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Psychiatric Care as an Other-than-Human Entanglement

Anthropological Reflections on Forest Therapy

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Abstract

What can we learn about the therapeutic landscapes of in-patient psychiatric care by focusing on the invisible, the seemingly unimportant? To explore how mental affliction and caregiving acts are connected to other-than-human dimensions and sensory experience, I analyse the role of trees and forests in a Swiss in-patient psychiatric clinic. Using ethnographic vignettes and introducing the forest as a therapeutic landscape, I discuss the role of trees in a ward's day-to-day life, a psychiatric sufferer's modes of self-perception in the forest, and a physiotherapist's active 'tinkering'. My central argument addresses a problematic element in the research on psychiatric care in Switzerland: it is largely devoid of anthropological attentiveness to sensory perception and the atmospheric. I propose an alternative view where the experiences of illness, recovery, and violence are fundamentally co-created by a sensory context—including its marginalised, nonhuman, and atmospheric dimensions—and a conceptual framework informed by an anthropological adaption of feminist notions of 'matters of care' as well as sensory and ecological anthropology.

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Keywords

Psychiatry, Nature, Sensory Ethnography, Therapy, Medical Anthropology.

> ‘Worlds seen through care accentuate a sense of interdependency and involvement. What challenges are posed to critical thinking by increased acute awareness of its material consequences? What happens when thinking about and with others is understood as living with them? When the effects of caring, or not, are brought closer?’
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> —María Puig de la Bellacasa, *Matters of Care: Speculative Ethics in More Than Human Worlds*

Introduction

In this research paper, I follow interlocutors’ nearly imperceptible tales and engagements with trees and the forest within in-patient psychiatric care in Switzerland. By focusing on embodied and phenomenological dimensions, I highlight the ethical importance of the senses and aesthetics in psychiatric clinics—institutions that are increasingly becoming troubled places (Disney and Schliehe 2019). To date, research in clinical forest therapy has primarily been conducted within the medical and health sciences (Doran-Sherlock, Devitt and Sood 2023; Tsunetsugu, Park and Miyazaki 2010), with few exceptions (e.g., Guyon 2020; Harris 2020, 168–74). Ethnographic research that focuses on the senses, social atmospheres, and materiality in psychiatric contexts (Duff 2016; Simonsen and Duff 2020; Duque et al. 2021; Sumartojo et al. 2020) has thus far not focused explicitly on trees and forests within clinical premises. I address this research gap via an anthropological lens that focuses on the role of trees and forests in psychiatric care and an expanded notion of therapeutic landscapes that encompasses the spatial, the social, and the symbolic (Winchester and McGrath 2017, iv). In so doing, I contribute to a growing body of sensory anthropology that explores sensory environments that have hardly been discussed so far, offering insights into the human-nonhuman sensoria of everyday life (Low 2023, 4–5). I add to a growing body of interdisciplinary research on therapeutic landscapes (Gesler 1993, 2003; Winchester and McGrath 2017) by proposing that the role of trees and forests in psychiatric clinics deserves critical, non-anthropocentric

thinking with care (Puig de la Bellacasa 2017). In that vein, I focus on trees as ambivalent therapeutic actors that co-constitute human experiences of illness, care-receiving, and caregiving.

The field

My explorations of clinical forest therapy are based on ethnographic fieldwork I conducted in 2022 in Switzerland. I was present at two clinics during two intensive fieldwork periods (two and twelve weeks), and after each observation period, I conducted follow-up interviews.

I entered the field shortly after the peak of the COVID-19 pandemic when the ongoing public mental health crisis began to escalate. The situation was intensified by an ongoing increase in austerity measures within public psychiatric healthcare that has been and continues to be discursively justified by a lack of financial resources, combined with a dramatic shortage of staff.[1] Swiss advocacy groups for psychiatric sufferers[2] and their relatives argue that the lived, psychosocial dimensions of psychiatric care are increasingly sidelined within Swiss psychiatric clinics.[3]

In Switzerland, there exists a basic healthcare insurance model, which is mandatory for everybody and provides access to 'public' healthcare services. 'Private' health services are offered for those who pay a higher monthly insurance fee; such services come with benefits such as private rooms and extended services in hospitals. Some previous problematisations of healthcare services in other contexts that may be applicable to the Swiss context, where many psychiatric sufferers experience ethical loneliness, include O'Loughlin's (2020, 4) observations of tendencies in the UK, where 'systemic misrecognition and social violence [are] too often at the heart of psychiatric "care"—a system [. . .] increasingly enacting anti-human, managerial, neoliberal systems of delivery', as well as Jenkins' (2015, 95) criticism that in biomedicalised US psychiatric care, 'focusing on symptoms and psychotropic medications is not only reductive but also counterproductive in that it fails to acknowledge and support an active struggle in which persons have the capacity to develop strategies for living'. In the aftermath of the 'decade of the brain' (Estroff 2004, 282) and within current emphasis on the

[1] Recent examples of a succession of austerity measures include the cancellation of a large number of social workers' positions, combined with large public psychiatric clinics in Switzerland eliminating major pillars of social psychiatry and shutting down various wards (Bundesamt für Gesundheit BAG 2024).
[2] I use the terms 'psychiatric sufferers' and 'residents' interchangeably as a replacement for the term 'patient'. The debate about which terminology to use to describe care-receivers in psychiatric institutions is ongoing (see for example Christmas and Sweeney 2016).
[3] Conversation about a recent survey with a founding member of the Dachverband der Vereinenigungen von Angehörigen psychisch Erkrankter (Swiss Association of Relatives of People with Psychological Disorders) in March 2023.

'neurochemical self' (Rose 2009, 187), mental illness has increasingly been modelled as a matter of 'biochemical imbalance' of the brain in psychiatric and lay terminologies (Jenkins 2011). In my field (within public wards), interactions among psychiatric sufferers and staff members were variously influenced by biological models of mental illness, austerity politics, and concomitant power structures.

Conversely, taking more seriously these sufferers' 'problems in living' (O'Loughlin 2020, 3)—including their biographical, sensory and sociopolitical experiences—would require different, more holistic ethics of care and justice. One primary aim of my research is to introduce an ethic of human-nonhuman care into clinical research contexts. I travel this epistemological route by focusing on the role of trees and forests within clinical landscapes while placing an ethnographic focus on those lived experiences of human beings that are either barely recognised or cannot be captured by abstract diagnostic categories or medical language (Acolin 2019, 40).

Motivated by this interest, I started to follow psychiatric sufferers and staff members in the field when they circulated outside the wards, which figured as 'epicentres' of clinical expertise. I narrowed my focus to those caring interactions that were less noticed within clinical hierarchies and treatment models and often lacked financial and ideological support within institutions. These were the therapies offered by 'therapeutic services'—encompassing art therapy, movement therapy, music therapy, animal-led therapy, and ergotherapy, to name a few examples. The rooms for these therapies were mostly located in other buildings outside the wards. Within clinical hierarchies, the work of these therapeutic services remained secondary, despite their high popularity with psychiatric sufferers.

In one clinic, the coordinator of therapeutic services criticised the prioritisation of such services, stating that whether art, movement and other non-medical therapies were cherished or, at worst, relegated to the status of a pastime or 'unspecific therapies' (in the sense that if such a service would not help, neither would it hurt) depended 'on the personality and professional background of psychiatrists in charge'. Interestingly, many instances of biomedically oriented care in the wards that involved psychotropic medication came with ambiguity and uncertainty, but with considerably smaller impacts on their institutional standing. While many doctors told me that the prescription of certain psychotropic medication was a matter of 'trial and error' and a lack of prior knowledge (see also Rose 2019, 116ff), this view did not seem to question the institutionalised legitimacy of psychotropic medication or lower its status as a 'nice to have'. Along these lines, the coordinator of therapeutic services continued:

> In their training, doctors and nurses hardly learn anything about our work. It should be compulsory for every new medical staff member to attend one session of art therapy, movement therapy, and so forth. This would at least offer them an embodied experience of what we are actually providing.
>
> Not to forget that we explicitly create safe, welcoming therapeutic spaces, which are otherwise scarce in the clinic. In many wards, the atmosphere is rough [and] hectic, and patients are under constant observation. How could anybody heal in such an environment? (Interview, October 2022.)

According to clinical hierarchies, it was staff from the wards who had to transfer psychiatric sufferers to alternative therapies and provide therapists with detailed indications. Within that context, the frequent staff turnovers in the wards presented a constant challenge to the standing of non-medical therapeutic services. The coordinator's remark about the doctors' and nurses' lack of *embodied* knowledge of art and movement therapies is crucial; I take this remark as an entry point for gleaning ethnographic insights about what 'exceeds the frame' of conventional (Puig de la Bellacasa 2017, 55) medical perceptions of care in psychiatric wards. By focusing on psychiatric sufferers' fleeting interactions with trees and forests, I redefine mental affliction and recovery as *processes* that 'link human and nonhuman spaces, bodies, objects, and forces in the joint expression of an enhanced capacity to affect (and be affected by) other bodies and spaces' (Duff 2016, 59). Many anthropologies on madness exhibit a tendency of focusing on the immaterial, such as thoughts, stories, and voices (Bala 2022, v), while relegating the sensory to the margins; conversely, I ask what we can learn about affliction, recovery, and care within psychiatric clinics by focusing on encounters between humans and trees.

A focus on forest therapy in the Swiss context is inextricably entwined with local connotations of trees and, more generally, landscapes. Most people who grew up in Switzerland have embodied biographical experiences of forests, mountains, and other elements of the environment, simply because those are dominant landscape features of many Swiss villages and cities, and hiking and skiing are common pastimes for those who can afford them. In one clinic in an urban area, the interlocutors' connotations of forests and other landscapes were particularly related to their childhood memories. While one potential reason for this may be the inclusion of mountain ski camps and country school weeks as part of the curriculum for elementary school students in this locale, another may be that many psychiatric sufferers who were living in the vast catchment area of the clinic had spent their childhood in villages on the countryside, with some having relocated to the urban area later. For many interlocutors in the field, their encounters with trees provoked highly subjective and varying memories and associations that were often related to times before they had adopted their role as psychiatric 'patients'.

As I outline several ethnographic vignettes below, I focus on what exceeds conventional perceptions of care within clinical psychiatric landscapes. By 'thinking with care' (Puig de la Bellacasa 2012) about encounters between trees and humans, I aim to offer new perspectives on the sensory and spatial structuring of suffering, caregiving, and care-receiving.

Forests, trees and their situatedness within clinical landscapes

> Field notes, October 2022
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> Friday morning, 09:00. The nurses in the ward did not seem to know the exact programme of physiotherapy, but among residents, the word has spread that on Friday mornings, physiotherapy [has been] held in the nearby forest. A relatively stable group of attendees had formed within our ward. Last week, Beat,[4] who was suffering from anxiety and depression, had not attended the weekly session as usual. As we start walking across the lawn area towards the physiotherapy building, I ask him why. He sighs:
>
> > See, last week, an acutely psychotic sufferer arrived. I know that he is no hostile person—he was just terrified by being locked in the ward. But during breakfast, he started to lash out at others, shouting loudly. I was too afraid to enter the eating area. We were left to deal alone with him because of the staff shortage. The two nurses were busy doing the morning check-ups. As I had not eaten, I felt too weak to expose myself to the forest.
>
> Thursday morning**,** 08:50. During the staff huddle in the station's office, a nurse interrupts the meeting, alarmed. She just saw the resident Carol through the window as she was strolling through the park with his headphones on. 'She's outside alone, but she is not supposed to be! Who let her out?' she shouts, worried. The intern, who had let her out, rushes out and returns, accompanied by Carol minutes later. In the meantime, the case is discussed among doctors and nurses: Carol has been threatening repeatedly to commit suicide by eating leaves of the old—and poisonous—yew tree that grew outside in the park. I knew the tree, it was part of the clinic's nature trail whose countless old, rare tree species motivated many sufferers to go outside for walks.

What stands out in those instances is how trees, which are clearly distinguished from the clinical epicentres, the wards, are nevertheless present in the ward's daily practices of caregiving, affliction, and care-receiving. When viewed as part of therapeutic landscapes (Winchester and McGrath 2017; Gesler and Curtis 2007), the symbolic signification of trees could easily be interpreted as primarily an expression of service users' and staff members' subjective perceptions and experiences. Here, I propose a different understanding, where the signification of trees as healing or harmful therapeutic actors is co-created by the rapidly changing

[4] All names of interlocutors have been changed.

circumstances within wards. In both the sufferers' and staff members' accounts, trees figure symbolically and materially as spaces *within* clinics but *outside* wards—the latter being highly structured loci where 'extraordinary conditions' (see also Jenkins 2015, 259) are confronted with institutionalised practices (Lester 2007, 381). For Beat, the forest symbolised a desirable but challenging therapeutic space that was undermined by trouble in the ward, whereas Carol used a yew tree in a counter-reaction against the ward's caring control. Although originally planted in the park for healing purposes, the yew tree had been adopted in an inversely destructive manner, thereby challenging the intended meaning of a nature trail as a therapeutic landscape.

In both cases, trees and forests do not carry stable significations; their symbolism is instead inextricably entwined with the landscapes of clinical trouble. As I discuss elsewhere (Hänni 2024), psychiatric wards were varyingly characterised by an atmosphere of the acute, which arises from a high density of severely afflicted people who have been voluntarily or involuntarily hospitalised within an austere clinical landscape. Several users felt 'misplaced' in such wards because they did not feel as though they were '*that* ill'. For others, such as those suffering from acute psychosis, their fellow sufferers and medical authorities were frightening, leading them to experience wards as dreadful places. 'Wards' represented sites wherein healing and harm, trust and mistrust coexisted in a complex, sometimes debilitatingly proximate entanglement. The ambivalence of psychiatric wards and their thresholds must be discussed, at least partially, in light of the austerity-driven, exclusionary economies that govern current healthcare systems (Kehr, Dilger and van Eeuwijk 2018; O'Loughlin 2020).

The ways in which trees surface in the vignettes as symbolic spaces that are simultaneously beyond and interconnected to the wards can be analysed from a Goffmanian (1961, 38) perspective. Goffman (1961, 230) focuses on how the psychiatric clinic, as a 'total' institution, disrupts sufferers' sense of personhood and 'personal economy of action', and he mentions (although not in reference to forest therapy) a 'patch of woods behind the hospital' as an example of a 'free place': a platform for 'tabooed activities' that is characterised by a reduction of 'patient density' and surveillance, operating beyond the 'usual performance of staff-inmate relationships'. However, in the aforementioned cases, it would be misleading to reduce the signification of the trees and forest to the mere 'counter spaces' of more controlled or troubled institutional therapeutic landscapes. Instead, I propose another, more complex interpretive pathway wherein trees co-constitute an 'affective atmosphere' of ambivalent landscapes of affliction and recovery (see also Duff 2016, 63). While sufferers and therapists navigate processes of recovery and relapse together, nonhuman agents and landscapes—built or grown—also co-constitute those encounters. Accordingly, trees must be

understood not as entities beyond institutionalised social performativity and surveillance, but as ones that are liminal to such concepts. Trees thus co-constitute a therapeutic landscape that functions symbolically outside wards yet remains part of daily clinical life in the form of a site where illness and recovery unfold between humans and nonhumans.

While the instances above might seem idiosyncratic, they provide a powerful reminder of the unexpected, contradictory ways in which therapeutic landscapes can be appropriated and experienced by different actors (Winchester and McGrath 2017, iv).

In the following, we will journey through the forest as a lived, sensory therapeutic landscape through a vignette from group physiotherapy.

Entering the forest as a therapeutic landscape

> Field notes, October 2022
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> Residents gather in the physiotherapist's waiting room and sign the registration list. As acquaintances from different wards greet each other, a book titled shinrin yoku,[5] which had been placed on a coffee table, is being handed around. As the physiotherapist arrives, she explains: 'Forest bathing is a huge trend right now, and we will try it out today. Don't be afraid; it's nothing esoteric. I will guide just a short session. Always remember: you have to be nice towards yourself. Here, you don't have to perform or achieve anything. You can simply be.'
>
> [. . .]
>
> Entering the forest, the group stops beside a huge, felled tree trunk that has been left beside the pathway: it's the 'forest wardrobe'. The therapist leads a short session of silent mindfulness practice, with a focus on nonjudgmental acceptance of all feelings and thoughts present. She closes the contemplation by inviting participants to symbolically 'deposit' all difficult thoughts and feelings at the tree trunk by silently touching it.
>
> She hands out small sitting mats and gives instructions for a six-minute phase of forest bathing:
>
> > You can choose a tree you like and just spend time with it. It's like meeting a person you are close to and having a coffee together. Just spend some nice time with a tree, regardless of whether you are touching it or not. Did you know that trees communicate with each other? We can have meaningful

[5] This therapist connected her approach to forest therapy to the practice of forest bathing, or *shinrin yoku*, which emerged in Japan during the 1980s. The term can be roughly translated as 'taking in the atmosphere of the forest' (for recent overviews, see Kotte et al. 2019; Tsunetsugu, Park and Miyazaki 2010)

> social interactions with other humans, but also with nature, if we tune into it. [In doing so], we no longer feel alone when we are in the forest but that we're in good company.

Later, in an interview, the physiotherapist explains the importance of the 'forest wardrobe' in forest therapy, as she can't leave severely afflicted people on their own in the forest: 'Left alone with their thoughts in the forest, they might sink too deep into dark emotions. The "forest wardrobe" is a small gesture that helps sufferers to enter a phase of increased wellbeing—if only a temporary one.'

Figure 1: 'forest wardrobe'. Tree trunk on the grounds of a Swiss psychiatric clinic. 9 September 2022.

Transformative states of human wellbeing in the forest are more than a matter of (human–nonhuman) relationality. They also require, in Hartmut Rosa's (2016) terms, a *resonant* setting that allows for experiencing the unknown, as well as a certain openness towards the uncontrollable outcomes of mutual interaction (Peters and Majid 2022, 18–9).

In the instance captured in the vignette, the caring interaction, trees, and affects merge into a web of entangled interdependencies, a phenomenon Kavedžija describes as caring 'conviviality'. Conviviality, the 'arts of living together' (Kavedžija 2021, 13), encompasses constant, skilful effort to create and maintain human wellbeing and nurture interpersonal relationships. Kavedžija (2021, 21) emphasises the importance of *how* we attend to the nonhuman as a defining force that influences *what* we perceive and expect. The subjective experience of trees as part of psychiatric landscapes is, in turn, fundamentally shaped by how we *conceptualise* and think about them and how they are introduced as part of our lifeworlds.

The physiotherapist actively uses and introduces the forest as nonhuman therapeutic landscape—specifically on a sensory level, which serves as an example of how, in Low's terms, sensory cultures frame social order and disorder (Low 2023, i). The physiotherapist encourages psychiatric sufferers to enter (nonhuman) social interaction by framing trees as silent but trustworthy friends that allow for a state of presence and 'just being'. This instance offers psychiatric sufferers—with exceptions, as I discuss below—the opportunity to engage in social interactions outside of the troubled (and troubling) social environment of wards. I propose that this fleeting encounter between trees and humans bears a profound potential to offer service users transformative—if ambivalent—states of self-perception. Here, my analysis resonates with DeNora's call for a more relational, 'ecological' perspective on psychiatric care in research. If we take trees as social beings within psychiatric clinics seriously, we can redefine human wellbeing as a socio-ecological matter, shifting 'in relation to things outside of individuals, ecologically, and in ways that amalgamate people, practices, culture, and things' (DeNora 2013, 9).

A feminist, non-innocent view (Puig de la Bellacasa 2017, 164) of the forest as a caring space accepts that care can be full of predicaments. It therefore does justice to the ambivalent ways in which human interaction and self-perception are influenced by the 'thingness' of clinical spatiality (see also Goffman 1961, 126ff). In this regard, DeNora's (2013, 45–6) reworking of Goffman's notion of 'asylums' is useful by extending the spatially anchored Goffmanian definition of the 'asylum' and framing it instead as an *experience* of ontological security and wellbeing. An asylum can thus be either a physical or conceptual space, offering refuge from hostility by opening up spaces to 'play on/with one's environment, whether alone or in concert with others' (DeNora 2013, 47). A therapeutic engagement with the forest bears the potential for destabilisation *and* the opportunity to create an 'inner' asylum that differs symbolically and sensorially from psychiatric wards. The vignette above underscores how a sufferer's medical identity as a 'patient' can recede, if only temporarily, in favour of other modes of social interaction and self-perception.

I suggest that the therapist's integration of trees into therapeutic practice is best described as a multisensory, atmospheric—not instrumental—therapeutic use of the nonhuman. Navigating the sometimes unforeseeable encounters between trees and psychiatric sufferers, the therapist introduces the forest as a multisensory environment that facilitates an atmosphere of recovery (Duff 2016, 69). In other words, the therapeutic value of trees emerges from the capacity of humans to co-create atmospheres that draw something not yet present into being (Sumartojo and Pink 2019, 30).

Caring with trees as tinkering

Field notes, October 2022

Equipped with walking sticks, we walk through the misty autumn morning towards the small, nearby patch of forest. Some participants continue conversations, others keep to themselves. News from different wards is exchanged, and the lack of weekly structure due to staff shortages is discussed, creating an atmosphere of the ordinariness of a shared forest walk amidst the extraordinary conditions of in-patient treatment. It's during these hours when I most easily learn something about interlocutors that exceeds their identities as 'patients'. As we admire the sunbeams in the mist, a woman who usually keeps to herself tells me about her passion for photography and how the forest reminds her of the times 'back then'. Beat suddenly reveals his passion for skiing as we talk about the misty weather. As we find ourselves in a group, I repress the urge to ask him how he feels about our shoes being covered by mud. He went through a relapse into compulsive cleaning in the ward recently, and I wonder about his experience of the forest today.

John, a man in his twenties, suffers—in his own words—from 'disorientation'. After his initial enthusiasm for the tree's beauty, he starts showing growing sensorimotor confusion as we enter the vast, dense greenery of the forest. Unexpectedly, he veers off rapidly, losing the path and leaving the group behind. Unsure how to react, I slow down as do others in the group. The therapist waits silently. After a short while, John regains his orientation, joins the group again, and describes his confusion. The therapist listens to him and proposes an exercise she calls 'standing together': we walk shoulder to shoulder in a line, adjusting our speed to each other without taking our gaze from the horizon. After ten minutes of the exercise, John's pace becomes steadier, and he mostly stays on track. After the exercise, he sighs, relieved and with a smile on his face: 'That was difficult for me—as soon as my thoughts took over, my feet went off the path. I was lucky that I had you as a group as a reference point. Whenever I lost you, I realised that my head and feet had carried me away. I then realised I had to slow down.'

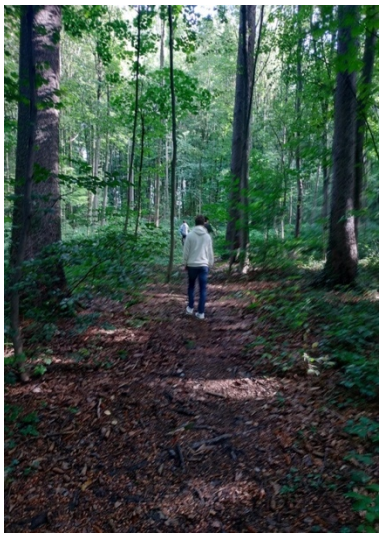

Figure 2: Group session in physiotherapy, silent walking in the forest. 9 September 2022.

Later that week, I overhear a conversation between two residents in the acute ward's smoking room. They talk about the possibility of leaving the ward although both are still on partial curfew. One warns the other: 'Be careful! The deeper you go into the forest, the darker it gets on the outside, and the darker what surfaces on the inside will be'.

During the group session of forest therapy, I was granted the privilege of getting to know facets of the psychiatric sufferers' personalities that would hardly have surfaced previously during the countless hours we had spent together within the ward. This reflects the fact that institutional structures—whether invisible or tangibly material—fundamentally influence the psychiatric sufferer's 'moral career' (Goffman 1961, 127–8) as well as the staff members' social positionalities and self-perceptions (Goffman 1961, 74ff).

In phenomenological terms, it was both the sensory and social setting of the forest that allowed sufferers' expanded registers of experience and self-perception. As the forest diverged from the more structured, hierarchised, pathology-oriented therapeutic landscapes within wards, social interactions unfolded in new ways.

While sufferers' experiences of therapeutic landscapes can never be generalised (see also Winchester and McGrath 2017, iv), this ambiguity became especially salient in my research on trees and the forest. The controllable, built environments of wards were left behind, and the forest required different forms of bodily movement and sensory attunement from all persons present. Regarding Tilley, Ingold (2011, 47) describes how '[T]hrough walking, in short, landscapes are woven into life, and lives are woven into the landscape, in a process that is continuous and never-ending'. A seemingly stable or unambiguous place always holds an array of complexity: the forest contains multifarious experiences and perceptual angles for every sufferer present, ranging from increased wellbeing to troubling destabilisation.

Mental afflictions like schizophrenia can alter sensory perception in various, sometimes dramatic ways, such that objects, sounds, voices, faces, and other impressions can be perceived entirely differently and with heightened complexity (Jenkins and Barrett 2004, 309). The residents' caution not to face the 'darkness of the forest' in the vignette above indicates that even as the affective materiality of the clinic itself can induce a sense of danger, so too can the trees that grow beyond the epicentre of the clinic.

In the case of John, his immersion into the forest's sensory meshwork and 'currents of materials' (Ingold 2011, 31) first presented a destabilising experience during an acute phase of illness. Nevertheless, facilitated by the therapist's care, the group-based walking exercise, and the surrounding forest, John regained his orientation while walking through the forest. This reorientation was felt both in terms of his physical surroundings and his self-perception of being carried away by 'thinking'. Both human and nonhuman sociality were necessary to facilitate this therapeutic experience of losing and regaining one's orientation. John's description of his encounter with the forest represents a non-innocent, ambivalent

view of care (Puig de la Bellacasa 2017, 164), as he experienced both awe, (dis-)orientation, and shame.

This ambivalent yet therapeutic experience was facilitated via embodied wayfaring through the trees (Ingold 2011, 162), not abstract transmission. In other words, this environmentally induced transformation of self-perception would not have been possible within the ward. In Ingold's terms, human becomings and plant becomings were allowed to encounter each other in the continuously evolving tapestry of life (Ingold 2011, 9). As a therapeutic environment, the forest embodies this tapestry—it houses sentient beings that move, listen, watch, and feel in continuous responsiveness to the environment rather than in isolation (Ingold 2017, 19).

As a therapeutic environment, the forest presented the therapist with new challenges, underscoring both the conflicts and ambiguities that are often part of caretaking practices (Puig de la Bellacasa 2012, 204) and the 'tinkering' that caretaking can include (Mol, Moser and Pols 2010; Lutz 2016). Leaving behind the known sensory landscape of the ward and therapy rooms, the physiotherapist had to improvise in a constant effort to balance the ambivalences of human-nonhuman conviviality and care (Kavedžija 2021, 26) for psychiatric sufferers. Her therapeutic recourse to the 'forest wardrobe'—the tree trunk at the entry of the forest—exemplifies one approach to this improvisation and 'tinkering': she used a tree to facilitate a temporal state of relief for sufferers. The trees also figured as therapeutic actors in this session of forest bathing by, for example, representing 'close persons' for the sufferers to meet up with and entry points for a state of presence and self-acceptance.

Although those instances might seem trivial compared with the urgencies of acute psychiatric care, they forge a path to a new understanding of the impact that the nonhuman can have within therapeutic landscapes. They remind us that *being in the world* in times of affliction is always a more-than-human matter (Andrews and Duff 2019, 131), even if this impact can be marginalised or at odds with institutionally recognised ways of caretaking in various ways. This also relates to a largely disregarded aspect within austere clinical landscapes: the ways in which recovery and caring conviviality can be both created and undermined by fleeting environmental and sensory aspects (Kavedžija 2021, 17).

In the following, I close my reflections on these clinical vignettes with some final theoretical thoughts. I discuss how a feminist ethic of care and a focus on the nonhuman can enable more careful, realistic insights within therapy research.

Thinking with care about therapeutic encounters

Puig de la Bellacasa's feminist, other-than-human concept of care, which she introduced within science and technology studies (STS), can be helpful in building a theoretical frame for my findings; in this case, I am specifically inspired by her thinking around *matters of care* (Puig de la Bellacasa 2017; 2011), which is a feminist, more-than-human conceptualisation of caretaking. The introduction of this expanded notion of care into institutional ethnographies of psychiatric care (see also Smith 2005; Smith and Griffith 2022) responds to an ethical necessity in the field and calls for anthropologists to address current research gaps critically and creatively.

Outlining her notion of *thinking with care*, Puig de la Bellacasa proposes that '[C]are is a human trouble, but this does not make of care a human-only matter' (Puig de la Bellacasa 2017, 2). Such a notion of care encompasses all activities humans undertake to maintain, regenerate, and repair their worlds while sustaining them as liveable places. Here, the term 'worlds' refers to the totality of continuous activities of bodies, selfhoods, and environments that are interwoven in a 'complex, life-sustaining web' (Tronto, cited in Puig de la Bellacasa 2017, 3). This stance highlights interconnection and dependency as fundamental, non-negotiable characteristics of a web of life that would not exist without caring relations (Puig de la Bellacasa 2017, 4). Inspired by Haraway's reflections on situated forms of knowledge, Puig de la Bellacasa (2017, 69) argues that 'relations of thinking and knowing require care and affect how we care'. One advantage of *thinking with care* within therapy research is that both human and other-than-human entities can be addressed from a feminist perspective; moreover, the speculative project of introducing care into STS (Lindén and Lydahl 2021, 5) encompasses much more than trees, including objects, physical forces, animals and other living beings, and spiritual entities (Puig de la Bellacasa 2017, 1).

As I discuss elsewhere (Hänni 2024), encounters that constitute 'caring' within in-patient psychiatric care can be experienced in various conflicting ways by different people in ever-changing configurations. The vital 'ethico-affective everyday practical doings' (Puig de la Bellacasa 2012, 199) of care unfold beyond idealised visions and ideals of harmonious smooth interaction and can include experiences of healing, as well as those of coercion and harm. The analysis of trees and forests as therapeutic landscapes is one of many ways in which we can discuss how '[R]elationality is all there is, but this does not mean a world without conflict nor dissension' (Puig de la Bellacasa 2012, 204). *Thinking with care* requires us to think with immanent uncertainty and ambivalence: 'Care means all these things and different things to different people in different situations. So while ways of caring can be identified, researched, and understood concretely and empirically,

care remains ambivalent in significance and ontology' (Puig de la Bellacasa 2017, 1). Caring relations are also marked by stark power imbalances that leave caregivers susceptible to exerting control (Puig de la Bellacasa 2017, 1). In this context, *thinking with care* offers an epistemologically promising way for researching why it is that many psychiatric sufferers experience 'therapeutic' landscapes as ambivalent and contested (Gesler and Curtis 2007).

One final advantage of *thinking with care* is how it allows ethnographers to include the invisible and the marginalised in their research foci. Interactions that might be considered petty and unimportant—those seen as unproductive, however essential they may be for a liveable existence—can be indispensable contributions to the web of sustained life. What 'exceeds the frame' (Puig de la Bellacasa 2017, 55) of institutionalised engrained definitions of care is what deserves careful attention by feminist researchers. These invisible relations of care invite us to follow Harding's (cited in Puig de la Bellacasa 2017, 58) call for a more profoundly democratic manner of listening to neglected things that speak 'from below'. Researchers can *reclaim care* by becoming sensorially attuned to those dimensions rendered invisible in hegemonial terms, focusing instead on grounded, situated, practical engagements (Puig de la Bellacasa 2017, 11).

Current forest therapy practices within Swiss psychiatric clinics are, in many ways, dispersed and hardly formalised, so I do not attempt to generalise them here. Instead, the preceding theoretical reflections highlight the general importance of the sensory, other-than-human dimensions of caring landscapes within in-patient settings. This theoretical frame encourages therapy researchers to take seriously the mundane and the invisible—those dimensions that are ultimately formative of service users' all-encompassing experiences of 'being in the clinic'.

Concluding remarks

I approached clinical forest bathing within an ecological framework of mental health and caregiving and as an experiment in how Puig de la Bellacasa's notions of *thinking with care* can be translated into ethnography. To this end, I explored trees and forests as marginalised therapeutic landscapes within biomedically dominated psychiatric clinics, redirecting the ethnographic gaze towards the nonhuman, less visible facets of institutionalised care. Based on vignettes from the field, I discussed how sufferers' experiences of illness, recovery, and harm are fundamentally created by sensory contexts, including their material, nonhuman, and atmospheric dimensions. The importance of conviviality and wellbeing—practices that can be characterised by a certain beauty (Kavedžija 2021, 13)—can be largely denied in stigmatised places like psychiatric clinics. *Thinking with care*

about human-nonhuman therapeutic landscapes is thus an ethical necessity in therapy research, as reflected in Wittgenstein's (2002, 86) famous statement that 'Ethics and aesthetics are one and the same'.

The currently troubled nature of psychiatric care in Switzerland makes it an ethical necessity to explore such sites of psychiatric care via ethnographies of aesthetics and the senses. More specifically, I propose that this approach responds to feminist calls for radically democratic ways of 'listening to neglected things speaking from below' (Puig de la Bellacasa 2017, 58, referring to Harding). It increases the visibility of marginalised experiences—in this case, those of psychiatric sufferers who are most prone to experiencing 'ethical loneliness' in institutionalised care (O'Loughlin 2020).

By providing these ethnographic reflections on clinical forest therapy, I aim to contribute to the emerging, interdisciplinary scholarship around therapeutic landscapes. Thinking with care (Puig de la Bellacasa 2017, 55) about in-patient psychiatric landscapes enables us to identify and refine a useful analytical toolkit for researching mental illness and health in neoliberal times. This ethnographic positionality allows us to integrate the fleeting domains of experience and the atmospheric into more structuralist or governance-oriented analyses. In light of the preceding discussion, I close with a call for more *careful* research—that which builds on the politics of the mundane and the nonhuman as matters of care—on therapeutic encounters in clinical spaces. Through such efforts, we can gain critical, ethically significant insights into the lived experiences of those who most vulnerably inhabit psychiatric landscapes.

Authorship statement

The article was written in its entirety by Anna Hänni.

Ethics statement

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