

From Literature to Lived Experiences: Architectural determinants of Subjective Well-Being in Post-Stroke Rehabilitation

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Abstract. Post-stroke rehabilitation environments involve multiple user profiles. While the influence of architecture on well-being is increasingly acknowledged in healthcare settings, a comprehensive understanding of how architectural determinants relate to the subjective well-being of these users in post-stroke rehabilitation remains limited. Based on a previous systematic literature review, twenty-one architectural themes impacting subjective well-being in post-stroke rehabilitation contexts were identified. These themes reflect a wide range of spatial, environmental, and experiential aspects discussed in existing research. Building on this review synthesis, this article explores how these themes are perceived and experienced by different user profiles in a real-life post-stroke rehabilitation setting within a Belgian context: not only long-term inpatients, but also healthcare professionals, informal caregivers, and visitors (family members). To do so, the study adopts a qualitative methodology combining walking interviews in the rehabilitation service with semi-structured interviews relying on photo-elicitation (n=10). Participants are invited to discuss photographs of rehabilitation environments to support their reflection on experiences, perceptions, and priorities related to architectural space and subjective well-being. This methodology aims to facilitate expression in a sensitive clinical context and to capture nuanced, subjective perspectives that may not emerge through verbal or self-administered questioning alone. The article brings into dialogue the insights from the systematic literature and the empirical material. It also examines whether engagement with various users' profiles in a real rehabilitation context reveals additional architectural themes related to subjective well-being beyond those identified in the literature. By articulating insights from the literature with situated user experiences, this research seeks to refine and extend current knowledge on the relationship between architecture and subjective well-being in post-stroke rehabilitation contexts.

Keywords. Architecture, Subjective well-being, Stroke, Rehabilitation service

1. Introduction

Worldwide, stroke is the second leading cause of disability [1]. The prevalence of this condition is projected to rise consistently over the coming decades, driven by demographic shifts such as population growth and aging, alongside improved survival rates and the increasing prevalence of key risk factors [2].

In response to rising clinical demands, the impact of the physical space during post-stroke rehabilitation has become increasingly significant, affecting a growing proportion of long-term patients and their careers. Consequently, the built environment is no longer a mere backdrop but has emerged as a pivotal concern in modern healthcare architecture, serving as an active component of the recovery process. In this context, the hospital environment can be understood as a space that represents a significant rupture in the individual's life journey [3]. Unlike acute healthcare settings, which are often characterized by short stays and intensive medical interventions, post-stroke units involve a long-term, multidisciplinary approach to revalidation. In this specific clinical context, the rehabilitation service often takes on a "quasi-domestic" character. Given the extended duration of recovery, the unit ceases to be a transient medical station and instead functions as a prolonged living environment. For some patients, the hospital setting becomes their primary residence for periods lasting up to two years. The ultimate objective of this prolonged stay is to restore the patient's independence and prepare them for a successful return to their home environment.

The architectural challenge is further intensified by the complex and heterogeneous nature of stroke. As recovery paths are profoundly unique for each individual, the design of rehabilitation facilities faces a significant challenge in addressing a wide array of post-stroke conditions. These include physical impairments such as hemiparesis or hemiplegia [4], as well as diverse cognitive deficits affecting memory, orientation, and attention [5]. Because "no two strokes are alike" [6], a rigid or uniform architectural approach is insufficient. As noted by Lipson-Smith et al. [7], the impact of stroke is wide-ranging, often requiring patients to relearn fundamental motor skills, such as walking, alongside cognitive abilities like speaking or executing everyday tasks. This complexity requires a multidisciplinary and multifactorial response. Consequently, it is essential to consider the totality of the profiles involved in the service: long-term inpatients with varying needs, healthcare professionals from multiple disciplines and informal caregivers. Each of these stakeholders perceives the architectural space through a lens shaped by their specific needs.

While international research has begun to explore these architectural determinants, a significant geographical imbalance persists. A systematic review by Lipson-Smith et al. [8] established that the majority of existing studies are concentrated in Australia and Sweden, highlighting an urgent need for more diverse international perspectives. Since stroke rehabilitation services and their architectural designs reflect local clinical cultures and organizational specificities, findings from these regions may not be directly transposable to other contexts. This study aims to address this need by exploring the French-speaking Belgian context, which possesses its own cultural and organizational characteristics. The service under study was refurbished in 2017 to consolidate most inpatient rehabilitation areas on a single floor, while a separate floor is dedicated to outpatients. This service treats patients with various conditions requiring physical rehabilitation, including stroke survivors.

Beyond this geographical gap, there is a concurrent need to better define the diverse architectural factors that impact patient well-being. The built environment in

rehabilitation is a complex assembly of multi-dimensional features, ranging from spatial layout to sensory qualities, each carrying different implications for recovery. Mastering this diversity of "architectural themes" is essential to ensuring that design interventions are evidence-based rather than purely intuitive.

To address these challenges, we conducted a systematic literature review where twenty-one distinct architectural determinants impacting well-being were identified. There is a clear interest in bringing these themes into dialogue with the lived reality of a Belgian rehabilitation service to understand how they are perceived in this previously unstudied context.

This article seeks to bridge the gap between these theoretical findings and empirical experiences. By bringing the twenty-one architectural themes identified in the literature into dialogue with the perceptions of stakeholders in a real-world Belgian rehabilitation service, the study aims to answer a dual research question: How are the themes identified in the literature perceived by actors on the ground? And more broadly, what are the specific contributions of architecture to subjective well-being within the unique context of post-stroke revalidation? The research goes beyond testing the existing determinants. It also explores whether there are any additional emergent themes that come to light when working with stakeholders.

2. Theoretical background

2.1. Subjective wellbeing in healthcare environment - a multi-perspective approach

It is widely established that the design of the built environment exerts a significant influence on human well-being [9]. However, reaching a universal consensus on the definition of "well-being" remains a challenge in current literature [10]. This research specifically focuses on Subjective Well-Being, a concept defined by Jackson [11] as depending on what individuals personally perceive would improve their own lives, rather than relying on external or objective values imposed by others.

The architectural impact on this subjective wellbeing is particularly critical in medical settings. While hospital design is known to affect patient outcomes, there is a notable lack of evidence-specific design guidelines for stroke rehabilitation facilities [12]. This gap in the literature underscores the necessity of investigating the unique environmental requirements of this context.

Furthermore, recent scholarships emphasize the importance of a multi-stakeholder perspective in rehabilitation [13]. Although the emotional well-being of staff and visitors was identified as a priority by Lipson-Smith et al. [8], these groups have rarely been the primary focus of direct empirical studies. Consequently, there is a clear call for future research to examine how the built environment affects staff and caregivers, and how their specific environmental priorities can be effectively balanced with those of the patients.

2.2. 21 architectural determinants from systematic literature review

To establish a robust theoretical baseline, a systematic literature review (SLR) was conducted following the PRISMA guidelines, as documented in another publication [14]. The objective of this review was to synthesize existing knowledge on the relationship between architecture, post-stroke rehabilitation, and the well-being of all users. More

specifically, it sought to research how, according to existing literature, architectural design influences the subjective well-being of long-term post-stroke inpatients and all users involved in these rehabilitation services. The search was performed across three major scientific databases: PubMed, Scopus, and Web of Science; covering a ten-year period from 2014 to 2024. Publications written in English were included. The search strategy utilized keywords categorized into four thematic pillars: (1) well-being, (2) stroke, (3) architecture, and (4) hospitals. The analysis of the twelve selected articles [6] [7] [12] [13] [15] [16] [17] [18] [19] [20] [21] [22] identified a significant geographical concentration of studies carried out in Australia (n=5), Sweden (n=3), Canada (n=2), and Germany (n=1), confirming that the Belgian territory remains unaddressed in this specific field of research.

The data extraction process led to the identification of 21 architecture-related themes impacting subjective well-being. As specified in the review [14], some of these themes were explicitly expressed in the literature and reused as such, while others required the creation of new categories based on more implicit statements. These implicit extracts were also occasionally added to existing subcategories. These 21 themes are listed below:

- | | |
|---------------------|---------------------------|
| • Acoustic | • Mobility/ Accessibility |
| • Aesthetic | • Nature |
| • Appropriation | • Outdoor vision/ contact |
| • Bearing capacity | • Relaxation |
| • Communication | • Safety |
| • Control | • Sense of normality |
| • Efficiency | • Sensory experience |
| • Flexibility | • Social Interaction |
| • Home feeling | • Spaciousness |
| • Intimacy/ Privacy | • Stimuli |
| • Light | |

Furthermore, the review associated these themes to the diversity of spaces that constitute a typical rehabilitation service, such as private areas for staff (cafeteria, nurse room, staff office), clinical areas (therapy rooms, physiotherapy room, ergotherapy room), patients' rooms (bedrooms, bathrooms) and public areas (common spaces, corridors, outdoor spaces). The SLR also demonstrated that each determinant can take on multiple priorities depending on the profile-space intersection. Indeed, depending on the areas of the service, certain determinants may take on greater importance, such as the question of privacy in relation to the bedroom space.

The complete definitions and the detailed mapping of these themes are provided in the full paper [14]. This 21-theme framework serves as the analytical grid for the present study, which seeks to confront these theoretical findings with the lived reality of a Belgian rehabilitation service.

3. Methodology

3.1. Study setting

The research was conducted in collaboration with a physical rehabilitation center located in Belgium. Situated in a densely wooded environment, the facility offers a specific landscape context that contrasts with more frequent urban hospital settings. This study focuses exclusively on the inpatient unit. Architecturally, the service is primarily organized on a single floor (plateau), regrouping most functions: patient bedrooms, common rooms, nursing stations, occupational therapy rooms, storage, and neuropsychological consultation offices. A second, smaller floor houses additional consultation offices and a meeting room.

3.2. Participants and Selection Criteria

A key aspect of this study is the inclusion of all stakeholders, based on the premise that the functional success of a healthcare environment depends on the subjective well-being of all its users (including patients, staff, and caregivers) rather than the patient alone. Data collection thus involved a diverse range of actors (N=10) involved in post-stroke rehabilitation: patients (n=2), nurses (n=2), a physical doctor (n=1), a psychologist (n=1), a speech therapist (n=1), an occupational therapist (n=1), a physiotherapist (n=1) and a neuropsychologist (n=1). We deliberately recruited more patients and nurses. For nursing staff, this allowed the capture of diverse experiences across different shifts and work cycles. For patients, given the high clinical diversity of stroke profiles, multiple perspectives were essential. Patient selection was conducted in consultation with the medical team based on three criteria: a stay of sufficient duration to ensure familiarity with the building; being over 18 years of age, and being non-aphasic to facilitate communication. This resulted in interviews with one inpatient (staying for several months) and one outpatient (who had stayed there six months prior).

3.3. Qualitative Tools: Walking Interviews and Photo-Elicitation

To capture the nuanced and subjective perspectives of a sensitive clinical population, the study adopts a hybrid qualitative methodology combining walking interviews [23] and semi-structured interviews relying on photo-elicitation [24] [25].

- The Walking Interview: After informal meetings and navigating the institutional hierarchy, it became evident that discussing architecture while physically present in the spaces was valuable. During walking interviews, participants were asked to walk through all the spaces they frequently used during the day, reflecting on factors that were beneficial or detrimental to their well-being in each space. This approach made discussions more accessible, reducing cognitive load and allowing for greater spontaneity. Furthermore, it encouraged reflection on what could be important for their well-being and helped them 'refresh their memory' regarding the spaces before the subsequent photo-elicitation phase.
- Photo-Elicitation Process: Participants were invited to select visual elements they perceived as beneficial or detrimental to their well-being. The 21 themes

identified in the SLR were translated into a set of pictures cards. This visual tool was developed with the specific aim of representing a diversity of spaces and profiles. The primary goal of this selection was to encompass all the different areas within the service and, consequently, to cover the full range of profiles and their respective environments. Similarly, the various photographs featured a wide range of people in order to reflect the multifaceted reality of the rehabilitation context and to enable each of the individuals interviewed to identify with this series of images. Some themes were represented across multiple cards. Participants were invited to refer and react to any aspects of the images they wished, in complete freedom. This method was chosen to trigger new ideas and possibilities beyond the existing physical environment of the center itself.

3.4. Clinical Adaptations and Flexibility

The data collection process was strictly adapted to the rigorous constraints and unpredictability of the clinical environment. Interviews were strategically planned for approximately 30 minutes: for patients, such a short duration was essential to maintain concentration and prevent fatigue; for staff (especially paramedics), it aligned with their intense schedules and 30-minute consultation slots.

In practice, the researcher in charge of data collection (first author) had to be flexible about time and settings. The average interview time was 26 minutes. However, due to unforeseen clinical issues, as well as interruptions when staff, patients or visitors approached and interacted, interviews had occasionally to be shortened by up to a third of this duration. In these instances, the focus shifted primarily to the photo-elicitation phase to ensure that the 21 architectural themes were still addressed. As Kevdzija [26] supports, this rapid yet precise data collection was reinforced by the researcher's preliminary shadowing within the service. This immersion facilitated a faster and deeper understanding of participants' remarks, enabling more qualitative data to be collected within a short interview duration.

3.5. Visual Tool - The Card Set

To facilitate discussion, the 21 themes identified in the systematic literature review were translated into a dedicated set of images (see example on Figure 1). This visual tool was developed with the specific aim to reflect the multidimensional reality of the rehabilitation context. To ensure a comprehensive scope, the set encompasses all functional areas of a typical service (including therapy rooms, staff rooms, patient rooms, and public spaces) while depicting a wide variety of stakeholders, such as nurses, paramedics, and patients (in both ambulatory and wheelchair-using roles).

Since the cards were intended as a catalyst for discourse rather than a rigid classification task, certain themes were purposefully represented across multiple cards. To start, the protocol invited participants to identify and discuss cards they perceived as beneficial or detrimental to their well-being.



Figure 1. Example of cards illustrating the themes (from left to right: Bearing capacity; Flexibility; Relaxation).

Once the interviews had been conducted and transcribed, a thematic analysis [27] was carried out using NVivo software. This process aimed to identify the themes addressed by each participant and to highlight their connection with the specific context of the post-stroke rehabilitation center. This analysis enabled us to confirm or refute the theoretical themes, whilst remaining open to new priorities that emerged in the field. Using this method, we were able to identify the various needs and understand their significance for each individual.

4. Findings: Comparing Theory and existing context

Through the systematic literature review, all themes mentioned in the included articles (n=12) were identified and quantified. Figure 2 ranks the most frequently mentioned themes within the 12 selected articles.

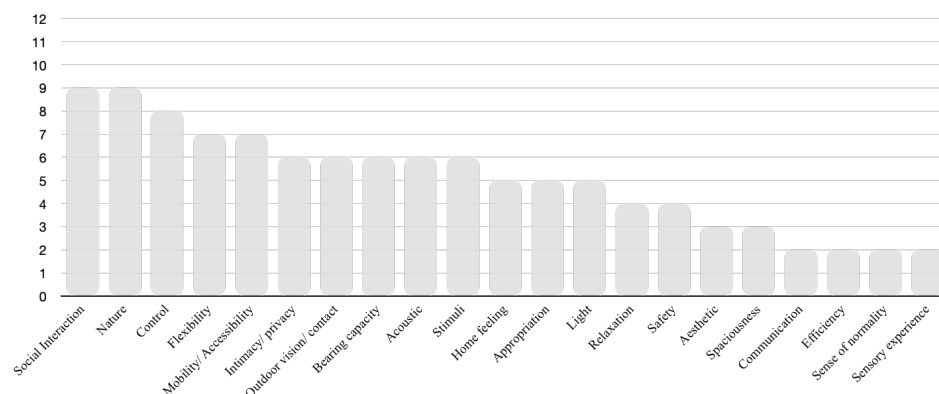


Figure 2. Number of articles from the SLR mentioning each topic.

The most frequently cited themes in the literature are "Social Interaction", "Nature", and "Control". Social interaction encompasses the need for communal spaces, and how people engage with these areas [21].

Nature is a well-known factor in promoting well-being. Its positive effects have been confirmed in our context, including relaxation and peacefulness [7] [13] [21], a sense of serenity [13], and positive distraction [13] [19] [20] [22].

Control in this specific literature translates into the capacity to exert influence over one's surroundings; revolves around the ability of all users (including patients, staff and visitors) to make individual choices regarding their physical environment [7]. This sense of autonomy in turn fosters a sense of empowerment allowing users to balance privacy, social interaction, and stimulation levels. In rehabilitation, such flexibility is essential for adapting environments to changing therapeutic needs [7]. Additionally, control extends to staff requirements for environmental oversight to effectively monitor patients within the clinical setting [20]. Conversely, four themes appeared in only one article each: "Communication", "Efficiency", "Sense of Normality", and "Sensory Experience".

Building on these objectives, this study compares the previously identified literature trends with the specific themes raised during the interviews. For each participant, we compiled a comprehensive list of the themes addressed, focusing on capturing the diversity of topics rather than their frequency of recurrence at this stage. It is important to note that stakeholder feedback is often heterogeneous; a single theme may be discussed in either a positive or negative light regarding its contribution to well-being. To investigate the nuances of subjective well-being within the specific center we chose for our field work, we categorized the themes addressed by each profile. Figure 3 illustrates the distribution of these themes across the different participant groups.

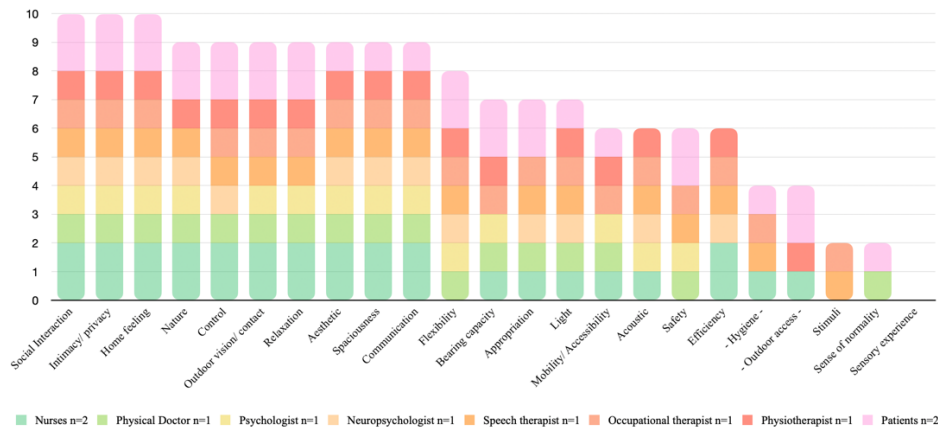


Figure 3. Topics covered in interviews with stakeholders (n=10).

The comparison first confirms the relevance of most theoretical themes within the studied context. Nearly half of the themes were discussed by 9 or 10 out of 10 participants, demonstrating a high level of interest in these issues. However, different priorities emerged in the field rankings: the themes most frequently mentioned by all interviewees (n=10) were "Social Interaction", "Intimacy/Privacy", and "Home Feeling". One topic is not mentioned by the users, namely « Sensory Experience ». Others are only mentioned by the medical staff. "Acoustic", for instance, is mentioned by almost all professional profiles as important for ensuring that cognitive exercises run smoothly, as patients have great difficulty concentrating and can quickly lose focus during their

sessions. It is also highlighted as being important in consultation rooms to maintain a degree of privacy and to uphold medical confidentiality. For healthcare staff, « Efficiency » can take many forms: having enough space to carry out all necessary movements and care procedures, or a sufficiently uncluttered space to improve bearing capacity, so that they are not interrupted in their work. The theme of Stimuli was exclusively addressed by healthcare professionals. One participant emphasized the importance of avoiding visual clutter for patient well-being: “having all those lines would be visually overwhelming.” Another highlighted that since sensory stimulation is already a core component of active rehabilitation sessions, the architecture itself should not serve as an additional, potentially taxing, sensory burden. Similarly, Sense of Normality was discussed by only a few participants. It was primarily associated with the desire for spaces that evoke a domestic environment, such as a “living room” or a “library”, to create a warmer, more human atmosphere. This theme is, therefore, intimately linked to the concept of a “Home Feeling”.

4.1. Emergent Themes: Hygiene and Outdoor Access

Two new categories emerged directly from the interviews that were not explicitly categorized in the initial SLR framework: Hygiene and Outdoor Access. The first concerns the link between the chosen materials and the maintenance of hygiene in a hospital context for patient health, but also for maintaining good conditions of hygiene, as cited by a nurse regarding the use of carpet: *“Yes, because despite everything, they are still patients with germs. We still need to be able to sanitize the place after they've been there, and with the carpet...”*. The second theme, Outdoor Access, involves access to external spaces to have more contact with the outside, both for staff interest and for rehabilitation, as explained by a physiotherapist: *“As soon as patients are able to walk, we get them out of bed, out of their chairs and out of the physiotherapy room, and we also use the outdoors. That's an advantage here, we can take patients who are able to walk outside, (...). As soon as the sun comes out, we'll do exercises outside. We walk in the woods, if we can. That's... It's important to remember that rehabilitation doesn't only work in a smooth corridor”*. This theme also allows patients to relax and enjoy the light, as expressed by one participant: *“The terrace is really nice. The terrace is definitely a plus because, as I was here from February to July, yes. It's true that we were able to spend time sunbathing rather than sitting in a dark, dreary room. So that was... That's an important point”*.

4.2. Nuances and Divergent Perceptions of Themes

The interviews revealed that highly discussed themes often carry different meanings depending on the stakeholder's profile and needs. For instance, while “Intimacy/Privacy” are often viewed as personal needs for patients, for professionals, these concepts are directly linked to medical confidentiality, as noted by a neuropsychologist: *“Well, it's professional secrecy. [...] I ask questions that the person in the next bed isn't supposed to know the answer to, at least”*. Furthermore, staff expressed a need for privacy as a way to retreat from constant visibility, with one nurse stating: *“But one thing I don't like so much [...] is the fact that it's all glass. I think that during a break or a little rest, you should be able to hide away, not be seen all the time”*. Similarly, the theme of “Home Feeling” revealed a significant dilemma across the different profiles. For

patients, a home feeling is perceived as essential for psychological endurance during long stays: *“I stayed for six months, but some people stayed here for two years. Psychologically, you have to hold on. I mean, of course, we're not in prison, but still, we're not in prison, but we're not at home either. So, first of all, we lose our ability to make choices in our lives, in our bodies. For me, my brain had had enough and my body was giving up in certain areas. You feel deeply diminished and so you have no choice but to live here, for months or even years for some people. Yes, I think it's absolutely necessary to bring in something more residential that promotes well-being during this ordeal.”* However, a psychologist argued for a careful balance, reminding that the hospital must remain a place of transition, as a psychologist stated: *“The problem is that they stay here for a long time while they wait for approval. That means it's... Well, between one month and 18 months. And I think we need to make it clear that this isn't their home and that life is outside. And that even though we're here to support them, we're mainly here to support them and help them move on to the outside world. So no, I don't like it being like a living room. That doesn't mean it can't be warm, welcoming, all that. But no, not a living room, they're just passing through. They're here to reintegrate into their lives outside”*.

4.3. Defining Well-being: Living Space versus Workplace

Finally, a significant finding lies in the diverging definitions of well-being between the different user groups. For patients, the center represents a temporary living space, sometimes for durations extending into years, where they must rebuild themselves and regain independence after a stroke. Conversely, for the staff, the facility is primarily a workplace. Many participants were keen to remind that the clinical mission remains the priority, as stated by a doctor: *“Here, we work, we do rehabilitation, it's professional”*. Interestingly, the interviews highlighted that for many professionals, their own well-being is intrinsically linked to that of the patients, as their core mission is to care for others. This is reflected in remarks such as *“Knowing that our patients are well is good”* from a nurse, or *“So, it's for my own well-being, but my well-being is also that of my patients”* from a physiotherapist. This interdependence created a visible difficulty during the interviews, as staff members often struggled to focus on their own architectural needs, frequently redirecting the conversation back to the patients, as noted by an occupational therapist: *“(…) but here, I am still talking about the patient”*.

5. Discussion

5.1. Diverging Perceptions of Well-being: Life vs. Work

The confrontation of different user profiles reveals that the definition of well-being is intrinsically linked to the user's role and their functional objectives within the space. A fundamental tension exists between the patient's perspective, where the rehabilitation center is perceived as a long-term living environment dedicated to identity reconstruction, and the staff's perspective, which remains firmly anchored in professional duty and clinical efficiency. For healthcare professionals, the facility is primarily a workspace

where clinical missions often take precedence over residential comfort, although patients' well-being always remains central.

This distinction is crucial for architectural design because it suggests that subjective well-being is viewed through multiple, distinct lenses. Interestingly, the study highlights a transfer of subjective well-being; staff members frequently find it difficult to focus on and define their own spatial needs without referencing the quality of care provided to patients. Their professional satisfaction is derived from an environment that facilitates their mission of "taking care of others," indicating that functional efficiency and quality of care remain, for them, the primary architectural driver of well-being. These diverging perceptions lead to significant challenges in aligning diverse needs, thereby reinforcing the importance of adopting a holistic view of all users. This observation aligns with the literature emphasizing that the design of inpatient stroke rehabilitation facilities must foster the emotional well-being of all users simultaneously [7].

5.2. Finding the "Cursor": Balancing Diverse Needs

The inclusion of multiple profiles brings essential nuances to the theoretical determinants identified in the literature. The results show that a rehabilitation service is a place where conflicting architectural requirements come into play, and where an architectural determinant can take on various forms. This highlights the challenge of positioning correctly the "cursor" or balance in design.

A prime example is the dilemma between a "hospital" and "home-like" feeling. While a residential atmosphere supports the psychological endurance of patients during long stays, it must be balanced with the clinical requirements of the staff and the institutional necessity of preparing the patient for discharge. As noted by a psychologist during the interviews, the architectural objective must remain transitional: the environment should foster comfort and appropriation without obscuring or slowing down the ultimate goal of regaining autonomy and returning home.

This necessity is confirmed and expanded upon by Daemen [17], who emphasizes the importance of establishing the right balance between clinical and personal environments for all stakeholders. For instance, while patients and families require personal spaces for privacy and emotional respite from draining rehabilitation activities, the environment must simultaneously remain clinical enough to ensure the proper conduct of medical actions. This balance is particularly critical in post-stroke care, where stays are typically longer than in other hospital departments.

Furthermore, this finding aligns with Lipson-Smith [7], who argues that including staff perspectives is vital to ensuring that the "domestication" of a space does not impede clinical efficiency or the technical quality of care. Ultimately, these results suggest that the architectural "cursor" must be mobile, allowing for a hybrid environment that acknowledges the hospital as both a place of medical care and a temporary place of life.

6. Conclusion

The results from this Belgian field study largely confirm the relevance of the twenty-one themes identified in the systematic literature review, while significantly enriching them through the diverse perspectives of all stakeholders. Beyond mere enrichment, these findings reveal a shift in the hierarchy of importance compared to the themes' ranking in the literature. This highlights that a theme's prevalence in academic

publications does not necessarily correlate with its clinical impact on the ground; for instance, determinants such as 'Spaciousness', 'Communication', and 'Aesthetics' emerged as important pillars of subjective well-being in the real-world rehabilitation setting, despite being less mentioned in theoretical frameworks.

The inclusion of staff alongside patients has revealed that architectural subjective well-being is not a static or universal concept; rather, it is a dynamic negotiation between the "home-like" needs of long-term patients and the "functional-clinical" requirements of professionals. This cursor between conflicting needs is not limited to the residential feel of the space but applies to various other themes where interpretations diverge. This underscores the necessity of a deeper, nuanced investigation into how each theme is perceived across different profiles.

As a perspective, this research will be extended to a second rehabilitation center in Belgium, involving the same categories of stakeholders. This comparative approach will allow for an analysis of how different architectural designs and organizational structures influence the perception of these themes. By deepening the nuances of each category and exploring the challenges that emerge from conflicting needs, this work aims to provide architects and hospital managers with a more balanced and empathetic toolkit for designing future stroke rehabilitation environments.

7. Ethical Committee Approval

This study was approved by the Ethical Committee by the Social Sciences Ethics Committee of ULiège and the CHU Ethics Committee. Each participant gave their consent to participate in the research study. The patients, depending on their abilities and possible post-stroke impairments, gave their consent in a written or verbal (recorded) way.

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