Therapeutic Gardens – Deficiencies and Potentials

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Abstract

The term ‘therapeutic gardens’ encompasses a range of garden types, such as gardens for the blind, gardens for practising horticulture therapy programs or ‘closed gardens’ for people with mental diseases. If the garden is therapeutic, it is important to answer the question, what this therapeutic benefit comprises. Is the garden itself a therapy or is it only a tool? Although the general therapeutic effect of nature has been verified, the detailed methods for the garden planner still have to be developed. These ought to be patient-oriented, therapeutical, but also should not deny or neglect the garden culture. On the basis of conceptions of deficiencies and potentials, which are of central importance both for therapy and for garden design an methodological approach to ‘therapeutic gardens’ is described.

INTRODUCTION

The term ‘therapeutic garden’ has so far neither been clearly defined nor firmly established (Baird and Bell 1994, Cooper Marcus 1999, Gerlach Springs et al. 1998) It is therefore not surprising that it often acquires negative connotations depending on the particular point of view, be it of a gardener, planner, or therapist.

Does the term ‘therapeutic garden’ suggest that one has to seek for a justification of gardens by referring to studies that show that they lower blood pressure, or by planning exclusive outdoor spaces for concrete therapeutic situations (Ullrich 1986, 1991)? Or, are gardens intrinsically therapeutic, because, as a part of our culture for thousands of years, they have always provided a space for physical and mental recreation? It seems that a number of modern diseases are the product of the loss of gardens and experiences of nature in general. Is it now up to the gardener to play the role of a ‘better therapist’ by laying out so-called ‘therapeutic gardens’ in order to address the situation? Theoretical discussion about therapeutic gardens is mainly concerned with means and ends and culminates in the question: Does a garden complement therapy or is it in itself therapeutic?

The practical approach, that attempts to come to terms with therapeutic gardens by describing exteriors and/or the necessary equipment, and that is evident in the repeated claims for raised-beds, barefoot paths, etc., equally fails to contribute to a clarification of the term. On the contrary, it causes further disagreement because the ambitious garden planner feels restricted in his possibilities to cultivate a cultural asset. Good garden design cannot mean total instrumentalisation and reduction to collection of therapeutic furniture.

In the development of a ‘therapeutic garden’ I consider it important to search for solutions that integrate the claims of the different approaches. In this respect the new discipline called garden therapy that integrates but does not instrumentalise the garden could be of help, in particular the notions of ‘deficiencies’ and ‘potentials’.

DEFICIENCIES AND POTENTIALS

From a therapeutic point of view, an approach that combines deficiencies and potentials is always essential. Every therapy aims at diagnosing the existing deficiencies in order to do away with, reduce, or compensate for them, or at least to keep the present state or slow down the process of deterioration. Patients should always be understood individually according to their particular living conditions and capabilities. It is essential that one be potential-oriented.

These two principles can very well be applied to the creation of a suitable habitat for
Looking at gardens as humanized forms and a reshaping of nature means that they can also be defined using the notions of deficiencies and potentials. Deficiencies represent those aspects that limit nature to the human horizon, as in for example our limitations concerning our possibilities of mobility, the spectrum of perception, or the capacity of understanding. A garden only makes use of nature in so far as it is accessible to us. One should also consider human potentials - values and capabilities such as our particular understanding of art and our sense of harmony, but also others like sociality, personal freedom, or tolerance. Gardens do not merely restrict but enrich nature with our particular virtues. It is in this striving for adjustment as well as enrichment of nature that the more profound meaning of garden planning present in the human soul, that itself has directed the history of gardens over thousands of years, lies. For this reason a good therapeutic garden has to be a good garden in the first place if it is not to break its bond to anything human.

Approaching therapeutic gardens with these ideas in mind does not mean that we give up the language of formality that we have come to treasure, or that we restrict or renounce the variety of plants and everything else which makes the art of gardening what it is. On the contrary, it is precisely through the means of gardening that the spectrum of therapies is being enhanced. At the same time the requirements of therapy focusing on the potentials of patients enrich traditional gardening.

RECOGNISING DEFICIENCIES

Orientation in the deficiencies of human beings is a basic characteristic of every garden creation. That this should be the case when a garden is laid out for people with special needs is obvious. Thankfully, such thoughtfulness has become common practice for garden planners in a lot of situations. Whenever laying out a garden the principles of obstacle-free planning should be observed and gentle slopes and surfaces suitable for wheelchairs chosen. However one has to be careful: there are many deficiencies that are much more difficult to recognize and that may also vary individually. In many cases they are extremely difficult to spot without the help of therapists, doctors, and nurses especially because they are not standardised cases of people in wheelchairs.

The task of laying out an enclosed garden for people with organic brain syndromes may here serve as an example. Such a clinical profile affects the ways in which these patients perceive, understand, and process their surroundings – this is also the case with a lot of other psychological disturbances. These are limitations that influence directly memory, temporal and spatial orientation, or the selection of perceived impressions. They also bring to bear on the perception of the garden as a complex and eventful outdoor space. A profusion of colours and scents, that we usually tend to consider as desirable and therapeutic, could put too much strain on such patients. Open views and expanses can also have negative effects because some patients may feel carried away. In such cases support is urgently needed and should be reflected in the layout of the garden. It is therefore important to recognise particular deficiencies.

What may be needed most by patients who depend on psychiatric drugs is shade. Others may require plants that do not cause allergies, or may depend on paths suitable for wheelchairs as I have already mentioned. In order for these special needs to be recognised gardeners need to renounce their normal standards and to orient themselves towards patients – a step which can definitely be called therapeutic.

Such considerations are not all limitations. A garden that provides for enclosed areas can draw for its inspiration on the history of gardening in so far as one can fall back on a tradition of inner gardens. The history of plant cultivation could be of help in other cases.

RECOGNIZING POTENTIALS

A therapeutic garden, even if largely adapted to special needs, would still be a proper garden and not simply an exercise ground, as long as the inspirations and tools discussed above are kept in mind. A therapeutic garden needs to integrate deficiencies but
it should also focus on potentials – an approach that similarly plays an important role in therapy. One who works with seriously affected patients, for example, is better off focusing on the available potentials than on the deficiencies. Further, no one is simply just ill or completely healthy. Health and illness both depend on personal judgements. A garden should always address the healthy side of patients: the wellbeing that is already available and that which can be fostered.

One example would a garden for blind people. Of course the gardener needs to keep in mind “visible” deficiencies such as orientation and freedom of mobility. But such a garden ought to be based on the potentials of its users. The blind experience gardens especially through their senses of smell and touch - a pleasure also known to visually unimpaired people if they explore the possibilities of their senses other than sight. It stands to reason that the senses of smell and touch should form the basis of a garden for blind people – but this is also enriching to anyone who enjoys such a garden and to the practice of gardening in general. One may practise the use of aromatic plants by laying out a garden for blind people.

CONCLUSIONS

The notion of a therapeutic garden is not new. The most important source may be located in the psychological reform movement of the 17th century, associated with people like Rush, Pinel or Reil. This movement established the occupational therapy (with gardening), not only with focus on the disease, but on the healthy and recovering part of the patient. This included the design of special living conditions, including the garden design. In this alignment the particular requirements of the therapy need not to be restrictive but can serve as an enrichment for gardening, as in the example of a garden for the blind (Niepel 1999). By drawing upon the heritage of gardening planners can choose from an immense range of possibilities for adaptation. They should also remain rooted in an occupational culture that represents a deep insight on the nature of humankind. The principles of gardening do not necessarily need to be given up in order to create therapeutic gardens that constantly balance the particular potentials and deficiencies of their users. A therapeutic garden is the result of a positive coming together of therapist and gardener.

Literature Cited


