

The Art of Being Elsewhere Neoliberal Institutions of Care

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Abstract: *The being of human beings and, in particular, their wellbeing is profoundly spatial and temporal. We feel well in dramaturgically stimulating, sheltered, yet expansive spaces that lend themselves to daydreaming, much like we feel well in “thick” time that, like a complex melody, textures our existence aurally, kinesthetically, and proprio-centrally (influencing our body’s sense of balance). This existential relation is created through movement, sound, language, chronotypes, physical and symbolic objects, all of which weave bio-social matrixes, micro-cultural landscapes, even individual inscapes – internalized terrains of symbolic meaning. This essay offers a socio-phenomenological account of a medium-security forensic service unit River House, part of the Bethlem Royal hospital, a psychiatric hospital located in Bromley, south London. Its aim is to articulate the interdependence of practice, space, and inscape, while simultaneously shedding light on a very particular, emergent form of existential vulnerability caused by the increasing precarization, the reponsibilization of the individual, and the culture of blame.*

Keywords: *activated space, archive, gelassenheit, inscapes, parasites, precarization, risk management, vulnerability.*

A Spatial Transplant

On July 6th 2013 I visited Sunfayre, the annual open day at Bethlem Royal Hospital, a psychiatric hospital located in two hundred and seventy acres of land in Bromley, south London. Upon entering the immaculately kept hospital gardens, my attention was immediately drawn to a quizzical, wagon-like object made of cardboard, incongruously parked next to car. On closer inspection, the mobile object revealed a tiny door and a sunroof window, made of what resembled pink and blue plexiglass. An energetic middle-aged man, who was later introduced to me as patient¹ X, approached me, explained the purpose of the mobile object: to travel *through* the hospital and to be taken around the hospital grounds, and asked me if I’d like to have a go.

¹ I use the word “patient” in its Latin meaning, to signify suffering and endurance, not passivity. Although the neoliberal “service user” can be seen as less stigmatizing, it also places the responsibility for recovery largely with the patient.



Figure 1. Patient X: Cardboard Mobile, Bethlem Royal Hospital, London, July 2013. Photographer anonymous.

It was a warm sunny day and the inside of the cardboard mobile was inviting, bathed as it was in pink and blue light. At once reminiscent of early childhood spaces – tents improvised in the living room with a sheet and a couple of broomsticks – and a sophisticated rumination on the bio-social dimensions of human existence in the style of Alice Aycock or Krzysztof Wodiczko, the mobile exuded a sense of mystery. It was also an unmistakable critique of lived space. The shortest way to describe Alice Aycock’s work is as a sustained engagement with collective memory and individual experience. Aycock’s seminal 1975 *Simple Network of Underground Wells* consisted of an underground structure into which visitors crawled in the dark. At first, the configuration appeared to be simple and clear, geometric and rectilinear, resembling a staircase leading to a cellar. The actual experience of descending the staircase, however, was not at all clear or simple. As the visitors moved from light to dark they entered a much more mysterious place whose unexpectedly narrow confines they were forced to explore with their faces, bellies, knees, and elbows. Evoking memories of cozy hiding spots, fallout shelters, and nightmarish prisons, *Underground Wells* simultaneously instigated sensations of excitement, panic, and fear. Krzysztof Wodiczko’s work, by contrast, situated at the interstice of sculpture, public art, and engineering, foregrounds the socio-political dimension of underprivileged human lives – those of the homeless and immigrants. His 1988-1989 *Homeless Vehicle Project*, a stylishly designed multifunctional vehicle, at once a suitcase, a trolley, a table, and a collapsible bed, was simultaneously an insightful rethinking of a homeless existence and a means of a dignified public appearance. It brought the physical existence of politically invisible citizens into view by exposing their spatial and temporal “being there,” their *Dasein*², and in this way

² A term extensively used by Martin Heidegger. See Martin Heidegger, *Being and Time*, John Macquarrie and Edward Robinson, tr. (Oxford: Blackwell Publishers Ltd., 1962).

staging an emphatic critique of what Achille Mbembe was later to call “necropolitics”: a mode of government that makes and lets die through neglect and denigration³.

In similar vein, patient X’s mobile simultaneously disclosed and hid a very particular, existential form of vulnerability. Operated by patient X himself, the fragile vehicle excavated early-childhood feelings of sheer glee associated with being invisible to the outside world, while, at the same time, creating an unpredictable sense of space endlessly extended in time. When, at the end of the journey, I was told that I had spent no more than twenty minutes inside the vehicle I had a genuinely hard time believing my interlocutors. My kinesthetic and proprioceptive memory was of a much longer and far more elaborate journey, with many stops, turns, crossings, and encounters with cars, vans, and bicycles. Lying flat on the vehicle floor I was much more “outside” than when walking outside; I viscerally felt every, even the most minute change in the texture of the ground – pavement, grass, pebbles – much like I felt every single stray stone that momentarily swerved the otherwise steady motion of the wheels. And yet, the mobile structure felt like a second skin in which my vertical, socialized self could be abandoned in favor of dissipating into an assemblage of tactile, kinesthetic, and aural sensations. It was a form of spatial surgery: a transplant whose topology exposed the passenger to the precariousness of chance as well as to introjection; traveling was here a form of a searching for a proper place, for lost time, for “thick” existence. The vehicle’s slow, minutely textured motion afforded meditative rumination of a very specific kind: a Heideggerian *gelassenheit*, a “releasement towards things.”⁴ For Martin Heidegger, *gelassenheit* is an immersion in thick time cued by an existentially relevant relation to dwelling. Residing in a form of relationality he terms the fourfold – the earth, the sky, the mortals, and the divinities – dwelling involves one’s physical, visceral existence, much like it involves rediscovering a sense of place, and a sense of belonging⁵. In this context, a log, a hut, or a bridge, none of which have a single, delimited, strictly utilitarian purpose, afford dwelling as a “way of staying with things.”⁶ They produce a form of thinking-feeling that is simultaneously alert and relaxed. *Gelassenheit* is, for this reason, also an antidote to goal-orientated, calculative thought associated with technology: *gestell* or enframing. However, in Heidegger’s parlance, technology does not refer to gadgets or technicalities, but to a scientific, material, and social form of *ordering* as related to systems of knowledge, exchange structures, and means of production⁷. Enframing therefore refers primarily to emplacement, sequencing, and fixing; to a spatio-temporal organization that summons the forces of life into a set of manipulable reserves. Heidegger’s example of such a “summoning” is that of coal: “[t]he coal that has been hauled out in some mining district has not been supplied in order that it may simply be present somewhere or other. It is stockpiled; that is, it is on call, ready to deliver the sun’s warmth that is stored in it.”⁸ The problem here is not delivering coal where it is needed; it is robbing the world’s resources of their present-ness and their futurity by organizing them according to a single, predetermined principle, that of extraction, stockpiling, and use.

Within the hospital context, enframing is, of course, not related to extraction or stockpiling. It is, however, related to predetermination, albeit of a different kind, one that concerns two

3 Achille Mbembe, “Necropolitics” in *Public Culture* 15:1, 2003, 11-40.

4 Martin Heidegger, *Discourse on Thinking*. John M. Anderson and E. Hans Freund, tr. (New York: Harper and Row, 1966), 54.

5 Martin Heidegger “Building, Dwelling, Thinking” in *Poetry, Language, Thought*, Albert Hofstadter, tr. (New York: Harper, 1971), 145-161, 153.

6 *Ibid.*, 151.

7 Martin Heidegger, *The Question Concerning Technology and Other Essays*, William Lovitt, tr. (New York: Harper Colophon Books, 1977), 20.

8 *Ibid.*, 15.

important socio-phenomenological registers: the custody-care continuum, and the index offence. As the modern matron suggests, many patients come to Bethlem “as very damaged people.”⁹ A forensic unit that houses patients who, apart from being ill, also have an index offence – the gravest of two or more offences committed in the moment of or *because* of their illness, ranging from homicide, attempted murder, and grave bodily harm, to arson or theft – will seek to provide custody as well as care. However, custody will organize the patients’ time and movement into what may be experienced as repetitive, constraining patterns. The index offence, on the other hand – a moment of derailment that occurred years, or, in some cases, decades ago – is by many perceived as an inexorable force that continues to enframe their lives by sequencing their actions, and programming their reactions within the monitored recovery process, while also influencing the way they are perceived by others.

In contrast to such a sequenced, restrained, and potentially incriminating mode of existence, *gelassenheit* is focused on the here and now – the moment, the process, the sounds, the somatic-environmental sensations – all of which make the percipient dwell on “what is closest ... the here and now”¹⁰ and, in so doing, activate space. “Activated space” is a concept derived from native Indian art. It makes the existential dimension of a physical-symbolic relation with elements similar to Heidegger’s fourfold – explicit. Within this context, space is activated via a performed action whose primary purpose is restorative. For example, the color of the Plains Ojibwa’s moccasin beads activates the wearer’s existential relationship with the environment through the action of walking or running: white is here placed in relation to the light of day, red to the horizon and the limits of the world, blue to the sky, green to plant life on earth.¹¹ Similarly, Navajo sand paintings, made on the tamped floor of especially built “song houses” – altars upon which the song man, or shaman, performs the ritual connected with a particular petition – are restorative. If there is a persisting health problem (which is often the reason behind such rituals), the petitioner is placed in the center of the painting, so that the space activated through performed action may impregnate his/her body.¹²

In a sense, all space is active, as is all existence. As *Dasein*, we are always engaged in a transitive, dynamic activity of nearing and distancing. Our body is a matrix that “remembers” past configurations and orientations. Each local situation or experience within a specific environment becomes a part of the body’s memory through repetition. The wearing of moccasins or the shaman’s ritual only *amplifies* this relation by stimulating the flow of the vital energy, since, in native Indian cultures, like in Chinese medicine, illness is equated with the obstruction of the flow of the vital energy, often attributed to a lack of relationality with existentially relevant elements. Similar ideas have also been voiced by trauma theorists; for Jeffrey Prager, trauma is “a memory illness” that manifests “as a collapse of timeliness...The present is distorted to incorporate the memory of an un-metabolized, or unprocessed, past: a *then* folds in upon the *now* largely without awareness or distinction.”¹³

It goes without saying that the Bethlem staff are abundantly aware of this. Not only does the units’ and wards’ spacious, open-plan design reflect this awareness, but the units’ names – River

9 Interview with the Modern Matron, Bethlem Royal Hospital, London, 9 May 2014, np. Author’s Private Archive.

10 Martin Heidegger, *Discourse on Thinking*. John M. Anderson and E. Hans Freund, tr. (New York: Harper and Row, 1966), 47.

11 William Jones quoted in Ruth, B. Phillips, “Comments on Part II “Catching Symbolism” Studying Style and Meaning in Native American Art” *Arctic Anthropology*, Vol. 28, No. 1, 1991, *Art and Material Culture of the North American Subarctic and Adjacent Regions*, 92-100, 95.

12 Kenneth E. Foster, “Navajo Sand Paintings” in *Man*, Vol. 63 (Mar., 1963), 43-44, 43.

13 Jeffrey Prager, “Jump-starting Timeliness: Trauma, Temporality and the Redressive Community” in *Time and Memory*. Ed. Jo Alyson Parker, Michael Crawford and Paul Harris, eds. 229-245 (The Netherlands: Koninklijke Brill, 2006), 229, emphasis original.

House, for example – purposefully connote flow, recovery, and change, both in the qualitative and the demographic sense of the word.¹⁴



Figure 2. River House, Bethlem Royal Hospital, 2014. Photographer anonymous.

While some patients have been at Bethlem, albeit on different wards, for seven or eight years, others leave after only a few months, never to return again. Yet others return, once, twice, or several times, either because their condition worsens, or because “they feel vulnerable in the outside world” and yearn for the “predictability of the hospital routine.”¹⁵ Despite their length of stay, not a single patient, or staff member, out of the several dozen I interviewed during the four-month period of observation conducted in the spring and summer of 2014, underestimates the need for rules and fixed routines, in other words, for a certain degree of enframing. No patient underestimates the gravity of his/her condition, or the need for recovery, either. And yet, patient X’s activated space where a restorative *gelassenheit* might take place is conspicuously constructed to *escape* the hospital space. Ambiguously situated between intimacy, exposure, and fantasy, the vehicle is a vociferous demand for a sheltered “elsewhere” that might act as “an instrument against chaos,”¹⁶ a function Gaston Bachelard ascribed to all secluded spaces that order space, time, and existence. Among patients, the yearning for such a space is universal. Given this state of affairs, one may well ask: if most patients accept that a degree of enframing is both desirable and necessary, what is it that prevents Bethlem’s units, equipped with such enviable facilities, full of committed and highly competent staff, from providing the much-needed combination of shelter and *gelassenheit*?

14 Interview with the Modern Matron, Bethlem Royal Hospital, London, 9 May 2014, np. Author’s Private Archive.

15 Ibid.

16 Ibid., 136.



Figure 3. Bethlem Royal Hospital garden, London, 2014. Photographer anonymous.

Living in the Archive

At first glance, Bethlem looks like an ideal place to rest, not only on account of its beautiful grounds, but also because most units, River House included, foreground liminality: a space-time where “former [social] obligations are suspended”¹⁷ and where experimentation with the “elements of the familiar”¹⁸ is the order of the day. Apart from being a place where old, sometimes life-long ailments are cured, River House is also a place where new identities (are hoped to) emerge. It is therefore both a place and a non-place. The difference, according to Marc Augé, is that “place,” is formed over time by “individual identities, through complicities of language, local references, the unformulated rules of living know-how,” and repetition.¹⁹ By contrast, “non-place” is temporary. It refers to places of transit, formed in relation to specific ends, and characterized by a projection forward. However, place and non-place are not mutually exclusive. They operate along a continuum, much like custody and care do. Place is “never completely erased.” non-place is “never totally completed; they are like palimpsests on which the scrambled game of identity and relations is ceaselessly rewritten.”²⁰ A palimpsest is a paper that has been written upon and erased several times; it contains no original writing, but bears witness to the *process* of writing, erasure, and rewriting. It is simultaneously a site of novelty and repetition. This dual, inscriptive and erasing function is particularly important in the creation of lived space, which, to borrow from Michel de Certeau, is “practiced place.”²¹ Heavily patterned ground, characteristic of “place,” that makes people move in one direction and not another,

17 Victor Turner, *From Ritual to Theatre: The Human Seriousness of Play* (New York: PAJ Publications, 1982), 27.

18 Ibid.

19 Marc Augé, *Non-Places: Introduction to an Anthropology of Supermodernity*, John Howe, tr. (London: Verso, 1995), 101.

20 Ibid., 79.

21 Michel de Certeau, *The Practice of Everyday Life*, Steven Rendall, tr. (Berkeley: University of California Press, 1988), 91-96.

would not be appropriate for an institution of care where the emphasis is on the restorative, stabilizing function of time and performed action, and where a degree of habit-formation is desirable but “institutionalization,” a form of automatism, is frowned upon.²²

Due to the fact that some patients’ early life experiences are those of abuse and molestation of the extent that even the seasoned hospital staff dare not repeat, and that these experiences are often additionally aggravated by extremely difficult adult lives, security is, naturally, taken very seriously. Alongside physical security, such as fences, personal alarms, and locks, there is also relational security, which refers not only to the “knowledge and understanding staff have of a patient and of the environment” but, more importantly, to the “translation of that information into appropriate responses and care.”²³ Relational security hinges on observation. As a clinical psychologist explains: “you want to know whether their [patient] interaction is usual or unusual for them; in a familiar environment people will observe that “you are not acting your usual self”²⁴. Knowing what is likely to happen affords the delicate balance between pattern and novelty, since stabilizing new behaviors, and thus also habits and identities, is a crucial aspect of the recovery process. It converts the hospital into a “domesticated” ground, and creates navigable maps of the possible and the permissible. To an extent, repetition also affords freedom. It neutralizes demarcations and divisions, such as the ubiquitous CCTV cameras, or the procedural “no trespassing lines,” those that separate the nursing station – an area only staff may enter – from the rest of the ward. Such lines of separation tend to disappear in a heavily patterned ground, and ground springs back as a space of multiple trajectories.

This balance is carefully monitored; stability is, of course, needed yet care is taken to avoid monotony. Settled rhythms are constantly altered by purposeful action, such as the quizzical objects placed in the hospital corridors by the occupational therapy staff. A cotton bag with mysterious, semi-visible content will thus unexpectedly appear on the edge of a corridor chair; a spatial intervention in the form of a mobile cardboard object such as that authored by patient X will be placed in the adjacent corridor (Figure 4). Intended as syncopal elements that break the usual spatio-temporal layout of the hospital, these sculptural provocations, and the ensuing debates, improvisations, and often, humorous remarks and excitement, *valance* the space as a space of inter-subjective co-creation, and thus also possibility and change. The ability to maintain this delicate balance between repetition and novelty, that serves the bigger goal of maintaining the balance between custody and care, is largely dependent on the number of available staff, however. As one nurse explains: “it looks like we’re stepping back in time, we only have three nurses at night now, and nights can be very difficult.”²⁵ A veteran nurse with more than thirty years of experience, she adds that: “patients are very complicated in hospital today, multiple axiologies, learning disabilities, obsessive behaviours, ritualistic behaviours, anger management problems, and a mental illness all rolled into one person.”²⁶ Given this state of affairs, and the nurses’ ambition to maintain the high standards crucial to the practice of their profession, encapsulated in the “six c’s formula: being caring, compassionate, committed, courageous, communicative and competent,”²⁷ the neoliberal precarization of the workplace is decidedly not conducive to providing quality care.

22 Interview with Nurse D, Bethlem Royal Hospital, London, 7 May 2014, np.; Interview with Occupational Therapy Technician, Bethlem Royal Hospital, 8 July 2014, np. Author’s Private Archive.

23 Interview with the Head of Security, Bethlem Royal Hospital, London, 6 May 2014, np. Author’s private Archive.

24 Interview with Clinical Psychologist A, Bethlem Royal Hospital, London, 22 May 2014, np. Author’s private Archive.

25 Interview with Nurse D, Bethlem Royal Hospital, London, 7 May 2014, np. Author’s private Archive.

26 Ibid.

27 Ibid.



Figure 4. Patient X's spatial intervention. River House, 2014. Photographer anonymous.

Consisting, among other factors, of temporal compression, cuts in staffing, and of increased worker responsabilization, precarization is, as Isabell Lorey has argued, neither an accident nor an exception. It is “a rule,” an “instrument of government, social regulation, and control,”²⁸ It subjugates through frequent job cuts and the threat of economic ruin, and, in so doing, feeds into the dogma of the risk society. Narrowly related to the digital compression of space and time, which decouples the “here” from the “now,” and stockpiles tasks beyond the possible, the risk society is, according to Ulrich Beck’s prescient theorization, a “systematic way of dealing with hazards and insecurities induced ... by modernization itself.”²⁹ It is characterized essentially by the impossibility of an external attribution of hazards and their dependence on “managerial decisions, which makes these decisions politically reflexive.”³⁰ Added to this is the neoliberal intensification of moral regulation based on the withdrawal from government and the responsabilization of individuals through measures such as regulated choice making. Present in education, healthcare, and child rearing – to name but a few examples – regulated choice making transfers responsibility from the public institutions to the individual. It is no longer the institution, service, or the government that is responsible for any form of malfunctioning; it is the individual who, having made the wrong choice, only has itself to blame. Unsurprisingly, the one thing that neoliberal institutions provide in plentiful supplies is training in how to

28 Isabell Lorey, *State of Insecurity: Government of the Precarious (Futures)* (London: Verso Books, 2015), 1.

29 Ulrich Beck, *Risk Society: Towards a New Modernity* (New York: Sage, Publications, 1992), 21.

30 *Ibid.*, 183.

make a supposedly informed choice. The hospital employees are thus tasked with attending all manner of workshops and courses that instruct them in how to climb ladders, move and handle objects, open and close windows without hurting themselves or others.³¹ The purpose here is to assign predictable or potential accidents to the employee's erroneous choice, rather than to the decisions of the higher managerial echelons. Needless to say, such operational principles reinstate vulnerability and insecurity of a professional, moral, and financial kind. Several staff have had to repeatedly interview for their current post, not to mention the long periods of trepidation when the job cuts are announced but not confirmed, which can last for up to six months at a time.³² Many staff are also painfully aware that staff shortage often makes it impossible to escort patients when they go on leave – leave being any time that a patient spends away from the ward, even if only fifteen minutes. This has a direct effect on the patient dynamic and on relational security, since, unsurprisingly, the patients' reactions to such curtailing are often violent.

There are, of course, entire rule structures designed to prevent peripheral problems from interfering with the projected hospital practice; they take the form of written, verbal, and agreed rules. Meal times, medication time, and rest time, as well as most staff-patient interactions – recovery team meetings, shift handovers, and the patient's leave – are regulated through scripts which specify precisely how, when, and where something is supposed to happen. Agreed rules are those created by ward staff and communicated to patients; for example, that staff will not accept patients passing remarks on their looks or clothes, as this may create a deceptive sense of familiarity.³³ Equally, if not more important, are the unwritten rules, such as the extra attention granted to all patients returning from a meeting with a relative, the recovery team – clinicians, nurses, and occupational therapy staff – or their lawyer, as the patient's mood might have changed during the meeting and could be the cause of a violent attack or verbal abuse. Staff shortage makes optimal alertness and the much-needed flexibility, which, as several nurses have explained, includes “bending the rules when a particular situation requires it,”³⁴ much more difficult to achieve, however.

Aware of the effects the neoliberal pressures to do more in a given unit of time with fewer resources have on patients, staff are adamant to create “open spaces;”³⁵ opportunities for recuperation and change. As a member of the occupational therapy staff in charge of River House's art classes explains: “[i]deally, I would like the room to change all the time – to be modular – I want it to feel free, like a place where anything can happen.”³⁶ However, he also adds that many patients are “institutionalized”³⁷: instead of doing what they want to do, they do what they think staff would like them to do. The reason behind this is simple; they are in pain and they want to make themselves as non-vulnerable as possible. But they are not the only ones. The same expression is also used for staff who are overly eager to label and tabulate according to pre-established norms so as to avoid any (extra) personal responsibility. As one nurse explains: “some staff are very punitive, very institutionalized.”³⁸ The reason for over-zealous rule conformity is that staff, too, are subject to surveillance. While patients are observed

31 Interview with Occupational Therapist C, Bethlem Royal Hospital, London, 23 May 2014, np. Author's Private Archive.

32 Ibid.

33 Interview with Nurse D, Bethlem Royal Hospital, London, 7 May 2014, np. Author's private Archive.

34 Interview with Nurse J, Bethlem Royal Hospital, London, 7 May 2014, np. Author's Private Archive.

35 Interview with Occupational Therapy Technician, Bethlem Royal Hospital, London, 8 July 2014, np. Author's Private Archive.

36 Ibid.

37 Ibid.

38 Interview with Nurse D, Bethlem Royal Hospital, London, 7 May 2014, np. Author' private Archive.

through the CCTV cameras, special surveillance provisions, such as hidden monitoring rooms, and medical writing – notes written up to three times per shift, and made available to the entire recovery team – staff are observed through the now ubiquitous performance reviews. This means that both patients and staff live in the archive. They live with the certitude that some, if not all entries and/or recordings will be examined. Living in the archive is an abstract condition that renders the everyday transcendent: every action may at any point be interpreted as problematic, inappropriate or, worse still, dangerous. Depending on the interpretation, an utterly insignificant gesture may lead to long-term complications; in the case of patients, it can endlessly extend their sojourn at the hospital. In the case of staff, it can lead to self-doubt, lack of confidence, and the loss of employment security. In rendering the insignificant significant in an unfathomable way, the archive ceaselessly creates new, treacherous temporalities by organizing the smallest details into a temporal architecture that reverberates with ominous consequentiality. It also affirms the authority of the archivist (whether human or technological). The imaginary residence in such an archive – and it is worth remembering here that, according to Jacques Derrida, the word “archive” refers both to “*commencement* and to *commandment*”³⁹ – destroys stability. It also corrodes personal relationships and contaminates personal space. Its working is not solely destructive; it is also propelling: it forces the individual to perform. As Jon McKenzie suggests in *Perform of Else*, in the twenty-first century, performance is “an emergent stratum of power formation.”⁴⁰ The performative subject has internalized discipline, not only because of the multiple surveillance mechanisms, but also because of the ubiquitous performance imperatives. Given that such a subject is “fragmented rather than unified, decentered, rather than centered, virtual as well as actual,”⁴¹ and that the subject’s personal, professional, medical, financial and legal records are “produced... through a variety of sociotechnical systems,”⁴² the subject is in constant need of *optimization*. This requires a very particular, dispersed form of sensitivity to an ever-growing multitude of requirements, further aggravated by the quantitative demand – to do more in a given unit of time, such as peruse large documents with new regulations, or write more detailed reports, with hardly any time to do it in. One of the results of the conflict between what has to be done, what can be done, and what has to be *shown* as having been done, is compassion fatigue. Several nurses and an occupational therapist defined compassion fatigue as a combination of “exposure to trauma and frequent violent episodes,”⁴³ but also of “work overload, time famine, and the ever-increasing amount of unnerving surveillance mechanisms.”⁴⁴ Unnerving not because there is an *actual* lack of competence but because the practice of constantly introducing new regulations and new methods for doing old things, creates a perceived lack of competence, which not only looks bad in the obligatory performance reviews, but also undermines interpersonal trust, a very important, if not *the* most important feature of the hospital employee’s relationship to what is, without a doubt, a very dangerous work environment. Another unavoidable aspect of the hospital space is sound.

39 Jacques Derrida and Eric Prenowitz, “Archive Fever: a Freudian Impression,” *Diacritics*, Vol. 25, No. 2 (Summer 1995), 9-63, 9, emphasis original.

40 Jon McKenzie, *Perform of Else: From Discipline to Performance* (London & New York: Routledge, 2001), 18.

41 Ibid.

42 Ibid., 19.

43 Interview with Nurse D, Bethlem Royal Hospital, London, 7 May 2014, np; Author’s Private Archive.

44 Interview with Nurse J, Bethlem Royal Hospital, London, 7 May 2014, np; Interview with Occupational Therapist C, Bethlem Royal Hospital, London, 23 May 2014, np. Author’s Private Archive.

Sound as Parasite

Despite the fact that River House is known for its sound facilities where patients make – compose, improvise, play and produce – their own music, cuts in resources, mostly those related to maintenance, claim their due. Being empty, the hospital corridors through which trolleys with food, medication, cleaning products, and equipment are wheeled five times a day, have a resounding echo. Regardless of where you are, in the interview room, on the ward, in the communal areas, in the multi-faith room, in the gym, or in a patient’s room, the sound of clunky steel trolleys whose steadily deteriorating wheels, although mostly with a 360 degree swivel, regularly get stuck in corners, lifts, and under stairs, is unavoidable as well as painful.

Painful not only because it prolongs the interminably long and far too frequent trolley diminuendo, but because the interminably long, and therefore irritating sound of the trolleys is, like all irritating sounds, anticipated. It is heard not only when it is actually taking place but every time a similar sound – and there are many – is heard. The nursing station is soundproofed, but as there are always many conversations going on simultaneously, accompanied by the not too intrusive but nevertheless incessant sound of the television coming from the communal living room, as well as, on occasion, screams and torrents of verbal abuse, the soundscape is dense, to say the least. This is complemented by loud music coming from the patients’ private television sets, or from their headphones. The hospital does not use swipe cards but, instead, heavy keys, which continue to cause injuries to staff who lock and unlock up to fifty doors a day.⁴⁵ Needless to say, the sound of locking and unlocking doors echoes in the empty corridors thus undermining what the open-plan design has tried to bypass: signifiers of incarceration. When escorted outside, patients are taken through long corridors and sometimes up to twelve doors. The unavoidable agglomeration of parasitic sounds inculcates the body actionally and sensorially.

All parasites are colonizers that cannot be removed from the body, whether a house, a dwelling, or an institution. As Mark Wigley, re-interpreting Jacques Derrida, suggests: “the uncanniness of the parasite is that it is never simply alien to the body it haunts ... Rather, the body is haunted by that which exceeds it: para-site, that which is supplementary (para) to the site.”⁴⁶ As a figure of excess, located neither inside nor outside, the parasite is perversely violent, since it is never purely external. All aural violence is internal to the body; it creates affective residue through repetition. Shigenori Nagatomo has termed such calibrations of the body “attunement,” although this word, in Nagatomo’s parlance, has both a positive and a negative meaning. It refers to the “engagement that obtains actionally as well as epistemologically between a person and his/her living ambiance.”⁴⁷ Otherwise put, attunement is a process by which “affective residue” sediments through the “experiential momentum”⁴⁸ – the repeated engagement in particular somatic structures as related to movement, sound, kinesthetics and proprioception. Given that attunement impregnates the body sensorially and configures future engagement with the living ambiance, the effect of the experienced aural intrusions is not merely cumulative; it creates unwanted kinesthetic matrixes: wincing, grimacing and the tensed shoulders, which many patients, as well as staff, exhibit at the very sight of trolleys or keys. Furthermore, the creation of somatic-affective paths is related to the passage from the hazy to the clear horizon of

45 Interview with Occupational Therapy Technician, Bethlem Royal Hospital, London, 8 July 2014, np. Author’s Private Archive.

46 Mark Wigley, *The Architecture of Deconstruction: Derrida’s Haunt* (Cambridge, MA: MIT Press, 1997), 180.

47 Shigenori Nagatomo, *Attunement through the Body* (Albany: State University New York Press, 1992), 179.

48 *Ibid.*, 198.

consciousness. The hidden, interoceptive, recessive part of the body, which we are often entirely unaware of, is continually in the process of passing from the hazy – or unconscious – to the clear horizon of consciousness. While the former is related to humoral events, the latter is related to clearly discerned emotions. Once a particular experiential engagement and affective path have, through affective residue, created emotions, these emotions *inform* future actions. The ambient sound of the hospital is therefore far from innocuous. Even if not experienced as nerve-racking at first, it *shapes and orients* future experiences; it configures perception.

The monotonous trailing of the malfunctioning, and, on occasion, screeching wheels, the interminably long locking and unlocking of door after door are oppressive in their regularity, to say the least. If one closes one's eyes and merely listens to the sound one finds oneself in a (sonic) labyrinth since there is hardly a time when no sound of locking and unlocking doors is heard. When moving through the hospital, as staff do all the time, and as patients do when they go on leave, or for their numerous checkups, consultations and occupational therapy groups, one's ears are assaulted by yet another traumatizing sound, which forms part of the experiential momentum, and which, as both staff and patients report, has a highly irritating effect: the frequent alarms.⁴⁹ Triggered by perceived or actually dangerous situations, alarms produce a deeply disturbing, hurtful sound that causes panic and tumult in the less accustomed, and irritation in the accustomed. Like (a certain degree of) spatio-temporal enframing, alarms are, of course, necessary. What is not necessary, however, as well as directly counterproductive, is their shrillness. Despite numerous staff debates about the unnecessarily shrill sound of these alarms, nerve-racking alarms, like hand-hurting keys, do not seem to be a priority on the list of required changes⁵⁰ In the various hospital meetings, such concerns are overridden by more urgent concerns with risk management, and the steadily growing health and safety agenda, both of which are a direct consequence of the neoliberal litigation culture.

These unnecessarily aurally harsh working and living conditions have a lasting effect on the sensorimotor system, however. They cause an increased use of headphones in patients (which isolates them from their environment), and a less disposed, because irritated and exhausted attitude in staff.⁵¹ More importantly perhaps, sound also marks and partitions time. The temporality produced by the ambient hospital cacophony is not only that of incarceration, but almost one of aural torture, given the regularity of the various sounds and their anticipation. In addition, the echo of the long corridors amplifies repetition thus multiplying the partitioning of time. What such sound does is to disassemble the spatial perception of the hospital. The hospital space is no longer perceived as open. Rather, it is perceived as an overly dense, “swarming” temporal agglomerate, in which everything happens all at once. Such a temporal structure disables temporal succession, and thus also *resolution*. This has a mentally extremely taxing effect. As one patient put it, “if you aren't on heavy drugs the din wears you out, if you are, you're half dead anyway.”⁵² However, this particular aural-kinesthetic, highly noxious effect is, for organizationally mysterious reasons, impossible to rectify. Instead, preference is given to workshops that instruct staff in how to “manage” persistent problems in new ways, thus simultaneously de-materializing material problems, and turning them into the employees' own

49 Interview with Patient G, Bethlem Royal Hospital, London, 3 June 2014, np. Interview with Patient H, Bethlem Royal Hospital, London, 19, June 2014, np. Author's Private Archive.

50 Interview with Nurse J, Bethlem Royal Hospital, London, 7 May 2014, np. Interview with Occupational Therapist C, Bethlem Royal Hospital, London, 23 May 2014, np. Author's Private Archive.

51 Interview with Nurse D, Bethlem Royal Hospital, London, 7 May 2014, np. Author's Private Archive

52 Interview with Patient B, Bethlem Royal Hospital, London, 8 May 2014, np. Author's Private Archive.

problems. But where does that leave those who have lived in the hospital for months, perhaps even years?

Inscape Closure

In contrast to the shared cultural, narrative, physical and affective constructs or landscapes, inscapes are internalized terrains of symbolic meaning.⁵³ They are created through the individual's psychosomatic processing of the socially shared, symbolically charged spaces. A number of enabling devices, such as "the buddy" – a GPS that enables patients to leave the hospital premises unescorted – are, in fact, experienced as constraining objects. As one patient put it: "even when I'm away from the hospital, the hospital is all around me."⁵⁴ Instead of leaving the physical space of the hospital, the patient feels remotely controlled by the very space s/he is trying to leave. The reason for this is that s/he has internalized the buddy's symbolic connotations. However, there are many other reasons why the residual hospital inscapes are those of turmoil, or, worse still, fear. As one patient explains: "I'm looking forward to being discharged. I'm doing everything that's required, all the groups... I'm finding this very overwhelming, too many people. But I'm totally isolated. I have a shower and breakfast and I go to groups, I work in the library downstairs, it keeps me off the ward... Last year I was nearly strangled while doing laundry. I feel safer outside than I do here."⁵⁵

There are also patients who, after a significant, or repeated period of incarceration, see themselves as fused with the hospital space. They get very angry about such things as rubbish not being taken off the ward as soon as it touches the ground, although, this, too, is by no means regular practice, but a direct consequence of staff shortage. As a female patient points out, "they're polluting the only space we have...the hospital corridor is not a street where you just leave your empty packet of crisps, or don't care if you spill coffee."⁵⁶ The theme of pollution, or defilement, is not surprising given the aural and relational density of the hospital space, and the ease with which affective contagion occurs in all social environments without exception. The particularity of the hospital environment, however, is that a person's jitteriness, caused by an inscape of fear, is often the reason why coffee or tea is inadvertently spilt on the floor. This feeds directly into another patient's affronts-and-insults-tinged inscape, and is the cause of violent arguments, which not only aggravate the already difficult situation, but also further "cement" the existing inscapes. The most accurate description of this process, which can be seen as one of deterioration, came from a patient who had spent many years on a number of different hospital wards; he called it "permanent desecration."⁵⁷ A sacred place – a church, a mosque, or a temple – can be desecrated only once: when pillaged, destroyed, or used to purposes such as torture or rape. The very occurrence of torture or rape robs the church, the mosque, or the temple of its sanctity. "Permanent desecration," by contrast, refers to a *perpetual worsening* of an already impossible or highly offensive situation; it refers to the violent imperative to make do with the unacceptable, until, finally, there is nothing left to protect.

The conflation of the physical space of the hospital, its practice, patterns, accidents, and one's identity, is not unusual, regardless of mental health, given that our existence is inseparable from

53 This is derived from Gerard Manley Hopkins's notion of inscapes. See W.H. Gardner "Gerard Manley Hopkins and the Poetry of Inscape" in *Theoria: A Journal of Social and Political Theory*, No. 33, October 1969, 1-16.

54 Interview with Patient G, Bethlem Royal Hospital, London, 3 June 2014, np. Author's Private Archive.

55 Interview with Patient K, Bethlem Royal Hospital, London, 21 May 2014, np. Author's Private Archive.

56 Interview with Patient L, Bethlem Royal Hospital, London, 21 May 2014, np. Author's Private Archive.

57 Patient Y quoted by Occupational Therapy Technician in Interview with Occupational Therapy Technician, Bethlem Royal Hospital, London, 8 July 2014, np. Author's Private Archive.

space and time. This is why some patients will purposefully try to bring disorder into the existing spatial arrangements when showing disagreement with a particular hospital practice, as was the case with a patient who tore up all his books and magazines in an act of protest. When asked to photograph their environment, and thus, also, indirectly, show their inscapes, many patients produced photographs of incarceration, peril, decay and oblivion.



Figure 5. Patient P's photograph of the hospital grounds. Bethlem Royal Hospital, 2014.



Figure 6. Patient R's photograph of the hospital grounds. Bethlem Royal Hospital, 2014.

One of the reasons for this may be that, in addition to the various actions, sound, physical and symbolic objects, inscapes are also formed by the *content* of the frequent torrents of verbal

abuse, or, more precisely, by their linguistic performativity. In discussing the constitutive function of language, and in reference to Toni Morrison, Judith Butler suggests that language is “an extended doing, a performance with effects.”⁵⁸ This statement is indebted to J.L. Austin’s theory of linguistic performativity, according to which words do not describe the world, but *do* things in the world, and to Louis Althusser’s theory of interpellation, which suggests that the subject is formed as a consequence of social address. The difference here is one between recognition and constitution. The subject does not respond to a particular interpellation because it recognizes itself in it – Althusser’s example is that of a policeman hailing the passerby with “hey, you there”⁵⁹ – but because the subject is *constituted* by that social address. It comes into being as an “obedient citizen,” or, simply “the citizen” as a result of the interpellation. Likewise, the constitutive power of language resides in “the power to injure.”⁶⁰ A name, whose key function is to “freeze, delimit, render substantial,”⁶¹ can have an enabling, inaugurative function, as well as a disabling, denigrating one. Given that interpellation is a methodology by which “subjects are formed and reformulated,”⁶² all subjects are vulnerable to it. Words are “threats to one’s physical well-being” because “language sustains the body not by bringing it into being or feeding it in a literal way” but by granting it “a certain social existence.”⁶³ This is why the address of the other both “constitutes a being within the possible circuit of recognition” and, “outside of it, in abjection.”⁶⁴

Within the hospital context, people, patients and staff, are often called the most offensive names imaginable. Some of these names constitute the person as stupid, immoral, ridiculous, ugly, irremediably ill, and generally worthless. Because of this, great pains are taken to elicit positive attitudes and to inaugurate positive roles. Patients will thus often be addressed as talented human beings, much like staff will be addressed as exceptionally committed and hardworking. A patient who has an interest in fashion will be addressed as Lady Gaga; a patient who is passionate about music making will be called Dr. Dre; a member of staff who works long hours in order to improve patient experience will be nicknamed “robot,” the reference here being to the lack of need to rest. These linguistic devices are used to create a very specific form of order and conviviality that seeks to overcome the necessary enframing of the hospital, alleviate the suffering created by the clashing inscapes, and erase the boundary between the hospital and the outside world.

But the question remains: is this enough? With inscapes formed by countless somatic-affective paths that weave together place, daily practice, intended or unintended interpellations, accidents, and symbolic objects, it comes as little surprise that many patients feel the need to escape. For some patients, this means filling in a delineated stripe of paper in pencil – to physically *see* the time passing and to feel their approaching discharge. For others, it means playing imaginary chess with an imaginary opponent, in their rooms, with headphones on. There are also those, who, like patient X, construct vehicles and invent stratagems, such as diplomatic immunity, that, in addition to the transplanted space, where *gelassenheit* may take place, creates the status of intangibility. The crowning feature of patient X’s copious production

58 Judith Butler, *Excitable Speech: A Politics of the Performative* (London and New York: Routledge, 1997), 6.

59 Louis Althusser quoted in Judith Butler, *Excitable Speech: A Politics of the Performative* (London and New York: Routledge, 1997), 3.

60 Judith Butler, *Excitable Speech: A Politics of the Performative* (London and New York: Routledge, 1997), 2.

61 *Ibid.*, 35.

62 *Ibid.*, 160.

63 *Ibid.*, 5.

64 *Ibid.*

of steadily more sophisticated cardboard vehicles, such as that depicted in Figure 7 was the invention of a miniature diplomatic passport. The purpose of the passport was to ensure that his movement through the hospital was circumscribed by diplomatic immunity, given that, in legal terms, diplomats reside on the soil of the *sending state*, not the receiving state, and are not subject to the jurisdiction of the local courts.⁶⁵



Figure 7. Patient X's Yellow Cardboard Mobile at a petrol station, Bromley, London, 2014. Photographer anonymous.

Although such a stratagem could easily be dismissed as a fanciful illusion, play, a joke, or even delusion – after all, Bethlem is a psychiatric hospital – it is none of those things. It is a pragmatic way of “escaping the [lived] space of the hospital.”⁶⁶ In this sense, patient X is already doing what the neoliberal responsabilization of the individual is asking everyone to do: take care of themselves. The only problem is that, as many have noted, Alain Ehrenberg,⁶⁷ and Byung-Chul Han⁶⁸ among them, mental illness is on an unprecedented rise. The multiple and steadily proliferating vulnerabilities created by the culture of misplaced personal responsibility and blame are claiming their due. In a unit like River House, in an institution like the Bethlem Royal Hospital, the assumption is that care-providers are less vulnerable than those in need of care. But how much longer will this be the case? Without wishing to equate indescribably difficult lives with professional hazards, the question that poses itself is not “who will take care of the care-seekers if the care-providers themselves become care-seekers on a mass scale?” but “what can replace the practice of care?” Much like the (embodied) subject is constituted in language, as well as through multiple, and increasingly impactful mnemotechnical processes, it is also constituted through relations of care or neglect. While self-care is, of course, important, the care, and, conversely, the neglect of others, has *constitutive effects*. At stake here is thus not a particular case, or a dozen cases, but the destruction of bio-social tissue on a grand scale, comparable to

65 Mitchell S. Ross, “Rethinking Diplomatic Immunity: A Review of Remedial Approaches to Adress the Abuses of Diplomatic Privileges and Immunities” in *American University International Law Review*, 4:1 (2016), 173-205.

66 Interview with Patient X, Bethlem Royal Hospital, London, 11 July 2014, np. Author's Private Archive.

67 See Alain Ehrenberg, *The Weariness of the Self: Diagnosing the Contemporary Age* (Montreal: McGill-Queen's University Press, 2009).

68 See Byung-Chul Han, *The Agony of Eros* (Cambridge, MA: MIT Press, 2017).

such “grand” necropolitical enterprises as colonization, ethnic cleansing, and covert forms of genocide.

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