In-Patient Psychiatric Care as a Space of Ambiguity

Therapeutic Encounters from a Sensory and Embodied Perspective

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Abstract In social anthropology, there exists only little research about the sensory and intersubjective aspects of in-patient psychiatric care. Proceeding from vignettes from ethnographic fieldwork in two psychiatric clinics in Switzerland, this article outlines two empirical research interests and puts them into dialogue. On one side, therapeutic interactions and practices within the clinical setting are analyzed through the lenses of sensory ethnography and embodiment. On the other side, a multiplicity of "therapeutic cultures" and spaces co-exist within clinical premises. In some cases, they encompass diverging or even conflicting aims and basic assumptions about psychopathology and healing. As a result, various possibilities of human sociality and interaction open up to psychiatric sufferers, many of them characterized by ambivalence. What is being perceived as "therapeutic" and what, to the contrary, as a threat to human integrity and health can lie close together and can vary individually. I discuss how closely experiences of ambivalence – be it among psychiatric sufferers or staff members – are related to spatiality, embodied perception and to temporality. Referring to sensory ethnography and Hartmut Rosa's writing on resonance, I argue that, in in-patient psychiatric settings, the human social is inextricably intertwined with the nonhuman.

Keywords sensory ethnography – psychiatry – medical anthropology – phenomenology – therapy

Introduction

The following reflections are based on 4 months of ethnographic fieldwork within two Swiss public psychiatric clinics[1] in 2022, followed by several follow-up interviews. In both clinics, I did my research in the position as a research student and participated in the ward's daily life. In both cases, in-depth access was restricted to one specific ward (one acute ward and one therapy ward). Beyond that restriction, many other therapeutic and institutional spaces beyond wards were accessible to me. During my research, I became interested in different professional understandings of care. Namely, in cultures of medical and non-medical care, and the concomitant sensory and affective lifeworlds. I speak of "cultures" of psychiatric care because I encountered sometimes blurry, sometimes profound differences between therapeutic settings within one and the same institution, accompanied by psychiatric sufferer's ambivalence around the question of what "the therapeutic" entailed in specific instances. My interest led me to follow Jenkins' call to investigate more thoroughly how culture – in this case therapeutic cultures ranging from the biomedical to embodied and creative therapies – shape every aspect of mental illness (Jenkins 2015: 249). My research is driven by the joy of bringing experimental and experiential insights into spaces hardly recognized by social anthropologists: the sensory and atmospheric microcosms of in-patient psychiatric care. This research also attends to the crisis and reorientation towards the cultural and social in which academic psychiatry currently finds itself in (Kleinman 2012; Di Nicola & Stoyanov 2021).

During my fieldwork in both clinics, I had access to wards which accommodated varied clientele: I met privately and publicly insured service users (while there exist exclusively "private" clinics, many provide services for both) and accompanied them, as well as staff members, in their daily activities. This included that I accompanied service users to non-medical therapies that, in many cases, took place outside wards in other build-

ings of the clinic. What I subsume here under the broad term "alternative therapies" includes a wide range of methods such as art, movement and music therapy, animal-supported therapies, and group-sessions in spiritual care. Every clinic had its own unique way of treating psychiatric sufferers and staff, and even every ward presented an entirely different picture of what "in-patient psychiatric care" looks, feels and sounds like. Note that, due to the limited scope of this article, I won't focus on conversational psychotherapy here – one of the most institutionalized non-medical therapies in both clinics.

Two issues emerged during my fieldwork. First, it struck me how partial and individually different the knowledge seemed that the ward's doctors and nurses had about alternative therapies. It all depended on the people in charge in the wards (typically doctors and nurses), whether non-medical therapies were integrated or rather sidelined in treatment. In interviews with doctors and nurses, this inconsistency surfaced as some cherished alternative therapies as "equally important as medication", while other relegated them to the realm of "day-structuring activities" or "unspecific therapies". The latter is borrowed from medical jargon and could be paraphrased as "there's no harm in trying". In this case, a kind of wellness effect was expected but no significant impact on individual pathology. In contrast to that, the importance of psychopharmaceutical treatment and electroconvulsive therapy seemed considerably less questioned within wards. While "alternative" therapies were an important part of institution's marketing, of therapy plans and even received funding from health insurances, their standing seemed more complicated. Obviously, this reflects the ongoing prevalence of biomedical models of mental illness within western psychiatry (Rose 2019). Tellingly, many non-medical therapists questioned the institution's biomedical bias. In one clinic, a new ward was on the verge of being opened and, according to alternative therapists, "the management" had not granted any budget for their involvement into therapeutic plans. Tellingly, a considerable amount of service users used and mentioned alternative therapies as an important part of their experience of in-patient treatment. Some of them continued to attend to them as outpatients.

The second issue that emerged from my research material: many users on acute wards complained to me that they felt "not being seen" and "not being listened to" in situations when they would have needed it the most. I was puzzled by both, the sufferer's feeling of invisibility and the complex coexistence of different therapeutic ontologies. Those varied possibilities of human sociality and "choreographies" of *doing* mental affliction and therapy (Klausner 2015: 121) complicate simple notions of "care" and point towards the ambivalence tied to giving and receiving care. I ask: How do structural aspects of the clinic relate to the sensory and embodied dimensions of *experiencing* in-patient psychiatric care? How are psychiatric sufferer's and staff's ambivalent entanglements between healing, harm and affliction connected with the sensory, material and immaterial dimensions of the everyday?

Doing phenomenological anthropology in the psychiatric clinic

My research is influenced by Byron Good's call for "the development of critical studies of how illness comes to meaning, of how reality (not simply beliefs about it) is organized and experienced in matters of sickness and care" (Good 1993: 63). It is precisely my attempt to understand the multiplicity of realities I encountered within the microcosm of the psychiatric hospital, indebted to a "critical phenomenology" (Good 1993: 63). This radical prioritization of experience allows me to trace how concepts of mental illness and normality, even the very definition of "reality" and the normal are fluid, contested (Jenkins 2015: 9) and performatively constituted in social context (Rose 2019: 9). I encountered a stunning variety of different (sub-)cultures of therapy and of illness within the very same institutions and even within wards, depending on the people and spaces I found myself interacting with. While I perceive the picture that Erving Goffman draws of the psychiatric clinic in his 1960s-work *Asylums* (Goffman 1961) as too structurally static, it certainly captures the huge impact that institutional structures and hierarchies have on the self, social roles and everyday interactions. While *Asylums* falls short on the changed landscape of psychiatric care today, Goffman's insights into the embodied and perfor-

mative nature of clinical interactions remain inspiring. Used with caution towards his structuralist generalizations, Goffman's concepts deliver a theoretical background tending to the epistemic hierarchies, social performativity and the entanglement of care and constraint within psychiatric clinics (Goffman 1961). Bearing Foucauldian concepts of psychiatric power in mind, institutional ethnography (Smith 2005) seems more apt to capture the diverse, often ambiguous, experiences present in day-to-day life. My focus on embodiment and the sensory allows me to understand the "extraordinary conditions" of mental illness (Jenkins 2015) as a complex, fluid entanglement between lived experience, materialities and embodied practices.

Foucault's writings on the emergence of psychiatric practice as normalizing power (Foucault 1988a) capture the history of my research sites. Still, this representationalist, textualized view of psychiatric power does not do justice to the phenomenological richness I encountered in the field. I agree with Csordas' critique that Foucauldian approaches view social reality as "inscribed" into individual bodies and subjugate the body to the semantic (Csordas 1993: 136). Ambiguity and not-knowing are omnipresent in day-to-day interactions within in-patient psychiatry; mental illness can be incommensurable, unbearable and incomprehensible, both for the afflicted and those who are not (Jenkins 2015: 261). Practicing phenomenological anthropology allows us to appreciate indeterminacy in psychiatric practice as a matter of intersubjectivity:

> Beginning from perceptual reality, however, it then becomes relevant to ask how our bodies may become objectified through processes of reflection. […] What is revealed by a return to the phenomena – and the consequent necessity to collapse dualities of mind and body, self and other – is instead a fundamental principle of indeterminacy that poses a profound methodological challenge to the scientific ideal. The "turning toward" that constitutes the object of attention cannot be determinate in terms of either subject or object, but only real in terms of intersubjectivity. (Csordas 1993: 149).

I argue, that doing phenomenological ethnographies about in-patient psychiatric care is a more than human matter. Integrating the environmental and material into the scope of "experience" allows for insights that go beyond cartesian dualisms between "mind" and "body" and the tendency in the field of psychiatry to treat the human brain as an isolated entity (Rose 2019: 95, 189). As a phenomenologist, I am inspired by Kavedžija's approach to human wellbeing as a processual, more-than-human matter of conviviality (Kavedžija 2021) and by Navaro's ethnographic exploration of how feelings (in this case "spatial melancholia") emerge as entanglements between (human) subjects, objects and non-human environments (Navaro-Yashin 2009: 16). On a conceptual level, I draw from environmental anthropology (Ingold 2002; 2011) and postphenomenological thinking that sharpens ethnographer's awareness not only of the "ontological unity of people and things" (Ihde & Malafouris 2019: 204) but also of how people are *changed* by things and technologies (Ihde & Malafouris 2019: 209).

Besides my theoretical interest in human and other-than-human relationalities, intersubjectivity figures also as an important emic category in my field. It is not only at the core of suffering and the provision of care, but often comes with ambiguity, both for psychiatric sufferers and staff members. A decisive factor which determines whether psychiatric sufferers experience clinical interactions as healing or, to the contrary, as harmful, resides in experiences of intersubjectivity. Joan Tronto (Tronto 2015) argues that good care involves much more than just organizing acts of caregiving. It involves the identification of caring needs (*caring about*), accepting one's own responsibility to do something about that need (*caring for*) and finally an assessment if needs have been met by the caregiving (*care-receiving*). Those are not instrumental interactions, but involve morality and value commitments. Those who deliver "good care" cultivate being attentive, responsible, competent and responsive towards other's needs (Tronto 2015: 3–9). Seen through Tronto's theoretical lens and Csordas' paradigm of embodiment, in-patient psychiatric care emerges as a deeply intersubjective practice that enfolds as an embodied entanglement between caregivers and psychiatric sufferers. I add to that point that in-patient psychiatric care does not merely entail human interactions but is equally co-created by

sensory, material and other nonhuman aspects that are fundamentally shaped by institutional and political surroundings. The multitude of ambivalent experiences I encountered in the field relate partly back to what Goffman (Goffman 1961) and Foucault (Foucault 1977; 1988a; 2003) have already exhaustively discussed: the institution itself is a place of power-infused hierarchies and social performativity that directly mirrors how a society deals with "troubled" individuals. Following Jenkins' reference to feminist thought, I approach mental illness and clinical practices as a condensation of the personal and the political (Jenkins 2015: 3).

Of atmospheric ambiguities: sensory ethnography and therapeutic encounters

In order to do justice to the ambiguity experienced by interlocutors as well as the indeterminacy of scientific reasoning, sensory ethnography offers methodological inspiration (Pink 2009; Ingold 2011). Pink frames ethnographic research as a mode of "emplaced knowing" (Pink 2009: 40) which is embodied, but includes materiality, the senses, imagination, reverie and remembrance (Pink 2009: 25 ff). The attunement to the imaginary, remembered and sensory dimensions of therapeutic encounters is crucial to prevent reproducing rationalist medical discourses that presuppose a dichotomy between "objective" reality and seemingly irrational beliefs (Good 1993: 194). My interest in ambivalence within in-patient therapeutic encounters draws on a "politics of atmospheres":

> Atmosphere does not so much reside in place as emerge from our ongoing encounters with it, opening up potential as we feel our way through the world, a process animated by affect (but not completely defined by it), a "spatially extended quality of feeling" (Böhme 1993: 117–118) [...] Accordingly, we argue that atmosphere must be thought of as pulling together affect with sensation, materiality, memory and meaning [...] (Sumartojo & Pink 2019: 30).

Atmospheres are political because they are not simply there, but continually emerge as contested, fluid entanglements. They are subject to constant appropriation, change and subversion by all actors involved (Sumartojo & Pink 2019: 31). This view of atmospheres as potentialities for change and transformation resonates with an emic category that was omnipresent and often contested in the field: the aim at psychological change and transformation, be it among psychiatric sufferers or as a narrative deployed by therapists and clinicians. Inspired by Ansdell and DeNoras' research on music therapy (Ansdell & DeNora 2012), I suggest an ecological view of clinical practices and their ambivalences. Walking fieldwork (Irving 2005; 2011) is crucial in that endeavour as it allows interlocutors, who often experienced different wards and treatments during their stay, to retrieve associations and memories tied to clinical spaces and their materiality. In return, accessing memories through walking fieldwork proved ethically challenging in the field as spaces like the emergency reception or a closed unit were associated with unresolved, unspoken trauma for several sufferers. Stasis and the inability to move – for example during acute depression – was equally part of my embodied encounter with in-patient sensory lifeworlds. Others I accompanied to therapy sessions beyond the ward and walks in the park. I rushed with senior psychiatrist's from ward to ward during their "rounds" as they replaced others in times of incessant personnel shortages, talked through lunch breaks with the nurses, and sat in staff meetings. Researching atmospheres requires an attunement to the rhythms, sounds, smells and aesthetics of clinical day-to-day lifeworlds.

Situating ambiguity within a theory of resonance

How can we theoretically situate experiences of ambivalence within the sensory and the embodied dimensions of therapeutic spaces? And how are subjective experiences tied to the political and cultural context of the psychiatric clinic? Even though I can only hint at his complex and large body of writing here, I find inspiration in German sociologist Hartmut Rosa's writing on what he calls resonance (Rosa 2016). Rosa opens his book *Resonanz. Eine Soziologie der Weltbeziehung* with the claim that, "If acceleration is the problem, then resonance may well be the solution" (Rosa 2016: 14, translated by AH). In the tradition of critical theory, he formulates a critique of neoliberal societies and the alienation they produce in various

aspects of our everyday lives (Rosa 2016: 253 ff; Peters & Majid 2022: 8). Rosa defines alienation as "relation of relationlessness" (Rosa 2016: 438) which is driven by "instrumental reason" (Rosa 2016: 74). He understands experiences of resonance as a powerful counterforce that enables experiences of aliveness. Resonant experiences create meaning in a modern existence otherwise characterized by interpersonal distance, coldness and unresponsiveness (Rosa 2016: 418; Peters & Majid 2022: 14). The adaption of Rosa's thinking to my research field is inspired by his claim that institutions embody the most powerful social force that shapes whether we experience states of resonance or alienation (Rosa 2016: 948). Rosa's theory also comes with its problematic aspects. As Peters and Majid point out, he entwines descriptive and normative elements of resonance (Peters & Majid 2022: 9) which, from an anthropological point of view, remains too far away from the intricacies and ambivalences of lived in-patient experience. By interweaving Rosa's theory with my phenomenological approach to psychiatry, I hope to creatively enrich those normative aspects with the complexity of lived human sociality. I shed light on the entanglement between intimate, embodied experience and the political that so fundamentally characterizes every facet of mental illness (Jenkins 2015: 3).

State of research

There is a rich body of anthropological research in the field of mental illness (see for example Good 2012; Jenkins 2018; Khan 2017; Lester 2007; Littlewood 2000) and global mental health (Kohrt & Mendenhall 2015; White *et al.* 2017) and I can only name a few of them here. But there has only recently been a surge in phenomenological ethnographies on the embodied experience of psychiatric in-patients within clinical premises (Garcia 2010; Klausner 2015; Heyken *et al.* 2019; Mewes 2019; Varma 2020) and research specifically on non-medical therapies in in-patient settings is still scarce (Mattingly 1998; Luhrmann 2000; Mewes 2019; Schmid 2020; Bruun & Hutten forthcoming). Albeit not primarily anchored in social anthropology or ethnography, there are important basic works – ranging from Rose, Goffman and Foucault to Smith – that focus on the genealogy of psychiatric practices and institutional ruling relations (Goffman 1963; Rose 1979, 2019; Foucault 1988a, 2003; Smith 2005). Recent publications in sensory and environmental anthropology intersect partly with my research interest as they focus on in-patient lifeworlds (Duque *et al.* 2021). In an inspiring article, Pink and Hogan trace the intersections between art therapy and anthropology (Hogan & Pink 2010; Pink *et al.* 2011; Pink & Leder Mackley 2014), while not emplacing their findings specifically within in-patient experiences and institutions. Conceptually, I am inspired by Luhrmann's outstanding ethnography, *Of Two Minds*, where she traces different professional practices and ontologies of mental illness within clinical practice in the US (Luhrmann 2000). DeNora and Ansdell's sociologically oriented work explores music therapy in community psychiatry. They ethnographically argue for the importance of research on music therapy beyond biomedical models of treatment and evidence-based assessment (Ansdell & DeNora 2012) and propose, similar to others, an ecological perspective on in-patient psychiatric care and its socio-material entanglements (Klausner 2015; Bister *et al.* 2016; Mewes 2019). Winz and Söderström discuss the sensory experience of psychosis in urban spaces through "biosensory ethnography", which defines the sensory in a more biological manner than I do here (Winz & Söderström 2021). In nursing research, there has recently been published an article that adapted Rosa's theory of resonance to nursing as "a new and inspiring phenomenological and critical lens" (López-Deflory *et al.* 2023). I hope to contribute to a growing body of ethnographic, phenomenological research about non-medical therapies within psychiatric clinics.

"We are not a wellness temple here": the institution as a site of trouble

"We are not a wellness temple here" – this quote from a clinic director re-surfaced in several conversations with staff and service users. This emic narrative positioned "the" public clinic as a counter-space to "better" (private) psychiatric care because, to come back to the director's narrative, "here, we have to treat the most severely ill patients because we have to fulfil the performance mandate towards the general population". Never-

theless, there existed a number of private wards within public clinics, which figured as substantially "better" in both user's and staff member's accounts. But even among the privately insured users, the overall impressions they related to me about their treatment could not have been more contradictory. The psychiatric clinic figured for many partly – for some fully – as site of healing, introspection and "hard work on the self".[2] Others, especially those stationed within public acute wards, experienced the clinic as a site of violence and violation of personal boundaries. During the long hours I spent with psychiatric sufferers, a common preoccupation among them became salient: they missed "being seen" and "being listened to". Most nurses and doctors mentioned the density of acutely ill people in overcrowded wards, combined with the lack of professionals and the growing scarcity of financial resources as underlying causes for institutional trouble. An increasingly austere and neoliberal atmosphere in healthcare characterized day-to-day life within wards. This reflects what Disney and Schliehe recently theorized: Institutions dealing with human trouble have become increasingly troubled spaces themselves (Disney & Schliehe 2019). One male nurse, who had been working in acute psychiatric care for nearly 30 years at that time, compared the clinic with a car factory: "nowadays, you have to treat as much patients in as little time as possible here". While those narratives of austerity seem plausible from a structural perspective, speculations about the causes for the "troubled institution" can look entirely different in service user's accounts. In a conversation with a user affected by psychosis and hospitalized against his will, he mentioned the "malignancy", "cold-heartedness" and "sadistic" nature of certain nurses as causes of his suffering. Still, this problematic background did not prevent a considerable number of service users from perceiving the clinic also as space of healing.

Biomedical cultures of care: psychotropic medication

Clearly, the advances in psychotropic medication have saved many lives and are, for some people, an indispensable part of recovery. While I don't engage primarily with the anthropology of psychopharmacology in this article, I shall discuss medication critically as a part of the sensory, ontologically diverse therapeutic landscape of the clinic.

Biomedical models of mental illness seemed both hierarchically and institutionally dominant in the clinics I was present. For example, in one ward, which was an institutional flagship for the "best" psychiatric care in the whole clinic, the term "therapy" referred first and foremost to the evaluation and adjustment of psychotropic medication. Psychotherapy was – contrary to official mission statements – not provided for everyone who received medical treatment. This bias towards medication seems to characterize the whole landscape of public psychiatric care in Switzerland.[3] In the majority of cases, this shortcoming was not questioned by staff and commonly explained to me with the argument that clients were "too acutely ill" to undergo psychotherapy and that they had to "stabilize" first. As I oscillated between the ward and alternative therapeutic services, the specificity of discursive, affective and sensory registers between biomedical and other interactions of psychiatric care became salient. Psychiatric sufferers' encounters with head psychiatrists were often biased towards verbal exchange and abstraction. In some clinics, doctors wore white coats, which instantly created a more distanced, distinctly "medical" atmosphere resounding with Goffman's analysis of the psychiatric hospital as a space of highly stratified social performativity (Goffman 1961). The digital documentation platform that operated at the core of the clinical everyday was important during the head psychiatrist's visit. Nurses and lower ranking doctors used it in order to inform head psychiatrists about medical compounds and treatment plans or make adjustments to them. Receiving "the best" care equalized the head psychiatrist's visit and the presence of a relatively stable team of nurses. The head psychiatrist's visit lasted around 10 minutes per client and took place once or twice each week. The head psychiatrist was usually accompanied by an entourage of as many as 12 persons, comprising other psychiatrists, students, nurses, interns, people from other divisions of the clinic, and figures like me, an anthropologist.

This typical conversation, that took place during the head psychiatrist's regular visit, might seem trite when considered by itself, but contin-

ued to re-emerge in various nuances during his rounds:

Head psychiatrist: "How are you today? You look a bit low-spirited compared to last week."

Psychiatric sufferer: "I feel sometimes foggy in the morning and don't know how to start my day. Shouldn't I be better by now? It's been three weeks!"

Head psychiatrist: "I see that you are suffering. This is part of your illness; It's an emotional blockage. We will adjust your medication and try out another compound. This will give you more motivation in the mornings."[4]

Despite the leading doctor's known expertise in psychotropic medication, psychiatric sufferers and some staff members questioned the format of his visits in conversation with me. The visit presented a moment of social stress for psychiatric sufferers as it offered too little privacy and time for them to communicate about their psychological state.

The magic pill as realm of the uncertain

Another paradox that became salient was tied to psychotropic medication: On one hand, psychotropic drugs were handled as omnipotent actors at the core of therapeutic treatment in medical discourses. On the other hand, psychiatrists stressed during their day-to-day work, that if and how an individual would react to a compound was in many ways unforeseeable.

The ambivalence and uncertainty tied to biomedical treatment reflects in Renata's tale, who suffered from frequent relapses into illness, accompanied by hospitalization. Medication figured as a reference point in her account of "regaining stability" and losing it. When she told me about one relapse after being discharged from the former clinic, she mentioned similar reasons as many other interlocutors: the lack of ambulant therapeutic treatment and that her medication had not been "well adjusted" at that time. As she depended on a psychiatrist when it came to adjusting or changing psychotropic medication, it becomes salient how biomedical models of treatment are inextricably entwined with medical hierarchies: It's the doctors who are granted the authority to explain and manage the effects and side-effects of psychotropic medication. As she relied on psychotropic medication, Renata perceived an intensive medical surveillance and biochemical treatment of her illness as an indispensable part of her healing journey. At the same time, she uttered a deep ambivalence about medication due to massive side effects. One compound had come with several hair loss. She also suffered from lethargy and pervasive tiredness. Renata granted psychotropic drugs the power to change her life for the worse and for the better – in a way she could hardly control herself. She relied, as many users who take psychotropic drugs, to doctors to orchestrate the array of biochemical actors whose impact on her body and her psyche was not foreseeable for her (see also Klausner 2015: 181–246). Other psychiatric sufferers told me that certain psychotropic drugs robbed them entirely of their sexual life and sense of bodily self – with destructive effect for their romantic relationships.

I met Beat when he had an argument with his ward's head psychiatrist. He was furious about both his medication and his involuntary return to the clinic after a weekend of stress endurance vacation (*Belastungsurlaub*) at home. Angrily, he shouted: "The medication does not help at all! Nothing! You [to the doctor] can eat them by yourself!" The doctor replied calmly: "Yes, I would take the medication if I needed it." Curious about his personal view, I met Beat shortly before his dismissal from the ward. I asked him what he perceived as most healing during his stay at the clinic. I was surprised by his immediate answer: the paintings and flower arrangements in the ward corridor had been, for him, facilitators of healing:

> I have suffered from insomnia for years and I have become suspicious of medication. When the doctor discusses with his assistants for the nth time what medication they could try out on me, I just can't take it anymore. At first, when I arrived here, I suffered from a terrible inquietude – I could not stand still. Then, I made a sport out of contemplating the paintings on the walls of the ward – they are beautiful. I started to meditate, to really contemplate those paintings. With the help of the artworks I regained focus. Later, I did the same with the flowers in the ward. Sadly, people did not understand. The nurses laughed at me in a friendly but belittling way – "so you are again meditating, yeah, yeah …"

The bio-medicalization of the psyche as hardening process: a short reflection

Meandering from the realm of medication into the sensory and the embodied, I end this brief insight into sensory, embodied and discursive experiences tied to psychotropic medication. I illustrated how psychotropic medication figures as both, omnipotent but potentially unpredictable actor in struggles for healing. The omnipresent, ambiguous agency of psychotropic drugs resonates with an era in which "neuroscience seeks to understand mental illness as a brain disorder instead of as behavioral disorder" (Jenkins 2015: 4–5). Medical narratives entail both the explanation and recollection of deranged, sometimes uncanny experiences of mental illness into psychiatric categories and the biomedical. Bearing in mind the messiness and ambiguity of the experience of mental illness itself (Jenkins 2011; 2015), psychotropic medication figures as an institutionalized gateway towards both, controlling the messiness of deranged experience and abstract discourses around "biochemical imbalance" (Jenkins 2015: 57). The concomitant interactions with doctors take place in temporally highly limited phases, often biased towards verbal exchange and visual perception. Medical narratives unite a paradox between biochemical incertitude and what Jenkins called "a religious metaphor of miraculous healing" (Jenkins 2015: 26). In some, but not every, aspect the atmospheric and sensory dimensions of concomitant medicalized interactions are reminiscent of what Arthur Kleinman described as "instrumental rationality in medicine" (Kleinman & Kleinman 1991).

Service user's accounts resonate, in many ways, with insights from Jenkins' in-depth ethnography of psychotropic medication in the US. Psychotropic medication comes with various critical aspects, one of them being long term sufferer's experience of "recovery without cure". While symptoms might improve significantly due to psychotropic medication, many sufferers perceive themselves as being far from healthy, and experience massive side-effects and social stigma (Jenkins 2011: 9). While I don't go further into that topic here, I want to stress the massive sensory and embodied impact that psychotropic drugs can have on user's self-perception and embodied, affective states of being.

Violence as multisensory entanglement

For service user Claire, "the ward" – which figures as the institutional epicentre of the "neurochemical self" (Rose 2009) – emerged as a conglomerate of intersubjective, subjective and sensory matters. According to law and institutional discourses, forced measures always had to be ordered by doctors and implemented through strict institutional regulations. In contrast to this legal framework, Claire perceived the fine lines between care-receiving, violence and coercion as a much more ambivalent matter. For her, this was also a matter of the senses – and a complex array of interpersonal relationships with staff members and service users. During a walking interview across the clinical premises, we crossed the building where the emergency reception and acute wards were located. The sight of the building led her to reflect on her initial hospitalization:

> I was first hospitalized in the psychiatric unit of a general hospital. I was in a very bad condition – starving and in the middle of psychosis. I was not sure if I was going to survive. When I first arrived there, they put me in a completely isolated room where there was nothing. Literally nothing. They told me that I needed to sleep and calm down – in a completely isolated room! It was in this room where I almost lost my mind. There, my condition worsened. Only after hours of waiting, I was transferred here, where I was locked in the acute ward for ten days [points towards the building's second floor]. I was not even allowed to go out for a smoke. The toilets were a mess in the women's ward and the door locks not working. I was put in a room with other people. One of them was a kleptomaniac, you always had to watch your stuff. Even after she had been transferred to another room, she sneaked into my room at night. I was afraid and could not sleep, until I begged the nurses to be transferred into the isolation room. I just wanted to be alone, to feel safe. They did not allow me.
>
> At one point I told them "If you aren't going to listen to me, I'm going to die here". They misunderstood me and thought that I must be suicidal. So they put even more restrictions on me. But that

> was not my point at all, I always wanted to live! I just wanted to feel seen!
>
> I have never been to the isolation room in this ward, but I often heard the screams of those who were in there. They tell me that it feels like prison. In wards, there are many rules, which often creates conflicts between patients and nurses. As a patient, you have to learn how to navigate these rules. If you don't obey, they will put you into an isolation cell. It all depends on how you click with the nurses, if you get along with them.

In contrast to Claire's account, nurses almost univocally stressed that their duty to exert forced measures went back to doctor's orders and was one of the most difficult parts of their job. Not only in the account above, but also in a senior nurse's account from the same ward, the isolation room figured as an ambivalent place. The nurse described it as a problematic, but sometimes inevitable "low-stimulus room" for those who needed to "calm down". Nevertheless, she was convinced that, If the ward would be able to provide one on one care, isolation cells would be unnecessary.

Instrumental reason and the sensory: a reflection

During her stay in the closed ward, Claire felt an atmosphere of "instrumental reason" (Rosa 2016: 74) extend into her material and human surroundings. While she had been treated correctly according to institutional procedures, some sensory and interpersonal aspects of her experience catapulted her into invisibility, anger and mistrust. Her experience is inseparable from the carceral materiality she associates with certain clinical spaces. Her experiences of being forced to spend time in different places that felt unsafe for her condensate into a feeling of not being seen. Her awareness of the paradox, that a caring site could potentially turn into a place of violence, coined her interaction with staff members. What she experienced could be described as "looping" in Goffman's terms, a "disruption of the usual relationship between the individual actor and his acts" (Goffman 1961: 35–38). The ambiguity underlying low-stimulus rooms and other clinical spaces results from an entanglement of both the social and the sensory. In Griffero's terms, the experience of social *and* materially enacted violence in this specific room is an instance of atmospheric "feelings poured out into space" (Griffero 2014: 108). This becomes even more salient if we analyze Claire's account through this lens of the atmospheric, "pulling together affect with sensation, materiality, memory and meaning" (Sumartojo & Pink 2019: 30). Low-stimulus rooms for forced treatment are institutionally legitimated healing spaces, but can come, paradoxically, with a feeling of dehumanization and isolation for psychiatric sufferers precisely *because* they deprive them from the very foundations in which atmospheric presence is anchored: sensory, material and significatory diversity. Human beings – and to an even greater extent psychiatric sufferers (Winz & Söderström 2021) – both live and feel enmeshed with sensory and material environments. Jenkins refers to mental illness as "complex processes of struggle" whose multidimensionality is more aptly described with the term "extraordinary conditions" than in the categories of psychiatric pathology (Jenkins 2015: 2).

With this theoretical background, I argue that the mute or even harmful interactions of in-patient care are entangled with the politics of atmosphere. The extraordinary experience of forced seclusion creates a "counter-atmosphere" that can destabilize the very experience of feeling alive and of dignity. This focus on the atmospheric and the sensory critically introduces a largely absent dimension within biomedical psychiatric discourses and ontologies of care. I argue that there is a need to complement biomedical spaces, practices and ontologies of psychiatric care with the ephemeral and the sensory. This acknowledges, to use Ingold's words, that "we do not then look beyond the material constitution of objects in order to discover what makes them tick; rather the power of agency lies with their materiality itself" (Ingold 2011: 28).

Resonance as analytical lens on inconsistent encounters

How can we relate the atmospheric dimensions of the clinical back to the emic notions of "being seen" and "being listened to"? Here, I relate these atmospheric micropolitics to Rosa's theory of resonance that situates "mute" and "resonant" interactions within a larger sociopolitical context

(Rosa 2016). Rosa outlines, through the course of his extensive writing, four criteria of resonant experience, the first two of them being deeply intersubjective: *affection* and *emotion* (Peters & Majid 2022: 18). Individuals are moved emotionally while being affected by something "other" outside the self. The emotional aspect of resonance opens us, according to Rosa, to putting some of our emotional energy into the experienced "other" in return, to give something of us back into the outer world of experience (Rosa 2020: 398). As a third criterion, which results directly from affection and emotion, Rosa names *transformation*: the self changes during resonant experiences in a fundamental way. The fourth aspect of resonance is especially important in my discussion of ambivalent experiences of care within psychiatric wards: *elusiveness*. Resonant experiences can't be planned or forced because they entail "uncontrollable relational experiences of Otherness" (Peters & Majid 2022: 18ff, 142).

The resonant experience of mutual attention can be destabilized or even thwarted by institutional structures and practices of care. This became salient by the example of the intricacies underlying practices of abstraction and management within the biomedicalized institution. Even more, the structural intricacies of the "troubled institution" that operates with a nexus between care and control fundamentally limit instances in which resonant experiences are facilitated. *Elusiveness* and *uncontrollability* (Rosa 2016: 1063) stand in direct contradiction to many demands that biomedicalized, increasingly neoliberal psychiatric care in Switzerland puts onto psychiatric sufferers. Time plays a crucial role in enabling resonant experiences in the realm of the uncontrollable and unforeseeable. Time is a dimension that has, according to Rosa, become increasingly scarce in the wider scope of neoliberal societies due to different sociocultural acceleration processes. It is a paradox that characterizes the experience of time in late modernity: while suffering social acceleration, a "frenetic standstill [...] in the development of ideas and deep social structures" takes place (Rosa & Trejo-Mathys 2013: 15). This paradoxical co-presence of stasis and increasing temporal acceleration manifests in the very intimate experience of psychiatric sufferer's interactions with staff and the materialities of the clinic itself. The lack of resonant experience in clinical interactions resonates with Rochelle Burgess' critique of biomedically biased psychiatry: Attending to the diversity and social embeddedness of mental illness requires the capacity to "hold complexity"[5]. It means refusing the violent act of simplifying lived experience into neat clinical categories and to strip sufferer's accounts off their lived socio-political context.

Ontologies of care beyond the biomedical: alternative therapies

In contrast to the entwinement of (bio-)medical expertise and psychotropic medication, non-medical therapies operated on different atmospheric levels. They took place in sensory, material and social settings that phenomenologically differed from wards – mostly in especially assigned rooms within clinical premises. Some psychiatric sufferers regularly attended alternative therapies, while others only went once or not at all because it seemed "too esoteric" for them. Those who participated, experienced a spatial and atmospheric change as they mingled with persons from other wards in fitness studios and in craft studios, while walking towards the dance and movement therapy rooms through the garden, gathered in music studios or walked through the nearby forest. Alternative therapies involved paint and canvas, plants, animals, body-centred practices, instruments, artworks, music, and many other sensory aspects.

One of the most salient observations was how the therapy rooms and other nonhuman aspects were actively created and used as therapeutic tools by therapists. One art therapist referred to his studio specifically as a "safe space" which he created by arranging shelves, plants and easels in a way "that gives patients a feeling of security but still harnesses the lightness and openness of the room". A movement therapist referred to the therapy room as "offering something different than the atmosphere in the ward" to psychiatric sufferers. Furniture, light, sounds, smells and objects were actively harnessed as atmospheric actors by therapists. Some therapists used parks and nearby forests as sites for group therapy. What stood out in many group sessions in alternative therapies was both, an atmosphere of the experimental, open-endedness and a fundamental at-

titude of "not having to perform". This stood in stark contrast to everyday interactions within the wards, which were usually permeated by the nexus between care and control (Goffman 1961; Foucault 1977, 1988a). During group settings, psychiatric sufferers often adopted a meta-perspective on their stay in the clinic and voiced how they "really felt at the moment".

Besides casual conversation, therapists actively encouraged psychiatric sufferers to express ambivalent feelings about the therapeutic interaction and the group setting immediately. As a result, shame, insecurity and non-compliance were voiced often more openly in alternative therapy spaces than within wards. At the same time, users did not have to expect direct consequences therefore because these encounters were explicitly taking place at the margins of the nexus between care and control that characterized wards. Several psychiatric sufferers referred to music, movement and dance therapy sessions as "challenging" because, often, shame and insecurity surfaced for them during group activities. Even if physical touch was never part of the sessions, the therapists centred sessions around both self-perception and the exploration of interpersonal boundaries. Frequently, participants left the room during the sessions, voicing that they needed a break or "had a crisis". Sometimes they came back, sometimes they didn't. This illustrates, that ambivalence surfaced no less than within wards in alternative therapies, but in fundamentally different ways.

Encounters in art- and movement therapy and spiritual care

Peter, a client diagnosed with autism, became one of my main interlocutors. Reflecting on our previous interview, he wrote to me via e-mail:

> One sees a doctor in this clinic for five minutes per week, at the very most. During this meeting, one or two questions are being asked. The movement therapist, on the other hand, observes a person for over 90 minutes and can try to give inputs to patients. But this requires an effort; this is real work. Sadly, for doctors and the pharma industry it is definitely more convenient to prescribe pills, to make profit…

This account resonates with a key issue that emerged within the contradictions between medical and non-medical care: temporality. Time to "observe" and "give inputs" was precisely what most doctors and nurses on the wards were short of and, paradoxically, what many psychiatric sufferers would have needed. In one-on-one settings, they had 50 minutes of face-to-face time with therapists. As group sessions centred around more casual topics, art and movement therapists told me that a considerable number of psychiatric sufferers used one-on-one sessions entirely for conversation. A movement therapist described her therapeutic approach towards clients as threefold: on an emotional, embodied and intellectual level. Thereby, an alternative experience to the feeling of "not being listened to" and "not feeling seen" was encouraged.

A physiotherapist told me:

> Patients are expected to relate their deepest issues to 'the god in white' [head psychiatrist] and his entourage of 10 persons in only 10 minutes. Once, a patient cried out his soul in my one-on-one session. Later that day, I followed the head physician's visit and saw the patient sitting on the bed, mumbling, 'I'm okay'. I totally understand him: how could one open up his heart in such an intimidating interaction?

She actively framed physiotherapy as a counter-space, an instance of mutual listening:

> When patients come to physiotherapy, they'll tell you every secret they haven't told anybody before. Sometimes heavy stuff – a woman voiced for the first time that she had been sexually assaulted. When the body moves, emotions and words start flowing.

When I asked the physiotherapist what she "does" with those narratives, she told me that she sometimes refrains from documenting everything in the hospital software, which contradicted the institutional protocol. She felt ambivalent about it because she was both committed to professional secrecy but also had a reporting obligation towards the clinic.

Pastoral workers were among the most critical interlocutors within many clinics as they inhabited an in-between position: they took part in day-to-day life of the clinic but organizationally, inhab-

ited an outsider position because they were still part of the parish. This hybrid position had the effect that some pastoral workers were – although there was a change planned in the near future – the only staff group who did not have access to the clinic's digital documentation system. One pastoral worker pointed towards the importance of that position, as it allowed her to clearly work "in the interest of the patient and not of the institution". She questioned notions of illness and psychiatric treatment models during an interview:

> Depression is a healthy response to unhealthy living conditions and behavioural patterns. It urges people to pause, to introspect. But see what happens in the clinic: Patients come here, get pathologized as 'ill', and the only goal of therapy is to make symptoms disappear.

She highlighted that pastoral workers were "probably the only staff group which patients – especially in the forensic wards – are allowed to send away. I like to offer patients that option. It can create a basis of trust if patients are allowed to send me away anytime". The pastoral worker organized group discussions on the ward that explored philosophical, open-ended questions involving the reception of artworks and literature. One example was, when she explored with a group of sufferers the feeling of disappointment via discussing an artwork by the Swiss painter Ferdinand Hodler. Many of the persons present referred to the pastoral worker, in general, as "someone who really listens".

When I asked Beat, what had helped him most while recovering from depression in the clinic, he mentioned art therapy and ergotherapy. Aesthetic perception and creative practice had supported him during a long phase of recovery from the "complete isolation" of depression. As mentioned in the vignette above, he had found relief by "meditating on drawings", but also by attending the arts and crafts studio. When he started to talk about the studio, his eyes lightened up:

> One of my favourite places is the crafts studio. You can weave, you can make your own leather belt, you can sew, you can carve – whatever you want. You meet real artists there. You don't have to talk to anyone If you don't want to, but still you are together with other people. After my worst phase of depression, I had lost contact with my family, with my loved ones. This was the hardest part of it all. In the studio, I carved stone figures, which I then gave to my grandchildren.

For Beat, overcoming depression was inseparably connected to materiality and the senses – dimensions of experience that he directly connected to his experience of illness and recovery, isolation and reconnection. The arts and crafts studio was bright, colourful and cozy. In a corner, there was a table for service users to sit and drink tea together. Some worked silently, while others talked while painting or doing manual labour, often commenting other's work. One especially quiet person from another ward discovered her talent for handcraft there, which came with conversations and social contacts. This way of "being seen" differed from what it was commonly associated with in the clinic. In this setting, psychiatric sufferers could, for a short time, leave their categorization within clinical pathology by, as Hogan and Pink call it, creatively harnessing "interior states as ways of *knowing* and *experiencing*" (Hogan & Pink 2010:158, emphasis in original).

Embodied therapies at the margins of the biomedical hegemony: conclusions

I return to the enmeshment between atmospheric traits of in-patient experience and the – sometimes alarmingly – fine line between mute and resonant interaction. First, it becomes salient that therapies beyond the biomedical treatment model can offer in-patients an enmeshment into distinct "currents of materials" (Ingold 2011: 31). I argue that psychiatric sufferer's ambivalence towards their in-patient treatment is not simply a matter of affect, but much more a materially and sensorially entangled existential experience. It is precisely during a walking session in the forest or by engaging in creative practices when spaces are created that grant the body, as Csordas puts it, the status as subject and existential ground of culture (Csordas 1990: 5). In these instances, politics of atmospheres beyond medical hierarchies are co-created among psychiatric sufferers, therapists and environments. Light, sound and feeling do not merely enfold within human bodies but "take possession of it, sweeping the body up into their own currents" (Ingold 2002: 134f). If we re-conceptualize the sensory as a pivot point of in-patient experience, service user's ex-

perience of the institution as a caring site seems coined by ambivalence. Medical and other ontologies of care coexist therein in sometimes separate sensory and social microcosms. The professionalization of human problems as psychiatric disorders can create a fundamental contradiction between lay, psychodynamic and biomedical views of "what life means and what is at stake in living" (Kleinman & Kleinman 1991: 293). The concomitant spatial and sensory embeddings of biomedical models of psychiatry reflect a Cartesian bias toward the privileging of mind and discourse which figures in an abstract, disembodied sphere. In a biomedical ontology of facticity and nosological order, indeterminacy is managed and controlled in favour of "hard science" which is, as Csordas puts it, always a result of a "hardening process, a process of objectification" (Csordas 1990: 38). I argue that non-medical therapies facilitate, precisely *because* they figure at the margins of clinical prestige, resonant experience by allowing uncertainty to enfold in its multi-layered multisensorial facets.

This leads me to my second conclusion, which centres around the experience and management of care and suffering, by both psychiatric sufferers and therapists. I complicate a uniform picture of "the" institution by suggesting, in its stead, that a variety of therapeutic cultures is actively co-created by the different actors in clinical space, resulting in a multiplicity of "politics of atmospheres". Of course, alternative therapies do not operate beyond the nexus between care and control that is written into the very fundament of the clinic (Foucault 1977, 2003). Nevertheless, they can be subsumed as spaces of resonance that foster human sociality, take psychiatric sufferer's embodied, sensory experience seriously and allow open-ended experiences beyond the social performativity of the wards. The crucial factor that determined whether users perceived a therapeutic setting as boundary-transgressing or as resonant was not the absence of ambivalence, but the sensory and intersubjective resonance offered to it. The embodied, explorative and open-ended attitude behind non-medical therapies attend to the existential ambiguity of being alive, and thereby, they address an existing caveat within medicalized ontologies of psychiatric treatment (Di Nicola & Stoyanov 2021). I argue that interactions that allow an unfolding of a mutual being-human within in-patient psychiatric care accept that humans are "constantly struggling to sustain and augment [our] being in relation to the being of others, as well as the nonbeing of the physical and material world, and the ultimate extinction of being that is death" (Jackson 2013: xiv).

This multisensory facilitation of resonance happens, paradoxically, often at the margins of institutionally privileged caring interactions. The complementation of the biomedical epicentre of the psychiatric clinic with embodied, multisensory therapies speaks to the embodied, indeterminant nature of being alive (Ingold 2002: 92–95) and of wellbeing as such. I have discussed ambiguity within psychiatric care from a sensory, environmental perspective because I argue, as others in similar research areas (Ansdell & DeNora 2012; DeNora 2013; Klausner 2015; Bister *et al.* 2016) that, for mentally afflicted people, illness and wellbeing are entangled with "things outside individuals" (DeNora 2013: 9) – embedded in human, nonhuman and cultural ecologies of being.

With these conclusions, I do not argue against biomedical psychiatry as such, but suggest a re-focusing of ethnographic research and practice within in-patient psychiatric care towards affective, sensory and intersubjective aspects of healing. The sidelining of the sensory, embodied and atmospheric dimensions in public psychiatric services is not merely a matter of aesthetics. It is one of the multifaceted factors that can make a huge difference for psychiatric sufferers during times of affliction. Atmospheric entanglements might be decisive points which determine, whether a psychiatric sufferer feels genuinely cared for or caught in violent, mute social interaction. Extending Csordas' claim that the body is the ground of human culture, I argue that we must situate experience within the politics of atmospheres in order to more fully understand the intricacies of in-patient psychiatric care.

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Notes

1 In Switzerland, there is a basic healthcare insurance model, which is mandatory for everybody and entitles for access to "public" healthcare services. Only those who pay a higher monthly insurance fee, have access to the benefits that come with "private" health services within clinics.
2 Emic notions of "work on the self" and narratives of stasis and "being stuck" invite for further reflection within Foucault's framework of "technologies of the self" (Foucault 1988b).
3 Conversation about a recent survey with the head of the Swiss association of Relatives of people with psychological disorders (www.vask.ch) in March 2023.
4 This and the following vignettes date back to ethnographic fieldwork conducted in 2022, including various follow-up interviews. They are paraphrased and translated from German into English by the author. All names have been changed.
5 Rochelle Burgess. The gifts that context give: Reflections on ethnographic encounters in Global Mental Health. Plenary Lecture, ASA-Conference 2023, SOAS London. April 12, 2023.

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