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Human-Nonhuman Encounters in Psychiatric Care: Crossroads Between Sensory and Institutional Ethnography

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Abstract: In this ethnographic study, I examine the intersections between human and nonhuman dimensions of care within psychiatric clinics in Switzerland. The research question was how institutional ethnography can help us understand the "hospital multiple"—a site where human and nonhuman elements converge in experiences of illness, care, and violence. Through a non-idealizing approach to caring encounters, I foreground the largely invisible experiences and marginalized perspectives within institutionalized care. Drawing on vignettes from the field, I explore insights and methodological approaches to tracing the ambivalences of care through sensory and nonhuman dimensions. I argue that sensory ethnography—specifically a focus on experiential atmospheres and collaboratively documented moving interviews—provides valuable tools for this endeavor. Institutional ethnographies of the hospital multiple open creative pathways to analyze both interlocutors' embodied knowledge and the broader power structures underpinning institutions.

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1. Introduction

With this article I would like to contribute an anthropological perspective to the institutional and organizational ethnographies of psychiatric care, based on ethnographic fieldwork I conducted in psychiatric clinics in Switzerland in 2022. In the following analysis, I draw attention to invisible and marginalized dimensions of experience within psychiatric clinics by combining institutional ethnography with sensory ethnography. Rather than focusing specifically on psychiatric diagnoses and symptoms, I instead continue KEHR and CHABROL's project of exploring the "hospital multiple," viewing institutions in their "[...]affective materiality, but also in their geopolitical situatedness and mundane everydayness" (2020, p.3). I use the concept of the hospital multiple in order to explore not only the different ways of how illness and recovery are envisioned by different actors in the clinic, but how they are practically *done* in medical settings (MOL, 2002, p.vii). By this focus on how illness and recovery are enacted actually in the material sphere, I argue that

"multiple" realities emerge because in every interaction, changing configurations of human bodies, practices and nonhuman objects are involved (p.5). Accordingly, institutional ethnographers of the hospital multiple can incorporate more-than-medical aspects in their analyses (KEHR & CHABROL, 2020, p.4), such as sensory clinical atmospheres, infrastructures, economies, the absence of care, materiality (ibid.), and affective architectures (MORALES, 2020). A note on terminology: In the upcoming vignettes, I analyze non-animated objects as well as animals, plants, and other aspects. When reflecting on these, I use "nonhuman" as an umbrella term in order to subsume the complex range of entities that, while not human, nevertheless fundamentally influence human experience. [1]

I drew inspiration from recent discussions in academic psychiatry in which authors pointed to a crisis within the discipline because of its predominating biomedical bias by which practitioners and researchers neglected—or pathologized—the lifeworld and social realities of those individuals who experience mental distress (ROSE & ROSE, 2023, p.46). As a result, scholars have argued for a reorientation of psychiatry towards paradigms of mental illness that are holistic and ecological rather than reductionist (FUCHS, 2023), more humanistic (KLEINMAN, 2012), more open to the contributions from the humanities (DI NICOLA & STOYANOV, 2021) and anthropology (ALEXANDER, LYNE, CANNON & ROCH, 2022). At the same time, an increasing number of interdisciplinary organizational researchers has drawn from ethnographic methods (BRANNAN, PEARSON & WORTHINGTON, 2007; GILMORE & KENNY, 2015; KOSTERA & HARDING, 2021; SUTHERLAND, PANDELI & GAGGIOTTI, 2022), finding valuable tools for conducting institutional ethnographies. [2]

Based on ethnographic fieldwork in Swiss psychiatric clinics, I explore how institutional ethnographies of "more-than-human public health" (KEHR, 2020) can be realized in practice. Focusing on human-nonhuman interactions and sensory experiences, I analyze psychiatric clinics as institutions where solid matter and human experience interact in significant and dynamic ways. Building on KAVEDŽIJA's (2021, p.21) proposal to understand human wellbeing as an ongoing, intersubjective process involving both human *and* nonhuman actors, I approach wellbeing as a deeply relational matter that is not merely performed by persons but is *constitutive* of personhood as such (p.28). I was inspired by PUIG DE LA BELLACASA's (2011, 2017) concept of *matters of care* and her contention that care encompasses all activities which maintain, regenerate, and repair our worlds as "complex, life-sustaining web[s]" of bodies, selfhoods, and environments populated by humans, objects, physical forces, animals, and other living beings as well as spiritual entities (PUIG DE LA BELLACASA, 2017, pp.1-3). Through my ethnographic material, I explore the crossroads between institutional ethnography and such expanded notions of care. [3]

For the research, I drew on a methodological combination of sensory ethnography (PINK, 2009; VANNINI, 2024) and anthropology of the senses (HOWES & CLASSEN, 2014; LOW, 2023) to explore how these approaches can

contribute to institutional ethnography as formulated by SMITH (2005). Using ethnographic vignettes from my fieldwork in Switzerland, I discuss how institutional ethnographies of the hospital multiple can be used to reveal mundane and extraordinary experiences that elude abstract diagnostic categories or medical language (ACOLIN, 2019, p.40). I give examples of how I used sensory ethnography to focus on experiential atmospheres and moving methods in the field. This methodological lens provides to me as a researcher a practical means of accessing marginalized experiences of care and violence within psychiatric clinics while maintaining a focus on ruling relations. SMITH defined the latter as "translocal forms of social organization and social relations" (2005, p.227), whereby ruling relations are predominantly mediated by texts, are objectified and operate beyond people's embodied experiences. [4]

My goal through this analysis is to demonstrate how ethnographers can redefine research as a "hopeful gesture" (PUIG DE LA BELLACASA, 2017, p.52), practicing feminist observations and reflexivity as political *acts of care*. Biomedically oriented, neoliberal psychiatry can lead to experiences of "ethical loneliness" within service users whenever they don't feel genuinely listened to, cared for, or are relegated to the status of nonpersons (O'LOUGHLIN, 2020, p.1). By combining ethnographic methods and feminist notions of care, researchers can make visible those marginalized experiences—for instance, through co-creating knowledge via participatory approaches (IRVING, 2011; MARENT, HENWOOD & DARKING, 2023) and exploring the knowledge of those most oppressed within healthcare systems, i.e., those who are ultimately the experts in our fields (BISAILLON, 2022, p.21). [5]

I will begin by describing my research project and my positionality in the field (Section 2). Introducing a first vignette, I outline my research interest that focuses on human-nonhuman interactions and the senses within institutional ethnographies of care (Section 3). This is followed by further vignettes which I analyze by using the concepts of the "hospital multiple" and experiential atmospheres (Section 4). In the following sub-section (Section 4.1) I discuss why such a research focus provides surprising insights about marginalized experiences within institutions. I continue by outlining the advantage of moving methods in such an endeavor (Section 4.2) and end with a conclusion (Section 5). [6]

2. The Field and Research Methods

I base my reflections on ethnographic fieldwork I conducted in psychiatric clinics in Switzerland in 2022 as part of the SNSF-funded project Coercive Space-Time-Regimes: Comparing Configurations of Care and Constraint in Different Institutions (2021-2025, grant number 192697). The project team compared configurations of care and constraint in prisons, nursing homes and psychiatric clinics. In my subproject, I concentrated on psychiatric clinics, where I conducted observations over periods ranging from two to twelve weeks, followed by additional interviews after each observation phase. My fieldwork took place in two clinics and all data were collected and handled in accordance with the ethical

guidelines of both the University of Bern and the participating institutions. During data collection and analysis, I followed the guidelines of anthropological research (PELTO & PELTO, 2012 [1978]) which included qualitative ethnographic research methods (KIRNER & MILLS, 2020), participant observation (DeWALT & DeWALT, 2011), ethnographic interviews (MISOCH, 2015) and document analysis as part of institutional ethnography (SMITH, 2005). Whenever ethical guidelines and participants' consent allowed for it, I included the multimodal research methods of sensory ethnography (PINK, 2009) which mainly consisted of sound recordings and photography. My research process reflected the *Gegenstandsentfaltung* [unfolding of the subject] which is a core aspect of qualitative research (STEINKE, 1999), allowing for an "unfolding of the research topic in the course of the research process" (RICHTER & HOSTETTLER, 2015, p.504). In this article, I base my reflections on a sample of 17 transcribed interviews, 39 photographs and my written fieldnotes which were collected in one single clinic. In the course of my argument, I will use excerpts from interview transcripts and fieldnotes which I selected in accordance with both the line of argument and ethical considerations[1]. With this work, I contribute to institutional ethnographies that focus on the senses and the nonhuman in Swiss psychiatric healthcare, which, to date, have been relatively rare (see, e.g., CODELUPPI, 2019; HUMMEL & PREISWERK, 2011; WINZ, 2018; WINZ & SÖDERSTRÖM, 2021). [7]

The fieldwork took place shortly after the peak of the COVID-19 pandemic, during which the incipient public mental health crisis began to escalate (STOCKER et al., 2021). The situation was exacerbated by an increase in austerity measures within public psychiatric healthcare that affected service users and staff members directly (KING, 2023).[2] Swiss advocacy groups for service users and their relatives have advocated against an austere, biomedically dominated system of psychiatric care, arguing that it increasingly side-lines the lived, social dimensions of mental illness.[3] During my fieldwork, I grasped those troubled aspects of psychiatric care as I accompanied interlocutors during their days—which also revealed many unexpected caring interactions that would have been invisible from the perspective of ruling relations (see also HÄNNI, 2023, 2025/Forthcoming). [8]

In this article, I draw on research conducted in one clinic, where access had been granted by a high-ranking psychiatrist—that is, only after I had refuted his fear that I would produce what he characterized as "another polemic view of the psychiatric clinic as a place of horror." I was permitted to observe activities in one

1 Due to data protection principles, only a small selection of audiovisual materials can be made public.

2 Austerity measures in psychiatric care continue to provoke political resistance; see, e.g., "Sparhammer in der Psychiatrie: Jetzt wehren sich die Betroffenen" [Austerity Measures in Psychiatric Care: Now Those Affected Defend Themselves], https://www.srf.ch/news/schweiz/psychiatrie-unter-druck-sparhammer-in-der-psychiatrie-jetzt-wehren-sich-die-betroffenen [Accessed: November 27, 2024].

3 Conversation about a recent survey with a founding member of the Dachverband der Vereinigungen von Angehörigen psychisch Erkrankter [Swiss Association of Relatives of People with Psychological Disorders] in March 2023. On January 10, 2024, the association changed its name to Stand by You Switzerland.

acute ward, where I adopted the role of an academic research intern and was handed a key and a name tag. As the offices in the ward were all occupied by doctors and interns, I was assigned a place in the nurse's station office—a small, crowded room with a large round table where paperwork, staff huddles, and coffee breaks took place. Positioned in this "epicenter" of the ward, I closely participated in the nurses' daily work and the events within the ward. [9]

While most nurses let me participate in their day-to-day routines and volunteered to give interviews, others were more suspicious. The fact that I had been introduced by a high-ranking psychiatrist as a "researcher from the university" instantly put me in an ambivalent position in the eyes of some nurses. This suspicion was encapsulated in one nurse's disillusioned remarks about my research aim: "There is so much research and talk in this clinic from those hidden behind the desk. But I never saw an impact—or even a basic recognition—of our daily struggles here in the ward." In contrast, medical staff members and therapists seemed more optimistic about the usefulness of research in psychiatric care. This was reflected in their interest in my research project and their eagerness to discuss the ethical questions that were raised during their daily practice in the clinic. DIAMOND (1992) addressed this complexity regarding the ethnographer's field access in his exemplary institutional ethnography on nursing home care in the US. He illustrated how ethnographers must navigate the projections and ascriptions of various institutional actors, ranging from complete rejection (pp.8-9) to gradual immersion in the daily realities of workers and their ambivalent relationships with management (pp.48-49). [10]

As an ethnographer, I possessed one of the scarcest goods in the clinic: Time to listen and sit with people. Despite being introduced as a researcher conducting participant observation, many service users addressed me as a staff member—someone who "could help"—and often approached me for support, seeking assistance with tasks such as getting dressed, receiving medication, finding an accompaniment to leave the ward, or managing acute crises as they queued in front of the nurse's office. Not being trained as a therapist or nurse, the extent of my involvement depended largely on the discretion of the nurses in charge. The tasks I was allowed to undertake were often those considered peripheral to the core of psychiatric care; for instance, I sometimes accompanied service users on walks outside or to therapy appointments in other buildings, sat with them in the common areas of the ward, or ate together with nurses and doctors in the canteen after having visited service users. Both participant observation and my active involvement in these "marginal" tasks enabled me, in SMITH's terms, to access the *actual doings* of the clinical day-to-day life as an "unfinished arena of discovery" (2005, p.39). [11]

Grounded in vignettes from the field, I now turn to the importance of fleeting interactions between individuals and the hospital multiple—those situated encounters that "go on to making institutions happen, whether they are recognized in institutional discourse or not" (p.157). [12]

3. Exploring Psychiatric Care From the Perspective of an Embodied Knower

I begin by addressing a frequently overlooked aspect of mental illness: The impact of the site of the psychiatric clinic itself on service users' embodied experiences of affliction and recovery, as well as on caregivers' routines and practices. In the vignette below I capture a short moment in which a staff shortage in a ward *materialized*—an instance rarely visible in institutionalized definitions of suffering and caregiving but nevertheless rooted in service users' embodied knowing (SMITH, 2005, p.24). This vignette stems from my fieldnotes from an acute ward, where I regularly accompanied Eva, a senior nurse, on her routine visits to service users. In the second part of the vignette, I describe my brief interaction with service user Erica and the nonhuman aspects of it. On the level of human sociality, I captured in the vignette how a shortage of staff, combined with the nurse's responsibility to fulfill institutionalized standards of care, delayed certain interactions with service users—particularly those not deemed acute or "psychiatric" as such:

> "I assist Eva,[4] the nurse, during the morning check-up as I push her equipped trolley and write down service users' blood pressure on a form. Erica, a frail service user in her eighties, mentions that the flower bouquet on her windowsill needs to be trimmed. Eva nods but cautions that it won't happen before the afternoon. Back in the corridor, she tells me why: No scissors are allowed for free use among service users and 'as Susan [a fellow nurse] is ill today, I am completely running out of time, I have more important things to do.' I offer my help, and Eva agrees, handing me the keys to the tool cupboard and rushing away. Minutes later, I knock on Erica's door and introduce myself. With a proud smile, she hands me her bouquet—a gift from her family. I shorten each flower stem according to her instructions and learn that flowers, gardens—and nature in general—are a main source of wellbeing for her. For the first time in the ward, we begin conversing. She tells me about her recovery, how she 'learned to accept help and reclaim a sense for the beauty of life' and continues, 'I need to learn how to accept the help and the support from others, but spending time in the ward's crowded common rooms is stressful for me. Instead, I go for walks in the park every single day. Except for today, as it is raining—and I already miss visiting the trees'. Half an hour has passed, and as I see her off, she thanks me for our talk and how I 'took care' of her. I am moved by our encounter. As I enter the ward's corridor, I instantly shift back into the 'acute' mindset I have gotten to know so well here. The ward's atmosphere is hectic these days, and another acutely psychotic service user has arrived. Suddenly, I feel awkward for carrying the huge garden scissors in my hands and quickly stow them away" (Fieldnotes[5], August 19, 2022). [13]

Through this fleeting interaction between humans and nonhumans (garden scissors, flowers, keys) I was offered valuable insights into how ruling relations shape individuals' embodied experiences (SMITH & GRIFFITH, 2022, p.xiv). In the following analysis, I focus on Erica's experience, as I consider her the most

4 All personal and place names included in this article are pseudonymous.

5 All fieldnotes were written in German and translated into English.

vulnerable person in this encounter. Taking her experiential knowledge as an entry point yields insights that often remain invisible within institutionalized and hegemonic definitions (BISAILLON, 2022, p.19; SMITH, 2005, p.8) of what care entails, such as checking vital signs or administering medication. Turning towards the hospital multiple (KEHR & CHABROL, 2020), I ask: What can we learn about ruling relations when we consider the role of the nonhuman in shaping human experiences? [14]

By foregrounding the experiential and the material in psychiatric care, researchers can question objectivist ways of knowing (in this case: institutionalized definitions of care) and prioritize experiential knowledge (DEVEAU, 2008, p.4) that begins with subjectivity as the foundation for reflexive inquiry (SMITH, 2005, p.10). From the standpoint of the overworked nurse, her choice not to help Erica is understandable: The ward is crowded with acute cases, and the pressures of understaffing necessitate differentiating between urgent and less critical needs. It becomes clear that Erica's needs, in this context, are marginal for two reasons. First, the nurse postpones the task to a later time, and second, she assigns it to an untrained researcher, as tending to flowers is not considered part of professional psychiatric care expertise. [15]

The rules surrounding service users' security—in this case, the presence of scissors—allowed me to step in and assist Erica. This involvement facilitated an important shift in perspective for me as a researcher, moving away from "explain[ing] *why things happen the way they do* to *how things happen the way they do"* (DEVEAU, 2008, p.6). Additionally, this helped me gain an embodied sense of how understaffing and ruling relations around "care" and "security" influenced ordinary interactions in the ward. [16]

Erica's experience of care was shaped by both human actors and the hospital multiple—for example, through medical forms, discourses around service users' security and lack of time, a flower bouquet, and garden scissors. The medical form, on which vital signs were noted during the nurses' hurried morning rounds, reflected the power of texts in determining where and how time for care was allocated—or, as in Erica's case, withheld. This document occupied a critical position, mediating Erica's embodied experience of ruling relations (SMITH, 2005, p.101). For Erica, having someone tend to her flowers represented an act of care, partially because the beauty of plants had become part of her therapeutic landscape (WILLIAMS, 2007; WINCHESTER & McGRATH, 2017) and partially because meaningful social interaction was otherwise challenging for her to access in the ward. Understanding this requires an ontological shift towards Erica's *embodied knowledge* in which wellbeing and suffering were not merely interior matters of the brain, but conditioned by her relations to human and nonhuman aspects of the surroundings; her lived experiences of isolation and connection involved humans as well as plants and the outdoors. By adopting this perspective, I propose an alternative to institutional and objectifying discourses (BISAILLON, 2022, p.21) of what "care" and "suffering" entail and follow HARDING's call for a more profoundly democratic manner of listening to neglected things, speaking "from below" (2008 cited in PUIG DE LA

BELLACASA, 2017, p.58) Researchers can *reclaim care* by focusing on both human and nonhuman components of caring practices (PUIG DE LA BELLACASA, 2017, p.11). [17]

In this vein, the researcher's "conceptual practices" can be seen not merely as theoretical undertakings but as *performed* activities in themselves (SMITH & GRIFFITH, 2022, p.29). For instance, by accompanying the nurse on her rounds and being granted the chance to assist Erica, I was allowed to learn about the doings of wellbeing and social isolation from Erica's perspective. Accordingly, SMITH and GRIFFITH (p.35) emphasized the importance of researchers acknowledging both their own embodied presence and that of others while locating discourses. They encouraged researchers to "step outside" texts while reading them, redirecting their attention to their bodily emplacement in space and time:

> "Recognising ourselves as being in our bodies locates us where a discourse happens, as it must, in what actual people are doing, have done, will do. It locates us in the materiality of the medium coordinating our activities—the texts we read and write, the words, phrases, syntactic arrangements, and so on that we have learned to use and recognise as others use" (p.36). [18]

SMITH's and GRIFFITH's focus on the embodied dimensions within ruling relations can be put into practice in several different ways—such as being attentive to the impact of objects, matter and the senses within psychiatric care. This contributes to a growing body of research on the impact of nonhuman things and bodies in institutional contexts (TAYLOR & FAIRCHILD, 2020, p.511) or, in a more theoretical manner, to introducing the "materiality of affect" (TALBOT, 2020) into institutional ethnography. Below, I discuss how I used a focus on experiential atmospheres in this endeavor as an inspiring epistemological and methodological tool. [19]

4. Experiential Atmospheres and the Hospital Multiple

In his sociology of resonance and the "good life," ROSA (2023, p.206)[6] also outlined the counter-experiences to states of resonance: Muted, alienated experiences and "relations of relationlessness"—experiences that also surface in psychiatric care whenever service users feel disregarded or not listened to due to institutional structures that produce "ethical loneliness" (O'LOUGHLIN, 2020). From ROSA's perspective, institutions are among the most powerful forces in Western society that determine whether individuals experience states of resonance or muteness (ROSA, 2023, p.662), which reflects the ethical importance of doing institutional ethnographies in psychiatric clinics. A second relevant point of ROSA's thinking is that he drew a connection between resonant experience and the sensory, material context in which humans find themselves: Spatial, material surroundings create *Stimmungen* [experiential moods], which impact directly if humans experience states of resonance or muteness (pp.635-

6 All translations from non-English texts are mine.

636). I now discuss, how I traced this connection between material surroundings and subjective experience through sensory and "atmospheric" ethnographies. [20]

By doing institutional ethnographies of the hospital multiple, researchers can focus on the interplay between institutional settings and subjective experience. For instance, MORALES (2020) showed in her research on experiences of temperature in a Bolivian hospital, how attempts at building hospital environments that are more "warm" and thereby inclusive of Indigenous users' cultural practices, missed their aim and, instead, reproduced racialized ways of medical intervention (p.3). Her work serves as an inspiring example of how, by tracing "clinical" atmospheres, ethnographers can address both embodied experiences and institutional ruling relations. [21]

By analyzing the following vignettes, I discuss how the material, built environment shaped the experiences of care, neglect, and even violence for both service users and workers in a psychiatric clinic. I also illustrate how, through participant observation, such knowledge became accessible:

> "A ward for geriatric psychiatry figures as one of the 'toughest' among nurses—there, the lack of time and staff seems to be the most alarming, which has led many nurses to quit their jobs recently. Ironically, as soon as one enters it, the ward radiates its precarity not only through a lack of time and staff but also through its materiality: the sitting chairs in the ward have begun falling apart but have not been replaced due to financial cuts by the management. Visiting the ward leaves me with a vague uneasiness and an impression of precarity" (Fieldnotes, August 26, 2022). [22]

By this observation from the geriatric ward, I point out the significance of infrastructure in psychiatric care and its power to create clinical atmospheres (KEHR & CHABROL, 2020, p.4) by bringing together materiality, sensory experiences, and ruling relations. In this case, austerity measures were directly reflected in the institution's furniture, which, in turn, co-created affective atmospheres that escaped hegemonic definitions of "care" while simultaneously reflecting neoliberal managerial systems of psychiatric delivery (O'LOUGHLIN, 2020). By this non-innocent view of institutional care as a matter of infrastructure, I question a uniform picture of "the" clinic as a singular architectural or atmospheric entity. Instead, I characterize the institution as a multiplicity that contains manifold, ever-changing possibilities of human-nonhuman interactions, ranging from healing places (GESLER, 2003) to sites of social violence (O'LOUGHLIN, 2020, p.4) and austerity that manifested through a ward's furniture. [23]

In other cases, service users described their experiences explicitly in atmospheric terms, such as Helen, whom I met when she stayed in both Wards 1 and 2. When we first met, Helen had been involuntarily placed in an "observation room" in Ward 1 and was under constant surveillance by the nurses. The ward's architecture was sober and austere, and the corridor was crowded—over twenty acutely ill service users were cared for by only a handful of nurses. When I entered Helen's room accompanied by a doctor, I noticed a stark contrast

between the tense atmosphere of the ward and the opulent decoration of her room. She had put countless stuffed animals and pink decorations on her bed and desk, which created an air of surrealness in this place of intense suffering and its ethically charged nexus between care and constraint. When I met Helen again later in the quieter Ward 2, I asked her how she had perceived her stay in the two wards so far. With eyes wide with both surprise and dread, she answered:

> "Nobody has ever asked me how I felt back then [in Ward 1]. What I can tell you is that it was traumatic for me: I had no idea what staying in a psychiatric clinic really meant until I arrived in this rough place, where I was instantly treated with coercive measures. The atmosphere in Ward 1 does not allow you to recover—it's hectic, the nurses don't have time for you, and the other patients are very ill. You'll hear them screaming all the time. I was put in the monitoring room. At least this was a single room, but I was constantly observed by the nurses through a window that went directly to the nurse's office. I wasn't allowed to do anything alone, not even go to the toilet, which, when I arrived, was a complete mess. When I was at last transferred to this ward (Ward 2), I finally entered a place that allowed me to heal. Everything feels quieter and more structured here, not like a psychiatric clinic but rather like a hotel. I would not have expected how much this atmosphere would make a difference to me. And here, I can move and decide more freely what I want to do, which, ultimately, I'll have to manage as well when I return back home. After I had been transferred here (Ward 2), for a long time, I could not even stand to look at the building of Ward 1 because of the traumatic memories I connected to the atmosphere there" (Fieldnotes, September 26, 2022). [24]

Helen ascribed experiences of care and violence to factors beyond social interactions or the interior domains of her psyche. Contrary to some psychiatrists' narratives that placed the service users' "interior" minds at the center of caretaking, for Helen, experiences of care and violence were an all-encompassing, "atmospheric" matter while she navigated the "extraordinary" (JENKINS, 2015) everydayness of being hospitalized against her will. Her ambivalent experiences of the two wards partly related back to the concept of the hospital multiple. For instance, Helen connected interior states and memories to spatial, sensory, and material aspects of the clinic, repeatedly using the term "atmosphere" when attempting to put her harmful and healing experiences into words. The contrast between her disturbing experience of Ward 1 and the countless decorations she had in her room exemplifies that experiential atmospheres are not all-encompassing or static but are rather subject to service users' attempts at subversion in sometimes unexpected ways (SUMARTOJO & PINK, 2019, p.127). Helen's memories and associations tied to the nonhuman aspects of the wards—the architecture of her room, the toilets, the soundscapes—were strongly influenced by her subjective trajectory through affliction, involuntary hospitalization, and recovery. Based on these observations, I argue that the hospital multiple has no stable or objective meaning; instead, it varies in its significance depending on the ruling relations involved and individuals' subjective experiences of them. [25]

While there exists a vast, interdisciplinary body of literature on spatial and experiential atmospheres (ANDERSON, 2009; BÖHME, 2017 [2006]; HASSE, 2008; MOOS, 1974; RAUH, 2012; REES, 2013; THIBAUD, 2015), these concepts have only recently been integrated into ethnographic explorations of psychiatric clinics (DUFF, 2016; SUMARTOJO, PINK, DUQUE & VAUGHAN, 2020) in anthropology and neighboring disciplines (BILLE, BJERREGAARD & SØRENSEN, 2015; EDENSOR & SUMARTOJO, 2015; STEWART, 2011; SUMARTOJO & PINK, 2019). SUMARTOJO and PINK's (2019, p.30) definition of atmospheres resonates with the focus on situated, embodied knowledge that characterizes institutional ethnography:

> "Atmosphere does not so much reside in place as emerge from our ongoing encounters with it, opening up potential as we feel our way through the world, a process animated by affect (but not completely defined by it), a 'spatially extended quality of feeling' (Böhme, 1993, pp.117-118) ... Accordingly, we argue that atmosphere must be thought of as pulling together affect with sensation, materiality, memory, and meaning." [26]

Contrasting with definitions of the atmospheric from affect studies, in this anthropological approach, atmospheres are not treated as an abstract agency independent of human subjectivity. Rather, the atmospheric captures an emergent, ever-shifting configuration that is firmly rooted in materiality, the senses, and the nonhuman (pp.17-18). Indeed, atmospheres can incite feelings of both belonging and exclusion (p.121). By thinking within and about atmospheres, researchers can uncover largely invisible dimensions of how affective atmospheres of care and violence are co-created through the material world. [27]

Helen's narrative about how she perceived Wards 1 and 2 through her "sensory scope" (SMITH & GRIFFITH, 2022, p.7) presents a deeply ambivalent and multifaceted picture of how "care" can be experienced by a single person in a clinical setting. This insight resonates with DUCLOS and CRIADO's (2020, pp.153-154) call for more "troubling" approaches within the analytics of care in medical anthropology, wherein they honored the ambivalences and complexities of care—including its nonhuman elements. Their approach mapped "the many intersections and frictions between the *enveloping* and the *diverging*, the *protecting* and the *containing*, the *enduring* and the *engendering*, as they play out in care practices" (p.155). DUCLOS and CRIADO framed their concept of care "from below" as an "ecology of support" (ibid.), which, I argue, bridges critical care studies with the hospital multiple. By envisioning care as an ambivalent and situated matter rather than a smooth interaction, researchers acknowledge that sites of care can readily morph into places of containment and exclusion (see, e.g., BRODWIN & VELPRY, 2014; FOUCAULT, 1988 [1961]; GOFFMAN, 1961). [28]

Through the following vignette, I explore how ethnographies of atmospheres contribute to analyses of "embodied knowledge" in the field (SMITH, 2005, p.24). Thereby, I demonstrate how walking interviews are an especially promising method for exploring embodied experience within the hospital multiple. [29]

4.1 Discovering the unexpected through institutional ethnography

By doing atmospheric and institutional ethnographies, researchers are enabled to learn *from* other people by closely engaging with what these individuals actually do and experience in the intimate contexts of their daily lives (PINK, 2009, p.5; SMITH & GRIFFITH, 2022, p.15). In both research paradigms, researchers emphasize the non-reducibility of the particular and reject its generalization. SMITH and GRIFFITH (2022, p.xiv) used the notion of the *particular* to describe how, within the framework of institutional ethnography, "the social" is envisioned as a lived, temporally and spatially situated process that cannot be generalized in terms of "meanings" or "norms." Ethnographies of atmospheres resonate with this claim, as they focus on *encounters* as key empirical moments in the field. By focusing on encounters, researchers highlight the particular interplay between places, feelings, people, sensations, memories, and things when they condense into what we call "experience" (SUMARTOJO & PINK, 2019, pp.39-40). [30]

Interviews are encounters in the field that offer multisensory, embodied insights. Open, structured, and semi-structured interviews represent more than a discursive-textual set of "data"; they are also carriers of sensory knowledge about the hospital multiple. Interviews are processual "place events" during which experiential, emotional, verbal, sensory, and social aspects of the field surface and offer valuable ethnographic material (see also IRVING, 2011; PINK, 2009, p.93). [31]

Below, I discuss a walking interview that served as a key moment in understanding how a service user's experience was co-created by the nonhuman environment. We follow one of my many encounters with Claire, a service user with whom I collaborated during her inpatient stay. By doing interviews with her, I was provided with fresh, surprising perspectives on how care and its absence could be grasped otherwise in institutional contexts. To put it in SMITH's terms, by following Claire's accounts, I was enabled to question the objectification of ruling relations and institutional discourses, which offered me a "way back to the actualities that are always there, always going on, and always ultimately more than can be spoken" (2005, p.123). The excerpt below stems from a walking interview during which we captured our conversation on a recording device. Additionally, either Claire or I took pictures of the places that provoked memories, reveries, and associations in her:

> "Claire, who invited me for a tour of her 'favorite beaten paths around here,' seems familiar with every inch of the clinical premises. As we cross the buildings where the emergency reception and the closed acute wards were placed, memories of her initial hospitalization resurface. She points at objects and buildings, and as we take pictures of them, she recalls past experiences: 'When I saw that fantastic artwork while we were approaching the emergency reception of the clinic, I knew—this place is right for me to recover. Do you see that building where, on the second floor, a roller blind is broken? There, I was first put in a closed ward, which was terrible. But look, somebody has dried some flowers and hung them out the window. What a good thing to do! You can be creative, even while being locked in; you have the liberty to write!

> You can craft!' As we cross a raven sitting on the grass, she stops. 'This is Gregg, my favorite animal therapist. During the last weeks, I went out and talked to him a lot. We perfectly understand each other. I don't need art- and horse therapists and stuff like that here—I just go outside and meet the animals on my own terms'. We then bump into one of her friends who she had met in another ward. He is sitting on 'their' park bench, where they meet regularly" (Fieldnotes, August 17, 2022). [32]

There are two points in particular that I wish to emphasize from Claire's account here. First, it demonstrated how, from her perspective, moving through the hospital multiple allowed her to recollect *and* narratively transmit what she had experienced thus far. Though I had previously conducted sedentary interviews with Claire, during the walking interview, she recalled previously untold experiences of violence and care. It was as if Claire had retrieved forgotten memories by walking through the atmospheric materiality of the clinic. Second, the interview provided a practical example of how vital it is for ethnographers of psychiatric care to integrate the nonhuman, drawing together people, practices, material, and cultural environments (see also ANSDELL & DeNORA, 2012, §107). [33]

During the walk with Claire, she directed my attention towards things beyond what I had considered as part of the "institution" so far—a raven on the lawn, dried flowers hanging from a windowsill, the stylistic details of an artwork near the emergency reception. I realized that from her perspective, such nonhuman aspects were as important as humans in shaping how she experienced and navigated ruling relations—bearing in mind SMITH's (2005, p.225) observation that the scope of the "institution" encompasses both physical matters on site as well as the related complexes embedded in ruling relations that are focused on this distinctive aim. As Claire introduced me to her nonhuman "animal therapist," the raven, whom she considered a viable alternative to the therapeutic regime within the ward, she granted me access to her subjective experiences of how the nonhuman, affliction, and recovery were connected. The entire walk, full of tales and surprising insights, made it seem as if Claire had appropriated and redefined the materiality of the clinic in her own terms. Giving feedback on our interview, Claire remarked that it had felt liberating for her to show me around and tell me about all the things "nobody had asked her before"—that is, her subjective experience of the stay in the clinic as such. [34]

Doing institutional ethnographies can be political in the sense that researchers can address the experiences of "ethical loneliness" (O'LOUGHLIN, 2020) which psychiatric ruling relations frequently produce in service users. During ethnographic interviews, individuals are invited to relate their experiences to a listener who does not instantly interpret them in medical, therapeutic, or pathologizing terms. Additionally, tracing experiential atmospheres is in itself a political act because thinking through and researching institutions atmospherically allows for the unexpected to surface and can open up routes towards future change (SUMARTOJO & PINK, 2019, p.123). Institutional ethnographers can draw from the methodological toolkit of sensory anthropologies of atmospheres to

gain valuable insights into the embodied lifeworlds of marginalized individuals (BISAILLON, 2022, p.19). [35]

In a closing reflection, I discuss how walking interviews—complemented, in this case, by audiovisual methods—offer psychiatric ethnographers specific insights into the interconnectedness between interlocutors' experiences and nonhuman institutional environments. [36]

4.2 Moving methods

While an in-depth discussion regarding the methodological challenges and demands of organizational research around aesthetics and the senses is beyond the scope of this article (for an overview, see, e.g., WARREN, 2008), I focus here on some of the epistemological advantages behind "moving." Multimodal ethnographic research methods (see also DICKS, SOYINKA & COFFEY, 2006). SUMARTOJO and PINK (2019, p.77) stressed that if ethnographers wanted to focus on experiential atmospheres, they must *move* alongside and in concert with interlocutors through such environments. [37]

In the field of medical anthropology, IRVING (2011) experimented with moving methods and attempted to trace the ever-elusive dimensions of interlocutors' inner worlds, and contextualized these within the environments through which they moved. IRVING (p.24) combined in his collaborative methodology walking, narration, and photography, wherein interlocutors were asked to walk around their neighborhoods and narrate their memories and thoughts about past events into a voice recorder while another person accompanied them. The companions asked questions, interjected with other queries, and took pictures of the places that elicited memories and interior dialogues. Thereby, interlocutors were encouraged to verbalize interior experiences and dialogues that would otherwise not have been voiced and shared with others (p.27). Through this method, IRVING bridged the divide between the inner and outer worlds, thereby allowing ethnographers to envision a "new relationship between people, their bodies, and their surroundings" (ibid.). Despite the importance of inner voice and dialogue to people's social lives, IRVING argued that there was a lack of applicable ethnographic methods for "[...]turn[ing] the problem of interiority into an ethnographic practice-based question to be addressed creatively and collaboratively with informants in the field" (p.23). Inspired by IRVING, I used collaborative moving methodologies as a means to explore the fleeting, often-contradictory, experiences that unfolded between ruling relations, the materiality of clinical spaces, and interlocutors' embodied experience. [38]

I adopted these moving methodologies within my own research to explore the atmospheric properties of different institutional spaces. During my fieldwork, I noticed that the facets of my interlocutors' personalities they revealed to me varied significantly depending on the institutional space in which we interacted. I discuss this observation in greater detail elsewhere (HÄNNI, 2025/Forthcoming), but it is worth noting here that this provided me with insights into how institutional power structures were spatially distributed. In addition to more structuralist or

historical explorations of how power structures influence subjectivity within psychiatric clinics (see, for example, FOUCAULT, 1988 [1961]; GOFFMAN, 1961), institutional ethnographies of the hospital multiple are inherently premised on the embodied experiences of those who participate in the daily life of institutions. [39]

By using moving, collaborative methods, researchers follow PUIG DE LA BELLACASA's (2012, p.204) call for non-idealizing and non-anthropocentric research on care, foregrounding aspects that "[exceed] the frame" of conventional perceptions of care by integrating the contradictory and the ambiguous (PUIG DE LA BELLACASA, 2017, p.55). She grasped the importance of materiality and other nonhuman aspects during caring interactions by her notion *matters of care*—a feminist concept of care which literally integrated "matter" into the scope of human interaction. Such an approach is especially suited for exploring why so many service users experience therapeutic landscapes within inpatient psychiatric care as ambivalent, contested spaces (GESLER & CURTIS, 2007). Thus, new perspectives emerge regarding the power imbalances inherent in caring relations which render caregivers susceptible to exerting control (PUIG DE LA BELLACASA, 2017, p.1). Institutional ethnographers can *reclaim care* by listening to neglected things that speak from below and by focusing on grounded, situated practical engagements (p.11). [40]

The encounters I discussed in the vignettes above allowed me to question my own susceptibility to "institutional capture"– a mechanism in which researchers and interlocutors alike tend to "subsume or displace description[s] based in experience" through institutional discourses (SMITH, 2005, p.225). All interlocutors shared with me their unique experiences of (human-nonhuman) configurations of care and constraint, which in some cases differed significantly from the institutionalized definitions and discourses I had come to know (*HÄNNI, 2023, 2025/Forthcoming)*. Coercive measures, such as Helen's forced hospitalization in an acute ward I discussed above, were some of the most prominent examples, wherein service users experienced institutionally legitimized ways of caretaking ambivalently or even as violent or transgressive. In other cases, service users considered interactions as caring that were not considered as such in clinical policies. For instance, Claire's relationship with an animal and an artwork on clinical grounds was such a key moment that inspired me to focus on human-nonhuman interactions in order to access experiences beyond the objectifying discourses of ruling relations (SMITH, 2005, p.28). [41]

5. Conclusion

Inspired by KEHR and CHABROL's exploration of the hospital multiple (2020), I outlined practical ways in which institutional ethnographers can research human-nonhuman interactions in psychiatric care. Drawing on vignettes from my ethnographic research in Switzerland, I examined how interlocutors' subjective experiences and my observations through participant observation were co-constituted by the nonhuman. I drew on the methods of institutional and sensory ethnography to discuss invisible aspects of people's lived experiences of care-receiving, caregiving, and violence. I also demonstrated how researchers can be inspired by combining anthropologies of the hospital multiple and institutional ethnography (SMITH, 2005), and discussed methods that allow researchers to trace "experiences" within institutions as matters of care (PUIG DE LA BELLACASA, 2011, 2017). Through these explorations, I argued that institutional ethnographies of the hospital multiple carry significant analytic potential by drawing on the embodied knowledge of interlocutors who are most prone to experiencing violence and marginalization. For instance, I explored how sensory ethnographies of experiential atmospheres can be applied within institutional ethnography. Finally, I highlighted the importance of moving interviews (IRVING, 2011) for exploring the interconnection between inner experience and sensory context within healthcare settings. [42]

I close by arguing that it is an ethical necessity for institutional ethnographers to address the ambivalences of inpatient psychiatric care—not only as a structural or subjective matter of the brain but also in its nonhuman, material aspects. I suggest that sensory institutional ethnographies are an immensely fruitful avenue for exploring how larger power structures, ethics and aesthetics intertwine within healthcare. Explorations of the hospital multiple through institutional ethnography are an opportunity to contribute holistic, humanistic perspectives to research in psychiatric care, thereby answering FUCHS' (2023) call for a more relational, "ecological paradigm" in psychiatry. This means that suffering, as well as caregiving can be explored by ethnographic research methods that direct researchers' focus on the social, emotional and sensory dimensions of suffering and recovery. Thus, an additional perspective to evidence-based research can be provided that includes human cultural interaction (ANSDELL & DeNORA, 2012, §104) and nonhuman aspects such as spatiality and materiality. While there is much research to be done in this direction, it comes with the exciting potential to "disrupt destructive dynamics of scientific knowledge that separates brain and hand, intellect and practice, from the 'heart'" (PUIG DE LA BELLACASA, 2017, p.15). [43]

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