a part of Maggie's?
  4. Did beauty make a difference?
  5. Has the building ever disappointed you?
- Defusion - Watch your thinking (the ability to observe one's own thoughts without remaining "hooked", and not acting automatically based on these thoughts.):
    1. What is your experience with this building?
    2. Do you feel different between the first day and today?
    3. What does Maggie's mean to you?
    4. How much do you think the support of the staff would be useful if the building was not here?
    5. Which room or part of the building do you like best?
  - Self-as-context - The observing self (the ability to stay in touch with a perspective of self that does not vary according to transitory emotions or thoughts, but which includes them without changing):
    1. I heard that there are no secrets in this building. If so, is it uncomfortable?
    2. Are you talking about Maggie's out of here at home?
    3. Are you worried about being in an open space hence with little confide and therefore with little privacy?
    4. What is the main problem you see?
    5. What sort of improvements or changes would you make to the building?
  - Closing (Final comments):
    1. Is there anything else you would like to add?

### III.d. Staff

1. CCS Dundee no.1 (2019) Semi-structured interview with CCS no.1 Dundee. Dundee, UK, 24 September.

2. CCS Dundee no.2 (2019) Semi-structured interview with CCS no.2 Dundee. Dundee, UK, 8 October.
  3. CCS Dundee no.3 (2019) Semi-structured interview with CCS no.3 Dundee. Dundee, UK, 10 October.
  4. CCS Oldham (2019) Semi-structured interview with CCS Oldham. Oldham, UK, 24 October.
  5. CCS Barts no.1 (2019) Semi-structured interview with CCS Barts no.1. London, UK, 28 November.
  6. CCS Barts no.2 (2019) Semi-structured interview with CCS Barts no.2. London, UK, 10 December.
1. Centre Head Oldham (2019) Semi-structured interview with Centre Head Oldham. Oldham, UK, 30 October.
  2. Centre Head Barts (2019) Semi-structured interview with Centre Head Barts. London, UK, 17 December.
1. Psychologist Dundee (2019) Semi-structured interview with Psychologist Dundee no.1. Dundee, UK, 18 September.
  2. Psychologist Oldham (2019) Semi-structured interview with Psychologist Oldham. Oldham, UK, 7 November.
  3. Psychologist Barts (2019) Semi-structured interview with Psychologist Barts. London, UK, 16 December.

### *Interview schedule*

Topic Guide: Semi-structured Interviews with Staff was to comprehend the level of cooperation of the building in supporting the main psychological changes sought in the psychological therapy. (Tot.Time: 1h).

- Opening (First impression/Architecture):
  1. Can you tell me how, why and when you arrived at Maggie's the first time?
  2. How was your experience of being in the Maggie's versus the hospital?
  3. What was the first thing that struck you most?

- Contacting the present moment - Be here now (being truly part of the current situation, including difficult thoughts and emotions, and being willing to accept them as part of the experience of life)
  1. What do you observe most in the first coming visitors?
  2. What is the hardest thing they encounter at Maggie's?
  3. How do you voluntarily direct people's attention, focusing on the present?
  4. How does the building help you to open people up to the concept of not struggling and working with reality while feeling free to make the choices they are offered?
  5. When is the moment that visitors start to feel part of Maggie's?
  
- Values - Know what matters (the identification of what is important to a person, of the qualities they intend to express and live in the various areas of their existence, of what they can make with their full and worthwhile life):
  1. How do you feel supported by the building in helping the visitors to see values, despite their illness?
  2. How do you focus visitors' attention on what is important to a person?
  3. When can you see that 'self-confidence / being in control', even of a physical action or movement or use of the building, begins to manifest in visitors?
  4. What room or part of the building do you like best? Why?
  5. What is the most helpful part for the visitors in the building? Why is it so?
  
- Committed action - Do what it takes (the ability to take concrete actions to move in the direction of what the person considers important, even when this act exposes them to unwanted emotions and thoughts):
  1. How useful do you think your support would be if the building wasn't here? Do you think it helps focus visitors' attention on concrete actions?
  2. Could you say that the building allows 'reciprocity' and 'generosity' in its users to take concrete steps towards what the person considers important?
  3. If so, where does this take place in the building? What other good 'concrete actions' do you notice emerging in visitors?
  4. How helpful do you think the support of the building would be, if the Staff were not there?
  5. What sort of improvements or changes would you make to the building?

- Closing (Final comments):
  1. Is there anything else you would like to add?

### IIIe. ‘Move-alongs’/ Move[Sit]-alongs’

Move-along Dundee no.1 (2019), Photo-diary/photo interview with Move-along no.2, Maggie’s Dundee. Interviewed by C. Frisone for this research, 23 September.

Move-along Dundee no.2 (2019), Photo-diary/photo interview with Move-along no.2, Maggie’s Dundee. Interviewed by C. Frisone for this research, 24 September.

Move-along Dundee no.3 (2019), Photo-diary/photo interview with Move-along no.2, Maggie’s Dundee. Interviewed by C. Frisone for this research, 27 September.

Move-along Dundee no.4 (2019), Photo-diary/photo interview with Move-along no.2, Maggie’s Dundee. Interviewed by C. Frisone for this research, 8 October.

Move[Sit]-along Dundee no.5 (2019). Interview with Move [Sit]-along no.5, Maggie’s Dundee. Interviewed by C. Frisone for this research, 15 October.

Move-along Oldham no.1 (2019) Photo-diary/photo interview with Move-along no.5, Maggie’s Oldham. Interviewed by C. Frisone for this research, 25 October.

Move-along Oldham no.2 (2019) Photo-diary/photo interview with Move-along no.5, Maggie’s Oldham. Interviewed by C. Frisone for this research, 31 October.

Move-along Oldham no.3 (2019) Photo-diary/photo interview with Move-along no.5, Maggie’s Oldham. Interviewed by C. Frisone for this research, 1 November.

Move-along Oldham no.4 (2019) Photo-diary/photo interview with Move-along no.5, Maggie’s Oldham. Interviewed by C. Frisone for this research, 1 November.

Move[Sit]-along Oldham no.5 (2019) Photo-diary/photo interview with Move [Sit]-along no.5, Maggie’s Oldham. Interviewed by C. Frisone for this research, 4 November.

Move-along Barts no.1 (2019) Photo-diary/photo interview with Move-along no.4, Maggie’s Barts. Interviewed by C. Frisone for this research, 10 December.

Move-along Barts no.2 (2019) Photo-diary/photo interview with Move-along no.4, Maggie’s Barts. Interviewed by C. Frisone for this research, 10 December.

Move-along Barts no.3 (2019) Photo-diary/photo interview with Move-along no.4, Maggie's Barts. Interviewed by C. Frisone for this research, 11 December.

Move-along Barts no.4 (2019) Photo-diary/photo interview with Move-along no.4, Maggie's Barts. Interviewed by C. Frisone for this research, 12 December.

Move-along Barts no.5 (2019) Photo-diary/photo interview with Move-along no.5, Maggie's Barts. Interviewed by C. Frisone for this research, 12 December.

Move[Sit]-along Barts no.6 (2019). Interview with Move [Sit]-along no.6, Maggie's Barts. Interviewed by C. Frisone for this research, 13 December.

### *Interview schedule*

Topic Guide: Basic topics guide for Follow-up interviews with Move-Along Participants to conduct a reflective analysis of the quality of the experience for both the participants and I. These interviews-with-photographs reflected on the physical movement and measured the building's ability to support users. Interviewees were encouraged to describe each photo and explain why they took them. (Tot.Time: 30min).

- Entrance / 'pause', Welcome / library (Sense of Identity/Authenticity):
  1. Can you tell me why you took this series of photos and what these areas represent for you?
  2. What do you remember about the first time you came to Maggie's? Did you actually pause and assess what was going on with freedom before coming in?
  3. Did the building actually encourage you to continue in and not leave?
  4. Is there a particular area within Maggie's where you identify with?
- Kitchen, computer desk, greenhouse (Sense of Agency):
  - Can you tell me why you took this series of photos and what these areas represent for you?
    1. When did you start feeling part of Maggie's and acting confidently?
    2. What is it within Maggie's that most encourages or instills in you a sense of 'agency / self-confidence / control'?
- Rooms with views releasing sense of safety (Sense of Prospect and Refuge):

1. Can you tell me why you took this series of photos and what these areas represent for you?
  2. Which room in the building do you spend the most time in? Why?
  3. In which part of the building do you feel safest?
- Closing (Final comments):
1. Is there anything else you would like to add?

### III f. Follow up conversations (Participation and Observation)

Follow-up Dundee (2019) Follow-up with Dundee's Participants. Interviewed by C. Frisone for this research, 15 October.

Follow-up Oldham (2019) Follow-up with Dundee's Participants. Interviewed by C. Frisone for this research, 19 December.

Follow-up Barts (2020) Follow-up with Barts' Participants. Interviewed by C. Frisone for this research, 4 March.

### III g. Other Informants

Centre Head Royal Marsden (2020) Conversation / Interview with Centre Head Royal Marsden. London, UK, 14 February.

Hawkes, D. (2019) Conversation with Darren Hawkes. London, UK, 4 December.

Howells, L. (2017) 'Howells in conversation with students', Maggie's Dundee, 1 November.

Howells, L. (2019) Conversation / Interview with Lesley Howells, London, UK, 7 February.

Howells, L. (2019) Conversation with Cathrine Brun, Andrea Placidi and Lesley Howells, Oxford, 13 March.

Jencks, C. (2018) Conversation with Charles Jencks, London, 18 June.

Lee, L. (2018) Conversation / Interview with Laura Lee and Lesley Howells. Interviewed by C. Frisone and A. Placidi, London, 9 March.

## IV. Interpretation of the Architectural Brief (Extract from dossier A4)

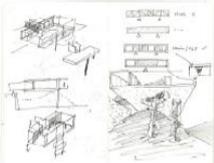
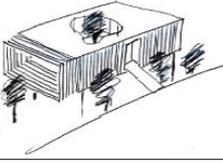
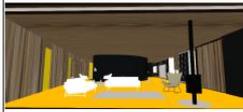
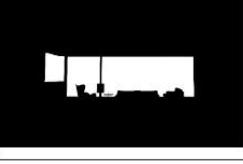
INTERVIEWEE	ARCHITECTURAL AND LANDSCAPE BRIEF - SPATIAL REQUIREMENTS - ENTRANCE/ WELCOME AREA/ LIBRARY			
Jasmin Sohi	<p><b>Entrance:</b> The entrance should be obvious, welcoming, and not intimidating, with a place to hang your coat and leave your broly. The door should not be draughty, so perhaps there should be a lobby. <b>Entrance/welcome area:</b> We think of this as a "pause" space, in which a newcomer can see and assess what's going on without feeling they have to jump right in. The first impression must be encouraging. There should be somewhere for you and a friend or relative to sit, a shelf with some books and an ability to assess, more or less, the layout of the rest of the building. <b>Library:</b> A place to find books and information and be able to sit and look at them comfortably. Some part of the library needs to have shelving for leaflets and booklets. This space could well be integrated with the "pause space" or an extension of it.</p>			
FEELINGS	RESPONSES	BRIDGE AS A 'PAUSE'	PULL AWAY FROM A WALL'	'ENTER TO A DIFFERENT WORLD'
Attracting, Welcoming	<p>"So, we knew that the centre had to be at the scale of a house, not institutional and that you have to feel comfortable. But also, there is this idea in the Brief that talks about the 'pause' space, and I think the way Richard Rogers wanted to create a nice situation, by having a little library as you enter, was really good. So that was something else in my mind while I was designing. I think one of your questions says: 'Why do you have the bridge?' Partially, it is about architectural tension, in terms of the design. If you have a building, you don't want to stick it up to the wall. It is always much nicer to pull it away and have an area, a kind of a buffer zone. For example, we have these trees that you go through. They help you to realize that you are going to a different world: from the world of the car park, then you go through the trees and, finally, you enter the building."</p>			
				
				
PLACE/DATE:	dRMM Office, London, May 2nd, 2018			
INTERVIEWEE	ARCHITECTURAL AND LANDSCAPE BRIEF - SPATIAL REQUIREMENTS - LARGE SITTING ROOM			
Jasmin Sohi	<p><b>Sitting rooms:</b> We need three "sitting rooms" which can be shut off from each other or opened up depending on how they are to be used: 1. The first large room will be used for relaxation groups, t'ai chi, yoga, lectures or meetings and should provide space sufficient to accommodate 12 people lying down and storage room for folding chairs and yoga mats. It also needs to be able to store table(s) for up to 10 people. A flexible space with options to provide more or less privacy would be helpful. The noise from the main hub area of the building needs to be buffered... it doesn't have to be completely sound-proof. It helps if this room is contiguous to the kitchen area, so that it is also possible to have fundraising events there.</p>			
FEELINGS	RESPONSES	TAJ - CHI AND YOGA MATS	FLEXIBILITY	SEPARATION
Call for relaxation and participating	<p>'we knew we had to have a separate area for yoga. In the Brief is quite specific. But, every time we put a glass screen, we thought: "This is not right". Besides, this holding sliding door never works well and people always battle with it. And then, because of the nice view, when we made our model, every time we tried to put something there, it really felt like we were blocking the view. Also, there was a big debate about the curtain, because Laura who has a lot of experience with the Maggie's Centres was saying: "When you pull the curtain, people will feel like to pull the hospital curtain. This is going to make people feel really uncomfortable, sad." But, then, we visited Petra Blaze in Amsterdam.' "Petra is showing Laura what the curtains are like. It really helped to persuade her that it won't feel like a hospital curtain, but like a piece of art or something much more beautiful.'</p>			
				
				
PLACE/DATE:	dRMM Office, London, May 2nd, 2018			

Table IV. Interview with Jasmin Sohi and Alex de Rijke (dRMM) - Maggie's Oldham (2017). *Entering into a different world.* (Copyright dRMM. Used by permission)

## V. Charts of ‘therapeuticity’ (Participation and Observation) (Copyright floorplans FGO, dRMM, SHA. Used by permission)

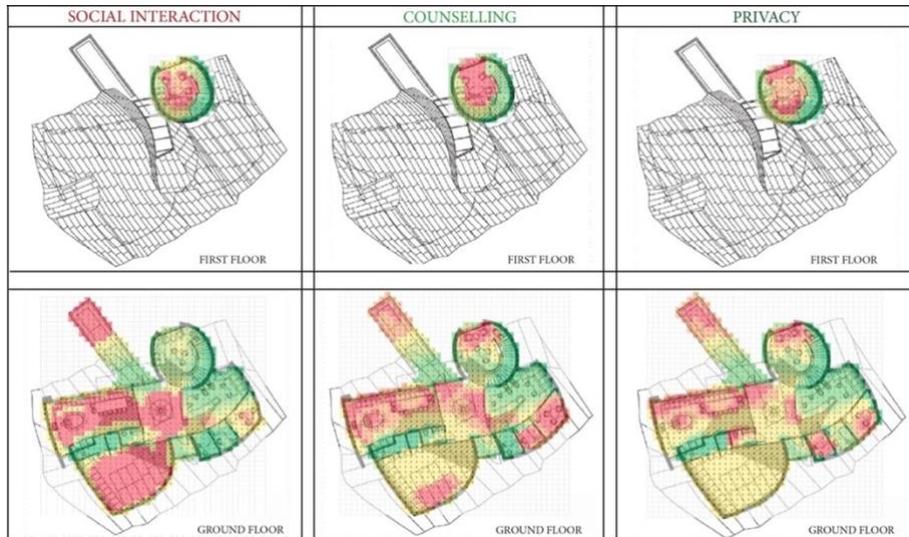


Table Va. Charts of simulation of the therapeutic level of Maggie's Dundee

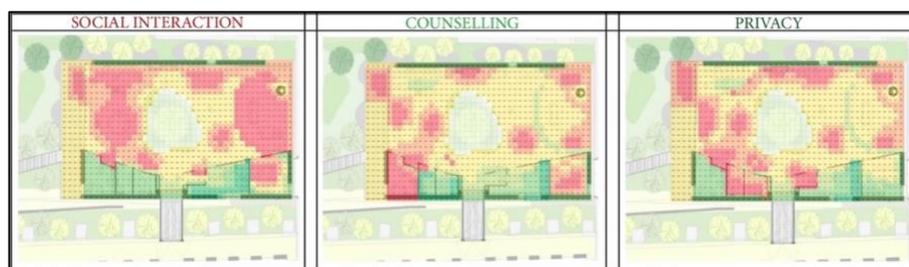


Table Vb. Charts of simulation of the therapeutic level of Maggie's Oldham

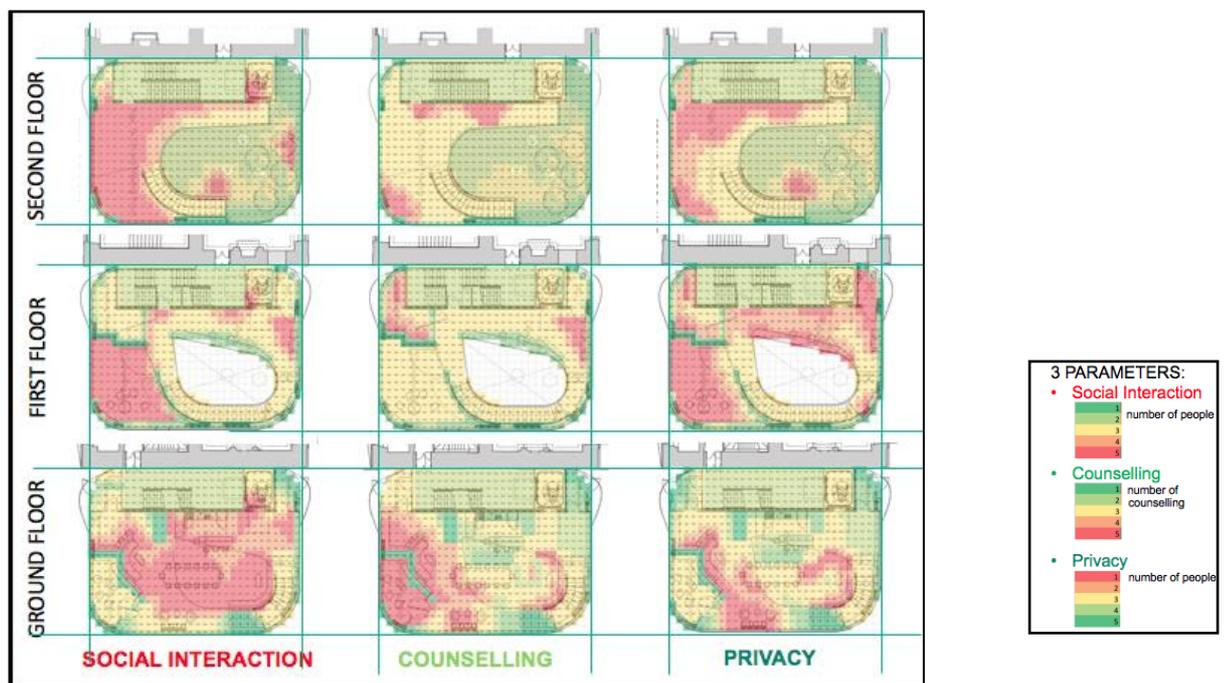
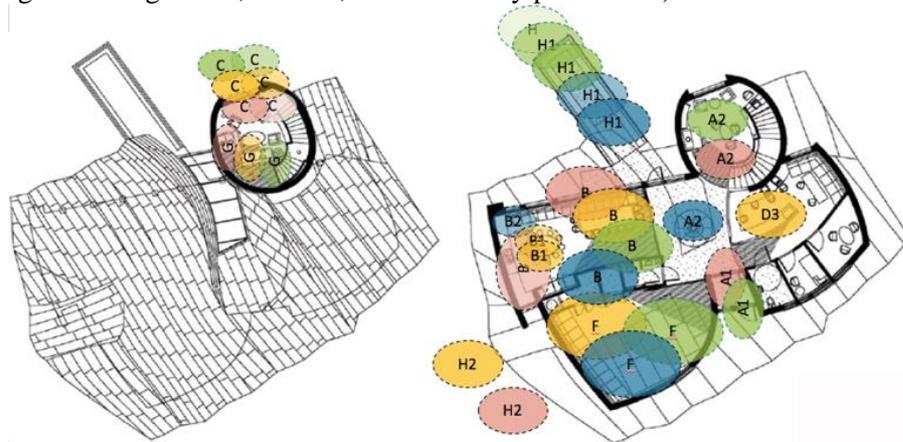


Table Vc. Charts of simulation of the therapeutic level of Maggie's Barts

# VI. Itineraries of favourite places (Move-along)

(Copyright drawings FGO, dRMM, SHA. Used by permission)



Maggie's Dundee	AGENCY			IDENTITY			PROSPECT & REFUGE		
	GROUND FLOOR > UP	FIRST FLOOR > DOWN	GROUND FLOOR	GROUND FLOOR > UP	FIRST FLOOR > DOWN	GROUND FLOOR	GROUND FLOOR > UP	FIRST FLOOR > DOWN	GROUND FLOOR
	WELCOME/ LIBRARY AREA =A2 TERRACE=H1	RETREATS (BENCHES, ALCOVES) =C FIREPLACE=G	ENTRANCE/ PAUSE A1 GARDEN/ OUTSIDE=H2 BIG LIVING ROOM=F OFFICE=D3 KITCHEN=B KITCHEN OVAL=B1	WELCOME/ LIBRARY AREA =A2 TERRACE=H1	RETREATS (BENCHES, ALCOVES) =C FIREPLACE=G	ENTRANCE/ PAUSE A1 GARDEN/ OUTSIDE=H2 BIG LIVING ROOM=F OFFICE=D3 KITCHEN=B KITCHEN OVAL=B1	WELCOME/ LIBRARY AREA =A2 TERRACE=H1	RETREATS (BENCHES, ALCOVES) =C FIREPLACE=G	ENTRANCE/ PAUSE A1 GARDEN/ OUTSIDE=H2 BIG LIVING ROOM=F OFFICE=D3 KITCHEN=B KITCHEN OVAL=B1 KITCHEN CORNER=B2
MOVE-ALONG N.1	A2	C	A2+A1+H2+B			B		C+G	
MOVE-ALONG N.2		C	H2+F+D3+B		C	B1		C+G	B1
MOVE-ALONG N.3	H1	C	A2+A1+F+B	H1	C			C+G	
MOVE-ALONG N.4	H1+A2		F+B	A2					B2

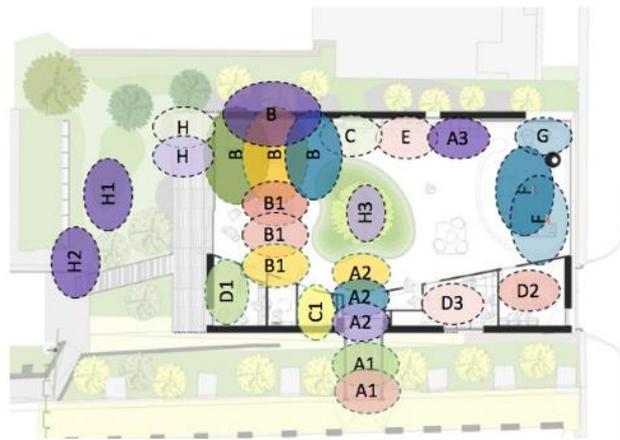
Table VIa. Favourite places of the Move-alongs participants at Maggie's Dundee

**Identity**  
Coming in here I don't remember the architecture of the inside, but what I remember is the environment of people. So the entrance, this spot is where I identify most.

**Prospect & Refuge**  
When you are in here you see the continuity with the outside. I am very aware that there is still life, that life is still coming in.

**Agency**  
You are asked to go into the labyrinth of cancer and in here you can go out quite easily. It was not easy to start with and nothing about this area was positive, but before I went home, I could see 'oh, it's not trapping you'. It's actually, allowing you to walk around in here and then come back out quite easily, so it moved to positive.

Table VIb. Follow up interview, itinerary and photos of the Move-along Dundee no.4.



Maggie's Oldham	AGENCY		IDENTITY		PROSPECT & REFUGE	
	GROUND FLOOR	OUTSIDE GARDEN BELOW	GROUND FLOOR	OUTSIDE GARDEN BELOW	GROUND FLOOR	OUTSIDE GARDEN BELOW
	ENTRANCE/ PAUSE= A1 WELCOME AREA (TREE OF LIFE) =A2 LIBRARY=A3 KITCHEN=B KITCHEN=B1 RETREATS (BENCHES, ALCOVES) =C TOILETS=C1 COUNSELLING ROOMS=D1/D2 BIG LIVING OFFICE=D3 COMPUTER DESK=E2 ROOM=F FIREPLACE=G	TERRACE=H GREENHOUSE=H1 HERBS=H2 GARDEN=H3	ENTRANCE/ PAUSE= A1 WELCOME AREA (TREE OF LIFE) =A2 LIBRARY=A3 KITCHEN=B RETREATS (BENCHES, ALCOVES) =C TOILETS=C1 COUNSELLING ROOMS=D1/D2 BIG LIVING OFFICE=D3 COMPUTER DESK=E2 ROOM=F FIREPLACE=G	TERRACE=H GREENHOUSE=H1 HERBS=H2 GARDEN=H3	ENTRANCE/ PAUSE= A1 WELCOME AREA (TREE OF LIFE) =A2 LIBRARY=A3 KITCHEN=B RETREATS (BENCHES, ALCOVES) =C TOILETS=C1 COUNSELLING ROOMS=D1/D2 BIG LIVING OFFICE=D3 COMPUTER DESK=E2 ROOM=F FIREPLACE=G	TERRACE=H GREENHOUSE=H1 HERBS=H2 GARDEN=H3
MOVE-ALONG N.1	B1		A1+A2++D2		D3+E	H
MOVE-ALONG N.2	B		A2+B1		C1	
MOVE-ALONG N.3	B		A1+A2		C+D1	
MOVE-ALONG N.4	A3+B	H1+H2	A2	H3		H
MOVE-ALONG N.5	B		A2		F+G	H

Table VIc. Favourite places of the Move-alongs participants at Maggie's Oldham

**Identity**

I have been to hell and back with my illness and to meet people with the same illness as mine has been a tremendous help. We don't always talk about illnesses; we talk about everyday things in life. The counselling room is the place where I spoke to the psychologist and did the psychology course that changed my life.

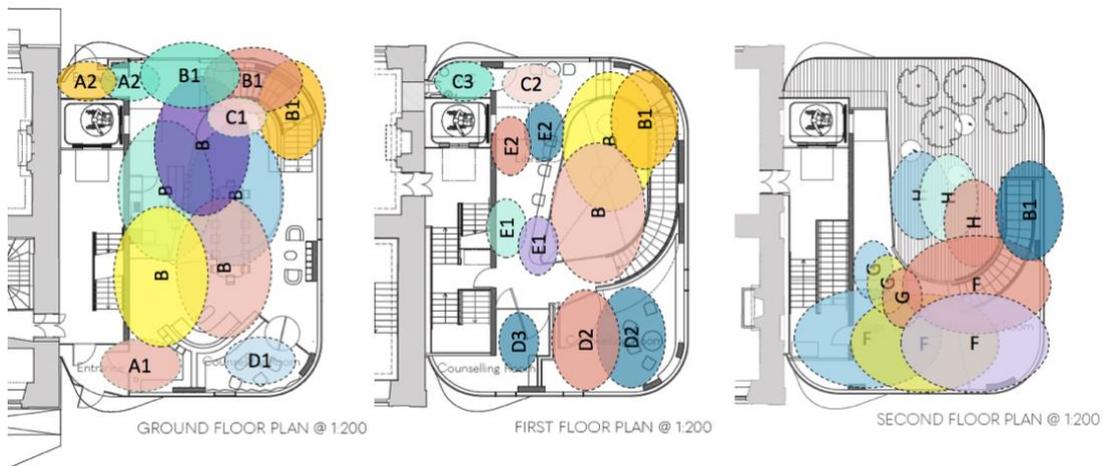
**Agency**

I always sit on this big table. When I was seeing Bernie, I started from the orange chairs, then when I became more confident I moved into the kitchen and this is my throne.

**Prospect & Refuge**

I sit in there so I can see the view out there.

Table VIId. Follow up interview, itinerary and photos of the Move-along Oldham no.1



Maggie's Barts	AGENCY			IDENTITY			PROSPECT & REFUGE		
	GROUND FLOOR	FIRST FLOOR	SECOND FLOOR	GROUND FLOOR	FIRST FLOOR	SECOND FLOOR	GROUND FLOOR	FIRST FLOOR	SECOND FLOOR
	ENTRANCE/ PAUSE/ WELCOME AREA=A2 MAIN SPACE/ KITCHEN=B STAIRS=B1	STAIRS=B1 RETREATS (BENCHES, ALCOVES)=C TOILETS=C1 COUNSELLING ROOMS=D2 OFFICE=D3 COMPUTER DESK=E2	BIG LIVING ROOM=F FIREPLACE=G GARDEN/ OUTSIDE/ GREENHOUSE/ TERRACE=H	ENTRANCE/ PAUSE/ WELCOME AREA=A1 MAIN SPACE/ KITCHEN=B	MAIN SPACE/ KITCHEN=B LIBRARY=E1	BIG LIVING ROOM=F FIREPLACE=G GARDEN/ OUTSIDE/ GREENHOUSE/ TERRACE=H	RETREATS (BENCHES, ALCOVES)=C COUNSELLING ROOMS=D2	RETREATS (BENCHES, ALCOVES)=C LIBRARY=E1	BIG LIVING ROOM=F FIREPLACE=G GARDEN/ OUTSIDE/ GREENHOUSE/ TERRACE=H
MOVE-ALONG N.1	B1	E2+D2	F+G+H	A1+B	B		B+C1	C2+E2+D2	
MOVE-ALONG N.2	A2+B1	B1		B	B				F+G
MOVE-ALONG N.3	A2+B1	C3		B				E1	H
MOVE-ALONG N.4	B				E1				F
MOVE-ALONG N.5	B1	E2+D2+D3	F+G+H	B		F+G+H	D1		

Table VIe. Favourite places of the Move-alongs participants at Maggie's Barts

**Agency**  
I don't feel any shame. It's just I have access, and it means I have access to friends whom I made here, whom I can share experiences with, because you know I don't want to talk to my partner and my family about the details, and they don't know the answers anyway. So it's very good to share people's experiences and you learn a lot. And you can give a lot.

**Prospect & Refuge**  
I don't sit often downstairs; I mean, I chat here, but I tend to sit on the stools, but not very much. Sometimes I am worried of getting stuck.

CF  
So, are you a social person?

Up to a point. I am also private. I like to share things. If I see that someone has a problem I will listen. But sometimes it's exclusive. Sometimes I call myself back. I prefer to be up here rather than down there.

**Identity**  
Yes, coming in here and opening up into this atrium... it's very sexy and very exciting. You know, when you're coming here at the hospital and you're in these big halls... actually this one is good, it's clean, it's relatively new, it's much upgraded, but some of it is a little bit depressing. It's institutional as there's no getting pass. While you come here and it's really uplifting.

Table VIe. Follow up interview, itinerary and photos of the Move-along Barts no.1

## VII. Summary of Key Themes Extracted from the Focus groups with Visitors

<b>Key themes on how the building supports providing:</b>			
<b>Safety</b>	Welcome (hug,) calm, warmth	Relief / protection	Comfort, relax (no pressure)
<b>Authenticity</b>	Presence (Staff and building)	Be yourself (not pretending)	Authentic Relationships (it does not discriminate)
<b>Trust</b>	Openness	Reliability	Privacy (confidentiality, intimacy)
<b>Normality</b>	Engagement	Encouragement	Far-sight (horizon view)
<b>Freedom</b>	Familiarity (another home)	No imposition (no rules, no sign)	Laughing and crying (free to cry)
<b>Sense of worth, Identity</b>	Feeling valued	Empowerment (garden, exercise)	Identity (community)
<b>Agency</b>	Beauty (a priority)	Design /Modern	Inherent kindness
<b>Control / Self-confidence</b>	Helpful to the staff	Personal, built for you	For free / well used
<b>Affectivity</b>	Attachment (Maggie's as a friend)	Reciprocity / gratefulness (helping others)	Addiction (I could not live without it)

Table VIIa. Key themes extracted from the Focus groups with Visitors

## VIII. Summary of Key Themes Extracted from the Interviews with Staff

<b>Key themes on how the building collaborates providing:</b>					
<b>Predictability</b>	Permission (to be emotional)	Stabilisation (it allows visitors to stay)	Authenticity (language and words, i.e. communication)	Safety (dropping the barriers) Confidentiality	Availability (Why people come back)
<b>Flexibility</b>	Freedom to choose	Normality (Cancer is not a subject)	Identity, familiarity (sense of community)	Openness, (Transparency of the way visitors are here)	A space of transition, of interface (Maggie's between hospital and home)
<b>Stimulus</b>	Beauty (Architecture, Art, Design, Furniture)	Agency, Self-confidence (Pride)	Affectivity, (Attachment, Addiction)	Tuning (the building is aging with you)	'Where now', (Future, make space for someone else)

Table VIIIa. Key themes extracted from the Interviews with the Staff