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FOUCAULT AND GOFFMAN. THE SHADOW AND THE MATTER OF DISCIPLINE IN THE UNIVERSE OF A PSYCHIATRIC INSTITUTION

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ABSTRACT. This paper focuses on the mechanisms of power and discipline that exist within a psychiatric institution in Transylvania, Romania. This is done through combining the theoretical perspectives of Michel Foucault and of Erving Goffman. While Foucault looks at power as the result of internalization through disciplinary mechanisms and discourses, Goffman puts emphasis on the micro-interactions and spatial arrangement that shape the institution. By bringing these two lines of thought together, this study tries to construct an analytical tool that reveals how surveillance, normalization and hierarchization operate concomitantly at structural and interpersonal levels. Using qualitative methods, more precisely participant observation, formal and informal interviews, the research explores patients' daily lives, the dynamics between individuals (be it staff or patient), the regulation of space and the interdependence of written and unwritten rules. It is suggested that institutional power is exercised not only through correction or direct surveillance but also through strategies and those strategies are built around visibility, divestment of space, documentation and collective self-monitoring. This, in turn, generates docile but truncated forms of subjectivity. The study also highlights the continuous existence of disciplinary strategies despite there being ongoing processes of deinstitutionalization, therefore showing how this psychiatric institution creates regulated, individualized and hierarchized existences.

Keywords: Foucault, Goffman, power, discipline, psychiatric institution, ethnography, surveillance, normalization.

Introduction

This paper will present the dynamics that exist in a psychiatric institution from Romania, Transylvania, trying thus to answer the question: *"How is power exercised in a psychiatric institution and what effects does it produce on the patients?"*

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To approach this matter, two lines of thought have been chosen, more precisely Goffman's and Foucault's. Although they are often presented as being divergent, the common points, the point that converge offer us two ways of looking at the lives of the patients, docile, institutionalized individuals. In this paper, their perspectives will be combined, their points of contact presented as complementary to one another. Rather than choosing or 'testing' which theoretical approach is stronger, they are brought together as to form an analytical tool capable of sectioning and exposing the dynamics all with the purpose of unveiling the mechanisms of power. If Foucault views power as the result of internalization, of disciplining through institutional mechanisms and normative discourses, Goffman looks at it through the lens of interactionism, emphasizing the concrete experiences that take place inside the institution, spatial arrangements, relations and the divestment of space. Brought together they offer a complete theoretical approach that doesn't sacrifice individual micro-interactions in favor of institutional mechanisms and vice-versa. The main argument of the paper is that power within a psychiatric institution is not exercised solely through coercion or surveillance. Rather, it is a multivalent and subtle combination of visibility, hierarchization, and the regulation of behavior through norms that, on the surface, present themselves as benevolent.

This is a qualitative research, grounded in participatory observation and having the support of both formal and informal interviews. The focus is placed upon the day-to-day lives of patients, including both their activities (workshops and labor) as well as their leisure time, all of this without overlooking the dynamics between the individuals. The perspective of the staff is also addressed, one that mirrors that of the patients, since the mechanisms of power extend to both sides of the institution. By employing the methodological triangulation, the study tries capturing the smallest details of the lives inside the institution, details that reveal the ways in which existences are organized, truncated, and brought into contact with one another. The interviews had the role of contextualizing the observation, but also of offering the researcher details otherwise invisible to the eye. In this way, situations that could have been explored only from a singular perspective were unveiled to reveal multiple facets, a multiplicity brought forth by the interpretations of subjects positioned differently within power relations. If at the beginning of the research the dimensions appeared concrete and lacking in depth, they diversified slowly, one by one, and thus brought to the surface complex processes of power exercise; processes that were accompanied by interpretations and discourses that seemed fragmented yet were in fact inscribed within broader institutional mechanisms. The research brought to light a unique

ecosystem, whose logic is basing itself just as much on written rules as it does on the unwritten ones. The latter undermine the former and these, together with the exceptions, have the role to reinforce hierarchies, individualization, and the weakening of social cohesion.

The choice of topic was based on a continuous curiosity regarding the functioning mechanisms of total institutions in Romania, while the selection of the institution itself was based on the openness provided through close relationships with some of its former employees. These aspects created favorable conditions for gaining access to the institution and initiating this study. The aim of this paper is, in fact, the construction of a theoretical framework, framework that is better equipped to understand the changes that come with systemic attempts at deinstitutionalization, attempts that are also making their presence felt in the country. Such studies are scarce in Romania, which creates a timely research context, while also leaving gaps that call to be filled.

Anthropological studies of this kind can shed light on the communities that form in such closed institutions and can bring forth a national contextualization regarding the functioning of medical systems together with a critical view of these. The creation of multidisciplinary documents addressing total institutions has the capacity to bring visibility to communities that otherwise remain submerged in invisibility. The importance of the ethnographic studies is all the more pressing given the fact that the public debate on mental health in Romania remains limited.

Goffman and Foucault

This paper will focus on the exercise of power, how does this take place and, perhaps most importantly, how it gives rise to discipline within a psychiatric institution in Romania. To shed light on the subject, two lines of thought were chosen: the Foucauldian perspective, which suggests that individuals self-regulate, they absorb the power and reproduce it, thus internalizing it; and the other, the Goffmanian perspective, according to which subjugated individuals are the result of being pushed into docility through deprivation, through systemic denial of access to the tools necessary for resistance (Leib, 2017). This paper argues that the two processes are not mutually exclusive but must be understood in a dialectical relationship, relationship in which the terms reinforce each other because of the multiple points they share in the arsenal aimed at enclosing the individual. The internalization of power will never reach perfection due to a set of countermoves, bubbles of resistance; for this reason, it must be doubled by a truncation of the self's possibilities of saving face. In this way, surveillance denies access to private spaces. There are no back regions, no backstage, and the self

is subjected to attacks from multiple fronts. As such, the analysis will be based on the relation between external and internal, more precisely, the way in which the external structures form and reinforce the psychological dynamic and vice-versa, the psychological states reinforce the external structures. The separation of the two is misleading, they are interdependent.

Microphysics and power as normalization

Ian Hacking (2004) talks about Foucault's work as being top-down, encompassing entire systems of thought, and Goffman's as bottom-up, focusing on individuals and specific locations. Nevertheless, both share common themes. Both study and critique psychiatric institutions while offering different perspectives on them. These perspectives are complementary, the Foucauldian concepts that critically address institutional power relations resonate with Goffman's analyses of the classification and interaction of individuals (Leib, 2022). Goffman's collection of essays *Asylums* provides us with a microsociology of total institutions centered on the everyday interactions, it shows us how the delimiting character of these institutions arises, a character that is symbolized by the breakdown of social spheres accessible to the individual, the prohibition of social interactions with the world beyond the institution, and the renunciation of it (Goffman, 2004). Nevertheless, Goffman doesn't question the issue of how these institutions appear, nor does he question the introduction of these in the normalcy of the society, thus becoming an element that semes more or less necessary for an optimal functioning of the world.

Foucault's macrosocial perspective fills in the gaps, it offers us a way of understanding the conditions of possibility of knowledge, of language, and the passage through successive institutional forms. His genealogies piece together the fragments and bring to the surface the ways in which the historical framework forms the individuals, shaping potentialities; and yet, he doesn't touch upon the ways in which these take place in the day-to-day life (Hacking, 2004). Combining these two authors, we can generate an analytical tool whose purpose is bringing together everyday interactions with the bigger structures of power, the institutional ones. As such, the microphysics of power is the meeting point between the two thinkers. Both construct a framework with which it is possible not only to identify, but also to observe and record the exercise of power as the hegemony of normalization (Burns, 1992). When Foucault talks about this concept, he refers to the way in which power functions at the lowest levels of social relations, where it takes, among other forms, the shape of normalizing power. Its validity is situated somewhere in the space between the grand mechanisms (in this

case, the institution) and the bodies themselves. Seen as such, it stops being a property, rather it becomes a strategy, a set of sites, tactics and mechanism (Foucault, 2005). Micro-physics, in fact, renders intelligible the multiple facets of power, but it does so in terms of the various spaces that the institution can attack and the body seeks to defend. We cannot reach a state of immobility, rather, it is a continuous flow of moves and countermoves. The intended outcome is the transformation of the individual in a calculable and regulated subject, brought into visibility. This visibility follows two paths, a non-discursive one, that of surveillance, and a discursive one, that of documentation. Documentation renders the invisible aspects of the individual visible. The individual loses anonymity becoming a case, being fixed in place (Leib, 2017).

Power defined in term of normalization is the main concept that ties the two thinkers together. For Goffman, according to Hancock and Garner (2011), this would take form in the ways individuals are coerced to conform with social norms and to adopt those competencies that are suitable for interacting with other individuals; as to uphold the social order. Such an interpretation pushes towards a perspective of the world rests upon the normative order, order that can be undermined, respected, transgressed etc. Another important point is the guidance that is provided by the frames. When we talk about frames, we refer to mental schemas or interpretive structures that enable the individual to understand situations and to make sense of the world. A frame can be seen as an o principle of organization of events, but also as a condition of possibility for the individual's participation in them (Goffman, 1986). As such, the individual's life is guided by frames, and assuming the idea of the character leads to direct regulation of one's behavior. The individuals with which we interact, having their own frames, impose indirect forms of control. We are not free to frame our experiences, they are constructions of the social collective., as such they have a productive role (they allow the world to be easily understood) and a repressive one (they constrain, define, form and determine social interactions and meaning) (Garner & Hancock, 2011).

Moves and countermoves

The normative order is for Goffman, and Foucault as well, subjugation, social control, but there also is resistance, every one of the elements are caught in a continuous flow; where there is power, there is resistance (Garner & Hancock, 2011). Power as normalization refers to the fact that it doesn't need to forbid behaviors, it just defines, and it defines what is normal, thus creating norms.

Having done this, it classifies, measures and, maybe most importantly for this study, it diagnoses and corrects deviation from the norm. The norm becomes a criterion for comparison, an omnipresent one, and one through which every behavior is assessed, and it does all of this through social, medical and educational apparatuses. In the end, the abnormal individual is not excluded, but rather it is formed as a subject that needs correcting, reintegrating, keeping under control; being normal becomes an obligation (Foucault, 2002). It is an extension of the disciplinary power, based on techniques of control, surveillance, normalization and correction. The sought after result is the formation of useful and docile bodies. The general principle for exercising power over the body and coordinating it in relation to the other bodies is the possibility of permanent visibility. Thereby a double movement of power is born on one side, it constrains, on the other, it individualizes (Power, 2011) and although a perfect system is desired, it can never be reached. The movements of power are coupled with counter-movements of individuals and the networks between them. Therefore, the mechanisms of normalization need to stay fluid, to grow, to change, to have a continuous flow as to avoid bifurcation points through adaptation.

Consequently, the disciplinary power does not suppress individuals but creates them, thus becoming a technology that acts upon the smallest units. Examination, together with visibility, assures the smooth exercise of power, examination constructs the individual as a case, an object that can be described, measured, analyzed and compared; the permanent visibility assures the automatic functioning od power (Foucault, 2005). Goffman, as well as Foucault, engage in an interior/exterior type of game, but if the emphasis is put on the social frames for the former, for the latter it falls on the institutional mechanisms. Power (2011) illustrates the differences between the two without diminishing their complementarity, noting that Goffman produces an account of the asylum while simultaneously producing a method that interacts with the asylum as an object, whereas the Foucauldian object is broader, an entire apparatus or dispositive of laws, architecture, administrative practices, and discourses. The latter can be brought to light through archeological inquiry.

Internalization and the divestment of space

The panoptic architecture emerges as the spatialization of disciplinary power and can be understood as a form of spatial organization that produces power through visibility and continuous surveillance. The architecture stops being an apolitical or neutral aspect, instead becoming one of the main channels

through which power is exercised. The continuous visibility brings with it self-control, thus the individual internalizes power, and it projects it further. A double movement takes shape, while patients are individualized through observation, power itself becomes de-individualized, its principle no longer embodied in a figure or a person, but in the distribution of space, the distribution of bodies, gazes and surfaces. Foucault also argues that being caught in such a field of visibility, a conscious capture, brings with it the internalization of the constraints imposed by the power, making them operate spontaneously upon the individual and, at the same time, becoming the principle of one's own subjugation (Foucault, 2005). This paper argues, however, that this is just a part of the process working inside the institution. The second part is the divestment of space, space that is necessary for managing and defining the self. Goffman, according to Leib (2017), presents the self as being a result of two processes: the negotiation of the various social toles that the individual must perform and the individual interacting with meaningful objects present in the surrounding environment. In society, the individuals try not to confuse their roles or to avoid the unplanned encounter between two different roles, as this becomes a source of anxiety. If such transgressions do take place, the individual can always retreat in the back region to regroup. The back region bestows upon the individual invisibility, there are actions which take place only in the back region, actions that are entirely private. If the front region is constructed for interaction, the back one, the backstage, are a space for relaxation.

The division of spaces becomes thus necessary for managing the roles. For the individual to perceive themselves as being in control, both regions are necessary, whereas panoptic institutions deny this division. The territory, as well as the space are visible, the invasion of these spaces places the person in a situation where regrouping is impossible (Leib 2017). A total institution is characterized primarily by the dismantling of the boundaries that separate the three spheres of individual life: sleeping, leisure and working; all these take place in the same space. Every action occurs in the presence of a great number of individuals, following a strict schedule. From this arises the inevitable appearance of various phenomena, such as that of contamination (Goffman, 2004). Although Leib argues that the exercise of power in such institutions takes the form proposed by Goffman rather than that advanced by Foucault, this paper does not endorse that position, but at the same time, it does not support the idea of the spontaneous internalization of constraints imposed by power either. Rather, the two perspectives are placed in a dialectical relationship, each depending on the other in securing subjugation.

The loop and the panoptic surveillance

A key concept is that of the loop. Goffman outlines a circularity regarding the interactions between individuals in a psychiatric institution. Behaviors are "set free" only to become the subject of psychiatric analysis by the staff. The spheres of existence open their borders to one another and merge in an institutional one, the outcomes of such a metamorphosis are, on one hand, actions in one setting cast their shadow over those in other settings, thus homogenizing behavior (Goffman, 2004), and on the other hand, they allow for the surveillance of all spheres of existence. This concept is further linked with that of panopticism, both processes involve a certain type of surveillance, one that touches upon multiple layers. Responses to monitoring themselves become the target for further evaluation, thus resulting in self-monitoring (Garner & Hancock, 2011). Therefore, subjugation takes shape on the basis of a fictive relationship, a relationship in which the individual's dissociation between seeing and being seen is ever present (Foucault, 2005). Patients are grouped into blocks, so as to facilitate permanent observation. The employees are agents of this process, employees whose activity is not guidance or inspection, but surveillance. In a crowd of institutionalized subjects (what Foucault calls *docile bodies*), the lack of submission will stand out (Goffman, 2004). The loop represents micro-spatial, face-to-face regulation, whereas the institutional architecture denotes a panoptic spatiality.

One of the problems encountered during field observation is that Goffman, being situated in a specific historical context, tends to lose some of the force of his examples and, implicitly, of his theory as time passes and macro-social changes unfold across different sectors. As such, starting in the 1950s, a concentrated, conscious and complex effort toward deinstitutionalization can be observed. The article by Chow and Priebe shows concretely that deinstitutionalization efforts have, over the years, moved in an increasing number of directions. The focus of the different movements differs from one decade to the other, from one country to another, and many of these enter into direct dialogue with Goffman's work (Chow & Prebe, 2013). The conclusion is that we must make conceptual leaps in order to explain the phenomena of a contemporary institution in Romania. Although such efforts are considerably smaller in the country, they do exist; the institution studied is profoundly different from the one portrayed in *Asylums*. The spaces of the self are no longer invaded, rather they are set free, even encouraged, being an important part of the path to recovery. We get to a stage of deinstitutionalization that is not particularly advanced, yet in manages to alter the internal dynamic of the institution. What in Goffman's work was a central concept, the loop, but one that functioned in complement to other processes of ensuring the submission of the institutionalized, now becomes the primary

phenomenon, with the others taking on a secondary, though not disappearing, role. The institutionalized are given tools with which to preserve and construct their sense of self, but these tools belong to the institution and are organized in such a way that they remain open to surveillance. Thus, every behavior, whether negative or positive, is recorded and subjected to value judgements, which in turn enter into the evaluation of the patient's condition, whether improvement or deterioration. What, at first sight, could be considered greater liberty, on closer inspection it becomes a tool for surveillance. Self-monitoring emerges here as a defensive response and is therefore internalized, its purpose being the achievement of a positive evaluation. Thus, what seems to be free behavior is free to the extent that it had already been carefully tailored to display a certain appearance, a certain measure, and a certain intensity. The self's spaces are no longer overtly invaded or prohibited, but rather carefully shaped so as to fit the institutional narrative.

A short methodological break

This study combines qualitative methods in order to explore the dynamics within a psychiatric institution and to reveal the mechanism through which power is exercised. The methods employed are the formal interview, the informal one and participant observation. The choice of the methodological triangulation was made with the purpose of consolidating the gathered data, given that these methods are complementary and, taken together, enrich both the volume and the depth of the data. The benefits of triangulation revolve around the deeper understanding of the context, of the behavior and the sense of the actions, as well as an increase in credibility and robustness of the results (Flick, 2024). Moreover, they offer a more comprehensive understanding of complex phenomena and helps with avoiding the bias specific to a single method (Patton, 2014).

When referring to formal interviews, I mean a planned and structured face-to-face meeting between the interviewee and the interviewer, with the purpose of obtaining a specific set of information through a dialogue led by an interview guide (Roulston, 2024). This method was used both within the institution and outside of it, with the interviews being semi-structured. They were divided in two categories: the ones with former employees and the ones with female patients from the institution. The interview guide for the first category covered several dimensions: relationships (with indicators such as employee-employee, employee-patient, patient-patient), physical abuse (beatings, degrading actions, imprisonment), psychological abuse (insults, deprivation of goods/theft, neglect and hierarchies) and sexual abuse (rape, forced abortion, sterilization,

sexual harassment). These interviews were conducted months before the observation period, and their purpose was an exploratory one. For the second category, the interviews focused primarily on the life trajectory in the institution as well as outside of it. The interview guide was split into 4 dimensions: genesis (childhood, adulthood, entry into the institution), conditions (material conditions within the institution, financial conditions, level of satisfaction with these), relationships (patient-patient, patient-employee, patient-individuals outside the institution), and activities (sports, ergotherapeutic activities, leisure).

In the field, several informal interviews were conducted. By informal interview I refer to conversational meetings used for gathering information without relying on the rigid structure of a list of preselected questions. The benefits of these are their flexibility and capability of bringing new themes to the surface based on each interaction (Roulston, 2024). As such the benefits are the maximization of flexibility and spontaneity, adapting to each individual that was interviewed or field situation, and allowing new lines of questioning directly linked to the context and thus diversifying the data (Patton, 2014). The informal interviews were an absolute necessity during fieldwork, taking place with both staff and patients. They proved to be a tool with a greater ability to collect data than formal interviews.

The participant observation was the main tool for gathering data, understood here as immersion in the studied situation, with the purpose of describing and participating simultaneously all in order to produce empirical material grounded in lived experiences. This qualitative method is central to ethnographic research (Bratich, 2024). The advantage of this tool lies in the easier understanding of the emic perspective without losing the ethical awareness; it offers deeper contextualization, uncovers unwritten rules and brings forth data that other methods could overlook (Patton, 2014). During field work I focused on the following dimensions: spatiality, relationships, rules and activities. With regard to spatiality, particular attention was given to the structure of the rooms, the visibility of the spaces (both from outside the room and in terms of their openness), the distribution of bodies, as much that of the patients as that of the staff, private spaces, referring again to both categories of people, but also the semi-private spaces. In terms of relationships, the indicators included the dynamics between the patients, those between the staff and the patients and those among staff members. Regarding rules, the indicators were the written rules, the unwritten ones, the transgression of these and the punishments that follow. The activities were divided into three, just like the ones in the interviews, namely sports activities, ergotherapeutic activities, and leisure.

The institution is located in Transylvania and was selected due to personal connections with former employees, which provided a certain degree of openness. Its geographical location also facilitated the research by granting me a higher

level of access than initially expected. One problem encountered during the research was a linguistic blockage. Because of its location, many from the staff speak Hungarian, as such, some of the dialogues were incomprehensible. This issue also extended, though to a lesser extent, to conversations between patients or between patients and staff. Another limitation was the psychological strain I personally experienced, as the atmosphere was often tense and, at times, unwelcoming. The size of the institution also represented a disadvantage, as the timeframe allocated for conducting the research did not allow me to spend extended periods of time within a single ward. Consequently, not every part or aspect of the institution could be investigated, which required omitting certain areas. Most of the participation therefore took place in the upper section of the institution, where wards A, B, C, D and E are located, as well as the medical office and administrative offices. The lower section, the section which includes the ward for elderly women, the pottery workshop, the canteen and the library, although it was visited, it was never systematically studied. Even in the upper section there were limitations, namely the medical office and the administrative offices remained inaccessible to me.

The choice of spending more time in the wards with the patients can be considered a positive one, as spending extended periods in the offices or the medical room could have led to resentment. Following the same reasoning, I also chose to avoid visiting the institution during the weekends. I was informed within the institution that at the end of the week there are no activities so there is nothing for me to observe, and, form former employees outside the institution, I learned that nurses are absent on Saturdays and Sundays, leaving only the orderlies, whose behavior is "more relaxed", a state of being that could have been inhibited by my presence. Also worth mentioning is the staff's reluctance to cooperate with me, reluctance that gradually diminished as I became familiar with their routines and behavior. Nevertheless, the presence of the researcher in the facility was rarely overlooked. The staff never ceased to feel observed, consequently, such questions as "What do you think?", "Is this okay?", or "Does this interest you?" were omnipresent. A final limitation, and perhaps the most significant, was the complete refusal of the staff to participate in formal interviews. This refusal was observed among some of the patients as well, particularly those with higher analytical capacity. Informal interviews did take place, with the staff being open to answering various questions or sharing stories about the patients or the institution, but these remained strictly conversational. Many of these limitations could have been overcome had the time spent in the institutions extended over a considerably longer period, however, the relatively short timeframe made certain barriers impossible to surmount.

The Institution

Spatiality

The buildings have a welcoming appearance, painted yellow, with benches, chair and tables outside in the sun, as well as in shaded places. The first two wards, A and B, are connected, forming a single building with doors linking the sections. Attached to these, on either side, are the offices and the medical room. Although one can move between sections through the interior, during summer the passage is usually made through the courtyard. The other wards, C, D and E are separate buildings. Wards A and B are considered good sections, although on a hierarchical scale, the girls in Ward B are regarded as more intelligent. Ward C is the "smart ward" and is situated at a greater distance from the others. The distance grants them a degree of isolation from the others, but since they do not have workshops within their own building, they participate in those located in Wards A and B. Ward d is known as the ward of "bad girls", those whose disabilities are more severe. Although they also lack workshops in their building, they do not travel to A or B; instead, they have their own occupational therapist and, aside from sports activities, they do not usually leave the ward. There are a few cases of girls who walk around, but most are kept inside. Wards E is the boys' ward, the only one of its kind, and it is located at a considerable distance from the others. The closest ward to it is D. With the exception of a few individuals, no one leaves the perimeter of the ward. They do not have workshops and there is a single individual who attends the pottery workshop and a few others who assist the staff with various tasks. The rest remain within the ward.

Each ward is different to some extent, the only ones resembling each other being Wards A and B. Here, the hallways are straight, and at their ends one can find the workshops, the canteen, doors leading to other sections, or doors leading outside. Each hallway is lined with doors signaling the dormitories, and each dormitory contains three beds. The dormitory doors have windows through which the inside is visible. The rooms are open, facilitating visibility, in some of them there are televisions, but in most the only pieces of furniture are the patients' wardrobes. Each room has its own bathroom. The workshops consist of a single room with tables at which one can work. The canteen is a spacious room, and it is filled with tables and chairs. The room where the dishes are washed and where the orderlies eat is separate from the one where the patients eat. In Ward A, contact between the canteen and the kitchen is made through a window with a counter. From there, food, water, or coffee is handed out. The patients' dishes are washed in one sink, while the staff's dishes are washed in the other. From the kitchen, there is another room branching off, furnished with

a table and chairs for the staff. This is where the staff eat, away from the patients' gaze. The windows of this room are covered with curtains that allow visibility toward the patients, but do not do the same the other way around. In Ward B, contact between the canteen and the kitchen is made through a door, giving the patients easier access to this space, but here too a clear segregation is evident between the facilities for the patients and those for the staff.

Ward C has no hallways and includes an upper floor. On the ground floor, there is a single dormitory reserved for women with mobility issues. The ground floor is open: on one side, there are wo tables with multiple chairs and a refrigerator for the patients' personal food, while on the other side there are couches with a television nearby. The kitchen is adjacent to the open space, and its entrance signals the beginning of the staff's territory. There is a single sink where all dishes are washed, though different sponges are used. Upstairs are the dormitories, each housing the same number of patients as in the previous wards.

Ward D has only one floor and is considered the "rejects' ward". There is a common room with tables, but since it was summer, most of the patients stayed outside. In this room, meals are served, and activities are carried out. There is an occupational therapist assigned here, but unlike in the other wards, male staff are also present. Outside, there is a gazebo with mattresses, tables, and benches, which serves as the main space where most of the time is spent. The staff area is small, consisting of a room with a table and a few chairs. It connects to the rest of the common room through a door, but patients are prohibited from entering.

Ward E, the men's ward, combines two spaces, an upper and a lower floor. On each floor, there is a common room where patients gather. The rooms are furnished with tables, chairs and a couch. There is also an outdoor space with a gazebo, though no activity was observed there. Patients have various activities, considerably fewer than in the other wards, and each common room has a Television. A significantly larger number of men work here.

The distribution of bodies is organized in such a way as to maximize visibility, and the architecture of each ward facilitates easy supervision. Where the architecture does not promote supervision, the organization of the patients compensates for it. Ward E is the best example of this aspect. The dormitories have no windows on the doors, so the patients are taken outside every morning and the doors are locked. The reason given by a nurse was that they "ruin the beds". There is also a separation between the two floors, the upper floor is kept locked and the patients there do not come down, except for a few cases. Ward D follows the same reasoning, once the female patients are taken outside of the rooms, the doors are locked. Grouping the bodies in masses that can be seen

from every angle (the rooms or the gazebo are open spaces, and the staff, numbering two or three individuals, is always present) ensures visibility. Any body that tries to move aways from the others is asked about their intention and, usually, is brought right back. In Ward C patients do not have the same restrictions, but they are still offered open spaces in which they are visible. In Wards A and B, any absence from a workshop is noticed, the women are divided into two groups, and each occupational therapist knows her patients. In the case of an absence, other patients are sent to bring the missing one to the workshops. The conclusion of these phenomena is the precise knowledge of everyone's location. Each individual has an exact position, at an exact time, where she must be, and any anomaly from this order is detected, even if it is not always resolved. Although what we have at first glance might be called a mass of people, they are in fact individualized, separated, yet together.

Another important aspect regarding spatiality is the private and semi-private spaces. When talking about such spaces, the reference in not limited to the physical spaces, rather we mean the entire range of entities over which individuals appear to exercise control. The distinction is made based on patients' access to these spaces: where patients have broader access or slightly restricted access, I will refer to them as semi-private spaces (patients' bathrooms, storage rooms, nurses' rooms); in the spaces that belong to the patients, those which each individual demarcates for themselves and to which they deny access to other, I refer to these as private spaces (the bed, the locker and the body). An important note here is that such private spaces are private only in relation to other patients. Staff always retain access to their lockers, just as they do to their beds and bodies. These are constantly evaluated and are directly linked to the patient's behavior; thus, an unmade bed is interpreted as a lack of interest or insolence, it is the same with a disordered locker. The bodies are carefully evaluated and reevaluated with the purpose of revealing the trajectory toward recovery.

The girls and the boys are given their own clothes, they have their own lockers, they have access to their personal care kits. An entire sphere is thus created in which they can fashion themselves, a sphere over which, at least in appearance, they exercise control. Patients are no longer shaved bald, in fact, haircuts are now permitted. Liliana, a patient from Ward D, the ward considered the most problematic among those for women, constantly dyes her hair. During the weeks I spent there, her hair color changed three or four times. Her friend and fellow ward-mate, Mira, went through similar changes. In addition to Liliana, she has longer hair, which allows her to adorn herself with different kinds of braids. Assisted by other patients or by staff members, she creates her own image in impressive and intricate ways. Both girls, and they are by no means the only ones, receive clothing not only from the institution but also from

outside sources, through various channels of social aid. The styles they adopt are, more often than not, different from the norms of the outside society, perhaps even unusual, yet they are unique and aligned with the patients' own desires. They are complimented for the way they dress but also admonished. A striking contrast emerges when compared to the wards where patients once had their heads shaved, wore identical clothes, and had their identities erased, with no access to reclaiming them. Nevertheless, they are subjected to the looping effect more intensely than the other girls. On my very first day, at the human resources office, Mira appeared together with another patient. She began speaking with a staff member, entering the office and bringing up an issue concerning temporarily leaving the institution. The staff member, quickly brushing aside Mira's questions, reached out and ruffled her braids, asking *"Well, look at yourself, what have you done to your hair? Who did it?"* (Adela, social worker). Mira stepped back, responded, requested reassurance regarding the issue she had come for, and, after receiving a confirmation laced with sarcasm but nonetheless affirming her request, she left. The staff member then turned to me and shook her head: *"Well, see what I have to deal with every day?"* (Adela), likely referring to the patient's strident tone, her appearance, and the fact that she had to provide reassurances she had given many times before. Another episode took place during sports class. Both Liliana and Mira attend these sessions, which usually start and 9 a.m., held outdoors if the weather is nice, or in the gym otherwise. One day while playing soccer, Liliana came wearing tight leather pants and was almost immediately sent back to change by Rebeca, the physiotherapist. During my stay, numerous similar incidents occurred. If T-shirts or pants were stained, the patients were sent to change them, if they got dirty, if the clothes were too large or if they were too small, they were sent as well. Hairstyles constitute another level of evaluation. If a haircut is deemed necessary by the staff, patients are encouraged to have one. If they dye their hair, they are often met with sarcastic remarks. Sarcasm is frequently used in response to the patients' attempts to dress up, but there are also compliments.

An unwritten rule in the institution is that the patients need to be complimented. In an interview with a former employee, this is presented to me quite clearly, the girls like the compliments: *"If you go there you need to tell them that they are beautiful, that they dressed beautifully, you will see it creates such pleasure. They smile so…"* (Alexandra, former nurse). One is expected to compliment their clothing, haircuts, the physical appearance as a whole. There are even compliments that have a sexual undertone, but those come mostly from the men working in the institution and are considered harmless. From my own observations, most patients seek out compliments, often asking whether they look good. An affirmative response from me never failed to bring a smile on their face. However, what becomes quite clear, even from the first day in the

institution, is that sarcasm is used as a tool in the hierarchical ranking of patients. Remarks such as: *"You're pretty, come on, go away"* or *"Yeah, you, you got dresses"* or *"Where did you get those clothes? You look good, what can I say?"* poison the string of compliments. Sometimes these comments seem genuine, but they are not. The same therapist, Rebeca, on another morning during sports class, compliments one of the patients and then turns to me laughing and shaking her head disapprovingly.

This type of behavior (compliments, sarcasm, sincerity, insults, prohibitions) extend over the majority of the patients' actions: in the ergotherapy workshops, at meals, in physiotherapy sessions, in the clay workshop, in the dormitories and so on. What might seem like a harmless exchange of remarks, praise and scolding, when applied across all of the individual's spheres, becomes a tool of control. Through the continuous hierarchization of clothing, behaviors and work, a clear framework is created for analyzing what is permitted and what is not, what is acceptable, what is desired, what must be avoided and so on. The patients end up self-monitoring the clothes they wear, the amount of work they do in the workshops, their attendance at these activities, ensuring they get regular haircuts, eating less, all in an effort to please the staff or to avoid consequences. Thus, we see that although the space of the body, the sheath, is private, it is so only in relation to other patients, the staff, through the loop phenomenon, hierarchizes and controls these private spaces. Constant control brings with it the internalization of certain norms, which in turn become institutional normality. The freedom to make choices about one's own appearance is therefore encoded within a set of indicators delineate what is considered normal from what is considered abnormal.

While helping one of the girls put some clothing items in her locker, she shows me a T-shirt she likes but does not wear because she does not want it to be seen that she gained weight (in the context where she is constantly told she needs to lose weight for her own health). Another patient, Paula, presents a similar problem, but approached from a different angle: she has good clothes, new ones, but she does not wear them because they are "too nice". As such, both a lower and an upper limit are constructed. Reality is built brick by brick, a carefully truncated reality that becomes internalized by the patients. Remarks such as: "I was lazy today, I didn't go the sports class" or "I helped the lady, I've been good" or "I want to be beautiful, that's the way I like it. I don't go around anyhow" demonstrate the desire to conform to institutional standards, a desire closely linked to the self-evaluation of the patients.

When conformity becomes problematic or does not occur, consequences follow. During a visit outside of the research period, I witnessed an episode in which I accidentally became involved, one that exemplifies the absence of truly

private spaces. Letiția, a patient in Ward B, regularly receives clothes from outside the institution. Having recently received a bag with clothes, she no longer arranged them neatly in her locker, as she was supposed to. The result was violent, the entire content of her locker was pulled out and thrown to the floor. This was followed by a heated exchange between the patient and the head nurse of the ward, Mrs. B, in which Mrs. B threatened that if she did not organize her locker, her new clothes would be thrown away, along with her other care products. These threats were accompanied by remarks such as: "*How many times do I have to tell you, girls, to keep things tidy!"* (Mrs. B), directed not only at Letiția, but at all the patients who had gathered to witness the quarrel. The situation calms down when I offer to her put her clothes back into her locker. Mrs. B leaves the dormitory and together we fold the clothes and place them in the locker. Only after reaching a greater state of calm, with a mischievous smile on her face, Letiția admits that she has not been particularly tidy, telling me also where she had received the clothes from. Mrs. B continues to make short visits during that hour, reminding her that if she does not keep her locker organized, she will not be able to find anything in it, discipline thus being reframed within a logic of efficiency. She tells us exactly how to fold the clothes, how to place them in the locker, and her tone softens with each successive visit. Thus, patients are given care kits along with their own lockers, but these are closely supervised and can only exist in accordance with the institution's standards.

Semi-private spaces shed new light on the hierarchy that emerges among other patients, a hierarchy established and maintained by the staff. Only the trusted girls are allowed to enter the storeroom, the others might steal, or their disabilities are deemed too severe for them to be entrusted with such a task. The trusted girls are those who clean, make their beds, are orderly and do not cause trouble. They are granted access to the room where the nurses are, are called upon to carry objects or food from one place to another and generally receive small favors from the nurses. The hierarchy is also felt by the rest of the patients, which in turn fosters a sense of hostility towards the trusted girls. In a conversation between the two occupational therapists from Ward A, one of them remarked: *"Well, what am I supposed to do if she manages on her own? If you give Angela money, you'll never see it again, so of course I keep sending her. What do they want?"* (occupational therapist from Ward A). In an interview with one of the patients, Marta, she explained that some of the other patients consider themselves superior to the rest: *"Some think they're very smart even though they're not. I just leave them alone because if you leave them alone, they won't bother you, but they're really stupid."* (Marta, patient on Ward A). Therefore, semi-private spaces become symbols of status. Access to them structures the hierarchy among patients and fosters antagonism.

Relationships

Relationships were divided into three categories: patient-patient, patient-staff and staff-staff. Across all levels, these is a noticeable lack of cooperation and relatively weak social cohesion. There are exceptions and these will be mentioned, but for the most part cohesion is low, interactions remain ritualistic, and a constant process of hierarchization is at play. Everyone has their place and that place is defined in relation to the position of others. The absence of collaboration is most visible among the patients. There exists a clear hierarchy between wards, a hierarchy recognized and reinforced both by the staff and by the patients themselves. From my very first day, I was warned about Wards D and R, those considered to house the "most problematic" cases. During the initial tour, I was advised to avoid those wards: *"You can go if you want, no one's stopping you, but over there, they are the way they are"* (Adela, social worker). Mrs. A presented ger own ward as being composed of "good girls," who sometimes "have their moments" but are, for the most part, not problematic. By contrast, in Mrs. B's ward, the girls are described as "a bit more resourceful." Even though Wards A and B are physically next to each other, the girls identify one another primarily by ward affiliation. For instance, when I asked one patient about a girl visible in the courtyard, she replied simply that she was form Ward B, a response that, for her, fully explained the girl's behavior.

Ward C is a ward of self-isolation, the women here interact very little with patients from other wards, and when they do, it is mostly out of necessity, either to ask for cigarettes or other valued items, or to seek information. Paula, a nonverbal patient from Ward D, has permission to wander the institution's pathways. She usually does so with a cup in her hand or a cigarette butt, looking for someone to light it for her, or for a bit of coffee from another cup. She makes rounds at each ward, but because Ward C is the closest and often has women who possess cigarettes or coffee, it is her first stop. Here, however, Paula is driven away by the women through remarks such as: *"Go on, get out of here," "Scram,"* or "*Go back to your own ward, Paula, this isn't your ward."* Paula is only one example among many similar interactions. Ramona, another patient from Ward C, when asked by me who is the person approaching us, she looked at me, smiled and said *"a sick one."* She is also the person who advised me not to speak with patients from other wards, to leave them alone, and to remain on Ward C because it is better there.

Inside the wards it is the same, the first hierarchy is established within the ergotherapy groups. Both in Ward A and in Ward B there are two workshop groups. In each, there is a "better" group, considered more capable of producing complex objects, with patients whose activity reports are more positive, and a "worse" group. The second line of stratification emerges between bedrooms.

Close friendships tend to form among roommates, dividing the larger collectives into smaller clusters. In an interview with Edna, an older patient and seamstress (whose pension income is supplemented by sewing work she trades with the staff), she told me she does not really have friends, except for her roommate. The others do not bother her, she does not beat them, but she has *"a big mouth"*. If she goes out for a smoke, she tells the others not to *"look into her mouth"*. She gives them the butt, but she wants to smoke in peace. If they need something, they come only as far as the door, they do not enter. She also does not attend the workshops anymore, as she considers herself as too old for them.

Each of these relationships is closely monitored by the staff. Quarrels between patients are evaluated as signs of behavioral deterioration, thus marking a decline in the trajectory toward recovery. The hierarchies that emerge do so both as a result of deviations from institutional norms (a negative aspect, tied to moral judgements), and from the very spatial distribution of bodies.

Between patients and staff, a completely different dynamic unfolds. In Ward C, unlike the other wards, the greatest degree of freedom is granted. The women here mostly have higher education, a higher social status outside the institution and pensions. They are allowed to leave the institution most often, their financial resources giving them a certain degree of independence in purchasing their own food or cigarettes, and participation in workshops is not mandatory. The spheres of the self are allowed to be constructed here; nevertheless, they are also the most rigorously evaluated. This is the only ward where meetings are held, once every few months, with the Psychologist and the Doctor. I was invited by the Doctor to attend such a session quite early during my research. I was told that it was a meeting for listening to the patients' problems and requests. Ramona, a patient on this ward, tells me that she cannot wait for the meeting, she did not get along with one of the other patients and wanted to tell the Doctor about it. The atmosphere on the ward was pleasant, all the women were gathered in the large downstairs room, chatting among themselves, divided into groups and waiting. Once the meeting begins, the women are asked, one by one, whether they have any complaints or requests, each is addressed individually, but always in front of the others; everything is made public. When one of the patients is asked whether she cleaned her room, her response is verified by turning to Mrs. C, the head nurse on the ward. When Mrs. C answers that it is not true, the patient is reprimanded, she is told that she must follow the rules and get along with the other patients. The same happens in several other cases. Although attendance at the workshops is not mandatory, the women are encouraged to take part in them in order to improve their condition. The label of 'lazy' is applied to those whose participation is low. The public presentation of problems is not limited to the patients, it also extends to the

orderlies, with the Doctor remarking that she knows everything that goes on and acknowledging that the behavior of the orderlies does not always meet institutional standards. Mrs. C also voices complaints about some of the girls and her word is taken as the image of truth against the statements of others. When it is Ramona's turn, although she previously told me about certain problems, she remains silent. The Doctor insists that she speak, but she says nothing. The Doctor brings up issues encountered in the past, namely the fact that Ramona does not sleep in her own room but instead in the one intended for common use. Mrs. C tells the Doctor that she still does not sleep in her assigned room and also highlights the strong attachment she has to one of the orderlies. Ramona is reminded that the room is meant for the use of all patients on the ward, not just her and that her relationship with the orderly is known, including the place where they go to pray, that everything is known, but that she must maintain a certain distance and cannot sleep in the common room simply to be closer to a staff member. Ramona remains silent, with tears in her eyes. This is how the rest of the meeting unfolds.

The types of relationships on this ward are complex and diverse, managing to encapsulate all forms of staff-patient interactions present within the institution. Although the women have their own cigarettes, purchased with their pension money, these are usually kept by the staff, and the patients must ask for them. If they ask too often, the request is refused, or they are scolded. Their money is held by Mrs. C, who distributes it evenly in an attempt to make it last until the next pension payment. The patients must ask for their own money and may be refused or reprimanded, even threatened that it will soon run out and they will be left without.

On Ward E, relationships are even more brutal, more mechanical; here the staff give orders to the patients, and the patients obey. Nothing is requested, only ordered, this being the only ward where such practices are present in such high numbers. On one particular day, a nurse dropped a piece of salami from her sandwich. She noticed it, stepped away and ordered a patient to throw it away. The patient picked it up and ate it. The staff's disregard for avoiding contamination among patients can also be observed on Ward A, where a nurse gathered crumbs from the countertop, pieces of luncheon meat and bread, threw them into a patient's bowl of semolina and handed it to her.

It can be seen, then, that patient-staff relationships can take multiple forms. There are those relationships of strong attachment (such as Ramona and the nurse with whom she prays). If cohesion is low among the patients themselves, many of the most meaningful bonds are created between patients and staff members. In my interview with Edna, she told me that she gets along best with the nurses, and she is not the only one. Most relationships, however, are ritualistic,

based on necessity, exchanges, or transactions. Finally, there are the negative relationships, characterized by quarrels, rejections or simple acts of ignoring. While I was speaking with one patient, another woman approached, wanting to talk to me. As she was from a different ward, the first woman turned toward her, spat at her and pulled me away.

Finally, there are the relationships among staff members, which largely follow the same patterns. Greater cohesion is found among the nurses, therapists and the cleaning staff working on the same ward. Mealtimes and moments of conversation are most often spent in a pleasant atmosphere, yet clear hierarchies exist. The ward supervisors, the head nurses, stand at the top. They are the only ones who take part in regular meetings to discuss institutional matters and are therefore universally seen as the heads of each ward. The therapists seem to form a distinct group from the nurses, although, as Rebeca told me, they are often required to perform nursing duties due to staff shortages. On the scale of status, nurses are ranked just above the cleaning ladies, who are responsible for maintaining cleanliness. During my stay in Ward E, a male nurse told me that many of the cleaning ladies had been turned into nurses, despite lacking the appropriate training. This phenomenon stems from the absence of new positions being opened and from the institutional requirement of maintaining a minimum number of nurses. A final division within staff relations, one that strongly underscores the hierarchical ordering of rank, is the "ivory tower", the medical office. Here, the Doctor holds the strongest authority and exerts the greatest influence over the patients. When the Doctor comes to visit, the women are told to be quiet. She is also the one who interacts with the patients most frequently. The Psychologist was presented as an appendix to the Doctor, nevertheless, her office is located in Ward E. In a conversation with her, she described the staff's lack of training and positioned herself above them, speaking of them as unqualified and lazy, in contrast to herself, who has formal preparation. Likewise, when speaking with a former employee, also in the role of psychologist, she confessed that the reason she left the job was that she felt there was no room for growth. Writing reports and suggesting changes was pointless, since the final word always belonged to the Doctor.

Rules

When this work speaks about rules, it refers both to the written rules, the unwritten ones, and their violations, along with the consequences that follow. It is important to note that the institution has multiple rules must be followed "on paper", yet the nurses do not see them as appropriate. Mrs. A tells me this

while showing me the clothing storerooms (a basement under the institution that doubles as a bunker in case of war) and those with cleaning supplies or various other utility objects. Theoretically, these rooms should remain open, but they are kept locked. If they were to let the women take whichever clothes they wanted, those unable to take care of themselves would end up with none, everything must be rationed and distributed equally. The same applies when it comes to daily-use products, with another danger arising from the fact that some patients might consume them. The confinement of patients is strictly forbidden, nevertheless there is one patient in Ward A who is always kept in her room, and another patient in Ward E in the same situation. If they were allowed outside, they would either run away or become violent. The patient form Ward A jumps into puddles, runs away, and, due to staff shortages, her supervision is impossible. The patient from Ward E is violent, both toward staff and his peers. He is the only one without roommates, even though there are three beds in his room. During inspections, however, these rooms are opened, all patients are let outside, and the illusion of rule compliance is complete.

Participation in workshops is not mandatory, but non-participation is regarded as a negative aspect and carries consequences, such as being deprived of coffee or cigarettes. Patients (in Wards A, B and C) are allowed to wander through the institution, but they are always asked where they are going or where they have been. In cases of longer absences, the other patients are questioned, and if they do not know at that moment, they ask around and find out, the information flowing from one individual to another without difficulty (a consequence of the low level of social cohesion). Any transgression from these seemingly free, yet carefully regulated behaviors leads to a deprivation of goods or rights. Such deprivations are regarded as very severe punishments, since items so common in the outside world acquire significant importance within the institution. In Ward C, all patients are allowed to leave the institution, but only with exit permits and only after stating where they intend to go. They are also given a specific amount of time during which they may be outside, and if this is not respected, the punishment is a temporary ban on leaving.

The written rule stating that no one must work is doubled by the unwritten rule of mandatory labor. In both Ward A and B, there are girls assigned to housekeeping, helping out on different days with cleaning tasks. Those who are able to help but refuse are labeled as lazy or considered bad. Remarks such as *"I helped the lady today"* are very common and praised. Quite often, such a statement is followed by a small reward, a slice of bread with margarine, a packet of coffee, each seen as a fitting compensation. In Ward C, every girl must clean her own room. During the meetings, this issue is often raised and linked to the process

of recovery: nor cleaning is considered antisocial behavior, a deviation from the norm, and public reprimand in front of the others is the most common tool used to address these problems. Work in ward D is assigned to a small number of patients, compared to the other wards, here it falls mostly on the staff, a sharp comparison to Ward E, where most of the tasks are carried out by patients. There are a few "core" individuals who are sent to perform all kinds of tasks, especially the dirty work. Şerban is one of these individuals: if X urinates on himself, Şerban is sent to change him, mop the floor and dress him in the clothes provided by a nurse. When Y defecated in bed, it was Şerban who was sent to remove the sheets and wash them. All of these are unwritten rules, and I have not observed any violation of them. When another patient is sent to bring some boxes, he asks: *"And what if I don't want to?"* The nurse replies: *"I'll make you want to."* Physical violence is not unfamiliar in this ward, therefore, although I have not personally witnessed any major events, transgressions could be punished through physical aggression. Patients are pushed, slapped, and insulted for the smallest mistakes (such as stepping into the dust that has just been swept or approaching the entrance with a lit cigarette in hand).

What can therefore be observed is a duplication of each written rule with an unwritten one. This duplication either reinforces the official rule or cancels it out. Every aspect of life is, in one way or another, regulated and this regulation consists either of norms or of clear prohibitions. The way money is spent is monitored. In one case, when one of the patients, Diana, was asked what she had spent her last money on, she presented some lighters she had bought from another patient in Ward D. When Diana complained that the lighters were almost empty, Mrs. C scolded her, accused her of making poor decisions, and insulted her. Bartering is therefore also monitored and sanctioned, the patient from Ward D was summoned and told to return the money because the lighters did not work. Thus, an ecosystem of informal regulation takes shape, one that is, most of the time, stronger than formal regulation. This regulation materializes in the construction of what is considered normal and abnormal reality. Sanctions serve the role of bringing individuals back onto the right path, the only one that actually facilitates the smooth functioning of things and the patients' progress toward recovery. Praise and small gifts play the positive role of maintaining desired behaviors in a favorable light, clearly delineating them. The medical discourse corroborates and reinforces this regulation of behaviors, providing it with a logic that can encompass every sphere of patients' lives, from their thoughts, to their behaviors, to the way they socialize, everything can be incorporated into the normal-abnormal framework.

Activities

Activities take several forms, but the main ones are sports, occupational therapy, and leisure. These are regarded as the significant activities in the patients' lives, and all take place in the first part of the day. After waking up, patients get dressed, wash and prepare for the start of the day. Meals are served at fixed hours, after which they are given half an hour to drink their coffee, relax and so on. Workshops begin at 9 a.m. and last until around noon, there is another coffee break. The rest of the day is free; the activities are over.

In the occupational therapy workshops, patients engage in various activities, some color or draw, other sew. In one of the workshops, carpets are made, and there is also a section dedicated to tailoring. In this section, employees and a few patients engage in monetary exchanges. Orders are placed, fabrics are brought in, and all sorts of objects are produced. Old clothes are also recycled or repurposed here. Patients with lower dexterity make balls of yarn from various crocheted or knitted garments. The yarn is then used to make carpets or braids. "Nothing is thrown away, everything is reused," one of the occupational therapists from Ward B tells me. All the objects made by the patients are later taken to exhibitions or sold at fairs and the money is used to purchase new materials. Some of the patients do embroidery. On Ward B, a patient with a severe locomotor disability manages to embroider all sorts of images. The occupational therapist draws the patterns for her and based on these, she brings the image to life. It is a difficult and painstaking process, her movements are slow, she makes mistakes, but she goes back, repairs them and although her working time is much longer than that of her peers, she completes her projects. Not all patients are able to engage in such activities, and they focus instead on various puzzles or dexterity games. One of the girls' favorite games is one made by the staff: a simple cardboard box with a clown's face drawn on the bottom and a hole where its mouth should be. The patients must move the box gently so that a ping-pong ball falls through the clown's mouth. This is just one example among many, but this is how the workshop hours pass, day after day after day. Some patients do not participate in the activities. They come, but sit on the couches, watching the others or staring into space, yet still present. In one of the workshops there are computers, and the patients are given music to listen to through headphones. I am told that some of them even write emails, but most of the time they just listen to music. All these activities are later evaluated. Once every six months they must be transformed into raw data.

Physiotherapy or sports represent another major branch of the institution. Not all patients engage in sports, but all are encouraged to make use of the gym. With a small number of patients, such as Liliana and Mira, outdoor games are organized, but the majority come and use the equipment provided. The exercises

are designed to encourage mobility, and the machines are used in turns, starting with one and moving on to the next. In this same room, the patients are weighed, measured, and their physical condition is assessed. These data are also entered into the files that are compiled every six months. Each patient has a file, and these thicken over time. The progress of each patient can be tracked, improvements or the lack thereof are indicated through numbers, descriptions of actions and graphs. All these files must be kept up to date, not for the institution itself, as one of the nurses tells me, but for inspections. She goes and opens several cabinets, all full of files, and she says to me: *"Just look at how many we have to do."*

When it comes to leisure, it cannot take many forms. Leisure, rather than being true free time, is more like idle time or dead time. The weekend is the best example of extended dead time. Since no workshops are held and there are only two nurses on each ward, the patients have no activities. Usually, they stay in the designated spaces, talk, smoke or simply walk from one place to the other. In an interview with Adina, a patient form Ward C, I asked whether the lack of activities bothers her in any way. She told me that it doesn't always bother her, sometimes she enjoys the relaxation, since during the week she gets tires, but sometimes she does get bored. Ramona, however, tells me a different story. She does not like weekends, she spends some time on her phone, but otherwise she has nothing to do. The nurse she is attached to comes only very briefly over the weekend and, since she has no close friends in the institution, she feels that the weekend is meaningless. These two perspectives are widespread throughout the institution, while more patients from Ward C prefer the dead time, patients from other wards prefer the days with workshops. The angles from which this temporal void can be viewed are twofold: on the one hand, it could be seen as a disciplinary failure on the part of the institution, one among many others, but on the other hand, it could be understood as a tacit strategy of control through passivity and uselessness.

Conclusions

In this work, I have described an institution that can be understood either as a panoptic one, in Foucault's terms, or as a total institution, in Goffman's terms. Regardless of which concept we choose, the processes and phenomena encapsulated in this institution bring the two authors together, indicating a high level of complementarity between their visions. Surveillance, a constant theme throughout the research, is present in two forms. On the one hand, we find the panoptic architecture, on the other hand, we encounter the loop. The rooms are open, without alcoves, without segments that might confer invisibility,

without objects that could block the gaze. The hallways are straight, joining at right angles and there is always the possibility that a nurse might be just around the next corner. The uncertainty of surveillance leads to eventual self-monitoring. The doors of the dormitories have windows, and the presence of roommates constantly ensures an extra pair of watching eyes. Patients are taken out every morning and kept in large spaces, where every movement can be observed. As for the loop, it operates at the level of the individual. Each action, once seen, is subsequently evaluated. What in the outside world would be considered an innocuous gesture becomes here a criterion for assessment. An unmade bed, disorder in the closet, non-participation in workshops, or antisocial behaviors all form part of the wide array of closely monitored aspects. The rupture between seeing and being seen leads to uncertainty in surveillance, by dissipating, it becomes stronger. The loss of centrality makes it, potentially, present everywhere and this, when connected with continuous evaluation, results, as we have seen, in self-monitoring. The patient's visibility and constant evaluation eliminate access to face-saving regions, the self has no private spaces, no backstage areas in which to retreat. The apex of this process is presented here by the meetings held in Ward C. The data collected over the months by the staff and by other patients are pieced together, in full view of everyone (a double visibility) and are connected to value judgments about the individual. Face-saving thus becomes impossible and past actions are overshadowed by shame. The remarks of the Doctor indicate a disembodied omnipresence, a presence that sees, listens and evaluates, which also extends its gaze onto the staff. Everybody, regardless of institutional status, is pushed toward docility through a constant assault of watching eyes.

Surveillance and monitoring are all the more supple and brutal because they are tightly bound to a medical discourse, one that clearly draws the boundaries between what is normal and what is deviant, abnormal. By overlaying science onto the judgements that come with monitoring, these are reinforced and absorbed into the logic of larger systems, systems that grant them a validity surpassing the confines of the institution, transforming them into universal laws. Thus, every aspect of patients' lives is medicalized, each transgression is framed as a step backward on the path to recovery, while progress is defined by the institution itself, through adherence to norms and the relentless placement within the domain of the normal. The organization of bodies becomes a tool of surveillance, each individual having their own clearly defined place, with absence being immediately noticed. Goffman's assertion that withing a mass of subjugated bodies transgressions can be instantly observed proves to be an accurate evaluation of life in this institution. Yet absence is not the only important criterion, the masses are further divided into smaller groups, where activity can be monitored

by therapists or nurses. Every game, every puzzle, every piece of handicraft ceases to be merely and activity, instead, they are inscribed into a larger system of testing. Every action is transformed into data, data which are then gathered into an evaluation file. Activities are coded and inserted into a system of relations within the medical field, turning the individual into a case, rendering their invisible aspect visible. Nothing remains hidden and when everything can be seen, the internalization of power becomes palpable. Thus emerge the patient' responses, remarks that reveal a regulated self-reflexivity, avoidance becomes malice, disorder becomes laziness, cleanliness becomes diligence. Once these frames are established, they spill over onto the other patients as well.

The flow of disciplinary power thus becomes incorporated into each individual, with every person's framework truncating their interactions with the worlds of others, their possibilities for action, and their interpretation of events. In this way, power manages to dissipate, to render itself invisible, while at the same time increasing its potency. It is no longer merely the staff who impose norms, rather these norms are imposed from within each body and through every relation between bodies. Any other patient becomes a point of emission for disciplinary power, as the institutional frames shape the possibilities of interaction and action, both on an abstract and a practical level. Gossip, accusations, denunciations, all are symptoms of the same process of normalizing a particular mode of existence. The visibility that falls upon each individual has an individuating role, these are, in fact, no masses of people, only accumulations of cases. The relationships that emerge between patients, given this context, are more ritualistic in nature. Cigarettes or cigarette butts are requested, cigarettes or butts are given, objects are sold, and money is borrowed, all without generating strong social cohesion. Thus, when a nurse asks about the location of a patient, her actions or her intentions, the answers are quick to surface. Surveillance, therefore, is not limited to the staff but extends outward, taking shape in every gaze, each individual, including the self, is watching. Transgressions are immediately identified and punished, which places an additional strain on the relationships between patients. The result is a constant lack of cohesion, a lack that is not addressed by the staff precisely because it becomes a convenient tool of surveillance. Yer the game of internalizing norms, of frame formation and of the absence of invisible spaces culminates in hierarchizations.

Hierarchies are present at every level of the institution and between all individuals. They serve a double role, on the one hand, they establish a clear chain of power, who answers to whom, while on the other hand, they foster antagonism among individuals. Patients are either praised or rewarded, as long as they conform to the institution's norms. Commons goods, such as cigarettes or coffee, become currency here and are carefully employed by the staff to

divide patients into "good" and "bad" ones. This type of hierarchization places an additional weight on relationships that are already fragile, breaking down larger blocks into clearly defined units. Providing information, allowing oneself to be monitored, participating (or refusing to) are all actions (or absences of action) that quantify behavior and set it in relation to that of others. Privileges and sanctions are the terms through which hierarchies are calculated and access to semi-private spaces becomes a key factor of demarcation. This access comes with a range of other benefits: the trust to carry out tasks (which simultaneously brings rewards), the overlooking of certain behaviors and greater freedom of movement. Yet these hierarchical antagonisms do not exist only among the patients, they are mirrored within staff as well. The wards communicate little with one another, concentrations of power exist, and staff members themselves are under constant observation. Complaints can be made both by patients and by colleagues. Of course, the way such complaints are received differs depending on the source, but disciplinary mechanisms are deeply embedded in the dynamics among employees as well.

The panoptic institution is not, however, perfect, there are many gaps, many points where discipline fails. In Ward E predominantly, but also present in Ward D, recourse to force becomes common. Here individuals slip through the cracks and transgressions must be punished brutally. The system of privileges does not function as it does in the other wards, surveillance is continuous but belongs primarily to the staff. Spatial isolation plays an important role, an isolation that allows staff to always have enough eyes watching. Where discipline fails, reliance shifts to the shutting down of the spheres of the self, freedom is minimal, the loop effect is brutal, and power is centered in figures whose absence mimics the very absence of power itself. Strong attachment relationships become potential barriers to continuous surveillance. Small bubbles of invisibility can be created, secrets shared between staff and patients. The institution relocates individuals to other wards only in the most extreme cases, but the majority remain where they are. Continuous surveillance counters the growth of such relationships, yet their very existence signals a clear weakness in the system. Another problematic aspect is the presence of dead time, idle time. Instead of the strict routine that divides time into intervals and manages to fill it, there are empty stretches without program. This could be read as more diffuse dispersal of disciplinary power, generating apathy and thus docility. Nevertheless, given the imperfections of the system, I am more inclined to interpret dead time as yet another pathogen within a problematic ecosystem.

In the end, the institution can be characterized as a total, panoptic institution. The play of gazes succeeds in reaching every aspect of patients' lives, rendering impossible the emergence of truly private spaces. The patient is quantified,

monitored and inscribed into a larger system of power relations. The internalization of power plays a key role in the fabrication of docile bodies, yet this process is closely accompanied by the denial of the self's spaces for face-saving and by the meticulous monitoring of the spheres of subjectivity. These two aspects are two sides of the same coin, and their intertwining provides a clearer vision of the dynamics within a psychiatric institution. What this work has sought to do is to provide an analysis of a practical framework in which the theoretical unification of these two authors reveals more than a study treating them separately would have done. Their systems are not always compatible, yet if the points at which they converge are identified and refined, an even stronger analytical tool emerges. Where Foucault leaves space for interpretation, such as in the mechanisms of microphysics (Leib, 2017), Goffman can fill in the gaps. Future studies should explore the nodes of connection between the two and reframe them within the contemporary context of total institution studies. With deinstitutionalization, the face of such places is changing, and the mechanisms of power are shifting along with them. Capturing these dynamics will require increasingly fine-tunes theoretical approaches. A longer period of time spent in this institution would have deepened the understanding of the dynamics at play within it. The constraint of time left many gaps in observation and thus only allowed for possible surface-level framings. The complexity of moves and countermoves within the institution requires research conducted over an extended period, so that familiarity with both patients and staff may grow, along with their openness toward the researcher. Such a scenario would bring fresh data, data to which this study did not have access.

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