THE LANGUAGE OF SPACE: A SILENT COMPONENT OF THE THERAPEUTIC PROCESS

The concept of space as a silent message in communication and its relevance to the therapeutic process — the author suggests that nurses must be sensitive to the spatial needs and cues of patients, and should be certain that their own spatial cues convey a message congruent with the intended communication.

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'When I use a word,' Humpty Dumpty said in a rather scornful tone, 'it means just what I choose it to mean — neither more nor less.'

'The question is,' said Alice, 'whether you CAN make words mean so many different things.'

'The question is,' said Humpty Dumpty,' which is to be master — that's all.'

Lewis Carroll
Through the Looking Glass

ALTHOUGH Humpty Dumpty went on to boast that he could manage all words, Alice remained baffled by what he was saying and termed her encounter with Humpty Dumpty unsatisfactory. Humpty Dumpty managed the words and Alice heard them, but the information gathered by Alice's ear did not reveal to her *what* Humpty Dumpty had chosen the words to mean. How often do we like Humpty Dumpty fail to communicate the message we intended our words to convey? Why, we frequently ask, are our words not understood as we intended? Not only are there a variety of semantic interpretations for words, but also accompanying

our verbal communication is a host of other cues conveyed by our tone of voice, our manner, body movements and gestures, and how we position ourselves in relation to the other person or persons.

Intimately involved in the decoding of the message is the recipient's perception of our communication. Perception may be defined as a process of selecting, organizing, and interpreting sensory data. Why, when there are human beings whose sensory apparatus and its arrangement are similar, and who are exposed to the same experience — that is, virtually the same data are available to be fed into their sensory systems — does the response of each tend to be different? Do some misperceive? Taguiri noted that the process of perception involves three major elements: the situation in which the person to be judged is imbedded; the person apart from the situation; and the perceiver himself.[1] Each of these elements of the process of perception as well as the component parts of the process, selecting, organizing, and interpreting, provides a potential source of variation. The idiosyncratic interpretation of a situation, according to Heider, is the result of perceptual style, rather than errors in perception.[2] Each person tends to develop a characteristic or distinctive mode of perceiving. One of the determinants of an individual's perceptual style is culture,[3] and one of the ways in which culture affects the perceptual process is through an individual's culturally learned use of space and spatial cues. Physical space is a culturally learned symbol and as such interposes a nonverbal message into the process of communication.[4] It is to the concept of space, man's culturally acquired need and use of it, and its relevance to perception, communication and the therapeutic process that the remainder of this discussion is directed.

Most of what has been written about man's spatial needs and his use of space as a silent communicator has been based on the studies and writings of anthropologist, Edward T. Hall, and psychologist, Robert Sommer.[5] [6] It is only recently, noted Hall, that much attention has been given to the idea that man's boundary does not begin and end with his skin. But, he has around him as extensions of his personality a series of expanding and contracting fields which provide information of many kinds. Man's perception of space is dynamic, being related to what he can do in a given space. The disposition of people toward each other is a crucial determinant in how space or distance relative to one another is used.[7]

Hall, who had studied the relationship between culture, space, and communication, has coined the term "proxemics" to refer to "the interrelated observations and theories of man's use of space as a specialized elaboration of culture.[8] From observations of, and interviews

with, healthy middle-class Americains, Hall has identified four distance zones which are learned in childhood and maintained throughout life in social situations. Each distance zone has a near and a far phase. These four distance zones are: (1) Intimate Distance: the near phase in the distance of love making and wrestling, comforting and protecting. The far phase extends from six to eighteen inches. Within this distance zone the presence of persons other than with whom they are intimately involved is experienced as discomforting by Americans. It is not considered proper to use this distance in public. In crowded situations, such as public transportation and elevators, intimate distance is tolerated, but is countered by special behavior which threats others as nonpersons. The individual remains rigid, withdrawing and pardoning himself if he touches another person. His eyes are lowered or focused on an inanimate object, allowing no more than a passing glance at any unknown person. (2) Personal Distance: this is like a "protective bubble" that person maintains between himself and others, keeping all but close personal contacts outside. The near phase is one and a half, to two and a half feet. A wife, but not another female, may stay within her husband's personal distance zone with impunity. The far phase, extending from two and a half, to four feet, represents the limit of physical domination — beyond this distance no one touches or expects to be touched without some special effort. (3) Social Distance: the near phase, from four to seven feet, tends to be used by people who work together. Impersonal business takes places at this distance. To stand and look down at a person from this distance has a domineering effect. Conversation conducted from the far phase, extending from seven to twelve feet, conveys a more formal character. The voice has to be raised, and at this distance it is more important to maintain eye contact than at a closer distance. To fail to do so shuts the other person out and halts the communication. A special feature of this far phase of social distance is that it can be used to insulate or screen people from each other. People can be in the same room at this distance and remain uninvolved without appearing rude. (4) Public Distance: this distance is well outside the circle of involvement. The near phase is from twelve to twenty-five feet. If threatened, an alert person can take evasive action at twelve feet. The far phase is twenty-five feet or more. Details of facial impression, movement, and the normal voice are lost, and must be exaggerated or amplified at this distance. The distance automatically set around important public persons is thirty feet.[9]

Sommer uses the term "personal space" to describe the area surrounding a person's body from which intruders are excluded. "Per-

sonal space" incorporating the concepts which Hall has indicated is encompassed within the personal distance zone. But, in addition to referring to the emotionally charged zone around each person, Sommer uses "personal space" to refer to the "processes by which people mark out and personalize spaces they inhabit."[10] Like Hall, Sommer did not regard "personal space" as absolute, but saw it varying with the relationship of the persons, the location of others in the situation, and bodily orientation of those involved relative to each other. According to Sommer, personal space does not extend equally in all directions: a stranger can be tolerated closer to the side than directly in front of a person.

Sommer conducted a series of studies of invasion of personal space.[11] Individual's privacy or personal space was intentionally encroached upon by investigators who seated themselves close to the selected subjects. The usual reactions to this intrusion initially were subtle indications of discomfort, tapping, restlessness, shifts in posture, and invariably the subject would subsequently remove himself physically from the area. Sommer concluded that invasion of personal space has a "disruptive effect and can produce reactions ranging from flight at one extreme to antagonistic display at the other."[12] Personal space is analogues to a "portable territory" being carried with the individual wherever he goes. It is very closely related to an individual's sense of self, and invasion of a person's space is intrusion into his self boundaries.[13],[14] In ascertaining if spatial invasion has occurred, proposed Sommer, it is essential to determine if the persons involved perceive each other as persons. Personal space cannot be invaded by a nonperson.[15]

How one uses space is a culturally acquired phenomenon, and within a culture, personality and environmental factors affect spatial needs and use. Introverts place a greater distance between themselves and others than do extroverts. A high noise level, low illumination, and shared fear tend to reduce distance, while fear of rebuke tends to increase it.[16],[17]

Crowding or cramped situations may force persons into behavior or relationships that are overly stressful. As stress increases, people become more sensitive to crowding. Thus, a vicious circle is begun. As people experience increasing stress as less and less space becomes available, more and more space is required. It is extremely important to recognize the various zones of involvement and the activities, relationships and emotions associated with each. Proxemic patterns indicate some of the basic differences between people, and they are differences, noted Hall, which can only be ignored at great risk.[18]

This concept of space, man's needs and use of space, carries with it implications for those involved in therapeutic endeavors. The patient's or client's perception of his physical and social environment will be mediated by his spatial needs and the spatial cues he receives.

In planning for the care of a hospitalized patient, do we consider his need for space and a place of his own? Moore and Garbe base their discussion of the hospital environment and spatial needs of patients on Hall's work.[19] An individual entering hospital is usually under stress which increases his sensitivity to crowding. Rooms should, therefore, be adequately large and arranged so that the patient does not perceive invasion of his personal space. Can he move around in bed or in the room without bumping into equipment or furniture? "Space in which the arms could be outstretched without overlapping the furnishings," is the unconscious requirement.[20] The space should permit placement of the visitor's chair at the "correct" distance, depending on the relationship of the visitor.

Is the arrangement of the furniture in patient waiting rooms or lounge areas flexible enough to facilitate visiting with relatives, friends, or other patients? Is it arranged around the periphery of the room tending to keep them apart, rather than in groupings which is more likely to bring people together and allow some privacy in conversation?

Do we allow a hospitalized patient personal space, his portable territory or do we make it evident that he is an intruder in our "territory" by invading his space unannounced, and arranging furniture and equipment for the convenience of nurses and physicians without consideration of the patient? If we violate the personal space of the patient and he is in a position where he cannot escape, then he may be expected to experience discomfort and stress. The nurse, and other hospital personnel, could relinquish at least part of their hospital territory to the patient by "knocking at his door, by introducing herself by asking his preference, by addressing him by name, or even by letting him chart his own medication."[21]

Are we sensitive to the interaction of our own personal spatial needs with those of the patient or client? Do we because of our own spatial needs refrain from coming to close to a patient or touching him, conveying an aloofness, or do we remain too close causing him to feel uncomfortable? Do we consider his emotions? When he is afraid, because of pain or the unknown situation, do we remain closer to him? When we carry on a conversation from the foot of the bed or at a distance, looking down on him, we are probably silently implying our dominance over the patient. When we stand at the

bedside or within hearing distance of the patient discussing his condition with another nurse or doctor without including the patient, treating him as an object or part of the background, we are conveying to him that he is a non-person; a nonhuman being. The substance of a conversation can demand special handling of space. Do we stand at the door of the room or at the other end of an intercom expecting a patient to communicate a message which may require closer distance?

The spatial cues of the situation, those emanating from the person, and the spatial needs of the perceiver all interact to affect the process whereby the perceiver selects, organizes and interprets the sensory input. If we wish the input to be therapeutic, then we must learn to read the silent communication as well as the spoken ones. It is essential that we become sensitive to the spatial needs of each patient or client as an individual with a culturally learned pattern, and who is now in a particular emotional state. We need to be aware of our own concept of space and how we make use of spatial cues — what are the silent messages we convey? Are they congruent with the intended messages and aimed at assisting the patient to regain or maintain his health? We must be certain, as was Humpty Dumpty, that the words and message mean to the patient what we choose them to mean.

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