REAL MATERIAL ETHEREAL

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On the affect of therapeutic spaces: A case for autoethnographic research in architecture

Abstract

Research interest in therapeutic or healing architecture has been increasing rapidly in recent years. Within this, evidence-based design has gained popularity, particularly in architecture designed to positively influence occupants' health outcomes, such as healthcare facilities. Evidence-based design approach focuses on quantifiable data and building performance, post-occupancy evaluations and measurable physical health outcomes. However, it lacks consideration for social and cultural aspects with its tendency to become overly reductionist in approach. Moreover, it does not capture the intangible power of built space. It cannot record the affective intensities of architecture; the way space makes us feel, and why.

This paper introduces the research project that is currently underway, which aims to address the gap in therapeutic spatial design research left by evidence-based design. The research project proposes a new methodology. Situated between subjectivism and post-structuralism, the research takes a New Phenomenological approach – die Neue Phänomenologie founded by Hermann Schmitz; the felt body (Leib), and the personal situation (personale Situation) are critical components of the theoretical framework for this research. Using autoethnography as a research method, qualitative data on the therapeutic affect – as perceived by the researcher – of spaces are gathered and recorded. Then, through the narrative and context analyses, autoethnographic data is contextualised within the broader social and cultural framework. Findings inform the architectural design process of therapeutic spaces – as perceived by the researcher with a possibility of resonating with other bodies.

Using autoethnography as a method in architectural research is relatively new. However, autoethnography offers a comprehensive and relatable approach in researching therapeutic spatial experience that considers social and cultural aspects often neglected in evidence-based design. This paper makes a strong case for conducting autoethnographic research in spatial design disciplines and using the current research project as a case study to demonstrate the process.

Introduction

Asclepieia in ancient Greece were dedicated to Asclepius – the god of medicine and healing. They were not only a place of worship but offered healthcare and therapeutic experience to its pilgrims. The approach to the treatment at Asclepieia was holistic; in addition to administering the rational interventions of Hippocratic or Knidian medicine of the time, a range of therapeutic and spiritual activities was provided. Chatzicocoli-Syrakou describes how the therapeutic qualities of the natural environment were emphasised at the Asclepieia, along with recognising the importance of psychological and emotional factors being conduits to activating the innate healing mechanisms of human beings.[1] The location and the building composition of the Asclepieion were carefully chosen to provide patients with natural beauty, rich vegetation, thermal springs and a variety of activities, exercises and social and spiritual interactions.[2] Two millennia later, current discussions in spatial design and built environment research once again aim to improve the psychological and physical condition of patients by providing a healthy, pleasant built environment to achieve better health outcomes.

Since the seminal work of Ulrich, where he argued for a direct link between the quality of a patient's view through windows and post-operative patient outcome indicators, research in architecture's ability to affect therapy and healing has increased rapidly.[3] In this context, evidence-based design practice has gained popularity in recent years. Evidence-based design is derived from the framework of 'evidence-based medicine' or 'evidence-based practice', which originated from the healthcare disciplines. Evidence-based design focuses on using evidence to inform the healthcare facility planning and design decision-making processes and evaluating the relationship between the built environment and outcomes in health.[4]

Evidence-based design relies primarily on quantifiable data and building performance, post-occupancy evaluations and measurable physical health outcomes. However, it does not capture the intangible power of built space. This paper discusses the limitation of evidence-based design and identifies a research gap in the field of architecture concerning therapeutic space. The paper addressing the gap using an unconventional methodology in spatial design research: the research employs new phenomenology (neue Phänomenologie) by Hermann Schmitz as a theoretical framework and autoethnography as a research method. Initial design tests are conducted to further understanding of this methodology.

Current Evidence-Based Design Approach to Therapeutic Architecture

Evidence-based design has garnered strong support within design disciplines in recent years. It is based on the much longer tradition of 'evidence-based medicine' or 'evidence-based practice' of healthcare professions that can be dated back to 1970s. This formalised approach developed in the early 1990s, which aimed to shift away from "intuition, unsystematic clinical experience, and pathophysiologic rationale" and towards more "scientific" practice decision-making by examining the evidence.[5] Since then, Sackett and colleagues further expanded the evidence-based practice model in clinical decision-making as a combination of research evidence, clinical expertise and patient preference.[6] The triad model of evidence-based practice was advanced even further by Satterfield and colleagues to a comprehensive transdisciplinary practice model that included a broader environmental and organisational context, as a fourth element[7] (see figure 1).

Figure 1. Transdisciplinary Model of Evidence-based Practice, from Satterfield et al. (2009) Toward a Transdisciplinary Model of Evidence-based Practice. Millbank Quarterly 87(2): 368-390.

Evidence-based practice was quickly and widely accepted in medicine, nursing and allied health disciplines and has been holding a pronounced position in the healthcare professional practices and their strategic plans ever since. For example, various nursing organisations around the world support evidence-based practice as a core competency in nursing practice and a primary strategy for the development of policy and education.[8] Interestingly, while the history of an evidence-based approach in the design disciplines is short, similar developments in professional practice are well established. The Design & Health Research Consortium was established by The American Institute of Architects and Association of Collegiate Schools of Architecture in 2015. The consortium set out to develop evidence-based tools as one of three core competencies for its members.[9] The Centre for Health Design, celebrating its twenty-fifth

anniversary in 2019, provides Evidence-based Design and Accreditation and Certification (EDAC) program, which launched in 2008. The program's mission is to "develop a community of certified professionals through education and assessment of an evidence-based design process",[10] and its vision is "a world where all healthcare environments are created using an evidence-based design process".[11] In addition to producing design professionals with an evidence-based design certification, the industry is also relentlessly working towards producing evidence-based design guidelines; to implement proven design approach and decision-making in anticipation of producing the consistent outcomes or performances in practice.[12]

However, there is a missed opportunity for the design disciplines amid an incredibly rapid adoption of the borrowed framework. Currently, discourses on the limitation or reflexive criticism of evidence-based design are primarily occupied with the relatively low uptake in the practice setting, opposed to the research that is becoming abundant in number. [13] [14] Therefore, the focus is on addressing 'common myths and misconception' of evidence-based design to set the facts straight and encourage more active utilisation of evidence-based design in practice.[15] [16] However, the most significant issues in the current evidence-based design approach, that led to the research gap addressed in this paper, are not based on misconceptions.

As discussed earlier, the evidence-based practice framework in healthcare disciplines has been developing over five decades, continuously evolving to suit each profession in healthcare disciplines, and the change continues even today. While becoming widely accepted across the board, the discussion on its limitation and criticism also has been active and rigorous. Particularly since the cultural turn resulting in an analytical shift in academia, the evidence-based practice framework has been facing a steep increase in criticism against its tendency to be overly reductionist in approach, and its inability to contextualise at the individual or social level.[17] The cultural turn introduced "a pathway to a clearer understanding of The Big Picture".[18] The new framework proposed by Satterfield et al. (Figure 1) reflects this shift in the context and demonstrates an acceptance that looking at evidence alone will not treat the patient.[19] However, the same degree of reflexive and critical discourse on its episteme is hardly found in the currently available literature on evidence-based design. Additionally, while evidence-based design successfully encourages designers to embrace the research, evidence-based design knowledge produced through current research remains fragmented and unreliable; studies are often based on non-representative, small samples, and do not clearly define stimulus variables.[20] [21] Psychosomatic surveys are commonly developed and used, but often not tested for their reliability and validity. Consequently, this leads to conclusions that are not

sufficiently substantiated or too generalised to add value in the specific practice context. These problems, while more exacerbated in evidence-based design, have certainly been persisting in evidence-based practice in the healthcare disciplines; as the spatial design disciplines adopted the evidence-based design framework, they merely brought the problems along with the anticipated benefits.

Furthermore, Roger highlights how the evidence-based medicine diverts our attention away from social and cultural factors that influence health, while still privileging outdated biomedical, individualistic models of health. In the process, vulnerable groups – including those disadvantaged by poverty, ethnicity, age, gender, and mental health – are left disenfranchised due to the lack of research that are relevant to them.

> "[…] we still need to ask whether EBM [evidence-based medicine] is intrinsically inimical to the interests of disadvantaged groups, or whether it is just that its potential is not being realised. This is a difficult question. […] It is possible that EBM could serve the interests of the disadvantaged, but this will only happen with a commitment to justice in health care at the highest possible levels, funded accordingly."[22]

The same questions and reflection should apply to the spatial design disciplines adopting evidence-based design. Additionally, discipline-specific questions evaluating the evidence-based design framework should also be seriously considered. Should evidence-based design replace the 'traditional' architectural design process where architects use their "analytical, historical, humanistic and formal approaches based on precedent and professional experience"?[23] Should the architects' role be designing a 'therapeutic' space that leads to improved health outcomes measurable by the biomedical model of health? The limitations in evidence-based design identified by the research gap in its epistemological framework highlight the need to consider broad and diverse perspectives on the role of spatial design on health and wellbeing.[24] Therefore, research that investigates alternative methodologies for spatial design research on therapeutic spaces is timely and necessary.

New Approach to Therapeutic Architecture

The previous section underlined the lack of discourse on the philosophical and theoretical position and considerations for social and cultural aspects within current evidence-based design. This paper introduces an architectural research project, currently underway, that explores a new approach to therapeutic architecture. The project aims to address the research gap revealed in the previous section. Against this context, this section explicates all three

elements of the research paradigm of the research project; its subjectivist and poststructuralist paradigm, a theoretical framework based on the New Phenomenology, and autoethnography as a method. In the next section, it explains the research design that consists of three phases and describes the data collection, analysis methods and synthesis of a series of spatial design responses.

The current research project is located between subjectivist and poststructuralist paradigm. Its epistemological assumption is that the therapeutic spatial experience is subject to each individual, where an individual may perceive the 'therapeutic' space differently from another and be shifting in relation to context; in which the specific context – underlying social relationships as well as biographical conditions – can be analysed and interpreted. Notably, post-structuralism offers strong counter perspectives to the limitation of positivism that the evidence-based design relies on.[25] The ethical turn in post-structuralism emphasises subjectivity, authorship and identity, and reflects the overall shift toward ethical, social justice concerns that characterises critical theory.[26] In this research project, post-structuralism significantly shapes the data collection, analysis and synthetic processes.

The New Phenomenology – die Neue Phänomenologie, founded by German philosopher Hermann Schmitz – provides the theoretical framework for the research project in pursuit of therapeutic architecture. New Phenomenology has remained unfamiliar to architectural theory and philosophy, at least within the English-speaking world. This is largely because there are only two English publications with Schmitz himself as the author (the first English translation of a book by Schmitz is due in September 2019), and only a limited number of secondary academic literature that discusses new phenomenology (see Gugutzer[27] and Tonino[28]) are available. However, Schmitz's New Phenomenology offers a philosophy that is application orientated[29] and valuable means to the research on therapeutic architecture that the current project has set out to realise. The research project primarily focuses on two critical aspects of New Phenomenology: the felt body (Leib) and the personal situation (personale Situation) (see Schmitz, Müllan and Slaby[30]), which form the theoretical framework for the research.

While the theory of New Phenomenology can be traced back to the tradition of phenomenology,[31] Schmitz thoroughly challenges the old phenomenology and redefines a phenomenon:

> A phenomenon for someone at a time is a state of affairs of which the person in question cannot in earnest deny that it is a fact. Importantly, what counts as a phenomenon is relativized to a specific person at a certain time. […] relative to

> conceptual perspectives – phenomena are not literally "the things themselves" but rather things as they appear from a particular (historical, cultural, local, etc.) conceptual framework.[32]

New Phenomenology privileges each individual's observations and everyday involuntary experience of life, over a high level of abstraction derived from Husserl's transcendental idealism in phenomenology.[33] Rejection of universality of phenomenological description by Schmitz[34] becomes the most apposite principle of New Phenomenology, which assumes the epistemological framework of the research project and supports the choice of its research method, autoethnography.

Autoethnography is "research, writing, story, and method that connects the autobiographical and personal to the cultural, social, and political". [35] It is a research method that (paraphrased):

> (1) uses researcher's personal experience to purposefully describe and critique cultural beliefs, practices, and experiences; (2) through reflexive practice, interrogates the intersections between the researcher self and society; (3) creates a mutual relationship with audiences in order to compel a response; (4) balances academic rigour, emotion and creativity and strives for social justice.[36 37]

Using autoethnography as a method provides a robust structure to applying a New Phenomenological approach:

(a) Narrating the researcher's own experience of the felt body (auto-)
(b) Evaluating the personal situation to interrogate where the researcher is "connecting the personal to the cultural"[38] (-ethnography).

Autoethnography is particularly appropriate and desirable for architectural research investigating therapeutic spatial experience, due to its similarity to how a typical architect makes design decisions. Architects intuitively conduct the first part of autoethnography: narrating or recounting their own spatial experience to guide their architectural design decisions.[39] This rather autobiographic process is familiar to many architects whether they intellectually acknowledge or subconsciously utilise this "spatial intelligence".[40] There are numerous examples and records of where an architect's personal spatial experience is a reference point for architectural design decision-making. Notably, Peter Zumthor, as below:

> […] I frequently find myself sinking into old, half-forgotten memories, and then I try to recollect what the remembered architectural situation was really like, what it had

> meant to me at the time, and I try to think about how it could help me now to revive that vibrant atmosphere pervaded by the simple presence of things, in which everything had its specific place and form.[41]

Hence, autoethnography as a research method can be a useful tool within the professional practice context, as well as in spatial design research. It allows ordinary, intuitive design decision-making process to be further elaborated in academic research, to become an instrument to engage with the broader social context.

Autoethnographic research design

The design research project consists of three phases: data collection, analysis and synthesis, and spatial design response. Essentially, the design research project is where the spatial design response – therapeutic spatial design interventions – is being thoroughly informed and determined by the autoethnographic study in therapeutic spatial experience. From the scope of design to its aesthetic qualities, the design outcome is a carefully synthesised response to the findings from the autoethnographic study.

For data collection, the research project will compile written vignettes and accompanying visual representations of the spatial experience that the researcher finds therapeutic as well as antithetical to therapeutic. These collected stories and their visual representations become narrative-based data that consists of subjective elements that constitute the (non)therapeutic experience - including and beyond sensorial qualities, enlightening how the researcher's body relates to space within the context. These autoethnographic recordings of spatial experience correspond to the felt body (Leib)[42] from the theoretical framework.

Additionally, biographical data on the researcher herself is collected in similar modes. This is crucial in order to contextualise the researcher's personal spatial experience within the broader conceptual (such as social, cultural and political) framework, and refer to the personal situation (personale Situation)[43] from the theoretical framework.

The modes of collected data (primarily written text and visual representations, with any other additional means that becomes relevant) and how data is presented (exhibitions, booklets and interactive displays) strive to communicate the researcher's personal experience appealingly. The aim is to engage audiences with the affective potential of researcher's experience effectively and to evoke cognitive, emotional and physical responses from them. The

researcher's subjectivity becomes a tool for creating an affective tie between researcher and audiences, which is one of autoethnography's central epistemic tool.[44]

For data analysis, two approaches in the inquiry will be taken: narrative inquiry and contextual inquiry. These analyses reveal incipient themes and deliver insights on certain dispositions of what the researcher considers as a therapeutic spatial experience. Following post-structuralism, detailed attention is given to continually shifting identity, knowledge and meaning. The aim is to locate the researcher herself and her personal experience within the broader cultural and social context. This ensures the spatial design response that follows – the design of therapeutic space that mirrors the researcher's therapeutic spatial experience – is not singular.

The projected outcome of data analysis is a synthesis between the analysis findings and a spatial design brief. Data analysis is expected to draw a comprehensive understanding of what constitutes therapeutic spatial experience for the researcher: from tangible elements such as a locale or materiality to intangible elements like afforded behaviours or emotions. From this understanding, a spatial design brief for therapeutic space that is specific to the researcher is to be derived. The last phase of the research project is to produce a spatial design response that corresponds to this specific brief.

The next section demonstrates the narrative and contextual analysis of the research project to give insights into the inquiry processes as well as the collected data.

Example narrative analysis

'A sense of home' is a critical theme in the researcher's therapeutic spatial experience. This emerged from the early stage of data collection and became the most abundant source of data. The later stage of data collection focused on collecting autoethnographic narratives that comprehensively explored the sense of home as experienced by the researcher. This highlighted the non-linear, interrelated aspects of the autoethnographic research process. The data was primarily in the format of written words – short vignettes, a poem and a reflection – and several accompanying visual representations – physical models, collages and found/collected objects. As the researcher arrived at the point where sufficient data on 'a sense of home' was collected, the collected materials were arranged in a structured format with an introduction, body of texts and a conclusion.

The close examination of the written words (short vignettes and poems), especially with narrative analysis, allows the scope of 'a sense of home' to expand and articulates its multi-dimensional manifestation within the researcher's understanding of therapeutic spatial experience. See the example analysis of the poem "Where is home":

Where is home

Mountains,
of concrete and
of rocks.

Oversized,
from people to houses and
from pine trees to mountains.

Not so oversized,
from people to houses and
from strange trees to rolling hills.

On the train,
with a small suitcase and
a large backpack.

Of someone else,
walls and ceilings,
gardens and sheds and
the letterboxes.

Of mine,
a desk and a fancy chair,
books and a bookshelf and houseplants.

The assembly of the poem shed light on how the researcher acknowledges the changing sense of 'home'. Here, along with the title, the poem indicates conflicts and uncertainty. Six concepts of home are outlined in chronological order as the researcher has experienced them. Additionally, the poem acts as an introduction to the series of written vignettes and visual representations that relate to the theme. Each stanza refers to a unique concept of home (Mountains, Oversized [surroundings] …) and core components (concrete buildings and rocky hills) for each concept. This structural information connotes the personal importance of each concept of home to the researcher.

Functionally, the poem serves multiple roles. The researcher (the author of this paper) uses the poem to encourage readers to review their notion of home and from which components

their sense of home is derived. To the researcher herself, the process of writing the poem was revealing as well as therapeutic. It legitimised the internal conflict felt by the researcher; an irreconcilable state against the inherent and ideal/conventional quality that is attached to the sense of home, which emulates stability, consistency and permanency. By allowing the researcher to construct a tangible list of the changing concepts of home, the poem solidified the plurality of home for the researcher. Additionally, it led to opportunities to elaborate on each concept of home in more detail using written vignettes and other relevant modes.

Figure 2 shows the visual representation that relates to the theme 'a sense of home', accompanying the written vignette elaborating on the first stanza from the poem "Where is home". The written vignette recounts the researcher's childhood memory, finding familiar comfort of home on the concrete rooftop located at a context she finds somewhat foreign:

> Nothing to heighten my senses, unlike the mountains, but only the familiar texture and the warmth from the sun. […] It takes some time to get used to, but soon enough, I can appreciate everything about this moment. My eyes are closed, but the sun still brightens. The sound and smell of mountains are distant, almost unnoticeable. The warmth emanating from the concrete surface gives comfort despite the hardness.

The visual representation serves two purposes. Firstly, it allows the researcher to identify the critical element from the spatial experience to represent visually; the process innately involves examining the experience spatially and often aids the researcher to elicit architectural design indicators. Secondly, it becomes an active device to engage other bodies. Visual representations have lower barriers for engagement than written words and can be designed to complement the static act of reading with interactive activities.

Here, the materiality of concrete – particularly its qualities under the summer sun – was identified as the critical element. Hence, the visual representation was developed as a physical model of the rooftop that accentuates the materiality of concrete, and the exhibition of the physical model aimed to simulate the researcher's experience by installing a heat lamp above it and allowing interactions from observers (i.e. touching the concrete surface to feel the warmth). It was successful at garnering observers' interest, which also often led them to read the accompanied written vignette and instigated various responses that could reveal the extent of relevant cultural context.

Figure 2. A photo collage of the visual representation 'the concrete rooftop' in the display, 2019

Example contextual analysis

Autoethnography allows the researcher to investigate which events and social and cultural discourses have defined her experiences through self-reflexivity,[45] "connecting the personal to the cultural".[46] The contextual, self-reflexive analysis reveals the elements of the researcher's personal experience that are not rational as well as the world of others in a personal, literal and experimental way.[47] For example, in relation to the researcher's plural senses of the home, two critical events from the researcher's personal history and associated social and cultural contexts can be identified: immigration and insecure housing situations.

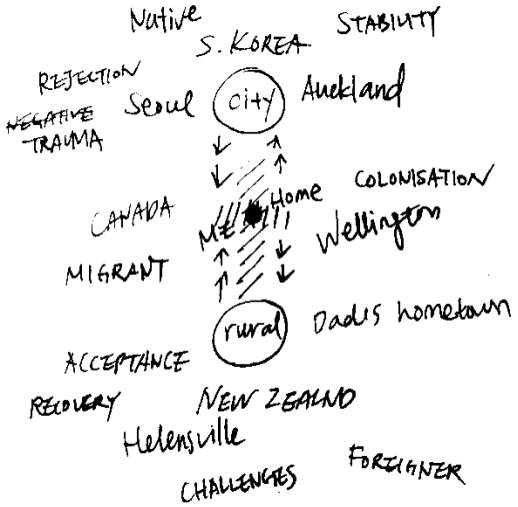

Figure 3. Wordcloud diagram, from the researcher's notebook. S. Chun, (2019).

The researcher's family moved countries when the researcher was aged between 12 and 13, moving from a big, metropolitan city of a small country in Asia to Canada, then to New Zealand.

The first three stanzas of the poem “Where is home” reflect this experience. Being raised within the immigrant family context has contributed to the researcher’s plural understanding of home, and further delamination of different concepts of home. Figure 3 presents the complex personal and cultural concepts that stem from being a migrant; the diagram indicates the researcher is identifying herself as situated “in-between” cultures, nations, places, with consistent push and pull in two directions, and with a limited number of “consistent” or “common” elements.

The last three stanzas of the poem “Where is home” reference the insecure housing situations – both voluntary and involuntary, and Figure 4 refers explicitly to the researcher’s recent experience of navigating the current housing crisis. Being unexpectedly evicted twice in a five-month period resulted in a significant rift between the established, ideal concept of home and the researcher’s prior experience of home. It became clear to the researcher that the ownership of a property is a vital requirement for the place of residence to convey ‘a sense of home’. Consequently, ‘agency’ was also emphasised as a critical element of therapeutic spatial experience.

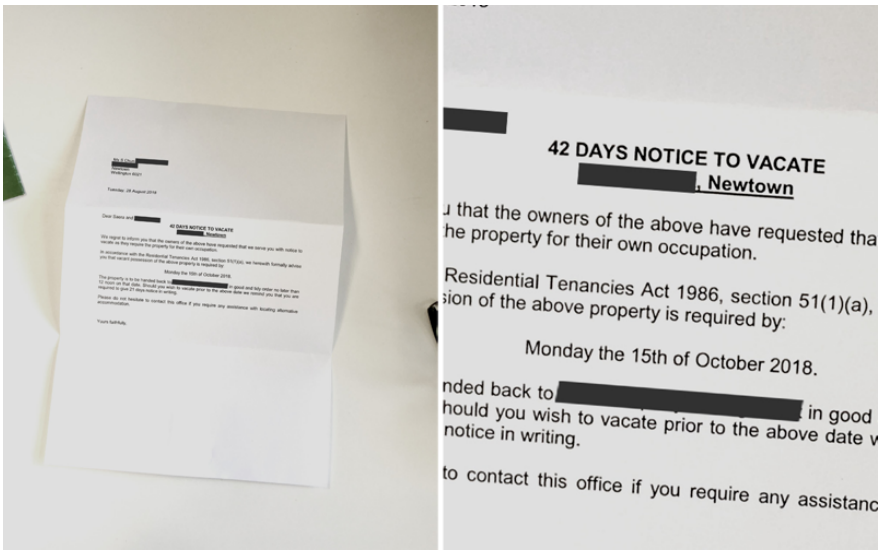

Figure 4. One of two 42-days notice-to-vacate letters received between Aug-18 and Jan-19. (2019)

Understanding the researcher’s therapeutic and non-therapeutic spatial experience in the context of her own personal, social and cultural identity ensures that the outcome of the analysis is not singular, and at the same time the limits to its interpretation are recognised. While conducting contextual analysis, it should be noted that the cultural studies originated to connect the criticism of power to opportunities for intervention. The analysis of the personal experience contains complex relationships to other cultural elements and social powers.[48] Therefore, revealing cultural and social forms of injustice through critical analysis is central,[49]

[50] [51] which should lead to investigating the possibility for change. In architectural research, the possibility for change can be developed as architectural problems that call for interventions at the built-environment context.

Discussion and Conclusion

This paper introduced the research project that is still in progress, which set out to address the gap identified in spatial design research on therapeutic spaces: a neglected concern for social and cultural factors by the rapid expansion of evidence-based design in spatial design research for health and wellbeing. The research project proposes an alternative approach by shifting to another research paradigm and exploring a new research methodology anchored by comprehensive philosophical and theoretical frameworks.

The primary aim of the research project is to design therapeutic spaces that mirror the researcher's therapeutic spatial experience, which has been contextualised in the broader social and cultural framework. The secondary aim is to propose a new methodology and furthers knowledge of autoethnography as a research method in spatial disciplines. While the research project is yet to be completed, there are provisional discoveries to reflect on both designing therapeutic spaces and research methodology.

Firstly, the analysis of autoethnographic data to date has revealed emergent themes that construct the researcher's therapeutic experience. Namely, a sense of home (that is plural and shifting), agency, escape and distraction, changing perspectives/scales through vertical elevation, temporal presence, and more. Some of these themes have already been revealed through the analyses demonstrated in this paper. Adding on to the emergent themes, there are two principal, but provisional, indicators for synthesising the spatial design brief for the final phase (spatial design response) of the research project:

(a) Therapeutic spatial experience is a social and personal construct, which is sensitive to the milieu of an observer's specific context, and therefore, may be continuously shifting
(b) The above finding redefines the scope and capability of spatial design responses. The limitation of spatial design interventions should be clearly acknowledged – this should lead to a comprehensive exploration on what the spatial design interventions can uniquely offer for therapeutic affect.

Secondly, it has become apparent that the autoethnographic research process is not linear but interrelated. The research process involves perpetual shifting between phases and continuously reframing of the ideas and findings. At the time of submission of this paper, the

project is primarily at the second phase where autoethnographic data is being analysed. The spatial design brief informed by the findings is also beginning to be synthesised, in addition to occasional data collection to satisfy the analysis. This non-linear progression of the research project strongly encourages reflexive practice and record keeping, not simply as a means to conduct autoethnographic research (inherently self-reflective) but to maintain academic integrity and rigour. As qualitative research that places a particular emphasis on the process, "the process itself is part of product".[52]

Autoethnography as a method is not without criticisms, and concerns regarding ethics, dependability or "affective immediacy"[53] leading to being not criticisable are legitimate and should be carefully considered by all researchers conducting autoethnography. Hence, it is imperative that the autoethnographic research project to clearly articulate the subjectivity, in order to become more objective. Tisdell stipulates that it is not a dichotomy between subjectivity and objectivity, however, it is through a careful examination and confrontation of the dialectic between the two that increases the dependability of the research.[54]

Additionally, there are considerations specifically for spatial design disciplines on conducting an autoethnographic study, and the research project is currently working through as they are encountered. This paper and further dissemination of the research project will further the knowledge of autoethnography in spatial design research for those considering alternative research methodology for investigating therapeutic spaces.

Endnotes

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