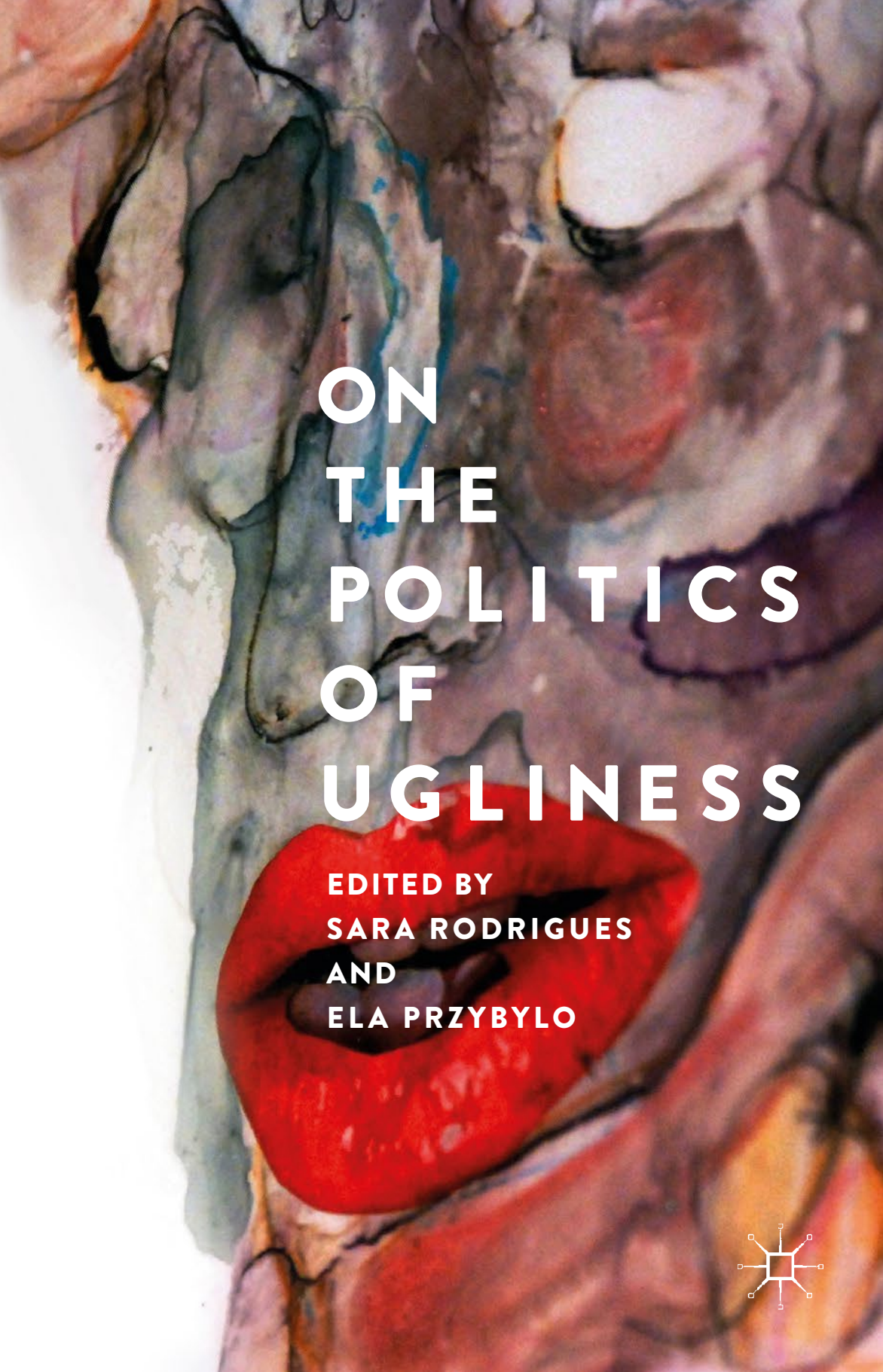
ON
THE
POLITICS
OF
UGLINESS
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10

Stigma Stains: The Somaesthetics of Institutional Abjection

Natasha Lushetich

Diverse art practices have, since time immemorial, sought to establish a direct, visceral, somatic link with the viewer's insides in order to problematize order and disorder, normativity and aberration, totem and taboo, life and death, as even a cursory lance at Domenico Ghirlandaio's portraits of decay, Pieter Bruegel's depictions of starvation and disease, the Viennese Actionists' performances with animal carcasses, feces, and urine, or Ron Athey's ritualistic work with HIV-positive blood will show. In all these works, the ugliness, the defilement, the disgust, and the horror are intentional, strategic—even ideological. By drawing attention to the abject, which, as Julia Kristeva has argued,[1] is simultaneously the remnant of the embryonic and the premonition of the cadaverous, such works question the symbolic order and its systems of inclusion and exclusion. Given the symbolic order's regulation of social, gender, class, and ethnic life through pronouncements on somatic practices—what should not be eaten, who should not be slept with, where urination and excretion should not take place—it is only appropriate that its hegemony be questioned in the somaesthetic sphere. Unlike aesthetics, which relies on exteroceptive senses, such as sight, hearing, and touch, somaesthetics includes interoceptive sensations, those inaccessible, or barely accessible to the conscious mind, such as the homeostasis-regulating viscera, the working of the

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lymphatic system, perspiration, digestion, queasiness, and balance. Although Kristeva does not use the word somaesthetic, or even somatic, her reference to the Platonian *chora*—the formless receptacle of the mother's body that brings form to life—is firmly rooted in the *soma*, both of the human and the environmental kind. Kristeva interprets *chora* as the primal desire for unity with the mother against which the subject must *struggle* in order to acquire language and enter into the symbolic space, that she designates, after Jacques Lacan, as the space of the father. Despite the fact that such binary delineations, and, more generally, the emphasis on the familial scene are not without problems, as numerous theorists, Gilles Deleuze and Félix Guattari among them, have argued,[2] Kristeva's point is nevertheless valid. *Chora* cannot be fully conceptualized as a space, a territory with any degree of stability, but, rather, as a *permanently shifting border* that separates the "I" from the "it," mineness from distance, existence from abyss. Kristeva writes: "I am at the border of my condition as a living being. My body extricates itself, as being alive, from that border. Such wastes drop so that I might live, until from loss to loss nothing remains in me and my entire body falls beyond the limit—*cadere*, cadaver. It is no longer 'I' who expel. 'I is expelled.'"[3]

When explicitly staged, as in the above-mentioned works, the nauseating, the horrifying, the contaminating, and the liminal is localizable and delimitable. It objectifies the abject and renders it less dangerous and less horrifying. But what of the unintentional, even decidedly unwanted, yet ceaselessly produced abjection? And what of the equally unintended, unwanted, but perpetually produced malice, which, like abjection, has neither subject, nor object, but is, as Mary Midgely has argued, "a negative."[4] In analog photography, a positive shows what is. A negative shows a vague and indefinable area of that which cannot be shown and, in this sense, goes no further than showing the gesture of showing but effectively showing nothing. For Midgely, to look for the shape and substance of malice, to look for something defined and tangible, is ultimately an error. Rather, malice designates "a general kind of failure to live as we are capable of living,"[5] which, in turn, consists of a series of small, everyday failures, much like, for Kristeva, it is the daily excretions that finally expel the "I."

In the following pages, I focus on ugliness as a composite of accidental abjection and non-intentional malice, an imperceptible operation of permanent slippage that, as Yve-Alain Bois and Rosalind Krauss have argued, has a performative effect.[6] In language, performative utterances alter the existent reality. Illocutionary performatives, such a judge sentencing a defendant to 20 years in prison, are authoritative; their effect is explicit and immediate. Perlocutionary performatives, on the other hand, such as gossip or hurtful

words, are not authoritative; their effect is diffuse, delayed, implicit, and non-localizable. Like ugliness, they defy definition. And yet, their unstoppable working, which corrodes the practice, the site, the social sphere, and the behavior it forms part of, is palpably felt. In this chapter, a medium secure psychiatric unit at the Bethlem Royal Hospital, London, is scrutinized through observational research, interviews with 31 clinical psychologists, nurses, occupational therapists, technicians, cleaners, and patients[7] carried out in the spring and summer of 2014.[8] My aim in focusing on a space that already hurts is to elucidate a very particular form of ugliness, one that emerges from the confluence of neoliberal precarization, increasing responsibilization, and abjection. As Isabell Lorey suggests, in the current age, precarization is neither an accident nor is it an exception. It is "a rule"; an "instrument of government, social regulation, and control."[9] It subjugates through frequent job cuts and the threat of economic ruin, and, in so doing, feeds into the dogma of the risk society. Narrowly related to the digital compression of space and time, which decouples the "here" from the "now," the risk society is, according to Ulrich Beck's prescient theorization, a "systematic way of dealing with hazards and insecurities induced … by modernisation itself."[10] It is a society characterized essentially by the impossibility of an external attribution of hazards and their dependence on managerial decisions, which makes these decisions "politically reflexive."[11] Neoliberalism can, for its part, be seen as the intensification of moral regulation based on the withdrawal from government and the simultaneous responsibilization of individuals through economic measures and the political regime of ethical self-constitution as consumer citizens. Regulated choice making, present in all spheres of life—education, healthcare, child rearing, to mention but a few examples—transfers responsibility from the public institutions to the individual. This means that regulated choice-making reinstates vulnerability and insecurity of a financial, professional, moral, and legal kind. The relation between abjection and the increasingly precarious work conditions is, in this chapter, examined in a medium-secure unit of what are traditionally seen as "closed" institutions, through three modalities of being: being spatial, being aural, and being watched. Important to note, however, is that these modalities of being, and their pertaining practices, are *not* specific to closed institutions. They have far-reaching implications for all institutions, and, more generally, practices, in which increased surveillance, time famine, and precarization lead to self-stigmatization.

Stigma is, of course, primarily related to belief and to normativity, rather than to (accidental) somatic and environmental processes. It is a characteristic "contrary to a norm of a social unit" where a "norm" is defined as a "shared belief that a person ought to behave in a certain way at a certain time."[12] Such and

similar definitions of stigma, which are certainly, if not exclusively, true, engender thinking about stigma as policy-related. This is also the reason why it is usually thought that mechanisms leading to disadvantaged outcomes must be addressed, and that deeply held attitudes and beliefs of powerful groups leading to labeling, devaluing, and discrimination must be changed and regulated. Although stigma, an internalized mark of disgrace, is usually inflicted on the disadvantaged by those in a position of power, my purpose here is to draw attention to the steadily more prominent practices of self-stigmatization, which are *residually produced*, as a result of work overload, lack of time, and, ultimately, exhaustion, but which, when repeated, became instituted as habits, and form part of institutional practice.

Being Spatial

With its beautiful gardens, highly aesthetized yet functional architecture, enviable facilities, and the exceptionally rich occupational and recreational content, the Bethlem Royal Hospital is the epitome of applied (ethical) aesthetics in spatial and relational terms. A thrown-togetherness of brick, glass and mortar, but also habit and memory—as all architecture invariably is—the medium-secure unit of the hospital called River House is visibly designed with socially remedial ends in mind. Its many spaces are also valanced as remedial through a sustained practice that resembles Nicolas Bourriaud's relational aesthetics. Although criticized by many, most notably Claire Bishop,[13] largely for its utopian nature, relational aesthetics departs from "the whole of human relations and their social context, rather than an independent private space."[14] This means that the aesthetic nature of relational works derives not from their material qualities but from the interpersonal relationships they cue and incorporate. By setting up real, interactive situations in galleries and museums, works such as Rirkrit Tirivanija's meal-making practices, or Carsten Höller's 2006 *Test Sit*e, a gigantic slide, which cues effervescent sociality in the sliders through the loss of control and vertigo—do not "represent utopias"; they actualize utopias by creating "positive life possibilities" in "concrete spaces."[15] Similar intentions can be found in the built and practiced environment of the River House. On the wards, areas around the nursing stations are semi-circular. This makes it possible for staff and patients to sit on the inside—or lean against the outside—of the semicircle and read newspapers while supervising the dining area and both corridors (the corridor leading to the patients' rooms and the corridor leading to the nurses' offices) while interacting with the passers-by (Fig. 10.1).

Fig. 10.1 River House Ward, Bethlem Royal Hospital (2014), photographer anonymous

Chairs and benches placed along walls are similarly social-interaction-cuing and often extend a few words uttered in passing into a lengthy conversation. The dining/living room area is, likewise, designed to allow for a simultaneous watching of television, playing of board games or snooker, and snacking around small tables. This is complemented by the occupational therapy team's—as well as the patients'— frequent placement of quizzical objects on the floor, in plant pots, on windowsills, and on chairs. A cotton bag with mysterious, semi-visible content will thus unexpectedly appear on the edge of a corridor chair; a spatial intervention in the form of a mobile cardboard object will be placed in the corridor (Fig. 10.2).

Intended as syncopal elements that break the usual spatio-temporal layout of the place, these sculptural provocations, and the ensuing debates, improvisations, and often, humorous remarks and excitement, valance the space as a space of inter-subjective co-creation, and thus, simultaneously, possibility and change. Like relational aesthetics, which seeks to construct utopias in a society oppressed by market fundamentalism, these interventions prompt the creation of a non-predetermined community based on inter-subjectivity. For Bourriaud, much like for Jean-Luc Nancy, community is always already dissolved, dislocated, and fragmented. Despite this, it nevertheless remains the only platform from which to fight increasing fragmentation,[16] and, I would

Fig. 10.2 Patient X's spatial intervention: Mobile Object, River House (2014), photographer anonymous

add, individual neoliberal responsibilization. Although many patients reject strictly communal forms of socialization, such as the community support group which they find both "infantilizing" and "offensive,"[17] they appreciate routine-breaking, tempo-changing events and activities. Despite the fact that the majority of the resident patients fully acknowledge their condition (some can, indeed, speak about it in very eloquent terms), they insist on seeing the space of the hospital—and themselves in it—as a liminal space.

In ritual, the liminal stage is marked by a clear period of separation during which "the initiand lives in unfamiliar surroundings";[18] in a space where "social relations are discontinued, former rights and obligations are suspended [and] the social order is turned upside down."[19] Similarly, the patients' sojourn at the hospital is a time-space in which transformation (is hoped to) take(s) place. As one patient lucidly put it, many patients cling to "the temporariness

of their condition, even if they have spent most of their lives in such and similar institutions."[20] Yet, despite careful spatial valancing and the manifold relational provocations—not to mention the carefully maintained cleanliness—abjection, desolation, and desperate loneliness manifest in the smallest and most negligible of details. A case in point are greasy fingerprints on the glass separating the nursing station from the ward which act as a *somatic* reminder of the frequency and the duration of time spent waiting for help and attention (Fig. 10.3).

Due to chronic staff shortages—the hospital has suffered three nursing staff cuts in the last four years—a patient can sometimes wait for up to 45 minutes if the nurses are busy, although every effort will, of course, be made to see the patient as soon as possible. Fingerprints, which imply leaning on a surface for better visibility, or, indeed, clinging, make for a jarring combination with the "My Recovery" or "My Shared Pathway" manuals and posters that promote a proactive, even entrepreneurial approach to psychiatric health, thus mimicking the objectives and targets of what Eskil Ekstedt has called the "projectified society,"[21] a society in which life, and everything that happens within it, is seen as a series of well-considered choices. Given that some patients have a violent past, consisting, on occasion, of infanticide, matricide, and patricide, the greasy fingerprints are not a minor aesthetic point but the cause of core and interpersonal disgust simultaneously. As Paul Rozin, Jonathan Haidt and Clark McCauley have argued, all disgust is related to oral distaste, but has, over time, become increasingly reflective of moral issues that play a significant role in negative socialization.[22] A complex construct ranging from concerns about ingestion and protecting the body from disease and infection, to distancing oneself from reminders of one's mortality—manifested in scabs and dry skin—disgust is also concerned

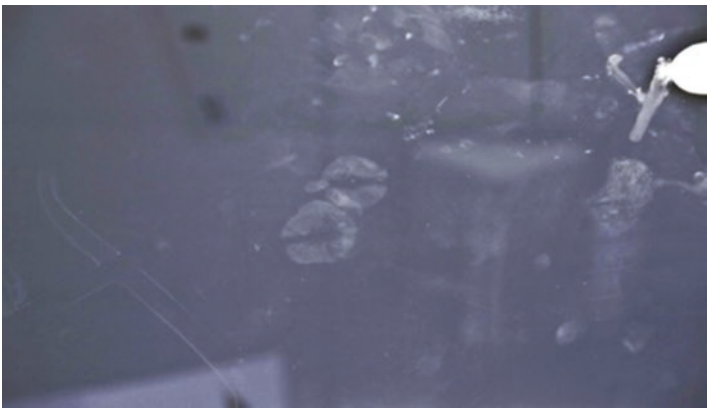

Fig. 10.3 Nursing Station Glass, River House (2014), photographer anonymous

with *protecting* the integrity of a single human being as well as with protecting the integrity of the social order. Although interpersonal disgust is often triggered by prejudice—much like stigmatization is—it is also produced in the somaesthetic encounter with the morally dubious other's sweat, warmth, and wetness.

The medication many patients are taking has profound effects on the functioning of their lymph glands. It induces profuse sweating. This, in turn, has an effect on the perceived danger of contamination. While we generally find sitting in the still-warm place of a stranger on the bus or the metro unsettling, the wet and greasy fingerprints of a seven-foot-tall multiple offender are doubly unsettling, particularly in a space that serves to incarcerate. Importantly, reactions to interpersonal disgust also connote the sense that one is better and less offensive than the offender. In inter-subjective settings, disgust serves as a stigmatizing tool and an out-group marker.[23] It increases belligerence and intensifies social hierarchies. Although the main reason why a patient does not want to socialize with another patient with a highly offending past is mostly fear, these seemingly negligible yet persistent somaesthetic experiences make the inescapable enmeshed-ness of the environment, the patient's individual body, and the social body of the institution, difficult to ignore. As several patients have observed, the dependence on the overworked—and, often, underpaid—staff, is here enmeshed with "concerns about physical illness and contagion."[24] Important to note is also that in this particular setting, normative ideas about what is clean, right, appropriate, and desirable, are very different. Repeated offenders command both staff and patient respect and are often referred to as "top dogs."[25] This is not because staff, or even patients, approve of, or wish to emulate criminal behavior, but because individual fearlessness and a zero-tolerance attitude are seen as the only form of resistance against the oppressive technocracy in which individual decisions—and particularly individual responsibility—are constantly required but not rewarded. Instead, ill-considered decisions are often used to culpabilize the individual, whereas well-considered decisions, with positive outcomes, are often lost in diffuse networks.[26] While bureaucracy, as Midgley has argued, is "the rule of nobody,"[27] technocracy is a form of *automated bureaucracy*; it is perpetuum-mobile-like in its incessant hegemonic working. Given that enraged patients sometimes, for lack of a better weapon, use their own feces as a performatively and extremely efficacious method of showing disagreement with the hospital rules or treatment, as well as their pain and despair, the abject and the contaminating do not necessarily reside in the act of throwing excrement—indeed, this act has something of the Kantian sublime in its unmitigated extremism—but in the enmeshed-ness of space, place, action, and actants; the deeply

hurtful fact is that it is the lowest-paid staff who clean the remnants of such outbursts of rage.[28] Yet, despite the awe-inspiring qualities of such an action, the somaesthetically felt echoes—the stench and the corresponding queasiness that permeate the ward for days, even weeks—engender remorse, self-reproach, and rumination, all of which cue self-stigmatization: feelings of perpetually self-attributed lesser worth.[29]

As a result of the general trend of individual responsibilization in the workplace, as well as of the litigation culture, many nurses, occupational therapists and occupational technicians spend inordinate proportions of their time in the various health and safety workshops—from how to climb ladders to why they shouldn't really do much more than phone for help if a fire breaks out.[30] Despite their minimally intellectually demanding nature, many of these workshops take up to three to four hours at a time, thus making the already scarce staff on the ground even more scarce. In addition, new rules of conduct appear almost every day. Some of these rules are informed by fatal incidents, such as the ban on leaving plastic bags in patient rooms, which appeared in the wake of a patient suicide by suffocation, however, others, as several staff have commented, remain unfathomable.[31] This constant curtailing of personal (patient) and professional (staff) freedom, paired with the diminished time nurses are able to spend on care,[32] translates into simplified procedures. A case in point is medical check-ups, which, due to their hurriedness, most patients find offensive. This is important in the context of the exposure and the examination of the patients' bodies in an almost pre-adult way, but without offering help with the most basic of ailments—a persistent cough or the flu.[33] Referring to the fact that actions such as medication-taking and eating are carefully monitored at all times of day, and that the patients, as well as their rooms, are regularly searched, this does not reflect an erroneous assumption that the nurses and the clinical psychiatrists should also be general medical practitioners. Rather, it reflects the not-so-strange idea that the right to pry into patient intimacy, which may reveal (what are often experienced as) shameful sights or feelings, should be accompanied by care and the ability to cure; that it should not be a routine checkup, carried out in a hurried fashion by a time-poor staff member.

One of the reactions to this infantilizing, as well as frequent, but ultimately offensive exposure of patient bodies can be seen and felt in moist and gooey chewing gums, found on walls, on skirting boards, in plant pots, under tables and chairs. Many highly-strung patients, those whose teeth are still unharmed by the medication they are taking, tend to chew a lot of gum. Sticking chewing gum in places where chewing gum is not supposed to be is a gesture that brings into view the exposed status of the patients' physical bodies in a pitifully

infantile way. According to both patients and staff, a large proportion of attacks take place when a patient is declined leave, leave being any period of time a patient spends away from the ward, even if only fifteen minutes.[34] This can, of course, happen as a result of uncooperative or obstructive behavior, however, the reason is often also staff shortage.[35]

Given the dangerous nature of the work, a missing staff member on the team is, more often than not, the reason for taking conservative decisions; for example, denying a patient recreational content or leave. As can be expected, reactions to such non-illness-related reasons for curtailing a patient's freedom are often violent. They manifest not only in broken glass, cuts in the furniture, wall contusions, but also in the bruises and injuries on staff and patients' bodies. In case of a patient attack at least four staff members will try to curb the patient, a maneuver regularly experienced as stressful and dangerous by staff and as humiliating and unnecessarily aggressive by patients. No matter how many times it is repeated that such things happen only intermittently, the spatio-temporal reverberations of the attack—in trace and picture—and the somaesthetic unease they cause, testify to the contrary: that the peaceful situations are, in fact, only a quiet before the (next) storm. This not only increases levels of apprehension, malaise, and fear, it also hurts the social body and causes self-stigmatization as well as stigmatization. Both patients and staff report feeling traumatized and permanently marked, although the bruises do, of course, go away after a while. In the case of the nurses, stigmatizing attitudes include the "serves you right" type of denigration that many people who do not work in psychiatric care adopt in relation to those who get physically assaulted at work.[36] In the case of the patients, it is the contamination of the environment by unnecessarily ugly behavior, manifested in the silences, the downcast eyes, the visibly felt remorse and regret, all of which trigger further rumination, self-blame, and self-stigmatization.[37]

Being Aural

Although River House is known for its sound facilities where patients make —compose, improvise, play and produce—their own music, which they sometimes also show to a wider audience, such as on Open Days that usually take place in the summer months, cuts in resources, mostly those related to maintenance, claim their due. Being empty, the hospital corridors, through which trolleys with food, medication, cleaning products, and equipment are wheeled five times a day, have a resounding echo. Regardless of where you are, in the interview room, on the ward, in the communal areas, in the multi-faith

room, in the gym, or in a patient's room, the sound of clunky steel trolleys whose steadily deteriorating wheels, although mostly with a 360-degree swivel, regularly get stuck in corners, lifts, under stairs, is unavoidable. The sound is also painful not only because it prolongs the interminably long and far too frequent trolley diminuendo but because the interminably long, and thus irritating sound of the trolleys is, like all irritating sounds, anticipated. It is heard not only when it is actually taking place but every time a similar sound—and there are many—is heard. The nursing station is soundproofed, but since there are always many conversations going on simultaneously, accompanied by the not too intrusive but nevertheless incessant sound of the television, as well as, on occasion, screams and torrents of verbal abuse, the soundscape is dense, to say the least. From a patient's room, this is complemented by loud music coming either from the patients' private television sets, or from their headphones. Headphones are worn most of the time—even when asleep—to avoid hearing other noises, made, or likely to be made, by people patients fear, but also to drown the voices in the heads, which form part of their illness. In the case of the latter, the music is violently loud and can often be heard through walls, not only when standing next to the person in question. There are also numerous other sounds. The hospital does not use swipe cards but, instead, heavy keys, which cause injuries to staff who are obliged to lock and unlock up to 50 doors a day (Fig. 10.4).[38] Needless to say, the sound of locking and unlocking doors echoes in the empty corridors thus undermining what the open-plan design has tried to avoid, namely signifiers of incarceration. When escorted outside, patients are taken through long

Fig. 10.4 A set of ward keys, River House (2014), photographer anonymous

corridors and sometimes up to 12 doors, which weds sound to processuality and inculcates the body actionally and sensorially.

Drawing on the mind-body philosophies of Yasuo Yuasa and on the work of Maurice Merleau-Ponty, Shigenori Nagatomo calls such repeated perceptions and actions, which ultimately create affective residue and calibrate the body, "attunement." Attunement is "engagement that obtains actionally as well as epistemologically between a person and his/her living ambiance,"[39] whereby "living ambiance" refers to the "totality of shaped things, either animate or inanimate."[40] Otherwise put, attunement is the process by which "affective residue" is sedimented through the "experiential momentum"[41]—repeated engagement in particular somatic (aural, kinaesthetic and proprioceptic) structures. It impregnates the body sensorially and configures future engagement with the living ambiance. The effect of aural intrusions is therefore not merely cumulative—which it, of course, is. It creates unwanted kinaesthetic matrixes as well; for example, wincing, grimacing, and tensed shoulders, which many patients, as well as staff, exhibit at the very sight of trolleys or keys. This incessant forging of a variety of somatic-affective paths is related to what, in Nagatomo's vocabulary, are the hazy and clear horizons of consciousness. The hidden, interoceptive, recessive part of the body, which we are often entirely unaware of, is continually in the process of passing from the hazy to the clear, conscious horizon of consciousness. This movement is simultaneously the passage from "orientational directionality"—unconscious humoral events—to "intentional directionality"—clearly discerned emotions.[42] Once an affective path has, through affective residue and experiential momentum, created emotions, these emotions *inform* future actional, exteroceptive, and interoceptive structures. The ambient sound of the hospital is therefore far from innocuous, even if it is not experienced as nerve-racking at first, precisely because it operates within the hazy horizon of consciousness, which, while inaccessible to the conscious mind, configures perception and shapes future experiences.

The monotonous trailing of the malfunctioning, and, on occasion, screeching wheels, the interminably long locking and unlocking of door after door are oppressive in their regularity, to say the least. If one closes one's eyes and merely listens to the sound one finds oneself in a (sonic) labyrinth since there is hardly a moment when no sound of locking and unlocking doors is heard. When moving through the hospital, as staff do all the time, and as patients do when they go on leave, or for their numerous checkups and consultations, one's ears are assaulted by yet another series of traumatizing sounds, which forms part of the experiential momentum, and which, as both staff and patients report, have a highly irritating effect:[43] the sounds emanating from the reception area. The reception sounds vary greatly but often consist of the escorted patients returning from leave, other patients and staff waiting

between doors (no two doors may be opened at the same time), visitors chatting in the waiting area, several phones going off, and the receptionist attempting to speak over the general noise, which often translates into shouting. This is complemented by frequent alarms—triggered by perceived or actually dangerous situations, which produce a deeply disturbing, hurtful sound that causes panic and tumult in the less accustomed, and irritation in the accustomed. Despite numerous staff debates about the unnecessarily disturbing nature of these alarms, nerve-racking alarms, like hand-hurting keys, do not seem to be a priority on the hospital's list of required changes.[44]

In the various hospital meetings such concerns are overridden by more urgent concerns with staff training, risk management, and the steadily growing health-and-safety agenda. These unnecessarily aurally harsh working and living conditions have a lasting effect on the sensorimotor system; they cause an increased use of headphones in patients (which isolates them from their environment), and an irritated and exhausted attitude in staff.[45] But this is not all. Sound marks, partitions, and, in fact, creates time. The temporality produced by the ambient hospital cacophony is not only that of incarceration, but almost one of aural torture, given the regularity of the various sounds and their anticipation. The echo of the long corridors amplifies repetition and multiplies the partitioning of time. Like the Kristevan powers of horror, which thrive on unintelligibility and the in-between, on the neither-entity-nor-environment status of horrifying "objects," such as when a dark corner is revealed to be swarming with an army of cockroaches, intrusive and aggressive sound disassembles the spatial perception of the hospital. The hospital is no longer perceived as spacious, sprawling, and essentially stable, but as an overly dense, confused, and "swarming" temporal agglomerate, in which everything happens all at once. Such a temporal structure disables temporal succession, and thus also resolution, which has a mentally extremely taxing effect. As one patient put it, "if you aren't on heavy drugs the din wears you out, if you are, you're half dead anyway."[46] However, this particular aural and kinaesthetic effect, which has visibly damaging results, is, for organizationally mysterious reasons, impossible to rectify.

Being Watched

Added to the constant presence of irritating and hurtful sounds, there is constant surveillance. Apart from the ubiquitous CCTV cameras, there is also around-the-clock report writing and architectural provisions, such as the small windows on the patient rooms' doors, which any staff member can look through at any given time. There are also purposefully built obser-

Fig. 10.5 Observation Room, River House (2014), photographer anonymous

vation rooms from which the various activity rooms, such as the gym, the interview room, and the family room, can be observed (Fig. 10.5). None of these surveillance provisions are visible; yet all interpellate prescribed or desirable forms of behavior, the purpose-built observation rooms in patients, the CCTV cameras and report writing in staff and patients alike. The feeling of being constantly observed, visually, and through behavior- and performance-monitoring reports, written at least once, and often up to three times per shift, as well as relayed to several staff members, and inspected by the higher managerial echelons, is further aggravated by remote digital surveillance, which can be termed "choral emailing." This particular form of communication is a fusion of digital correspondence, informing, and seeking reassurance in numbers. It refers to the copying in of colleagues when responding to emails, such as when a member of staff responds to a colleague's query about a particular procedure by copying in the entire managerial superstructure. This is apparently done for the purposes of information sharing and saving time, although it does, of course, potentially expose the said colleague as lacking in expertise. As Alexander

Bard and Jan Söderqvist have argued in *Netocracy*, there is no such thing as "mere information"—information with no politically shaped content.[47] All information, and particularly the generous overload thereof, often sent for reasons of pluralistic ignorance—the doubt or belief that others know more and better—in order to show that we, too, are information-rich and ideologically aligned with the imperative of information sharing, is invariably political. It performs solidarity while, in actual fact, creating a chronic information overload, which, like too much choice, has a stalling, even paralyzing, rather than an accelerating effect. Instead of making it easier to access new information and knowledge, such and similar practices undermine the existing knowledge.

Although the practice of "choral emailing" is by no means specific to Bethlem, it is particularly relevant within the hospital context where mistakes can have grave consequences. As two nurses have suggested, report writing is an exercise in tactics and an instrument of institutional micropolitics.[48] It makes the hospital employees perform to a specific audience and shapes the content of their performance. As Jon McKenzie suggests in *Perform or Else*, in the twenty-first century, performance is "an emergent stratum of power and knowledge formation."[49] The performative subject has long internalized discipline, not only because of the multiple surveillance mechanisms, but also because of the ubiquitous performance imperatives. Given that the performative subject is "fragmented rather than unified, decentered rather than centered, virtual as well as actual,"[50] and that its personal, professional, medical, financial, and legal records are "produced and maintained through a variety of sociotechnical systems, overcoded by many discourses, and situated in numerous sites of practice,"[51] the subject is in constant need of *optimization*. This requires a very particular, dispersed form of sensitivity to an ever-growing multitude of requirements, further aggravated by the quantitative demand—to do more in a given unit of time, such as peruse large documents with new regulations, or write more detailed reports, with hardly any time to do it in. One of the results of the conflict between what has to be done, what can be done, and what has to be shown as having been done, is compassion fatigue. Several nurses and an occupational therapist defined compassion fatigue as a combination of exposure to trauma and frequent violent episodes, but also of work overload, time famine, and the ever-increasing amount of unnerving surveillance mechanisms.[52] These mechanisms are unnerving not because there is an *actual* lack of competence but because the practice of constantly introducing new regulations and new methods for doing old things, creates a

perceived lack of competence, which not only looks bad in the obligatory performance reviews, but also undermines interpersonal trust, a very important feature in the hospital employee's relationship to what is, without a doubt, a very dangerous work environment.

In the case of patients, the effect of 24/7 surveillance is palpably felt in the sphere of identity performance. Many patients assert competence either with respect to their age—by performing a wise and temperate older man/woman—or gender—by performing an energetic and attractive young male or female, or, indeed, profession—by performing a shrewd, well-informed accountant, if this happens to be their profession. The purpose of impersonating healthy, jovial yet calm, as well as, importantly, stereotyped individuals, is to "pass," to borrow the queer performance theorist Jose Muñoz's expression. Referring both to ethnically and sexually minoritarian subjects who impersonate a different ethnic origin or sexual orientation in order to sidestep the problems associated with the minoritarian status,[53] "passing" is, in the hospital context, an insurance against the actual and perceived perils of the manifold surveillance systems. Unsurprisingly, many patients know that getting well and being transferred to a less acute ward—for example, a ward where daily unescorted leave is granted—are not necessarily the same thing.[54] In order to "get well" and to be transferred to a ward with more personal freedom, one has to be *seen to be getting well*.

Although there is a marked difference between staff and patient surveillance, many staff feel monitored by their patients. They feel that patients are trying to get a sense of who they are, how they could be manipulated or intimidated.[55] This does not come as a surprise in such an environment; however, it means that staff, too, feel compelled to assert competence or to "pass." Occasionally, a staff member will offer a bad performance, which will not go unnoticed by patients. As a patient has remarked, "they pretend to be looking at figures" or "pretend to know which medication you are taking, and you see them looking it up later."[56] However, by far the most problematic surveillance-related incidents occur when a member of staff insists that something be done in the easiest and most conservative, or "safest" way possible. "Safe" here does not refer to personal or patient security, which, naturally, is taken very seriously, but to a real or imagined performance appraisal. It is related to how a person in a position of authority might interpret and evaluate the action in question. Such conservative, "safe" ways of doing things often contradict the individually tailored psychiatric—as well as occupational—care River House is both well known for and prides itself on. The reason for such conduct, however, is self-protection from reproach and blame, both of which are closely related to the speed with which rules, and rule makers, change in the neoliberal workplace in general, and at Bethlem in particular. It is also related to the

precarious employment situation. Many staff have had to repeatedly interview for their current position, which, needless to say, creates diffidence, fear, and worry.[57] Such surveillance-related and existentially motivated erring on the side of caution often has disturbing effects, however. A case in point is the repeated demand, by several staff members, that a particular patient's room be tidied up. The room in question, which belonged to a very young patient, who was at a stage of recovery when prolonged unescorted leave could be granted, and who attended college with the aim going to university later, was what one may call "creatively messy." However, this level of disorder, which consists of clothing garments strewn on the bed, and of a few socks on the floor, was neither a threat to order, hygiene, nor, for that matter, to his mental or physical health. Yet, the nurses, themselves under vigilant surveillance, and perhaps unsure of the latest pronouncement on the individual leeway that may be granted in such cases, sought to assert competence by imposing order through punishment, by recommending, in their reports, that the patient's leave be suspended. The patient was denied leave and could not attend college for ten days. This had a detrimental effect on his immediate education as well as on his future plans as it occurred at a very important time in the education cycle: he was excluded from applying to university for that academic year. Unsurprisingly, the patient's reaction to these draconian measures was uncurbed anger and despair. What *is* surprising, however, is that his anger and despair were not seen as a logical reaction to such a drastic curtailment with long-lasting consequences, but, rather, as a deteriorization of his condition, which set his recovery back considerably.[58] And yet, it would be wrong to assume that such a regimented approach to patients' freedom—and wellbeing—is the product of a single person's frustration, bad faith, or incompetence. Although such measures seem unnecessarily harsh, they are the product of ubiquitous surveillance, the neoliberal responsibilization of the employee, the resulting employment insecurity, and the culture of blame. The malice here is residual, processual and networked, much like the performative subject is. The fact that this inextricable enmeshed-ness of system, actor, and confusion, caused by the multiplication and acceleration of choices and decisions, by the confidence-undermining monitoring, and general precarization, is difficult to disentangle—which is also to say that it is difficult to remedy—does not exonerate it in any way. It does, however, draw attention to the smallness and the insignificance of acts that tip the balance and cause further pain to those who already hurt too much.

At this particular point in time, marked by the entrepreneurial approach to just about everything, and by the increased, if often misplaced demand for self-reliance, as well as by an unprecedented increase in mental health problems,[59] it is important to understand the cul-de-sac nature of accumulated

abjection and malice. The constant production of ugly and/or malicious deeds, words, gestures, traces, behaviors, and thoughts, is easily observed within the walls of the Bethlem Royal Hospital, not because it is particular to this site, but because of the site's enclosed nature. However, the production of cumulative abjection and malice is as ubiquitous as is the recourse to self-stigmatization. As numerous psychologists have argued, the repeated self-marking as worthless, stupid, ugly, filthy, or irremediably ill, leads to significantly decreased sensitivity to others, to a diminished recognition of individual differences, and, often, to outright aggression.[60] Given that the coping strategies are barely coping strategies at all—they consist of rumination (the tendency to passively and repetitively focus on one's symptoms of distress and the circumstances surrounding these symptoms) and of hypervigilance (which prolongs and exacerbates psychological distress, inhibits emotionally expressive behaviors, and has numerous side effects, memory impairment among them)[61]—it is clear that self-stigmatization has lasting *social effects*. It cannot be contained by a single person, or, for that matter, by the institutional infrastructure. Rather, like its causes—the inadvertently produced abjectness and malice, which, in turn, produce the ugliness of moral and physical failure—self-stigmatization taints (shared) affective experiences. It also brings into view the mutual *vulnerability* of the environment, action, actants, and rules of engagement, all of which act micro-politically, through sheer performativity. To institute means to inaugurate by decree or founding gesture. However, it also means to adopt and incorporate, through daily praxis and repetition, even if this praxis operates in the individual's—as well as the group's— hazy consciousness. It therefore appears necessary *not* to look for specific solutions to specific problems—as the neoliberal managerial mantra would have it—not even to define the diffuse and the indefinable, but, instead, to learn to grapple with the ever-growing multiplicity of nebulae at a pre-cognitive level. It is also necessary to develop a sensitivity to infinitesimally small changes in the interoceptive region of hazy consciousness, as it is in this region that the most unstoppably corrosive processes take place.

Notes

1. Julia Kristeva, *Powers of Horror: An Essay on Abjection*. Trans. Leon S. Roudiez (New York: Columbia University Press, 1982).
2. Gilles Deleuze and Félix Guattari, *Anti-Oedipus: Capitalism and Schizophrenia*. Trans. By Robert Hurley et al. (London: Bloomsbury Academic, 2013).

3. Kristeva, *Powers of Horror*, 3–4.
4. Mary Midgley, *Wickedness* (London, Boston & Melbourne: Routledge & Kegan Paul, 1984), 62.
5. Ibid., 7.
6. Yve-Alain Bois and Rosalind Kraus, *Formless: A User's Guide* (New York: Zone Books, 1997), 14.
7. I use the word "patient" in its Latin meaning, to signify suffering and endurance, not passivity. Although the neoliberal "service user" can be seen as less stigmatizing, the disadvantage of this expression is that it implicitly places the responsibility for recovery largely (although not solely) with the patient.
8. This research forms part of the HASS-funded project "Spaces of the Mind" undertaken in collaboration with social psychologists and medical geographers from the University of Exeter. The onsite observation was conducted over a period of six months, including all days of the week and all times of day and night, in sessions ranging from half a day to three days in a row. Apart from observing communal spaces, such as the ward living room/dining room, the gym, the church, the multi-faith room, the hospital grounds, I conducted numerous interviews and informal conversations with staff and patients. All the participants' and interviewees' responses have been anonymized in compliance with the NHS ethical stipulations. Members of staff are identified by their job title only.
9. Isabell Lorey, *State of Insecurity: Government of the Precarious (Futures)* (London: Verso Books, 2015), 1.
10. Ulrich Beck, *Risk Society: Towards a New Modernity* (New York: Sage Publications, 1992), 21.
11. Ibid., 183.
12. Liz Sayce, "Stigma: Discrimination and Social Exclusion: What's in a word?" *Journal of Mental Health*, 7 (2008): 341.
13. Claire Bishop, Antagonism and Relational Aesthetics. *October* 110 (2004): 51–79.
14. Nicolas Bourriad, *Relational Aesthetics* (Paris: Les presses du reel, 1998), 113.
15. Ibid., 45–6.
16. Jean-Luc Nancy, *The Inoperative Community*. Trans. Peter Connor, Lisa Garbus, Michael Holland, and Simona Sawhney (Minneapolis: University of Minnesota Press, 1991), 22.
17. Natasha Lushetich, Interview with Patient B, Bethlem Royal Hospital, London, 8 May 2014; Interview with Patient H, Bethlem Royal Hospital, London, 19, June 2014. Author's Private Archive.
18. Victor Turner, *From Ritual to Theatre: The Human Seriousness at Play* (New York: PAJ Publications, 1982), 24.
19. Ibid., 27.

20. Natasha Lushetich, Interview with Patient G, Bethlem Royal Hospital, London, 3 June 2014. Author's Private Archive.
21. Eskil Ekstedt, A New Division of Labour: The Projectification of Working and Industrial Life. In *Building Anticipation of restructuring in Europe*, ed. Marie-Ange Moreau, Serafino Negrelli and Philippe Pochet (Bruxelles: Peter Lang 2009).
22. Paul Rozin, Jonathan Haidt and Clark McCauley, Disgust. In *Handbook of Emotions*, ed. Michael Lewis and Jeanette Haviland-Jones (New York: Guildford Press, 2000), 637–653.
23. Allan M. Brandt and Paul Rozin, *Morality and Health* (New York: Routledge, 1997), 73.
24. Natasha Lushetich, Interview with Patient B, np; Interview with Patient G, np; Interview with Patient H, np; Author's Private Archive.
25. Natasha Lushetich, Interview with Head of Security, Bethlem Royal Hospital, London, 6 May 2014, np. Author's private Archive.
26. Natasha Lushetich, Interview with Nurse D, Bethlem Royal Hospital, London, 7 May 2014, np. Author's Private Archive.
27. *Wickedness*, 63.
28. Natasha Lushetich, Interview with Occupational Therapist C, Bethlem Royal Hospital, London, 23 May 2014, np. Author's Private Archive.
29. Natasha Lushetich, Interview with Nurse J, Bethlem Royal Hospital, London, 7 May 2014, np. Author's Private Archive.
30. Natasha Lushetich, Interview with Occupational Therapy Technician, Bethlem Royal Hospital, London, 8 July 2014, np. Author's Private Archive.
31. Natasha Lushetich, Interview with Nurse J, np; Interview with Occupational Therapist C, np; Interview with Occupational Therapy Technician, np. Author's Private Archive.
32. Natasha Lushetich, Interview with Nurse D, np. Author's Private Archive.
33. Natasha Lushetich, Interview with Patient G, np. Author's Private Archive.
34. Natasha Lushetich, Interview with Clinical Psychologist A, Bethlem Royal Hospital, London, 22 May 2014, np. Author' private Archive.
35. Interview with Occupational Therapist C, np.
36. Interview with Nurse J, np.
37. Interview with Patient H, np.
38. Interview with Occupational Therapist C, np; Interview with Occupational Therapy Technician.
39. Shigenori Nagatomo, *Attunement Through the Body* (Albany: State University New York Press, 1992), 179.
40. Ibid.
41. Ibid., 198.
42. Ibid., 29.
43. Interview with Patient H; Interview with Nurse D, np.
44. Interview with Nurse D; Interview with Occupational Therapy Technician, np.

45. Interview with Nurse D, np.
46. Interview with Patient B, np.
47. Alexander Bard, and Jan Söderqvist, *Netocracy* (Harlow: Pearson Education Ltd., 2002), 75.
48. Interview with Nurse D; Interview with Nurse J, np.
49. Jon McKenzie, *Perform or Else: From Discipline to Performance* (London and New York: Routledge, 2001), 18.
50. Ibid.
51. Ibid., 19.
52. Interview with Nurse D, Interview with Nurse J; Interview with Occupational Therapist C, np.
53. José Esteban Muñoz, *Disidentifications: Queers of Color and the Performance of Politics* (Minneapolis: University of Minnesota Press, 1999), 3–7.
54. Interview with Patient B; Interview with Patient H; np.
55. Interview with Nurse D, np.
56. Interview with Patient G, np.
57. Interview with Occupational Therapy Technician, np.
58. Interview with Occupational Therapist C, np.
59. Alai Ehrenberg, *The Weariness of the Self: Diagnosing the Contemporary Age* (Montreal and Kingston: McGill-Queen's University Press, 2009); Han Byung-Chul, *The Burnout Society* (Stanford: Stanford University Press, 2015).
60. Bruce G. Link, Elmer L. Struening, Sheree Neese-todd, Sara Asmussen and Jo C. Phelan, "On Describing and Seeking to Change the Experience of Stigma," *Psychiatric Rehabilitation Skills* 6 (2001): 201–231; Bruce G. Link, Elmer L. Struening, Sheree Neese-todd, Sara Asmussen, and Jo C. Phelan, "The Consequences of Stigma for the Self-Esteem of People with Mental Illnesses," *Psychiatric Services* 52 (2001): 1621–1626; Susan Noelen-Hoeksema and Jannay Morrow, "Effects of Rumination and Distraction on Naturally Occurring Depressed Mood," *Cognition and Emotion* 7 (1993): 561–570.
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