Journal of European Ethnology
and Cultural Analysis (JEECA)
2017, 2 (1): 26–45

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Choreographies of clinical and urban everyday life. Results of a co-laborative ethnography with social psychiatry*

Abstract:

The aim of this article is twofold: Firstly, it is a methodological demonstration of an ethnographic mode of research that we call co-laborative. This mode enables new forms of reflexivity in European Ethnology and makes them analytically productive. Secondly, we use this form of co-laborative research with social psychiatry to argue that the dominant analytical dichotomies of the social and cultural sciences – namely normal vs. pathological or care vs. control – only describe today's psychiatric treatment processes insufficiently. Our ethnographic material shows how 'normal everyday life' is choreographed in hospitals for therapeutic purposes and how this choreographing becomes problematic in post-clinical everyday lives. Based on these findings, we discuss the extent to which a practice theoretical approach can extend the established critique of subjectification by focusing on the processuality of psychiatric treatment, thus problematizing the multiple embeddedness of the production of everyday life in clinical and urban environments.

Keywords: collaboration, choreography, psychiatry, theory of practice, everyday life, city

1. Psychiatry and an examination of social and cultural order

The role that psychiatric research and treatment play within the configuration of modern societies has been extensively discussed. Despite the fact that no articles on psychiatry have been published in the *Zeitschrift für Volkskunde* in the past 14 years, we will restrict this paper to an outline of changes in the German psychiatric landscape that have taken place since the late 1960s. Furthermore, we will also briefly describe the dominant thinking in the social and cultural sciences during this period. Firstly, we would like to illustrate the extent to which ethnographic studies on psychiatric practice have been increasingly raising questions about the establishment of social and cultural order above and beyond hospitals. Secondly, we would like to note that social psychiatry has appropriated central parts of sociologi-

* German version in *Zeitschrift für Volkskunde* 2015, 111 (2): 214–235. Translated by Julia Heinecke und Jessica Wallace.

cal criticism over the past 40 years. Psychiatry and the social and cultural sciences all now exist in a new constellation in which it is no longer possible to ignore a kind of double hermeneutics: The analytical concepts of the social and cultural sciences have been integrated into everyday social psychiatry. This development continues to require a dialectic form of critique that thrives on an analytical distance between ethnology and psychiatry. In this paper, however, we outline a different relationship between these fields, a relationship in which psychiatry becomes a productive ethnological research field in two senses. Firstly, it serves as a 'lifeworld laboratory' in which we analyze work on (re-)creating everyday routines, normality, ('healthy') sociality, or rationality under specific conditions; secondly, as a "co-laboratory," a place for experiments in which we examine our own epistemic foundations in close cooperation with partners in the field and adapt them for both sides.

People who are admitted into psychiatric institutions are in such grave exceptional mental states that they themselves, other close relatives or medical personnel have recognized that they require stationary treatment. Such acute psychological crises can mean many different things, but in every case, they demonstrate that everyday life and everyday routines, which seem self-evident to most people, elude these patients. Research into these crises and the 'treatments' for these situations can help to put the focus on (re-)establishing everyday life: how do people learn to once again participate in social relationships, to organize their everyday activities, to plan their lives? Various studies in recent years have determined that people must constantly invest time and energy in organizing their everyday lives after crisis situations (Amelang 2015; Charmaz 1991; Whyte 1997). However, since the event leading to the crisis is often still present, it can prevent everyday life from taking its unchallenged course, so that people continue to live in special circumstances. At the same time – and this applies to crises that arise due to illness in particular – patients can reestablish their everyday lives with the assistance of institutions and experts who have developed specific procedures and tools for this purpose.

In the field of psychiatry, these procedures are being heavily scrutinized for several reasons: Firstly, they are based on a diagnostic system that has been disputed since the late 19th century. There has been a great deal of controversy surrounding the recent publication of the fifth edition of the American *Diagnostic and Statistical Manual*, illustrating how the ontological status of psychological phenomena are being questioned in the field of conflict between psychoanalysis and molecular genetics. Secondly, the drug or therapeutic treatment of symptoms for most psychiatric diagnoses is not based on a clear understanding of the causes of the illness, which would facilitate a clinical intervention. Thirdly, psychiatric forms of treatment have a long tradition of massive infringements on the personal status and personality rights of those affected. Above all, the fact that psychiatry played a decisive role under the Nationalist Socialists has brought the discipline into disrepute not only

in Germany. Finally, many evaluations of psychiatric treatment methods have shown the extent to which patients act as "moving targets," adapting their way of life and their own self-concept to dominant methods of classification and treatment (Hacking 2007).

Sociologists and cultural anthropologists have, therefore, developed a justifiable skepticism of the psychiatric apparatus since the 1960s, a skepticism that is founded both theoretically and empirically. Arguments found in sociological and anthropological studies on psychiatry are inspired largely by the work of George Canguilhem, Erving Goffman, and Michel Foucault. Their perspectives on discourses and epistemes examine how behavior that is defined as 'ab-normal' is increasingly placed under the authority of interpretation and treatment of the medical professions and clinical psychiatry (Canguilhem 2000; Foucault 2003; Goffman 1961). The American sociologist Irving K. Zola addressed this perspective in the early 1970s and summarized it concisely in his "theory of medicalization," which has circulated widely since then:

> [Modern] medicine is becoming a major institution of social control, nudging aside [...] the more traditional institutions of religion and law. It is becoming the new repository of truth, the place where absolute and often final judgments are made by supposedly morally neutral and objective experts. And these judgments are made, not in the name of virtue or legitimacy, but in the name of health. (Zola 1972: 487)

This is the case, according to Zola, despite the fact that physicians do not have political power. Instead, this specific governing technique comes from an utterly undramatic development in the world in which the labels 'healthy' and 'ill' have become relevant for an ever-increasing part of human existence and everyday life.

Initially, these critical observations were made largely in reference to institutional psychiatry. Zola applied Goffman's theory of the "total institution" as a psychiatric institution whose treatment regime intervenes comprehensively in all fields of human existence and attempts to regulate and control them (Goffman 1961). Medicalization in this context is especially characterized by a confluence of regulation, standardization, discipline and institutionalization. While more recent literature particularly addresses the aspects of the theory of medicalization that criticize this power and have, thus, become a benchmark for psychiatric discussions, another aspect that was examined by Zola has been neglected in the social sciences. Zola understood medicalization as the consequence of a humanitarian, often philanthropic, impulse inherent in the modern age to resolve or at least relieve social and health problems. He believed that this humanist imperative was incorporated into the science of medicine and that the particular impact of this development is due to the specific way in which ethics and rationality are intertwined. According to Zola, people in the modern Western world believe that it is neither bearable nor rational to watch others suffer without intervening. His arguments are based on

the historical analyses of the British sociologist and criminologist Barbara Wootton, among others, who examined the role of psychiatry in combating "social deviance" and "antisocial behavior" in the 19th and 20th century (Wootton 1959). Zola stated that psychiatry in particular has played an important role in decriminalizing the mentally ill and freeing them – with the help of scientifically founded arguments – from the mechanisms of repression in a cruel, religiously rationalized penal system. He adds that the medicalization of the 19th century became a powerful instrument, which, however, always operated within the context of other equally powerful social institutions, leading to the development of contrasting dynamics and practices. In a similar fashion, a study conducted by Robert Castel and colleagues on psychiatrization, i.e. the expansion of psychiatric discourses and jurisdictions to include new public and private phenomena in the United States, describes how psychiatry became a natural component in the organization of everyday life (Castel et al. 1982 [1972]). The bottom line of the study was that a "psy-culture" had developed that extended beyond traditional psychiatric and medical institutions. Nikolas Rose focused on this aspect later in his analysis of the "psy-complex" (Rose 1985, 1998).

This interpretation of the medicalization theory illustrates that an expansion of the psychiatric authority of interpretation is by no means a simple linear process, but rather an intricate and controversial development. The theory of medicalization points particularly to contexts beyond institutions, without necessarily being the appropriate analytical instrument for this extended perspective. With reference to Ian Hacking, we are inclined to describe this as an extended looping effect: Not (only) does psychiatric classification have a direct impact on patients, changing their "way to be a person" (Hacking 2007: 296), but this form of circular power has also been institutionally and even culturally established and transmitted.

In this short review of sociological and anthropological analyses of psychiatry, we have so far omitted the special connection between sociological research and psychiatric practice in the second half of the last century. More or less parallel to the critical sociological and anthropological analyses mentioned above, psychiatric movements developed in the 1960s and 70s that were critical or decidedly opposed to psychiatry. These institutions were pushed forward by psychiatrists themselves, inciting considerable reform movements within psychiatric care systems in various countries. In addition to a critical analysis of psychiatric institutions, these movements were also characterized by an occasionally radical deconstruction of psychiatric claims to truth and authority (Basaglia 1974; Laing 1967; Szasz 1961). The link between the social/cultural sciences and psychiatry during this period is apparent in examples such as labeling theory, according to which mental illness is understood as the result of a social process of attribution (Becker 1963; Goffman 1963; Scheff 1975). This approach has been used as an explanatory mode – particularly in dif-

ferentiated further developments – in both the social sciences and psychiatry. This is just one example of how psychiatry – or at least many professionals in this field – reacted constructively to the critical analysis of power conducted by the cultural and social sciences and the mass media.

Above all, critical discussions changed the psychiatric care system permanently, including that of Germany where psychiatric reforms took place much later than in other countries. The reforms in West Germany were driven largely by the national enquiry into mental health care commissioned by the federal parliament in 1975 (*Psychiatrie-Enquête*) that took stock of psychiatric care at the time (German Bundestag 1975). The overall opinion was clear: The report declared the conditions in care facilities for the mentally ill to be "miserable and inhumane." Catastrophic overcrowding and a lack of personnel were among the problems it identified. The resulting reforms were essentially social psychiatric in nature[1]: the demand for community care, equal status for mentally and somatically ill patients, and the dehospitalization of 'chronically' *(chronisch)* mentally ill people who had been in the hospital for many years. The last demand was based partially on the belief that caring for mentally ill patients in large hospitals, which was often accompanied by a therapeutic nihilism, contributed significantly to the chronification of these patients. Returning the mentally ill to the community was deemed possible and 'beneficial' for the health of the patients. A reduction in the number of beds in hospitals was accompanied by the expansion of various community care facilities ('community psychiatry'). The psychiatric impact was no longer limited to the physical boundaries of hospitals or doctors' offices; through facilities such as assisted living, nursing homes, workshops or daycare, it was now extended to many spheres of life for the mentally ill. In addition to the psychiatric profession's self-defined position between the poles of social and biological psychiatry, these changes, the related shift in the professional attitude toward the mentally ill, and the resulting increase in the development and availability of psychopharmaceuticals modified the classification of 'chronic' and the possibilities of using the term in the late 20th century (Bister 2018).

Considering these developments, a one-sided continuation of a critical analysis of power 'from the outside' appears to be insufficient. Furthermore, the interlac-

1 We use the term social psychiatry (Sozialpsychiatrie) to describe the methods that were first used by a few individual West German psychiatrists in the 1960s. These led to the foundation of the Deutsche Gesellschaft für Soziale Psychiatrie (German Association for Social Psychiatry) in 1971. In summary, social psychiatry, as the term is used here, describes three aspects: Firstly, the incorporation of social factors to explain the causes and treatment of mental illness. Secondly, the reintegration of the mentally ill into society and the promotion of equality and social participation through community psychiatric services. Thirdly, social psychiatry is described by many of its actors as a specific therapeutic attitude that is understood as a social, political and moral responsibility towards the patients (cf. Klausner 2015).

ing of many practices of psychiatric treatment with everyday urban life, which is characteristic of psychiatric care since the dehospitalization movement of the 1970s, cannot be adequately described using either a critical analysis of power or subjectification. Based on our ethnographical material, we develop here different kinds of instruments for observation and analysis.

2. Co-laborative ethnographic research in and with psychiatry

How do we conduct research in a field in which many actors read critical social scientific literature and in which the process of reflection has been institutionalized in various formats to respond to the core of this criticism, i.e. the problem of a subjectified normalization through treatment? In other words, what should be done if fieldwork does not produce any insights that were not already known to the "natives"? (Boyer 2008) This phenomenon is not unique to psychiatry, but it does occur particularly frequently in this field. Our answer to this challenge is co-laborative research. Co-laboration defines temporary experimental epistemic work carried out jointly by the ethnographer and the informant over long-term periods.[2] Co-laborative research does not aim at a shared outcome. Instead, the focus is on experimenting with the different thought styles involved in the co-laboration. The goal is to produce a specific reflexivity: Reflexivity in the sense of mobility between actors, ways of thinking, methods, and apparatuses as opposed to reflexivity that is understood as a reflection of one's own position in a systemically conceived field (Hirschauer 2008). In its final consequence, this reflexivity promotes a critical approach to one's own professional knowledge. Criticism is, thus, no longer achieved through a dialectic movement between proximity and critical distance but originates more in different experimental involvements in the field and the resulting challenges for one's own way of thinking. A process of this kind does not rely on criticism based on absolute criteria. Instead, psychiatry is understood as an ecology of practices (Stengers 2005) from which the criteria for its criticism must be developed.

We developed this mode of co-laborative research from and in cooperation with everyday psychiatric practice in a research project of several years' duration. This project was dedicated to the "Production of chronicity in everyday psychiatric care and research in Berlin" (project title).[3] Over the course of several months of repeated participant observation in various clinical contexts (psychiatric wards in two different psychiatric hospitals and a psychiatric day hospital), we followed the classification 'chronically mentally ill' (chronisch psychisch krank) from everyday

2 See Niewöhner (2016) for an overview of the work of Marcus, Boyer, Fitzgerald, and Roepstorff in this new mode.

3 The project was financed by the German Research Foundation (DFG) from 2010–2015 (GZ: BE 3191/3–1). It was headed by Prof. Dr. Stefan Beck and carried out by the authors of this article in co-laboration with partners from the psychiatric field.

clinical treatment and administrative procedures in community psychiatric care systems in the private everyday lives of patients diagnosed with mental illness and in the psychiatric research landscape to achieve an ethnographic understanding of the development, stabilization and effect of this classification as an everyday 'process.' Within this context, 'chronicity' is not a clearly defined medical diagnostic category, but rather an indistinct classification that is produced in a convolution of clinical, scientific, economic, legal and political practices, as well as the everyday lives of patients. At the same time, it gives patients access to medical, social therapeutic and financial resources.

Our research project focused on the classification 'chronically mentally ill' suggested by a psychiatrist working as a doctor in the hospital in which most of our field research was carried out. In addition to his medical training, he had also completed a Master's in Medical Anthropology at a British university and has since focused on establishing a productive cooperation between the field of psychiatry and the social and cultural sciences in his sphere of work. Over the course of our research, we encountered very different actors in psychiatric care who really believed that a cooperation with other disciplines and especially with social scientific methods was essential for a critical analysis of current problems in the psychiatric care system. It was decisive that we developed a kind of "epistemic partnership" (Holmes and Marcus 2008: 83) with this psychiatrist and other professionals in the field of psychiatry during the research project. This type of partnership extends beyond the exchange of information from field research and incorporates informants as partners from the development of the research design onwards. Thus, the roles of all participants change and they are no longer simply experts in their own discipline, they also encounter one another as "technicians of general ideas" (Rabinow et al. 2008: 68ff.). Our co-laboration, therefore, addressed the broad question regarding which of the current changes in our research and everyday practice were significant for an anthropology of the contemporary and which concepts we could curate to make these changes tangible analytically.

On the other hand, it was necessary to create our own forms of cooperation with the corresponding direct informants in our field research. In addition to the well-established exchange with members of the field during participant observation, we maintained continued contact with some of the patients treated in the hospital for several years after their release to see how they lived with a diagnosis in their post-clinical, urban everyday lives. Moreover, we developed a variety of feedback formats with which we were able to integrate various groups of people in the field into the research process. We, thus, presented and discussed our analyses during training courses outside the hospital and group discussions with patients and the staff on the psychiatric wards in which we conducted our research. It was essential that these feedback rounds took place during the research process and not *after* we

had completed our research and analysis. Our goal was to give the people whose everyday lives we were researching some insight into our questions, hypotheses and early analytical considerations. Since a critical analysis of treatment practices in the field was explicitly desired, voicing criticism was not a problem; the challenge was to offer a critical analysis that extended beyond a simple criticism of subjectification with which all participants were already familiar. As we will explain in this paper, it was essential for us to change our perspective and engage with a practice theoretical approach to the psychiatric field.

3. A practice theoretical approach to psychiatric choreographies

An anthropological approach based on practice theory (Beck 1997; Schatzki et al. 2001) emphasizes that heterogeneous social, technical or institutional orders as they are presented by clinical psychiatry must be conceived of as "interactive matters of doing" (Hörning and Reuter 2004: 10). This perspective does not explain developmental dynamics in a unidirectional way, for example, the institutionalization of psychiatry as an effect of the power of medical knowledge. Instead, psychiatric practices are principally addressed as hybrid and contradictory: These practices connect social, narrative–discursive, and material–physical dimensions with one another and feature very different social positionalities and normative orientations of different actors.[4] Habitualization, infrastructuring and the related process of 'becoming natural' that phenomena, attitudes and orientations undergo are the focal point of interest. The practice theoretical perspective had been established in international social and cultural anthropology and European cultural anthropology by the late 1980s at the latest (Ortner 1984). The term practice assumes a double explanatory role in this field: 'Practice,' in this sense, focuses on a bundle of specific terms, such as 'tradition,' 'routine,' 'normative orientation,' 'implied' or 'bodily knowledge,' with which regularities or the 'logic' of individual behavior can be described (Rouse 2001; Turner 1994). On the other hand, practice also stands for a collective dimension of these systematics of activities – and their political aspects. In the social sciences, this perspective is expanded again under the label "practice turn" (Reckwitz 2003; Schmidt 2012). At the core of current debates, lies the assumption that 'the social' – as well as the normative sphere, social institutions, etc. – is the 'result of practices.' To quote the American social philosopher Theodore Schatzki and colleagues:

> Practice approaches promulgate a distinct social ontology: the social is a field of *embodied, materially interwoven practices centrally organized around shared practical understandings*. This conception contrasts with accounts that privilege individuals, (inter)actions, language, signifying systems, the life world, institutions/roles,

4 For more details on the term "material-discursive practices," see Barad (2003).

> structures, or systems in defining the social. (Schatzki et al. 2001: 3; italics added by the authors)

The statement that practices are always embodied and, simultaneously, entangled in material environments is important. They are characterized by 'shared practical/pragmatic understandings.' Choreography is what we call locally observed practical patterns, i.e. the specific way in which people and things are brought together in a routinized fashion based on a local understanding of 'good' psychiatric care (Klausner 2015). A characteristic feature of a shared practical understanding of 'doing psychiatry,' as we determined in our research, is a high degree of adaptivity to the individual needs of each patient and everyday clinical requirements. Social psychiatric choreographies, as we will later demonstrate in more detail, use a controlled learning process to help people out of a crisis and onto a stable path.

We adopted the term choreography from the science studies scholar Charis Thompson, who developed it during her studies on the production of parenthood in American fertility clinics (Thompson 2005). According to Thompson, the concept of ontological choreography describes the dynamic coordination of elements of different ontological status. This includes scientific, technical, relational, emotional, legal, political and financial elements that all contribute to making both parents and children. Unlike Thompson's descriptions of highly technologized reproductive medicine, a psychiatric ward in a district hospital in Berlin is a low-tech area in the field of medicine. Nevertheless, here too, matters of different ontological status participate in everyday practices: From the rooms and doors that open and close for patients, patient records and other paper technologies to specialized knowledge and medication that must be injected or swallowed or that is rejected and spat out. However, we believe another aspect of Thompson's argument is more important in this context: Her concept of ontological choreography refers to the variety and situatedness of *agency*. The forms of objectification that women particularly experience during the process of assisted reproduction do not simply make them passive recipients of reproductive technology (as traditional feminist criticism puts it). Instead, Thompson determined how *agency* is coproduced in these processes (Cussins [Thompson] 1996). Patients must not be seen simply as disciplined and passive; they participate actively in these ontological choreographies. As Thompson also points out, choreographies must always be observed in their specific local situations and corresponding arrangements and can thoroughly contradict a constitution of 'agency.' Choreographies, or rather the process of choreographing, thus, shifts the focus onto the specific social, narrative discursive and material-physical assemblage of practice, as well as on the effects of the (in)capacity to act that become possible or problematic in this flexible repertoire.

4. On the analysis of choreographies in everyday clinical practice

The hospital in which most of our research was carried out describes itself as one of the oldest social psychiatric hospitals in Germany. As part of a Berlin district hospital, the Mittendamm Clinic[5] is responsible for the mandatory care of a district and has the same responsibilities as other psychiatric hospitals in Berlin. What distinguishes this hospital is that it not only takes a decided social psychiatric approach 40 years after the *Psychiatrie-Enquête*, but also participates in the international development of corresponding methods. The focus of social psychiatric interventions is not on the patient as an individual or carrier of a disease, but on the "person as a social being"[6] who is embedded in social relationships inside and outside psychiatric care. The hospital in associating itself with social psychiatry is also indicating its position in contrast to the biomedically orientated psychiatric approach that is increasingly seen as the standard in the German psychiatric landscape. Social psychiatry today is seen by some as outdated and has lost some authority of interpretation to a psychiatric practice based on neuroscience, biomedicine and pharmaceutical therapy. This shift has hardly changed the number of illnesses that take a chronic course, but it has changed the way in which hospitals classify illness in everyday practice.

We noticed two things in particular during our research on the 'production of chronicity': Firstly, there was never any debate as to whether individual patients should be described as 'chronic.' Secondly, there was a striking lack of classification in direct conversation with patients. This absence of classification in clinical practice stood in a strange contrast to the relevance asserted by psychiatric professionals. The classification 'chronic' was, thus, absent and present equally in clinical practice. The first reason for this was a conscious and trained practice of avoidance on the part of the staff, which we call the 'deconstruction' of classification. There was a consensus – in both direct and indirect references to labeling or stigmatizing effects – that a label could have an effect on the person labeled. Accordingly, staff did not refer to patients as 'chronic' in direct interactions in order to prevent these patients from seeing their illness as untreatable and becoming even more ill instead of seeking the potential to improve their mental health. Secondly, the classification 'chronic' was present in numerous work practices among the staff and, thus, 'constructed' in daily life. The classification was sometimes used in formal and informal conversations when documenting treatment procedures, in medical discussions and in contact with health insurance companies. In these cases, chronicity was given different meanings in everyday treatment. Exemplarily, by using the term 'chronification,' classification was processualized and assigned to a chronological development. This led to a focus on chronic processes that addressed either the biographical or the symptomatic

5 All people and the hospital were given pseudonyms.

6 An excerpt from a patient description in an annual report from the Mittendamm Clinic.

illness of a patient or the increased frequency of hospitalization. 'Chronification' was considered to be a process that could be recognized and principally (still) counteracted. The phrases 'avoid chronification' or 'threatening chronification' were used especially when documenting treatments for health insurance companies to justify a required hospitalization, for specific therapeutic treatment or for recommending additional treatment after discharge.

Thirdly, during our research, we encountered – in addition to the two methods of dealing with classification mentioned above: deconstruction and construction – a 'modulation' of the classification, i.e. the use of additional terms that were given the meaning of the condition 'chronically ill' as a form of 'staying ill.' Expressions such as 'returner,' 'revolving door patients' or 'treatment-experienced' were used and could be found in medical and political documents and analysis papers on psychiatric care. The everyday use of these phrases oscillates between the wish to deal with the term 'chronic' very sensitively (creating absence) and the desire to make use of the potential of the term for professional work and to use the familiar process of classification (establishing presence) to deal with, explain, diagnose and treat the phenomenon of 'return–relapse.'

With this in mind, it became clear during our research that we could not place all of our focus on classifications as decisive moments in the production of chronicity. Instead, we needed to assume an ecological perspective that would allow us to understand the formation of path dependencies beyond classification. In this paper, we use the term 'paths' in a heuristic sense to problematize how the Mittendamm Clinic continuously included patients in treatment decisions by using certain kinds of therapeutic treatments, constantly requiring patients to participate in everyday therapy and offering feedback from medical personnel. It is important to us to distinguish between the term 'path' and the term 'track': Instead of presenting a predetermined track and attempting to literally put patients back 'on track,' the staff worked hard to sketch a 'path' for treatment which the patients then had to tread themselves. This mode of therapy was not aimed at teaching patients a specific modern self-realization as a foundation for (self-)intervention in their 'mentally ill self' and its normalization. Cognitive psychotherapies were only one of many important everyday treatments. Their efficacy was usually dependent on a much larger context than, for example, that of the ward. Patients were offered an everyday routine on the ward that was determined by a daily rhythm (meals and times for walks), the necessity to uphold and endure an increasing number of social obligations (therapies, ward responsibilities), an open-minded atmosphere, and a minimum of a stable self-image and foresight, which the patients were to adopt. Patients were expected to fulfill their obligations reliably with increasing frequency. The objective of this simulation of everyday life was not a 'cognitive' learning process which only led to recovery in the second instance. Instead, a mimetic learning in the sense of 'imita-

tion' and 'acclimatization' was the focus of daily life on the ward, for example, a re-routinization on a practical level of the patients' everyday lives which had veered off their previous paths.

The Mittendamm Clinic, for example, focuses on innovative treatment methods in the tradition of social psychiatry. One of these treatment methods, which illustrates the mode of choreographing in a special way, is the so-called conference treatment *(Behandlungskonferenz)*. This method, which was inspired by Scandinavian treatment models such as the need-adapted treatment and the concept of "Open dialogue" (Aderhold et al. 2003; Seikkula and Arnkil 2011), emphasizes the needs and resources of the patients. The goal is to promote the self-efficacy of patients by integrating them into the planning and evaluation of their therapy.

A treatment conference in the hospital consisted of several steps followed by a few variations of the following procedure: The previous and future therapeutic steps were discussed and joint goals defined in a conversation with several members of the medical staff, lasting about half an hour. The patient and the therapist who moderated the discussion sat in the middle of the circle. The chairs were arranged in a semicircle facing the two in the middle. Two to six other ward staff members participated in the treatment conference. The discussion usually began by asking the patient how the last week had gone and to what extent the goals of the last treatment conference had been achieved. These 'goals' and the 'next concrete steps' had been documented in the minutes of the last treatment conference, which were handed out to all participants of the treatment conference – including the patient. As an example, the goals of one patient, who we will call Ms. Siebert, were as follows: '1. Expand range of activities, 2. Go for a walk alone, 3. Meet friends.'[7] These goals were then translated into the following concrete steps: 'For 1. and 2.: Go outdoors several times a day (walk down to the streetlights frequently); find someone to go for a walk with; be conscious of the sounds outdoors and grow accustomed to them; for 3.: Call a friend and meet with them.' Ms. Siebert responded to the initial question about how the last week had gone by explaining in detail what went well and what was less successful. The moderator, often the patient's physician or ward social worker, asked questions in a specific way, repeating part of the previous statement ("So you made it to the end of Baumstrasse but on the way back, you had to fight your fears?"), requested more details ("Did you go along the front of the main building or along the back through the park near the rose bed?"), or tried to find out more about the emotion described by Ms. Siebert ("And why do you think you were afraid on the way back and not on the way there?"). After this review, the next steps were usually discussed ("What do you think could be the next steps for you?" or "What do you need to achieve this?").

7 These quotes are taken from the minutes provided by Ms. Siebert and the participating hospital staff.

This extensive discussion was followed by a team reflection, which the moderator introduced with the following words: "Now the two of us can lean back and hear what the others think about what we have just said." Often there was a period of silence until the first person voiced their thoughts. When speaking, this person did not address the patient or any of the staff but instead 'thought aloud': "I was impressed that, despite the setbacks of the last week, Ms. Siebert was able to motivate herself to go back to her training rounds in the park and wasn't discouraged…" Or: "I thought it was great how Ms. Siebert was able to show her feelings so openly in this group and that she trusts us to hear about her fears…" After this group reflection, the patient was given the opportunity to respond. Finally, the staff member who took the minutes summarized the treatment conference, stated which points had been noted as possible goals and the corresponding concrete steps for the coming week. The patient could and should respond to these points: Were these the goals that she had imagined, did she think these steps were realistic, or would she like to do something different or add something? These goals and steps were correspondingly added to the minutes, which were later handed out to all participants, including the patient.

Using the elements described here, the aim of the treatment conference was an ongoing analysis of the next steps of treatment. It was also intended to help achieve the goal of an increased 'self-efficacy' of the patient. In the therapeutic concept of the Mittendamm Clinic, self-efficacy primarily refers to the ability to reestablish a routine for everyday life that is as independent as possible, considering the conditions of the illness. As mentioned earlier, people in acute mental crises lose particularly the natural routines of everyday life: structuring their day (getting up regularly, eating, planning activities), maintaining contact with other people or moving around in the city. The example above of a treatment conference with Ms. Siebert demonstrated this aspect clearly: Moving around within the hospital grounds and the neighborhood or scheduling meetings with friends were everyday things she could no longer do with ease. Instead, these were tasks that she needed to work on as part of her therapy. The treatment conference was, thus, one building block in the treatment choreography practiced in the psychiatric ward. In addition to other forms of counseling and occupational therapy provided by doctors and psychologists, this choreography included primarily many routine tasks for which the medical staff were responsible: Opening and closing doors, setting times for medication and regulating which patients were permitted to pick up the medication themselves and which patients had medication handed out to them, negotiating agreements on leaving the hospital, noting on attendance and behavior, and providing a flexible use of rooms, including giving patients access to staff break rooms. These everyday practices, like the treatment conference, were not intended to lay down rigid rules for the patients

but were, instead, therapeutic measures that were aimed at activating the patients and helping them to shape their everyday lives as independently as possible.

Learning everyday routines: on the relationship between choreography and subjectification

Critics may note upon reading this analysis that all these practices could easily be understood as disciplinary techniques, although given a late modern appearance as instruments for normalization based on technologies of the self. Authoritarian discipline has given way to a governmentality regime, even in psychiatric hospitals. This may be so. However, research we carried out in the past few years in psychiatric hospitals and with psychiatric professionals allows us to offer a second complementary interpretation. This second interpretation cannot be sufficiently justified by emphasizing that psychiatric staff have also read Foucault and are attempting to consolidate control and care. Since, as Foucault stated: "people know what they do; they frequently know why they do what they do; but what they do not know is what what they do does" (Dreyfus 1982: 187). We would also like to expressly emphasize that co-laborative research does not simply produce accomplices; we did not attempt to tilt the critical tone in favor of psychiatry.

The practice theoretical perspective has illustrated that the goal of treatment is not aimed primarily at the subject, in Foucault's sense of the word, but focuses instead on specific performative acts, embodied learning and the routinizing of practices. Of course, this kind of treatment also has a subjectifying effect. For this reason, we see our theorization as complementary instead of alternative. Foucault's fundamental problem, the field of conflict between care and control, does not disappear. However, treatment of this kind with its focus on everyday life is not accompanied by 'one' subject position. Regimes based on power knowledge are regularly criticized for propagating specific processes of interpellation and, thus, giving individuals only two possibilities: a commitment to the predetermined subject position or more or less open resistance (e.g. Foucault 1978). Third paths are generally not considered. The psychiatric method of creating paths discussed here develops its indisputably existent power knowledge with more caution. It does not convey a single subject position, but, to a certain degree, allows individuals to choose how they would like to respond to the everyday activities they are offered, thus, creating new "degrees of freedom" (Haraway 2008: 72ff.) for patients who generally use these paths in two different ways. Firstly, patients consider the routines provided without necessarily addressing or even problematizing them. Secondly, they use the degrees of freedom offered by these paths to help organize and negotiate everyday life on the ward.

The choreographies on the ward offer 'agency.' This perspective is very different from Foucault's concept. The goal here is not an authoritarian disciplining of individuals, nor the establishment of a regime based on power knowledge that offers

a single specific subject position or relies on the regulating effect of technologies of the self. Nor does everyday life on the ward correspond to the discipline of early modern institutions that were expected to improve the behavior of deviant individuals. Instead, daily routines at the Mittendamm Clinic are coproduced by both the therapists and the patients, as well as within a network of actors of differing ontological status. Daily routines in this context must be understood as material-semiotic practice. The shared choreographies of everyday life on the ward offer patients more than just one subject position; they give them degrees of freedom within the structure of everyday life.[8]

This analytical perspective focuses on choreographies as a process. While analyses of subjectification usually have teleological elements analyzing interpellation from its end point, i.e. the problematic subject position, the term choreography is aimed at more open-ended processes. We focused our attention in our research on the 'production of chronicity' on the development of path dependencies because it is also important for practice theory to recognize that chronification is an 'act-uality' *(Tat-sache)* in the psychiatric field. Path dependencies and degrees of freedom in this context exist in a field of conflict. This conflict was often resolved on the wards in favor of additional degrees of freedom. The reason for this was that psychiatric actors whose job it is to react professionally to conflicts in everyday circumstances played an important role in the choreography of everyday life on the ward. Conflicts were regularly addressed, making it possible to maintain degrees of freedom. This created stable everyday circumstances in which patients with formerly acute mental distress could live and experience their everyday lives in 'stability.' These alleged successes reached their limits in extreme cases of mandatory treatment when medical staff determined that a therapy was essential to avoid self-harm or to prevent a patient from harming others. Furthermore, the stability learned on the ward often began to waver when patients were released into everyday urban lives in which the distribution of agency and the degrees of freedom in everyday circumstances had to be obtained in very different manners.

On the failure of newly learned choreographies after discharge

Patients were often faced with the challenge of rebuilding stable post-clinical everyday lives and routines after their treatment in the Mittendamm Clinic. The number of 'returners,' on each ward demonstrates that many were unsuccessful. Psychiatric research and the wider public discourse state frequently that patients themselves and their individual genetic, neuropathological, mental or personality factors are the reasons for a lack of success in treatment and, therefore, the cause of 'setbacks'

8 For more details on a practice theoretical approach to the methods used in modern social psychiatric treatment in different hospitals in Berlin and Brandenburg, see Bister and Niewöhner (2014).

and an increase in the prevalence of chronicity. The opposing standpoint, that of social psychiatry, is seldom heard: Mental illnesses and their chronification are social phenomena; an individual's illness, for example, is a reflection of problems in society, therefore, society must also change and not only the patient. In our opinion, both lines of argument – radical individualization or radical collectivization – do not do justice to the current situation of mental illness and its treatment. Our analysis of the process of choreography and its failure emphasize the 'empirical' problem in identifying when and how specific path dependencies are produced.

In the research project discussed here, we had the opportunity to maintain contact with patients who had been treated on the ward and could analyze the 'production of chronicity' in contexts outside the hospital. We were able to accompany several patients in their everyday lives at home after their stationary treatment to varying degrees and over extended periods of time of up to several years. These people lived in their own apartments and were visited by a social worker once or more times a week to discuss problems and questions. Without exception, all patients were taking medication prescribed by a neurologist and most had a legal guardian for financial, health and administrative matters.

As in the clinical context, it is possible to criticize the effects of subjectification inherent in this kind of care infrastructure. However, the ethnographic material also revealed another dimension. Patients tried to reestablish the everyday routine learned in the hospital as soon as possible after they were released. In doing so, they could no longer rely on the rigid clinical context. Instead, they put together their everyday routines using selected elements from the urban contexts and psychiatric infrastructures. These elements were chosen based less on a learned and reflected process of selection than on a system of trial and error. In order for this task to be successful, the openness of the city had to be reduced to manageable everyday routines that also permitted enough freedom for personal differences. In addition to community psychiatric infrastructure, for example, these routines included parks, public spaces and cafés where people could just sit for an afternoon without others finding this somewhat unusual behavior disturbing. They also included authorities whose employees were flexible enough to talk through living situations and family relationships. Field research illustrated how the smallest degree of freedom enabled patients to continue to choreograph the open and often overwhelming life in the city after being discharged from the hospital. We assume that while this form of 'making the city bearable' is especially apparent or observable in post-clinical individuals, it is principally a universal process. It is important to note that successful post-clinical processes in the true sense are not the result of cognitive, mental learning or even healing processes. Instead, patients learn to establish everyday routines more or less mimetically. They follow the paths laid out for them in the hospitals, to use ecological analytics as introduced by the British social anthropologist Tim Ingold

(Ingold 2010). Patients rarely have maps and signs, like those they could use in the hospital, in the open wilderness of urban spaces. The capacity to act, therefore, cannot be meaningfully located in individual cognitive performance and learning alone. It becomes clear that choreographies are a distributed socio-material process. Only a few patients can find new paths quickly because important props are missing after their release from the hospital. In most cases, the post-clinical redistribution of the patients' capacity to act leads to a loss of freedom. In addition to everyday conflicts of interest and the lack of support in the public sphere, the cutbacks and restructuring of public spaces, public authorities and the health care system over the past 20 years play an important role. As a result, the newly acquired everyday routines have the potential to collapse quickly outside the hospital. Consequently, patients feel overwhelmed and return to everyday life in the hospital.

Our project was only able to give some first insights into why these degrees of freedom are lost so quickly. However, the project, thanks to its long-term ethnographic research on the everyday lives of the people affected, was able to show that the analytical view of the distribution of the patients' capacity to act enables an intermediate position between the individualization and collectivization of psychiatric phenomena

5. Conclusion

Our co-laborative research enabled two things: Firstly, it allowed us to carry out long-term ethnographic research into the clinical and post-clinical everyday lives of patients. This was achieved largely by establishing trust, which was facilitated by continuous communication in various formats. Secondly, a new kind of reflexivity that we were able to establish in joint discussions played a role: A reflexivity that resulted in mobility between different perspectives. One could even say that this type of close cooperation not only made it possible to shift perspectives, but also allowed us to see how different communities act and think in the world: their "worlding," as Anna Tsing would call it (Tsing 2010).

Consequently, co-laborative research prevented us from voicing criticism on subjectification, which was already fully known in the field. This led to a joint search for an analytical perspective that could do justice to the new clinical forms of treatment without ignoring forms of subjectification. In addition to a continuous exchange of information with individual patients over a period of several years, we held regular, analytical meetings with psychiatric staff and feedback rounds that accompanied our research in the Mittendamm Clinic. In this paper, we have presented the results of these multiple research processes on contemporary everyday lives in psychiatric facilities: the concept of choreography. The aim was to note, firstly, that treatment is negotiated as a concrete practice on the part of both medical staff and patients and in a specific environment consisting of the ward, administrative

staff, disciplinary knowledge and medication. Secondly, we used the concept of choreography to emphasize the distribution of patients' agency in specific material-semiotic practices. These practices were the objects of our research, which we saw as important because these new forms of treatment were used to choreograph everyday routines and were, therefore, aimed primarily at everyday practice instead of the individual and his or her cognitive and mental capacities. Shifting the objective of medical intervention away from the subject toward practice resulted in a degree of freedom for the patients in view of their self-image and potential futures. The fragility of these choreographies and the fact that they can only remain stable under the controlled conditions of the psychiatric ward is reflected in the frequent breakdown of these choreographies after patients have been released into their everyday lives in the city. The disappearance of redundancies and flexibility in urban spaces, brought on by the economic crisis of the last few decades, has exacerbated this situation.

Psychiatric practice attempts to avoid the path dependency it calls chronification, which, ironically, does not arise from stabilizing patterns of practice through individual (genetic, mental) or structural (society, medicine) factors. It comes from the repeated collapse of established routines when patients change environments from the clinical ward back to their urban everyday lives. The cause of a continued chronification, as demonstrated by the practice theoretical perspective which we have developed here, is, thus, neither the individual nor society, but rather a material-semiotic meshwork of relations in everyday practice.

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